Common Credentialing/Privileging Mistakes that Healthcare Leaders Make: Case Studies and Lessons Learned

Session Code: TU06

Time: 10:00 a.m. – 11:30 a.m.

Total CE Credits: 1.5

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Quick Review!

- Credentialing—the evaluation of a candidate to determine if s/he meets criteria for **membership** (or **non-membership**) on the medical staff
- Privileging—the determination of what a practitioner is **authorized to do** by the board

Can a practitioner be credentialed and not privileged?
Can a practitioner receive full privileges with partial membership rights?

Case Study—An ‘Unannounced Holiday’

A member of a medical group takes an unexpected holiday and asks that management give a locum tenens practitioner “temporary privileges” so that she can take call while he is away. The medical staff reviews her file and finds significant issues around quality of care and compliance with administrative rules. What should the medical staff and management do?
Lesson: Follow your process, it is there for everyone’s protection!

Legal Precedents:

*Remember: your MEC recommended board approved process defines the standards you set for yourself.

Temporary Privileges (The Joint Commission Rationale for MS.06.01.13):

The circumstances for which the granting of temporary privileges is acceptable are:
- To fulfill an important patient care, treatment, and service need
- When an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the medical staff executive committee and the governing body

Case Study: “But I did it in residency”

A competent orthopedic surgeon performs an open reduction internal fixation of a fractured femur and is concerned about the possibility of vascular insufficiency of the femoral head and performs an elective intraoperative angiogram. When told by the president of the medical staff that he did not have privileges to do this, he stated, “But I did it in residency.”

What is the issue here?
Lesson: Nobody works without authorization

- An adverse outcome may result in charges of (aggravated) battery
- Not covered by organizational or professional indemnification
- Everyone is covered for emergency privileges in a life or death situation
- Federal law (and accreditation) requires that everyone must be assessed for current competence prior to receiving privileges

Case Study: More Form Letters

The President of the Medical Staff hears that a new applicant is a good clinician but does not like following rules or complying with administrative requirements such as medical record completion or signing out her patients prior to vacation. All of her references consist of form letters describing the amount of time she served but provide no meaningful information. What should the President do?

Lesson: “The Board knew or should have known”

Legal Precedent:
Gonzales v. Nork and Mercy Hospital (1973)

- You will be held accountable for information that is available
- Information errors are far more common than judgment errors!
- How do you define a reasonable professional reference?
The Joint Commission: The decision to grant or deny a privilege(s) and/or renew an existing privilege(s), is an objective, evidence-based process (MS.06.01.05) Peer recommendation includes written information regarding the practitioner’s current:
- Medical/clinical knowledge
- Technical/clinical skills
- Clinical judgment
- Interpersonal skills
- Communication skills
- Professionalism (MS.06.01.05, EP 8)

Case Study: An Awkward Request
The Director of Anesthesiology receives a request for a professional reference of an anesthesia colleague who has a drug addiction problem and has been recently asked to voluntarily resign from the Anesthesia group in order to avoid a report to the national practitioner data bank and state licensing board.

What should she say?

Lesson: There is NO duty to disclose; only a duty not to knowingly lie or misrepresent
Legal precedent:
Principle: When a request is difficult, help is available!
Case Study: Cart before the Horse?

A general surgeon takes a one week course in bariatric surgery, returns to the organization, and schedules his first case. The President of the Medical Staff informs him that he cannot schedule a case until he has bariatric privileges authorized. The general surgeon responds that his privileging document states that he is entitled to do any form of surgery of the stomach and large/small bowel and that the medical staff cannot interfere with his clinical privileges unless he has demonstrated incompetence.

What should the President do?


Lesson: When your Policies are Non-Helpful or Non-Existental, FIX THEM!

- Can you change or create a new policy once a request has been made?
- Must you apply it equally to all relevant practitioners?
- Do you have to take legacy exclusive agreements into account?

Best Practice:
1. Time out
2. Remand the issue to committee to resolve
3. Resume to process the inquiry

When should privileges be considered ‘outside of the core’? When they require different……

- Training
- Technique
- Judgment
- Skills
- Equipment
- Complication profile
- Infrastructure (e.g. unit with trained personnel and support systems)
How do you define your ‘non-core privileges’ in general surgery?

Typical ‘non-core’ privileges:
1. Use of the laser
2. Advanced laparoscopic techniques
3. Endovascular and advanced vascular techniques
4. Open or laparoscopic bariatric techniques
5. Advanced vascular techniques?
6. Thyroid/parathyroid surgery?
7. Oncologic surgery?
8. Stereotactic breast/sentinel lymph node biopsy?
9. Use of robot
10. Moderate sedation

Case Study: An ‘Interesting’ Request

A well respected general surgeon comes to the MEC and requests privileges for breast augmentation and reduction stating that he has taken a rigorous two week course and has been deemed qualified by the program to perform these procedures.

What would you recommend to medical staff leadership?

Lesson: Follow your Policies!

