The Golden Triangle of Midlevel Practitioner Credentialing Insurance, Risk Management and Law

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The Golden Triangle of Mid-Level Practitioner Credentialing: Insurance, Risk Management and Law

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Disclosure

This seminar is for general informational purposes only and does not constitute and is not intended to take the place of legal or risk management advice. Parties should contact their own counsel for any such advice.

Objectives

• Identify liability risks associated with emerging mid-level care provider credentialing practices.

• List insurance issues associated with evolving mid-level care provider credentialing practices.

• Identify practical approaches to address mid-level care providers credentialing risk management issues.
What’s in a Name?

In the US, “midlevels” are generally:

- Advanced Practice Registered Nurses (APRN)
- Physician Assistants (PA)

“CMS uses term "non-physician practitioner" (NPP)

“DEA uses term “clinicians, other than a MD, dentist, vet, Podiatrist”

What’s Different in 2014?

- “ACA”…of course
- State APRN laws
  - ‘Assistant Physician’ Role - Missouri
- Expanding practice settings
- Employment models
- “The Database” changes
- ACOs/credentialing
- Medical staff status changes & Medical / Nursing leadership responsibilities
- ICD -10 is coming!

AANP Practice Map

- Green = (20) Full Practice: State practice and licensure laws provide for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, institute and manage treatments —including prescription medications — under the exclusive licensing authority of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Boards of Nursing.
- Yellow = (17) Reduced Practice: State practice and licensure law reduce the ability of nurse practitioners to engage in at least one element of NP practice. State requires a regulated collaborative agreement with an outside health discipline in order for the NP to provide patient care.
- Red = (13) Restricted Practice: State practice and licensure law restricts the ability of nurse practitioners to engage in at least one element of NP practice. State requires supervision, delegation or team-managed by an outside health discipline in order for the NP to provide patient care.

Hello, My name is...
Mid-level Credentialing Practice Models

- Contractor
- Collaborative credentialing
- Employment-credentialing connection
- MSS
- Employed
- Staffing Agency

Liability Risks With Mid-level Credentialing Practices

- Licensure laws/regs – keeping updated!
- Institutional policies/Bylaws
- Hiring/credentialing practices
- Supervision/collaboration requirements
- MDs, other providers & patients understanding & acceptance
- OPPE/FPPE
- Medical staff status/Med & Nsg leadership responsibilities
- Accreditation standards-due process and peer review
- Fines/penalties/Licensure action/Restriction DEA

Midlevel Risk & Liability Exposures

- Billing/Coding
- Prescribing
- PL coverage requirements/limits
- Medical staff status/Med & Nsg leadership responsibilities
- Accreditation standards-due process and peer review
- Fines/penalties/Licensure action/Restriction DEA
Midlevel Theories of Liability

- Negligent Credentialing
- Agency theory /credentialing liability
- Corporate Negligence
- Enterprise Liability
- Economic credentialing
- Wrongful termination

In other words...

Insurance and Mid-level Provider Credentialing
Mid-Level Risk Analysis

- What are our RISKS with Mid-Levels?
- Do we understand these RISKS?
- Do we have the capacity to retain identify, retain and control the risk?
- Captives, RRGs, other self-insurance vehicles
- Do we need to transfer the risk?
- Monitoring RISK across the the New continuum - Futurecast

Mid-Levels as the “new” Care Integrator

Yep- The Landscape is Changing

- Currently about 85K certified PAs in US, up > 100% in past 10 years (per AAPA).
- PAs can prescribe in 50 states; must work under MD supervision.
- Currently about 155K APRNs; up from 111K (2003), per AANP. Vast majority work in primary care, clinics & hosps under MD supervision.
- In 18 states/DC, NPs can practice without a MD direct involvement but may need a formal collaborative arrangement with a doctor.
Food for Thought...

- Some experts say that midlevel providers lower malpractice risk because they spend more time with patients, especially on follow-up, and score higher in patient satisfaction ratings.
- "We often see claims because patients are dismissed too quickly, before their questions can be answered," said Robin Diamond. "NPs and PAs do spend more time with patients. When they are appropriately supervised, that helps build relationships and lowers liability risk."
- On the other hand, some attorneys and physicians argue that midlevels don’t have the same extensive training as physicians and often practice beyond their areas of expertise. "Whenever a midlevel is sued, you can be sure that the supervising physician will be sued as well."
- "Courts have held that the midlevel is an agent of the physician, who can be held vicariously liable for negligence even if he never saw the patient." Physicians don’t realize the extent of supervision necessary to keep the liability risk low.

