Transitioning to System-Wide Credentialing: Job Threat or Job Enhancement?

Horty, Springer & Mattern

WHY ARE YOU HERE?

Health Insurance Policy

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September 26, 2014
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As systems and medical staffs transition, what about the medical staff services professionals?

Medical Staff Secretary
\[\downarrow\]
MSSPs
\[\downarrow\]
Specialized Roles

- Database Manager
- Medical Staff Assistants
- Credentialing Specialists
- Credentials Coordinator
- Director of Professional Services

System Credentialing and Peer Review Dilemmas
Q. Can we have one medical staff?

For a long time…

CMS now says “If...the system elects to have a unified and integrated medical staff...each separately certified hospital must demonstrate that:”
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Keys to a “Unified and Integrated Medical Staff”

i. Medical Staff members have voted by majority to accept a unified and integrated medical staff structure

ii. Medical staff has bylaws, rules and regulations, etc. describing credentialing and peer review processes

iii. Medical staff is established in a way to account for each hospital’s unique circumstances and significant differences between the facilities.
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**Keys to a “Unified and Integrated Medical Staff”**

iv. Medical staff establishes and implements policies and procedures to assure needs and concerns of medical staff members at each separate hospital or practice location.

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**Allows for greater coordination to improve quality of care and patient safety.**

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**Continuum**

- Status Quo
- Centralized Verification
- Similar Standards and Processes
- Single Level of Care

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Dr. Dally, Ob-Gyn: privileges at Hospitals A and B. Only A does deliveries. At B, Dr. Dally does surgery only.

At A – repeatedly late for deliveries; multiple counseling sessions, letters, warnings, brief suspensions. Finally, revocation of privileges. Upheld by Hearing Committee.

Board gets recommendation and asks MEC at Hospital B to weigh in.

The Board should
  a. Accept both MECs’ recommendations
  b. Send it back to both and ask for a single recommendation
  c. Call a lawyer
  d. Something else
Different standards at different hospitals in the system are acceptable because:

a. Patients and physicians are best able to choose a patient's course of care
b. Patients' needs vary so physicians must have autonomy in care choices
c. Rarely, and only when approved and/or well documented reason for variance
d. Is this a trick question?

**Hay v. Scripps Memorial Hospital – La Jolla**

FP was unqualified for clinical privileges to perform D&Cs at La Jolla facility since not Board certified OB/Gyn.

Granted such privileges at Scripps - Encinitas by the same Board.

**Q.**

Dr. Eve's clinical privileges at A are subject to a second opinion confirming the necessity of each procedure before it is scheduled.

At B, Dr. Eve has no conditions and her volume in the cath lab is legendary.
Q. When a patient at B suffered a stroke and was left permanently disabled, the plaintiff’s allegations, supported by the expert report, were that the injury was caused by negligent performance of a procedure that was not clinically indicated. Who is liable?

a. Dr. Eve
b. The MEC that did not impose oversight
c. The Board, that had approved the conditions at A, but approved clinical privileges without restriction at B
d. Nobody, stuff happens
Q. Can we share information anywhere in the system?

Risks to sharing information:
- Patient in malpractice action argues waiver of peer review privilege
- Physician sues claiming defamation, slander, tortious interference, etc.

Risk of not sharing is arguably greater.
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Key components of sharing:
- System Policy or Agreement
- MSBY provision(s)
- Application language
- Education
- Release

Q.
Concerns are raised about a long-standing member of the Medical Staff. The physician agrees to take a LOA to get a health assessment.

Q.
No one thinks to tell his group, which is a hospital affiliate, and he continues to provide care in the office. Is this a problem???
Q. Would you handle this in a different way for a non-affiliated group?

Q. The MS has tried a wide variety of collegial interventions on a member about whom there are quality concerns. None have worked.

Q. The MEC of Hospital A commences an investigation. Can it share this information with the MECs of Hospitals B and C?
Q. The physician practices primarily at Hospital A but also has privileges at Hospitals B and C. In conducting the investigation, can Hospital A get information from Hospitals B and C?

Q. The outcome of the investigation is a detailed PIP which is approved by the Board. Are the MECs of Hospitals B and C required to adopt the same PIP?

Q. Should they?
The System may be held liable for what it knew or should have known about the PIP.

It is important to build this outcome into the bylaws.

Q. If the result of the investigation will affect the physician’s practice at all three hospitals, should all three MECs be involved in the investigation? The hearing?
Q. We are becoming more integrated and we started with the MSSD. Can we maintain one credentials file? One quality file?

Top 10 Tips for Medical Staff Professionals
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Change is (and always has been) difficult......
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Communication and knowledge are the keys.

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Knowledge Areas

- Legal
- Accreditation
- Credentialing
- Technology
- Informational Management
- Quality

Ongoing education is critical.
Collaborate with your system colleagues.

Essential Elements of Teams
- Common purpose
- Shared goals
- Interdependent actions
- Accountable as a group
- Collective effort

Essential Components of Teamwork
- Leadership & Followership
- Effective Communication
- Willing to call for help early
- Workload evenly distributed
- Comfort asserting concerns
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Define your standards and your objectives.

Examples:
- Terminology
- Application forms
- Policies
- Something more?

Consistency
It's Only a Vane If You're Not a Shooter.
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Strive for consistency…but know there is always wiggle room.

Compromise on politics, not quality.

Examples of political issues:
- Committee composition
- Process for selecting leaders
- Staff categories
- Voting rights
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Examples of quality issues:
- Criteria for appointment
- Criteria for privileges
- Clinical pathways

Know the barriers to change.

Potential Barriers
- Resistance to change
- Limitations of existing systems
- Lack of administrative commitment
- Lack of a “champion”
- Unrealistic expectations
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Understand the importance of historical land mines.

Example:
- Board certification
- Hospital-based physicians in leadership roles
- Compensation of physician leaders

Recognize the benefits and the potential for improvements.
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- Exposure to different views and methods
- Improved efficiency of operations
- Improved satisfaction
- Embrace new roles and responsibilities

“Those who commit themselves will be rewarded, those who do not will be punished.”