1. What is the eligibility criteria to request privileges to perform breast augmentation and reduction?
2. What is the volume threshold?
3. Thus, what do you tell the candidate?
Case Study: An Incomplete Reference

A pediatrician applies for clinical privileges and provides a professional reference that rates her as outstanding for technical skills and clinical judgment and average for interpersonal and administrative compliance skills. The Pediatrics Chair contacts the reference and asks why these ratings are average. The reference states that he cannot provide any additional information.

What should the Chair do?

Lesson: Don’t be afraid to deem an application ‘incomplete’:

“An application shall be deemed incomplete if any required items are missing or if the need arises for new, additional or clarifying information in the course of reviewing an application. Anytime in the credentialing process it becomes apparent that an applicant does not meet all of the eligibility criteria for membership or privileges, the application process shall be terminated, no further action taken, and the applicant shall not be entitled to a fair hearing.”

When important information is missing:

- Who has the burden of providing this information?
- Can this information be provided ‘off the record’?
- Can physicians be sued for requesting additional information?
- Can high/low risk applications be treated differently?
Consider risk stratifying applicants....

R-1: no issues/highly qualified ----EXPEDITE and place in consent agenda
R-2: issues that in the MEC’s opinion do not require monitoring or FPPE----- REGULAR PROCESS with individual discussion
R-3: issues that in the MEC’s opinion require monitoring and FPPE-----REGULAR PROCESS with individual discussion

Case Study: I’d like to do the next new thing.....
The orthopedists come to you asking that you develop new criteria so that they can perform joint resurfacing as they feel that it will add an important new service to the community.

They would like to schedule the first case next week.

What should you do?

Lesson: Have a policy to address the introduction of new privileges and new technology!
1. Create a committee to vet new services (e.g. Value Analysis Committee)
2. What is always the first question that must be answered?
3. What are issues that must be addressed?
4. When the decision is made to create new criteria for privileges, what issues need to be taken into account?
5. Prepare for lots of conflict and conflicts of interest!
Case Study: Early Retirement

A cardiothoracic surgeon decides that he would like to ‘cut back’ his practice and go back to performing surgery on gall bladders, hemias, and appendixes. He has not done any of these procedures in over twenty years but explains to the medical staff that it is like ‘riding a bike’ and that he will be ‘up to speed’ in no time.

What should the medical staff do?

Lesson: Apply privileging criteria consistently!

The Joint Commission:

Evaluation of all of the following are including in (privileging) criteria:

- Current licensure and/or certification
- The applicant’s specific relevant training
- Evidence of physical ability to perform the privilege
- Data from professional practice review
- Peer and/or faculty recommendation

(MS.06.01.05, A 2)

Case Study: “I didn’t know you did criminal background checks”

A nurse anesthetist applies for medical staff membership and privileges and is found to be a convicted felon for selling drugs on a criminal background check. On his application, he checked ‘no’ when asked if he had ever been convicted of a felony and he turned out to have a different name than the one listed on the application.

What should you do?
Lesson: Lying on an application should be addressed administratively

Recommended bylaws language:

“The applicant attests to the accuracy of the application and agrees that any substantive omission or misrepresentation in the MEC’s or Board’s opinion may be grounds for termination of the application process without access to a fair/judicial hearing or review.”

Lesson: There are felons and there are felons…. 

Recommended bylaws language:

“If convicted of a felony related to misuse of controlled substances, illegal drugs, fraud or abuse, violence, or any act that would reflect adversely on the reputation of the healthcare organization and/or the confidence of the community, the practitioner shall automatically and voluntarily relinquish membership and privileges without right to a fair/judicial hearing or review.”

Lesson: Security of Identity and Background

• Social Security Number
• Photo ID (many request passport or state license) that is sent to professional references and primary source verifications (e.g. fellowship, residency, medical school)
• Criminal background checks now becoming a routine part of a complete application
• Finger print/iris scan to come?

Case Study: ‘Back in the saddle again’

An pediatrician decides to get back into neonatology after a six year hiatus (he was formerly fellowship trained in that sub-specialty) and applies to the medical staff for privileges in neonatology and pediatrics. He takes a two week refresher course and has references attesting to his competency.

What would you do?

Lesson: Have a Policy regarding Physician Re-entry

A return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment.

Source: American Medical Association

What is an extended period? It is defined by state....

Years without clinical activity:

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1 2 3 4 5 case by case

A reasonable approach….

< 1 year absence: leave of absence with FPPE/proctoring upon return

1-2 years absence: formal preceptorship upon return + FPPE/proctoring

>2 years absence: formal re-entry program per state law and hospital policy

Many medical staffs are raising the bar.

Credentials Committee:
- Experienced and mature physician leaders with organizational wide respect
- Training to develop and hone expertise (e.g. legal, regulatory, accreditation issues)
- Longer term limits
- Compensation and performance evaluations by peers, management, and board
- Ex officio seat on MEC for Chair

An Important Recap:
1. Follow your policies (they are there for your and your patients’ protection!)
2. If you don’t have a policy to address the issue you are facing, create one!
3. If your current policy isn’t helpful, modify and improve it!
4. Place patient needs above local politics and short term pressures (e.g. Do the right thing!)
5. Be a leader and let the chips fall where they may.
Thank You for Joining Us!
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