Case Study: Centralized Credentialing, Privileging, Peer Review and Disciplinary Actions in a Large Healthcare Delivery System

Session Code: TU04

Date: Tuesday, September 20, 2016

Time: 8:00am - 9:30am

Total CE Credits: 1.5

Presenter(s): Brian Betner, JD and Susan DuBois, CPCS, CPMSM
Case Study: Centralized Credentialing, Privileging, Peer Review, and Disciplinary Actions in a Large Health Care Delivery System

National Association of Medical Staff Services Annual Conference September 2016
Brian C. Betner, Esq.
Hall Render Killian Heath & Lyman, P.C.
Susan Dubois, CPICS, CPMSM
Assistant Vice President, Medical Affairs, Intermountain Healthcare
President-Elect, National Association of Medical Staff Services

Introduction and Objectives

Why a case study?
The “systemization & centralization” trend
Best practices for centralized credentialing
Operational reality vs. legal considerations

A Perfect Storm

- Institute of Medicine’s “To Err is Human” & “Crossing the Quality Chasm”
- CMS’ hospital quality initiative programs
- National patient safety goals
- Dramatic advancements in HIT
- Negligent credentialing
- Increased fraud & abuse compliance enforcement
- Affordable Care Act
- Value-based everything
- Market trends
Bigger is Better: Systemization

- Stand-alone hospitals and smaller health systems are being absorbed into larger health systems
  - Causes range from the "grow or die" philosophy to survival
  - Most are looking for economies of scale or integration value in:
    - Asset management/capital allocation
    - Compliance
    - Contracting
    - Credentialing/privileging/quality
    - Finance/revenue cycle
    - Information systems/HIT
    - Legal
    - Mission
    - Payroll
    - Risk management

What We Mean by Centralized Credentialing

Credentialing, privileging, quality assurance/performance improvement activities have historically been facility-specific or local in nature

Origin: Part regulatory framework and part culture
A centralized approach to credentialing, privileging and QA/PI involves a system-level consolidation of these activities designed to achieve efficiencies and standardization Ranges from joint applications to joint credentialing committees

Intermountain Healthcare

- Headquartered in Salt Lake City: 38,000+ employees
- Created in 1975 when LDS Church donated its 15 hospitals to the community
- Integrated system:
  - Hospitals
    - 22 hospitals
    - 4,000 affiliated physicians
    - 41% of Utah hospitals, 44% of beds, 54% of discharges
  - Insurance
    - SelectHealth (1983)
    - >600,000 members
    - ~23% of market
  - Providers
    - Medical Group (1994)
    - 200 clinics
    - 1,300 employed physicians
Intermountain Healthcare

Mission
Helping people live the healthiest lives possible.

Vision
Be a model health system by providing extraordinary and superior service at an affordable cost.
- Clinical Excellence
- Patient Engagement
- Community Stewardship
- Employee Engagement
- Operational Effectiveness
- Physician Engagement

Intermountain Healthcare

Service Area
- Utah and Southeast Idaho

Clinical Programs
- Behavioral Health
- Cardiovascular
- Intensive Medicine
- Musculoskeletal
- Neurosciences
- Oncology
- Pediatric Specialty
- Primary Care
- Surgical Services
- Women and Newborns

Why We Centralized Credentialing

- Alleviate duplication
  - Providers & MSO/operations
- Standardize processes, procedures, forms
- Standardize data used in making decisions
- Eliminate problem providers moving within the system
- Gain efficiencies and effectiveness
History of Centralized Credentialing

- **Timeline**
  - 1991: Staggered implementation across system
  - 1993: Fully integrated system-wide program

- **Evolution of program**
  - Centralized Credentials Verification
  - Standardization:
    - Medical Staff Bylaws
    - Rules and Regulations
    - Privileging requirements
  - Single source of provider data
  - Delegated credentialing agreements

Organizational Structure

- **Organizational Structure**
  - Central Office medical staff and provider data services
  - Hospital medical staff offices
  - Medical Group
  - SelectHealth

- **Collaboration/Coordination**
  - Medical Director’s Council
  - Physician Leadership Council
  - CNO/CMO Council

Centralized Processes/Procedures

- **Defining accountabilities**
  - Processes
  - Follow-up
  - Timelines
  - Communication

- **Regulatory and accreditation Requirements**
  - Joint Commission
  - NCQA
  - CMS
  - State
  - Other

- **Screening new applicants**
  - Standardize criteria
  - Who does it?

- **Initial Appointment**
  - Application
  - Bylaws
  - Privilege request
  - Processes
  - FPPE

- **Reappointment**
  - Application
  - Schedule/dates
  - Privilege request
  - OPPE/quality review
Application sent to practitioner within 24 hours of receipt of request from facility MSO.

Completed applications will be processed within 5 business days of receipt by MSS.

Incomplete applications will be processed as completely as possible with a missing info letter, email or phone call sent to practitioner immediately. Copy also sent to facility(s).

Follow up on missing information will be sent three weeks after first request.

Applicant will be notified that application is considered incomplete until received.

Copy will be sent to facility.

When missing info received, it will be processed immediately.

Application & verifications summarized and sent to facility(s).

Verifications sent to facility(s) as received until all verifications have been received.

2nd requests will be sent 5 weeks after initial letter is sent. 3rd request will be sent, by email or phone call, 4 weeks after 2nd request is sent. The applicant and facility(s) will be notified of difficulties in getting a response and that the application is considered incomplete.