What are the Risks?

Taking Control – Risk Mitigation
The “Insurance” Conundrum – the Perfect Storm

**Coverages**

- Professional Liability, Medical Malpractice Exposures including vicarious liability
- Directors and Officers (Management Risk)
- Managed Care Errors and Omissions (Back to the Future, acting like a HMO, with Mid-Levels offering care)
- Provider Excess, Catastrophic Medical Reinsurance (Excess of Medical Loss protection – Mid-Levels at Risk)
- Regulatory Coverage (Fraud and Abuse)
- Punitive Damage Protection

The Case Study...

Practical Approaches to Address Mid-Level Care Provider Credentialing Management Issues
Do a Systems Check

- Applicable State & Federal Law Governing Mid-Level Providers
- Applicable Legal Requirements for Credentialing
- Relevant Accreditation Standards for Mid-Level Providers

Complete a Gap Analysis

<table>
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<tr>
<th>Item</th>
<th>Gap No</th>
<th>Gap Yes</th>
<th>Explanation</th>
<th>Recommended Change</th>
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</thead>
</table>

Look for compliance with required mid-level provider credentialing requirements.

More on Gap Analysis

- **Identify** Areas for Improvement
- **Develop** Action Plan to Address Mid-Level Provider Credentialing Gaps
**All Hands on Deck**

**Alignment!!!**
- Governing Body
- Elected Medical Leadership
- Clinical Leadership
- Medical Executive Committee
- Medical Staff
- Mid-Level Providers
- HR

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**Education - I**

- Risk Management
- Quality
- Patient Safety
- Human Resources

ALL in the context of MSP Education and Credentialing Mid-Level Providers

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**Education - II**

- Role
- Responsibility
- Communication
- Documentation
- Trouble-shooting

- Governing Body
- Elected Medical Leadership
- Clinical Leadership
- Department Heads
- Credentials Committee
- Medical Executive Committee
- Medical Staff
- Mid-Level Providers
- Medical Staff Services
- HR
Manage Key Relationships

- Recruiters
- Staffing Agency
- Human Resources Administration
- Getting information
- Providing information
- Timeliness of data
- Accuracy of data

The Contract in Credentialing

Deliverables
- Timeliness
- Accurate Information
- Performance Data
- Liability

- Recruiting firms
- Staffing Agency
- Independent contractors
- Employed care providers

- DNP
- NP
- PA
- CNS

The MSP RM Process Tools

Q1 The entity is:
- a tertiary, acute care hospital
- a community hospital
- a critical access hospital
- an ambulatory surgery center
- a behavioral health treatment setting
- a diagnostic imaging center
- a chemical dependency treatment setting
- a rehabilitation setting
- a long term acute care
- a physician practice
- a contracted physician service provider
- a federally qualified health center
- a telehealth provider

Key RM Indicators
- Incomplete files
- Inaccurate files
- Inconsistencies-HR information
- Inconsistencies-recruiter data
- Background check issues
- Reference woes
- Liability insurance questions
- Other
RM Process Tools-Cont’d

Sample: Communication Matrix – MSP Mid-Level Matters

<table>
<thead>
<tr>
<th>Request of</th>
<th>Request from</th>
<th>Authorization Level</th>
<th>When Needed</th>
<th>Management of Issue</th>
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Non-Hospital Case Example

• Free-standing birthing center with a medical “supervisor” who never reads the patient records. Takes verbal reports from NPs and CNMs.

• Woman expecting third child, had two prior C-Sections. Now wants a vaginal birth.

• MD takes verbal report on patient “request” for vaginal birth. Tells CNM patient needs to be “counseled.”

Case Continued

• Patient never counseled. Presents in active labor to the birthing center. Per policy & procedure, the on-call OB provider comes to the birthing center.

• OB provider reads the patient record. Learns that patient has not been counseled.

