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Illinois State Medical Society

Credentialing Red Flags and Best Practices

MEDICAL STAFF SEMINAR 2021

PRESENTED BY HALL RENDER'S MEDICAL STAFF SERVICES TEAM

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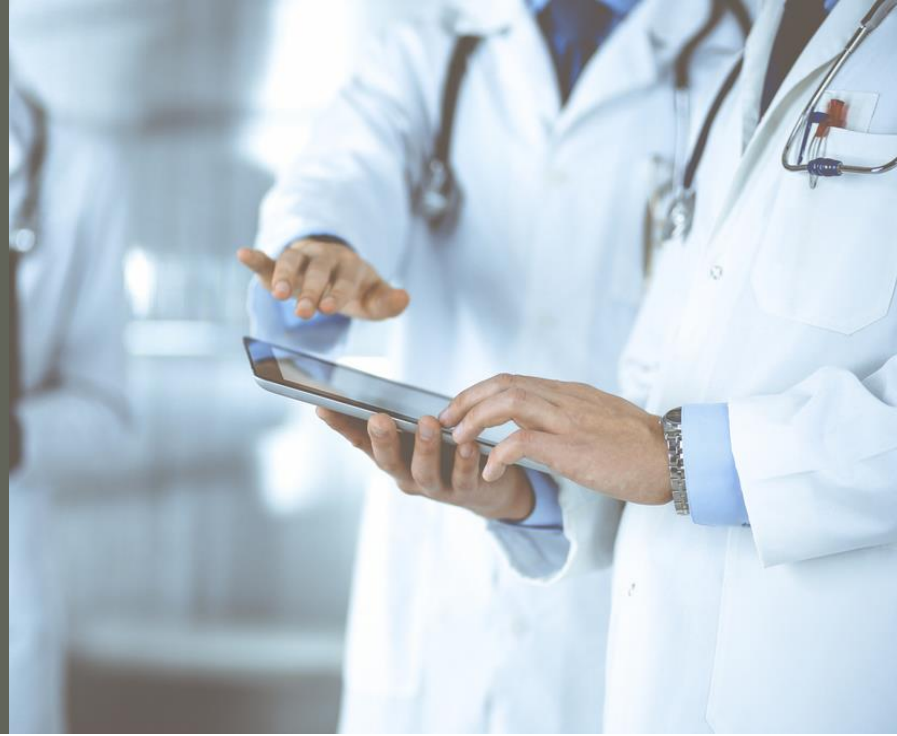

Presenter Info

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

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Overview

- The implied emphasis on credentialing
- Why credentialing is king
- Credentialing for membership v. clinical privileges
- Credentialing best practices and red flags
  - Striving for quality
  - Reducing risk

A Common Starting Point

- Institute of Medicine's "To Err is Human" and "Crossing the Quality Chasm"
- Trust Fund Insolvency
- Advent of the Triple Aim and clinical integration
- CMS/CMMI/Commercial Payer Quality Initiatives
- Dramatic advancements in HIT
- Increased fraud and abuse compliance enforcement
- Market trends related to consumerism, accountability, marketing, etc.

All Payers' Quality Strategy

- Guiding principles:
  - Using incentives to improve care
  - Tying payment to value through new payment models
- Changing how care is given through:
  - Better teamwork
  - Better coordination across health care settings
  - More attention to population health
  - Putting the power of health care information to work

Everyone's Golden Strategy

- To deliver high-quality, cost-effective care that produces value for patients and payers
- Harness information to the collective advantage of patients, physicians, facilities and all provider-types
- Individually and collectively become a "*Preferred Provider*"
- Seek to create high value through high reliability

Traits of High Reliability

- Be better culture: focus is on quality, access and experience – efficiency tends follows
- Reinforced goals through organizational culture
- Well-socialized improvement strategies
- Communication and cooperation among physicians and other providers focused on coordinating care and improving transitions
- Standardized clinical processes to reduce errors and improve quality
- It just doesn't happen: requires a deliberate approach

Credentialing is King

- Failure to achieve its core purpose: quality assurance
- Financial implications
- 3rd party liability, e.g., professional liability and negligent credentialing risk
- Workplace harassment
- Compliance risk
- Accreditation risk
- Medical staff/peer review litigation

Credentialing for Membership:

- Membership on the medical staff is a privilege – not a right
- Members must demonstrate that they can be, and will remain, good "citizens" of the medical staff
- Increasingly important with coordinated care
- Areas affecting *individual character and judgment:*
  - History of poor conduct? Prior action?
  - Unexplained departures from prior staffs/employment
  - Appropriate participation within the medical staff
  - Compliance with policies/procedures (e.g., medical records, call coverage)
- Document concerns as you would issues of competency

Credentialing for Privileging:

- Privileging involves:
  - —Consideration of what professional training, experience, and other qualifications are required to be granted specific clinical privileges
  - —Then obtaining and evaluating an applicant's qualifications to determine what clinical privileges should be granted (training, experience, volumes, nature and extent of liability history, etc.)
  - —Determining what particular medical staff category and Department/Clinical Service applicants should be assigned