2nd request sent to practitioner 8 weeks after initial request unless more frequent follow-up requested by facility. No response 30 days after 2nd request, CO will enter failure to respond and an end date in entity and close the instance.

Initial Appointment

Facility reappointment list sent to facilities for review six months before reappointment due (mid-month).

Updates made as necessary reappointment packets produced & distributed to MSS staff.

Mailed to practitioners within 5 business days of printing (exception: privilege/multiple entities).

Completed apps will be processed within 10-20 business days of being received by MSS (prioritized by date reappointment is due).

Incomplete applications will be processed as completely as possible with a missing info letter sent to practitioner immediately. Facility notified.

Follow up on missing information will be sent 3 weeks after first request. Facility notified. When missing info received it will be processed immediately.

2nd requests will be sent 5 weeks after initial letter is sent. 3rd request will be sent, by email or phone call, 4 weeks after 2nd request. The applicant & facility(s) will be notified of difficulties in getting a response and that the application is considered incomplete.

2nd request sent 6 weeks after printing date. (Standardized process) Facilities notified 21 days after 2nd request has been sent if application has not been received.

Facility(s) and SH to take action such as a certified letter. Facility(s) will get monthly update.

Reappointment

High Level

Medical Staff Documents and Governance

- Medical Staff Bylaws
  - Fair Hearing Plan
- Rules and Regulations
- Credentialing policies and procedures
- Other policies and procedures
- Medical staff vs. system
- Training and education
- CMS attestation
Medical Staff Organization
Structure Options

- Standard structure
- Region structure
  - Credentials Committee
  - MEC
  - Board
- System level structure

Sharing Data & Coordinating
Disciplinary Actions

- Coordinating issues
  - Hospitals
  - Health plans
  - Medical Group/employment
- Consent
- Policies/processes
- NPDB queries and reporting
- System level tools
  - Data collection and analysis
  - Reporting
  - OPPE/FPPE

Data Systems

- System-wide credentialing data system
  - Access and data management
    - Define roles, responsibilities and rules
    - Single source validation
- Quality
  - FPPE/OPPE
  - Standard metrics
Hurdles & Benefits
Processes & Procedures

• Common issues
  – Poor communication and engagement
  – Limited medical staff leadership resources
  – Inconsistent approaches to dealing with quality and behavior
  – Inefficient or obsolete structures and processes
  – Competing priorities
  – Resistance to change
  – Turf battles

Hurdles & Benefits
Regulatory & Accreditation

• Regulatory
  – Medicare Conditions of Participation (CoPs)
  – State hospital licensing requirements
  – Practitioner licensing standards
  – State peer review statutes
  – National Practitioner Data Bank
• Accreditation
  – Various accreditation requirements, whether JCAH, HFAP or DNV, impose hospital and medical staff specific obligations related to credentialing, privileging, QA/PI, etc.
• A minimum expectation of quality of care and patient safety should be the underlying focus of every credentialing requirement

Other Potential Centralized Programs

• Centers of excellence
  – Privileging criteria
  – Exclusive contracting for certain procedures
• System strategy for mentoring and proctoring
• Centralized peer review
Legal Considerations

“It’s not a problem until it’s a problem”
• Goal: Striking a balance between “over lawyering” and accommodating the practical reality of the pace at which health care is actually delivered
• Do the right thing for patient safety and quality improvement
• Legally possible?
• Getting ‘buy-in’?

The Sharing Dilemma

• Can we share? Lawyers’ creed: It depends
• It’s all about what your statute permits and protects
  – State peer review laws
• What and why are you sharing?
  – Sharing for mutual quality-related benefit is smartest approach
  – Any other reason risks waiving privilege
• Does it matter?
• What if we use a Patient Safety Organization?
• Confirm that Medical Staff Bylaws and related contractual agreements don’t inhibit

Legal Considerations
Sharing Data

• Whether something is privileged is generally a function of the process that was followed:
  – Who performed the review?
  – When was the data generated?
  – For what purpose was the data used? Was the use “exclusive” to the quality-related activities of the facility/group?
  – Does the data contain non-deliberative, patient care information?
  – Attractive facts and problematic court opinions
• Age old dilemma: Spirit vs. letter of the law
Legal Recommendations
Sharing Data

• Information Sharing/Confidentiality Agreement or policy that specifies:
  – Goals, purpose and use
  – For the committee’s benefit?
  – Protocol on what and to whom information will be shared
• Acknowledgement, consent and release by providers
  – Either standalone, in Bylaws, appointment application, etc.
• Ensure information shared is bona fide peer review information and not information specific to a patient’s care and treatment

Legal Considerations
Risk Management

• Litigation risk/cost related to enforcement of higher standards and expectations
  – If you turn over more rocks, what will you find?
• Malpractice risk/cost related to shift in standard of care
  – Prevalence of evidence-based measures and processes
• Negligent credentialing/corporate liability
  – One entity knew there was a problem and failed to disclose to another and/or take action

Legal Considerations
Risk Management

• Political/business risk for “forcing” change
  – Are there consequences to upsetting the high admitter’s apple cart?
• Compliance risks associated with increased quality scrutiny
  – Quality is inching closer and closer to becoming a condition of payment (if not already there)
• Moral obligation?
  – Do we find a solution or “damn the torpedoes” with regard to dealing with competency and behavior issues!
QUESTIONS

Brian C. Betner, Esq.
bbehtner@hallrender.com

Susan DuBois, CPCS, CPMSM
susan.dubois@imail.org