• OB provider discusses patient wishes—learns decision was based on misinformation.
Case Conclusion

- Once “informed,” the patient agrees to another C-Section.
- As she is being readied for the C-Section, she experiences a uterine rupture.
- Bad outcome.

Birthing Centers need credentialing & delineation of privileges

How credentialing could have helped to avert the bad outcome

Conclusions

- Explosion in utilization of Mid-Levels is not a fad.
- Do we need a new definition of “medical professional services” – Insurance speak!
- Different models will continue to evolve and Mid-Levels care key to network design and care management
- Credentialing care providers will involve more than quality – what is the Mid-Level Value Proposition
- Integrity and economic credentialing will be part of the picture.
- Follow an ERM approach for ‘Mid-Level’ credentialing and risk retention or transfer models.
Risk Manage Credentialing

• **Work it out:** HR, MSP, Medical Staff and other key stakeholders.
• Develop a practical, legally acceptable solution.

Process watched to ongoing legal-regulatory changes for mid-level providers.

Do Mid-Level Credentialing

Leverage the value of contracting with HCOs and with mid-level providers in credentialing.

Keep pace with changes in insurance coverages for mid-level providers that are important information used in the credentialing process.

Your Turn

Questions Anyone?

Thank You!
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<th>Request from</th>
<th>Authorization Level</th>
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**Communication Matrix Tool**
Critical Communication with Nurse-Midwives

There is an old saying that states “it is not only what one says, but how one says it that is important.” The phrase proved quite correct in a case from the District of Columbia Court of Appeals involving a VBAC patient.1

The case is filled with facts, issues of contract, scope of practice considerations, the role of a medical consultant vis-à-vis nurse midwives. Add to it issues of informed consent and cultural differences, and the stage is set for a major decision rigorously challenged by a dissenting jurist.

Important lessons can be learned from the case, particularly those involving communication between physicians and nurse-midwives.

The District of Columbia Case.

During her previous two pregnancies, Mrs. A-H. had undergone successful cesarean section deliveries. Now pregnant with her third child, she decided to seek prenatal care from DCBC, a birth center. Mrs. A-H. understood that her care would be provided by nurse-midwives.2

The birth center had a process in place whereby some patients would undergo a hospital-based delivery. This process was used for those patients for whom a birth center delivery was considered inappropriate. For patients who wanted to attempt a VBAC, the delivery would take place at WHC, a hospital. Such patients would be assisted by nurse midwives from the DCBC.3
DCBC had a Memorandum of Agreement (MOU) with Dr. M.M. who was the Chief of Obstetrics and Gynecology at WHC. He also served as the medical director at DCBC, and, under a separate MOU, Dr. M.M. also served as a consulting obstetrician for DCBC. In this latter capacity, Dr. M.M. evaluated patient records and accepted “...the transfer and medical management of patients who developed complications.” If a patient developed a complication requiring medical management, DCBC clients could select their own physician or use the DBC consultant or his designee.

Mrs. A-H. wanted to try a vaginal birth for her third pregnancy. Approximately six months after she started receiving prenatal care at DCBC, Nurse-Midwife A. completed a routine chart review of her file with Dr. M.M. He did not read Mrs. A-H.’s record. Instead, Nurse-Midwife A. reviewed the patient’s record and abstracted pertinent information to a form that she used to present to Dr. M.M. She also told the doctor that Mrs. A-H. wanted to have a vaginal birth. Dr. M.. was concerned about the increased risks of a VBAC with a patient who had a history of two prior cesarean sections. He told the nurse-midwife that he “…wanted us to be sure to reiterate the risk to the patient and asked if she had been properly consented and we do so again.”

On the abstracted information form which was inserted into the patient’s record Dr. M.M. wrote:

"P @ 35/7 weeks gestation. H/O c/s x 2. Pt. Desires VBAC. Pt. understand [sic] that the risk of VBAC after two cesarean section [sic] is much higher for uterine rupture - fetal death and risk for having increased morbidity for herself. Needs prophylactic antibiotics in labor."