Credentialing/Peer Review Goals

- ✓ Effective evaluation of conduct/citizenship
- ✓ Effective evaluation of clinical skills and competence
- ✓ Structured to support good faith decision-making
- ✓ Conducted to qualify for immunity and confidentiality

Best Practices/Red Flags:

- Credentialing culture
- Who's on first?
- Negligent credentialing
- Collegial ≠ no documentation
- Credentialing documentation: references
- Credentialing documentation: minutes

Culture Eats Strategy (and ideals) for Lunch

- Deliberate credentialing, privileging and quality/peer review activities are typically well intentioned and based on sound principles
- Many of these activities are frustrated before they begin because of culture or unwillingness to change, notions of risk, confusion, etc.
- Credibility of physician quality champion(s)
- The goal is to lift all boats – this needs to be known and believed

Credentialing and Quality Review

Traditional Approach

Generally speaking, today we focus on basic qualifications and react to problems

- We typically focus on a broad concept of "standard of care" – Not exactly medical malpractice but not what is underway

Credentialing and Quality

- Is there a **difference** between facilitating performance improvement versus identifying poor performance?
- How do your qualifications and privileging criteria target and further quality, collaboration and coordination goals?
- Do you privilege and educate for what you measure:
  - Care coordination, process compliance and patient-centric activities?
- Is it clear to everyone what standards and metrics are being assessed/targeted?
  - Or is there metric apathy and confusion: employment metrics, quality department metrics, department metrics, OPPE metrics, payer metrics and so on
  - Does your OPPE align with your quality strategy?

Who's on First?

- Be clear on which medical staff leader, authority, role or function has responsibility
- Credentialing = peer review = importance of communications, documentation, correspondence, minutes, etc.
- In what capacity are you providing that reference, writing that email, making that comment, etc.?
- It's either official or…. it's not

What Is Negligent Credentialing?

- Negligence occurs when a duty is owed to someone, that duty is breached and the breach resulted in harm (damages)
- Negligent credentialing occurs when a hospital (or other organization) grants membership/privileges to a practitioner who they knew or should have known is not qualified, competent or otherwise could reasonably create harm
- Also sometimes referred to as/or variations of:
  - Corporate negligence (larger umbrella → important distinction)
  - Negligent retention, hiring, supervision, etc.
- Negligent credentialing is recognized in more than 30 states – including Arizona

Elements of a Claim

- A finding that the hospital failed to meet the standard of reasonable care in granting membership/clinical privileges;
  - "A hospital has a direct and independent responsibility to its patients, over and above the physicians and surgeons practicing therein, to take responsible steps to (1) ensure that its medical staff is qualified for the privileges granted and/or (2) to evaluate the care provided."
- Practitioner breaches the standard of care in treating a patient; and
- Granting of membership/clinical privileges to the negligent practitioner was directly related to (the "proximate cause") of the patient/family's injuries → "but for"

Where Negligent Credentialing Resides

- Process: flawed or failure to follow
  - Not following bylaws, regulations or policies
  - Not consistently applying processes, requirements and criteria
  - Use of a poor or flawed process, policy or criteria
- Information: basis of decision
  - Information was available but not requested or reviewed
  - Failure to address identified concerns or red flags
  - "It's not a problem until…"
- Claims tend to arise from patients/families and other organizations

Examples

- Credentialing procedures prohibit fast track in certain scenarios but hospital proceeds anyway
- MSP identifies negative malpractice history trend and committee does not evaluate
- Providing inaccurate or misleading information in response to professional reference inquires → normal sinus rhythm
- Failure to address disruptive behavior, hostile environments or impairment
- Not applying commonly recognized standards regarding scope of practice, quality assessment activities, criteria, etc.

"Collegial" ≠ No Documentation

- Scenario: Credentials Committee at reappointment; application file is silent on unavoidable concerns
- Background:
  - Collegial intervention is often an important first step in addressing concerns; may as simple as a sit-down meeting/conversation with no action taken
- Mistake: not documenting the collegial intervention
- Lesson learned/result:
  - 15 years of undocumented "collegial interventions" make for a challenging process ahead

Credentialing Documentation: References

- The challenges are real:
  - Human nature, fear of being sued, perceived benefit of a pain free resolution
  - Uncertainty over what and how disclose, dissonance over moral duty…
- Generally **no duty** to disclose – but **a clear duty** to not misrepresent
  - The *value* of name, rank and serial number?
- If you do respond to privilege verification, make sure it is accurate
- See **who's on first**

Credentialing Documentation: Minutes

- Just the facts ma'am
- Content should emphasize and focus on actions taken and underlying basis
- Consider avoiding:
  - Transcript-based minutes at all costs
  - Details regarding discussion of action items
  - Identity of specific commentary
  - Personal observations, opinions and adjectives
  - Ending time
  - Recording!

Questions?

Contact Us

For more information on these topics visit hallrender.com.

Brian Betner
303-802-1298
bbetner@hallrender.com

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