Medical Staff Credentialing:

Common Challenges and Best Practices

HALL RENDER
KILLIAN HEATH & LYMAN
HEALTH CARE UNINTERRUPTED

Presenter Info

Brian C. Betner
Attorney, Hall Render
bbetner@hallrender.com
(317) 977-1466

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Agenda

- Credentialing and Privileging as a Cornerstone
- Common Credentialing Challenges
- Fear and Loathing: A Case Study

Credentialing and Privileging as a Cornerstone

Credentialing and Privileging

- Many of our successes and challenges in healthcare start and end with credentialing and privileging – starting with quality tends to lead to quality
- These processes largely focus on:
  - Credentialing and Privileging
  - Quality Assurance and Performance Improvement Oversight Activities
  - Corrective Action, and other oversight activities or interventions
- We tend to pursue these activities first for regulatory and accreditation compliance then for risk management followed quality of care/patient safety

Elevated Focus

- Evolving Patient Expectations
- Financial Incentives and Penalties
- Legal and Regulatory Pressures
- Workforce Retention, Engagement, and Satisfaction
- Competitive Advantage

Credentialing and Privileging Goals

- ✓Effective evaluation of conduct/citizenship
- ✓Effective evaluation of clinical competence
- ✓Structured to support good faith decision-making
- ✓Conducted in a manner that fosters credibility
- ✓Conducted to qualify for immunity and maintaining peer review privilege

Common Challenges

A Mixed Bag of Challenges

- Goals of credentialing and privileging
- The true value of initial appointment
- Professional autonomy v. Organizational authority
- Objective v. Subjective
- Credentialing inquiries
- Character and judgment v. Clinical competence
- Effectiveness of peer review process
- Proactive v. Reactionary
- Compliance with regulatory/accreditation requirements
- *F*acts v. f*acts* v. *facts*
- The value of a quality culture
- Professional relationships and role clarity
- Low/no volume providers
- Evaluating across care settings
- Collegial v. Official
- Reliability of actionable data
- Dynamics of employed/contracted providers
- The value of understanding the “root cause”
- Expediency v. consistency
- Performance improvement v. professional liability
- Prescriptive v. flexible
- Education/training

Fear and Loathing: A Case Study

Fear and Loathing: A Case Study

- Dr. Hunter Thompson is a 47-year-old general surgeon physician who recently applied for privileges at Green Valley Medical Center (GVMC), a mid-sized hospital 40 miles from the closest hospital.
- Dr. Thompson was to be the 3rd general surgeon at GVMC but 1 surgeon recently left the community.
- Dr. Thompson's application and subsequent tenure at GVMC involve the following:
  - Dr. Thompson completed his residency 15 years ago but has two notable practice/employment gaps:
    - An 8-month gap five years ago, with no explanation provided on his application.
    - A recent 6-month gap prior to applying to GVMC, during which he indicates he maintained a "consulting practice" but provides no further documentation.

Case Study cont.

- Dr. Thompson has an unlimited license after having received a USMLE maximum attempts waiver but is not board certified.
- Bylaws require 3 references and 5 years of hospital affiliation confirmation.
  - One reference responded with vague endorsements of ability.
  - One reference indicated awareness of negative rumors about his interpersonal communication style and care management approach but stated no personal knowledge.
  - A single affiliation response didn't answer the questionnaire section and instead provided a form response of dates of service and statement that Dr. Thompson departed in good standing.
- No pending malpractice claims or judgments.
- Bylaws require "Satisfactory history of clinical performance"

Case Study cont.

- The Credentials Committee Chair is new to the role and very motivated to simplify the credentialing process.
- The Chair determined that expedited credentialing was appropriate b/c Dr. Thompson possessed the requisite basic qualifications, no history of adverse actions, and the absence of malpractice judgments.
- Dr. Thompson was granted privileges among other applicants by consent agenda to the MEC and Board.
- The GVMC's FPPE/OPPE program was not cited as deficient during its last accreditation survey.
  - Concerns exist regarding attribution of data
  - Quarterly chart reviews are infrequent and lack rigor/minimal feedback.
  - It's generally known that many physicians view the process as a formality rather than a meaningful tool for identifying and addressing performance improvement.

Case Study cont.

- During his initial 5 months at GVMC, Dr. Thompson experienced:
  - An unusual rate of SSIs.
  - Surgical times were markedly greater.
  - Surgical team members questioned Dr. Thompson's unorthodox approach and adherence to surgical guidelines.
- A significant complication resulted in a patient being transferred for tertiary care. The patient died during re-surgery.
- A review of charts by the CMO revealed inconsistent practices, and inconsistent documentation, questionable case selection, et al.
- An ad hoc review process also revealed weaknesses in leadership training among physician leaders.
  - The Department Chair overseeing Dr. Thompson's credentialing and FPPE struggled to address or attribute his deficiencies effectively.
  - Committee members expressed uncertainty about how to apply policies and procedures consistently.

Case Study cont.

- The medical staff at GVMC has a reputation for prioritizing collegiality over engagement when quality questions are raised.
  - Members have been generally reluctant to engage issues involving concerns about their peers.
  - Several staff members resisted the idea of formally addressing Dr. Thompson's quality issues, arguing it might damage overall morale and frustrate future recruitment efforts.
- A lawsuit was filed by the family of the patient affected by the surgical complication. The plaintiff alleges that GVMC was negligent in granting privileges to Dr. Thompson.
- Dr. Thompson argues that GVMC's surgical team lacks necessary skills and has threatened to sue GVMC if his quality concerns are acted upon or lead to an adverse action.
- The legal threat has created hesitancy among leadership, who are concerned about personal liability and the hospital's support.

Case Study cont.

1) What steps should GVMC take to investigate and document employment gaps effectively?
2) How might these gaps signal potential issues with competency or fitness to practice?
3) How should GVMC address or obtain clarifications regarding Dr. Thompson's application?
4) What safeguards can be implemented to ensure accurate and comprehensive verification?
5) What is "satisfactory history of clinical performance"?
6) How can GVMC address questions about Dr. Thompson's clinical judgment and past performance?
7) What processes should be in place to evaluate and document quality concerns occurring outside the hospital?
8) How should GVMC balance fairness and objectivity in the peer review process while addressing the clinical concerns raised during the review?

Case Study cont.

9) What legal and operational steps can GVMC take to mitigate risk in light of the lawsuit?
10) What training and support should GVMC provide to physician leaders to handle credentialing, peer review, and quality oversight effectively?
11) How can GVMC foster a culture where professionalism and quality take precedence over collegiality?
12) How should GVMC address the fear of legal retaliation with peer reviewers while maintaining transparency and fairness?
13) What changes are needed to transform GVMC's FPPE/OPPE into a robust and actionable process?
14) How should GVMC's leadership balance being supportive of medical staff with holding them accountable to professional standards?

Questions?

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For more information on these topics visit hallrender.com.

Attorney name

bbetner@hallrender.com

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