The evidence presented indicated that subsequent to the chart review with Dr. M.M., none of the nurse-midwives reiterated with Mrs. A-H. the risks of the VBAC procedure after two prior cesarean sections. Further, Dr. M.M. was not apprised of any updates about Mrs. A-H. and he made no inquiries himself. Not only did the patient not know of the existence of Dr. M.M., Mrs. A-H. did not know that her care had been discussed with any care provider other than the nurse mid-wives at DCBC.

In April 2005, Mrs. A-H. thought that she was in labor and went to WHC for care. Following some period of monitoring she was discharged only to return to WHC that night. At the time of the second trip to WHC, Mrs. A-H. was placed in the care of nurse-midwife M.R.
In accordance with standard procedure, Nurse-Midwife M.R. notified the back-up obstetrician, Dr. V.L. that one of the DCBC patients was in labor. The nurse-midwife reviewed the patient’s medical history with the physician. The doctor was concerned about the delivery plan and she decided to discuss the situation with Mrs. A-H. She told the patient about the risks involved in attempting a VBAC and encouraged her to undergo a cesarean section. The patient gave her consent to the cesarean section and hospital personnel began the process of preparing her for the procedure.10

During this timeframe, the baby’s heart rate began to rise and then staff had difficulty obtaining the fetal heartbeat. Surgery was started and when Dr. V.L. entered the abdomen and visualized the uterus it was evident that Mrs. A-H. had experienced a uterine rupture. The baby was delivered through the rupture in the uterus. In the claim filed in the case the plaintiffs argued that the baby sustained brain damage and other injuries.11

In September 2005, the plaintiffs sued DCBC, Dr. M.M. and WHC for negligence. In response, Dr. M.M. and WHC filed a motion for summary judgment asserting that the physician did not owe a duty of care to Mrs. A-H. The plaintiff responded, arguing that Dr. M.M. had collaborated in the development of and the approval of a care plan involving an attempted VBAC delivery.12

The trial court granted the motion for summary judgment. The court based its decision on several considerations including:

- Dr. M.M. never met the patient;
- The patient did not know of Dr. M.M.;
- The doctor only commented on the patient’s care one time;
- The nurse-midwives were qualified to “exercise independent judgment;”13 and,
- The doctor was not paid to review the patient’s chart.14

The trial court also took account of applicable public policy. As the court said:

“Imposing liability on a consulting physician under these circumstances would discourage consultation between health care providers. Here, the District has seen fit under its regulations to allow nurse-midwives to provide standard primary care for pregnant women, without the aid of a doctor. Encouraging the nurse-midwives to consult with obstetrics professionals is in the public interest. Conversely, extending liability to such consultations, without more, contradicts that interest.”15
Following the summary judgment, the plaintiffs entered into a settlement with DCBC. An appeal followed to the District of Columbia Court of Appeals.16

Like other appellate courts reviewing a grant of summary judgment, the court looked at the facts presented “de novo,” analyzing “…the record in the light most favorable to the non-moving party, drawing all reasonable inferences from the evidence” in favor of the non-moving party.”17 To defeat a motion for summary judgment, the plaintiff must present

“a prima facie case establishing the applicable standard of care, showing that the standards of care has been violated and demonstrating a causal connection between the violation and the damage suffered.”18

The appellate court noted that the statutes and regulations in the District of Columbia granted nurse-midwives a broad scope of practice:

"[W]hen functioning within the authorized scope of practice," certified nurse-midwives "are qualified to assume primary responsibility for the care of their patients through ‘the use of independent judgment as well as collaborative interaction with physicians or osteopaths.’”19

The scope of practice set forth in the regulation encompassed caring for the normal obstetric patient. Managing the normal obstetric patient through labor and delivery included amniotomy, episiotomy, and repair.20 However, it did not include performing a cesarean section or a surgical abortion.21

In this case, Nurse-Midwife A. as the treating care provider never asked Dr. M.M. to assume responsibility for any part of the treatment of Mrs. A-H. Further, Nurse-Midwife A. never told the patient that she had consulted with a physician about her care plan. For the appellate court the situation did not involve a “traditional physician-patient relationship” such that it could have created a duty to intervene on the part of Dr. M.M.22

The appellate court went further, finding that Dr. M.M. did not “acquire a duty to order a pre-labor cesarean section”23 or to counsel the patient based on his relationship with DCBC or because of the chart review.24

For the court the legal agreements between Dr. M.M. and DCBC did not create a duty of care for the physician to “intervene without request in the care and treatment of DCBC patients.”25 The court did acknowledge that
some courts had ruled that even absent a formal arrangement, “the fact that consultation has occurred may create a duty to the patient.”26

The appellate court disagreed with the rulings of these other courts, ruling that Dr. M.M. did not have a duty to intervene. Instead, Dr. M.M. was characterized as a “peer” of Nurse-Midwife A. The court stated:

“While it is true that, as between Dr. [MM.] and Nurse-Midwife [A], only the doctor was qualified to perform a cesarean section, she was no less qualified than he to speak with the patient and arrange for the surgery. Nor was Dr. [M.M.] uniquely competent to discuss the risks of a VBAC with Mrs.[A-H]. He was entitled to rely upon Nurse-Midwife [A] discuss those risks with her own patient.”27

Here the facts suggested that Dr. M.M. had advised Nurse-Midwife A. to reiterate to the patient the risks associated with attempting a VBAC following two cesarean sections. As the court observed:

“The DCBC nurse-midwives were fully competent to discuss these risks with Mrs. [A-H] and to convince her that a third cesarean section was necessary. This was not an emergency situation – at 35-37 weeks of gestation, Mrs. [A-H] was not due for another few weeks. There was ample time for Nurse-Midwife [A] or one of her colleagues to approach Mrs. [A-H], to discuss the risks, and to seek additional help if she was unable to convince the patient to undergo a cesarean section. Dr. [M.M] did not have a duty to monitor the situation to make sure Nurse-Midwife [A] fulfilled her obligation to Mrs. [A-H].”28

Based on its review of the case, the court affirmed the trial court ruling and affirmed the grant of summary judgment for the defense.29

Observations on the District of Columbia Case.

The court’s ruling was the subject of a strong dissent. Taking the position that Dr. M.M. was not a “peer” of the nurse-midwife, the dissenting opinion noted that the MOU between WHC and DCBC placed the nurse-midwife in a subordinate role and under medical direction when, as here, a complication took place.30

The dissent went further pointing out that in his own handwritten entry on the form, Dr. M.M. did not mention that the patient should have a repeat cesarean section and he did not write down the request that he claimed he made to the nurse-midwife o impress upon the patient the
risks of attempting a VBAC. Adding additional emphasis on this point, the dissenting judge referred to testimony given by Nurse-Midwife A. that if Dr. M.M. had strongly recommended a cesarean section for Mrs. A-H., she would have written it in her note on the patient’s record. However, no such note was made in the record.31

Although the dissenting judge did not say so explicitly, he suggested that the failure to reiterate risk factors with the patient let her slip through the crack between Dr. M.M and Nurse-Wife A.

Critical communications between physicians and nurse-midwives can help prevent untoward outcomes. However, when critical conversations do not take place or the communication is less than clear, the outcomes can be poor. That no one documents such critical conversations can lead to tragic results.

Policy, procedure, process and MOUs should not create expedients that short-change quality patient care. Abstracting medical records, and reading “highlights” to a doctor is a step that could lead to misunderstanding. In some instances it could lead to less emphasis being placed on what is considered medically necessary measures in a care plan.

Physicians may argue that they do not have the time to read a record when fulfilling a medical director position. However, when it comes to defending a lawsuit, those physicians will have to find the time to participate in litigation. Perhaps a good lesson learned from the case is to rethink the way external medical directors function in a birth center environment of care.

The District of Columbia case is less about scope of practice than it is the very practical nature of care provider-to-care provider communication. It is also a case that reinforces the importance of clear, understandable communication with a patient for whom there may be possible cultural issues that did not get full consideration by care providers.

In this case the discussion about VBAC took place early on during the pregnancy. The patient signed a consent form at that time. However, the facts of the case suggest that the patient did not fully appreciate the risk of uterine rupture. Only when Dr. L. discussed it with her the patient’s pressing concern became apparent: a fear that a cesarean section might result in injury to her bladder. It was after Dr. L. assured her that her bladder would be protected that Mrs. A-H. agreed to the cesarean section.32
Perhaps the most important point is this one made by the dissenting judge:

“Such advice, had it been given timely, likely would have averted the tragedy in this case. A pregnant woman’s legal autonomy to make her own decisions including her right to assume a calculated risk, is only as good as the information she is provided about the risks attendant to the options available to her.”

Practical Strategies for Managing Communication with Nurse-Midwives.

In most instances physicians and nurse-midwives work well with one another, understanding scope of practice and when to transition care for patients with complicated pregnancies. Sometimes processes can impede smooth communication. There are several strategies to consider to improve critical communications with Nurse-Midwives. These include the following:

1. **Set Clear Parameters for Role and Responsibility.**
   Avoid misunderstandings between physicians and nurse-midwives by setting easy to understand, written descriptions about respective roles, responsibilities, coordinated patient management, and consultations.

2. **Develop a Communication Plan Among Care Providers.**
   Consider using a structured type of communication process such as SBAR to avoid misunderstanding about the serious nature of a patient’s case. Make certain that both physicians and nurse-midwives are conversant with the communication process, offering orientation and regular in-service programs. Discourage the use of ambiguous terms such as “I am concerned” or “I think this could be a problem.” Encourage care providers to use clear terms in critical communications.

3. **Require Firsthand Review of the Medical Record.**
   Design medical record documentation review processes that permit firsthand review by medical directors rounding on patient cases in a birth center environment of care. Avoid the use of abstracts or highlight pages that are read aloud to medical directors completing chart reviews. Think about how electronic medical records can be designed to facilitate firsthand review.
4. **Utilize Repeat Medical Record Review.**
Institute periodic prenatal record reviews by medical directors responsible for such activity. Recognize that the frequency of such reviews may be increased for patients with complicated pregnancies.

5. **Complete Quality Review for “Open Items” in the Record.**
Close the loop on possible risk factors in prenatal care management by completing regular documentation reviews. Look for such items as outstanding laboratory tests results, consultative reports, consent documentation, etc. Build into the process a review for incomplete, untimely, missing or other entry issues. Reconcile open items. [See Sample Tool]

6. **Use Chain of Command to Resolve Disagreements in Management of Obstetric Patients.**
Encourage nurse-midwives and physicians to utilize chain of command to help resolve care management disagreements affecting obstetric patients. Make certain that the process incorporates a timely resolution process.

**Conclusion.**

In contemporary healthcare there is much discussion about professional relationships and communication. Scope of practice, credentialing and delineation of privileges are central to developing a strong working relationship between physicians and nurse-midwives.

For both professions communications is a core issue. It is not only what is said but how “it” is stated that can make the difference between a patient proceeding with a risk-prone care plan and one that is premised on a healthy discussion of benefits and risks that gets to the “real” issue troubling a patient.

When a care provider says, “I am worried” or “I am concerned” about a care plan, such a statement is subject to many interpretations. A far better approach is to state clearly the “concerns” and suggested solutions. If reasonable minds disagree, a process can be followed to resolve such issues. But there will be a resolution involving critical communications between care providers that in the end help a patient make a fully informed choice about a VBAC and repeat cesarean section.
2. Id. at 984.
3. Id. at 985.
4. Id.
5. Id. at 986.
6. Id.
7. Id.
8. Id.
9. Id at 987.
10. Id.
11. Id.
12. Id.
13. Id.
14. Id.
15. Id.
16. Id.
17. Id. at 988
18. Id.
19. Id, referencing 17 DCMR §5800.1 (2002).
22. Id. at 991.
23. Id.
24. Id.
25. Id. at 993.
27. Id. at 994.
28. Id at 996-997.
29. Id. at 997.
30. Id., at 1007.
31. Id. at 1008.
32. Id. at 1014.
33. Id.
## Sample Tool

### “Open Item” Quality Medical Record

*This sample tool includes a number of “highlights” or “flags” which when identified require follow-up and completion.*

*The data gleaned from this tool may be use to trend record documentation practices, and also, point to the need for improvements in orientation and in-service training.*

*The tool may be useful in medical practices, prenatal clinics and birth centers in which there is care provided by physicians, nurse-midwives, PAs and others. The document should be used under the aegis of process improvement and quality assurance.*

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care provider completed patient communication time-out.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care provider identified patient has specific cultural/religious needs.</td>
<td>✓</td>
<td></td>
<td></td>
<td>CNM requested consult with Muslim physician on proper management of patient.</td>
</tr>
<tr>
<td>Patient signed consent form.</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>Pending - waiting for consult with culturally sensitive Muslim care provider.</td>
</tr>
<tr>
<td>Patient counseled on high-risk pregnancy.</td>
<td>✓</td>
<td></td>
<td></td>
<td>Pending - waiting for consult with culturally sensitive Muslim care provider.</td>
</tr>
<tr>
<td>Patient counseled on medication management.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral made for nutritional counseling.</td>
<td>✓</td>
<td></td>
<td></td>
<td>Pending-waiting for consult with culturally sensitive Muslim care provider.</td>
</tr>
<tr>
<td>Medical director completed medical record chart review 1st Trimester.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical director completed medical record chart review 2nd Trimester.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical director completed medical record chart review at 32 weeks.</td>
<td>✓</td>
<td></td>
<td></td>
<td>Patient admitted to hospital for observation at 29 weeks.</td>
</tr>
</tbody>
</table>

**Observation**

*CNM should follow-up with requested consult in a timely manner. Waiting for cultural consult more than five weeks is not consistent with policy. Impact on care plan. Patient with gestational diabetes. Care provider indicating he was not available to complete consult with CNM. Should ask another qualified provider or use chain of command.*
SAMPLE OBPI CREDENTIALING AND PRIVILEGING RISK ASSESSMENT

The following is an excerpt from a risk assessment tool from OneBeacon Professional Insurance. The sample demonstrates the level of questions that can be posed in completing a risk management assessment in mid-level provider credentialing. For more information, please contact Patricia Hughes, Senior Vice President of OneBeacon Professional Insurance at: phughes@onebeaconpro.com.

Q1 Please enter the demographic information below.
   Legal Company Name (e.g. business, corporate, system):
   Facility/Campus Name
   Name / Credentials of Person Completing Survey
   Title
   Email:
   Phone:
Q2 The entity is:

- a tertiary, acute care hospital
- a community hospital
- a critical access hospital
- an ambulatory surgery center
- a behavioral health treatment setting
- a diagnostic imaging center
- a chemical dependency treatment setting
- a rehabilitation setting
- a long term acute care
- a physician practice
- a contracted physician service provider
- a federally qualified health center
- a telehealth provider
- an assisted living facility
- a skilled nursing care facility
- a continuing care retirement community
- a retail clinic
- an urgent care center
- a home health agency
- an occupational health service
- a spa/fitness center/wellness center
- a health care staffing agency
- other (Please describe): ____________________
Q3 The organization/entity has the following accreditation /certifications (include most recent accreditation/certification date)

- Joint Commission (JC)
- Det Norske Veritas (DNV)
- CIHQ (Center for Improvement Health Care Quality)
- CHAP (Community Health Accreditation Program)
- AAAHC (Accreditation Association for Ambulatory Health Care)
- AAAAFS (American Association for Accreditation of Ambulatory Surgery Facilities)
- American College of Radiology (ACR)
- Intersocietal Accreditation Commission (IAC)
- Certified Stroke Center
- Certified Staffing Agency
- American Association for Accreditation of Ambulatory Surgery Facilities
- Institute For Medical Quality (IMQ)
- American Society of Anesthesiologists (ASA)
- Utilization Review Accreditation Commission (URAC)
- National Committee on Quality Assurance (NCQA)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Continuing Care Accreditation Commission of the American Association of Homes for the Aging
- Accreditation Commission for Home Care (ACHC)
- Clinical Laboratory Improvements Act (CLIA)
- College of American Pathologists (CAP)
- Accreditation Council for Graduate Medical Education (ACGME)
- Accreditation Commission for Health care (ACHC)- home health, hospice and alternate sites
- Magnet Hospital
- Other (Please describe)
- Surveyed only by HHS for CMS CoPs
- In the process of accreditation (please name the accrediting agency)
- No accreditations, but follow accreditation standards (please name the standards)
- No accreditations, do not follow any accreditation standards

Q4 Did your organization receive any deficiencies in mid-level provider credentialing/privileging standards during your most recent survey?

- Yes
- No

Q5 Please attach any deficiency reports involving mid-level provider credentialing. These reports will be treated confidentially.
Q6 Have all deficiencies in mid-level provider credentialing/privileging standards been resolved to the satisfaction of the accredditor and/or CMS?

- Yes ____________________
- No ____________________

Q7 Please attach final corrective action plans for mid-level provider credentialing deficiencies cited during accreditation/CMS survey.

Q 8 There is an organized medical staff at the entity.

- Yes ____________________
- No ____________________

Q9 The organization uses a CVO (Credentials Verification Organization) in the mid-level provider credentialing process.

- Yes (please provide the name) ____________________
- No

Q10 The CVO used by the organization is accredited.

- Yes; name of accreditor ____________________
- No

Q11 There is an annual in-service regarding credentialing/privileging of mid-level providers for the following

- Governing Body
- Senior Leadership
- Department Chairs
- Division Chairs
- Human Resources
- Nursing Leadership
- Medical Staff Leadership
- Credentials Committee
- Medical Executive Committee
- Other ____________________
- Yes, to above checked, but not annually (indicate frequency) ____________________
- None
Q12 Credentialing criteria for mid-level providers includes

- Clinical competency
- Professionalism
- Regulatory compliance
- Communication skills
- Documentation practices
- Other ____________________
- None of the above

Q13 The Credentialing process for mid-level providers includes a process for monitoring expirables including

- Professional provider license
- DEA check
- Proof of professional liability coverage
- Board certification
- Other certification
- Other ____________________
- No

Q14 Has the organization ever had mid-level providers providing care who have an expiration/lapse/non-renewal of any professional license, DEA, professional liability insurance coverage, Board certification or other?

- Yes ____________________
- No
Q15 For an initial applicant, the credentialing process for mid-level providers includes

- A letter of explanation outlining responsibilities of the applicant
- An explanation of the timeline for decision-making
- A requirement of three references from individuals familiar with the applicant's work
- A structured set of questions posed to those listed as references
- A signed release authorizing references to provide frank and candid responses without fear of litigation absent evidence of malice or bad faith
- A checklist for documents required from applicants
- Criminal (state) background check
- Criminal (federal) background check
- State sex offender registry check
- Written authorization for Fair Credit background check
- Background checks for exclusion by Medicare, Medicaid
- A review of the scientific misconduct database
- DEA check
- A review of the LEIE database (List of Excluded Individuals/Entities)
- Interviews with department chairs/other ____________________
- A query of NPDB or subscription to “Continuous Query” option
- A review checklist for the Credentials Committee and/or Department Chair
- ____________________
- A review checklist for the MEC
- Documentation of the recommendation made to the Governing Body

Q16 The mid-level provider credentialing process includes regular monitoring OIG for sanctions.

- Yes ____________________
- No ____________________

Q17 As part of the credentialing process mid-level applicants are required to submit

- A list of open professional liability claims
- A list of complaints involving Medicare, Medicaid or a private payer A list of pending or closed complaints before a state licensing board
- A list of criminal convictions, including driving under the influence
- A list of voluntary or involuntary restriction, suspension, revocation, relinquishment, loss of clinical privileges or membership from an healthcare organization, licensing board, registration
- Statement about health/ability to practice privileges requested
- Signed application attesting to accurateness of information provided
- Other ____________________
- None of the above
Q18 The organization/medical staff has a process in place for delineation of privileges of mid-level providers.
○ Yes ____________________
○ No ____________________

Q19 The delineation of privileges for mid-level providers is based on
☐ q Scope of practice
☐ q Applicable law and regulations
☐ q Service lines in the organization
☐ q Availability of necessary equipment in the organization
☐ q Availability of clinical personnel
☐ q Availability of ancillary services needed to support the service for which privileges are requested
☐ q Defined criteria/pre-requisites for the care provider to meet the requirements of the requested privileges
☐ q On going demonstrated ability of the care provider once granted the privileges
☐ q Other ____________________
☐ q None of the above

Q20 The organization has policies in place to evaluate care when there is a change in practice pattern of a mid-level provider.
○ Yes ____________________
○ No ____________________