

Briefings on

Credentialing

The monthly newsletter
for medical services
professionals

Credentialing today's vendor representatives in the OR

**Before taking on a Herculean task,
make a list of helpful allies**

Vendor representative credentialing is evolving as fast, if not faster, than the clinical advances in medical technology. As a result, the burden on MSPs to ensure that industry representatives in hospitals do not put their business objectives before patient care guidelines has also increased.

The good news for already overtaxed MSPs is that there are countless resources available to aid in the credentialing of vendor industry representatives. For example, when MSPs are evaluating the most recent industry regulations and reviewing accreditation requirements from the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission (formerly JCAHO), they can consult professional societies. These include the Association of periOperative Registered

Nurses (AORN) and the Advanced Medical Technology Association (AdvaMed). They can also consider whether using a vendor-focused, third-party credentialing agent such as Vendormate would be a better use of resources.

AORN's OR Protocol® Program

AORN is a professional association whose mission is to support RNs in achieving optimal outcomes for patients undergoing operative and other invasive procedures by providing education, services, representation, and standards of practice. These standards of practice extend to the

Enclosed:

This month's *Clinical Privileging White Papers*:

- **Total hip replacement (update)—Procedure 97**
- **Podiatric medicine and surgery/podiatry (update)—Practice area 163**

development of proposed credentialing criteria that a medical staff services department or a hospital's HR department can adopt, as applicable.

In addition to working with surgeons, anesthesiologists, and other nurses, operating room (OR) nurses work with healthcare industry representatives (HCIR).

HCIRs' role is to provide training and guidance to practitioners. They need access to the OR and catheterization laboratory to fulfill that role, says **Fred Perner**, AORN's vice president of business development. "However, a balance exists between access and risk management considerations at the healthcare facility in question, whether a hospital or ambulatory center."

Perner says AORN recognizes that HCIR credentialing plays an important role in achieving that balance, which is why the organization works to develop proposed credentialing criteria.

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HCPPro

Vendor reps

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AORN is in the process of developing new credentialing criteria with the help of other professional organizations. However, Perner says for several years, many facilities have used AORN's OR Protocol course as a starting point for developing criteria. The course is based largely on AORN's position statement on "The Role of the Health Care Industry Representative in the Operating Room." The course is available for a fee on AORN's Web site at www.aorn.org.

The request for new, more comprehensive credentialing criteria came from the field, says Perner. "We received multiple requests to investigate this area from our members, the hospitals they work for, and from industry partners," he says.

As a result, AORN is working with AdvaMed, the Association for Healthcare Resource & Materials Management, the American Association of Critical-Care Nurses, and other industry representatives to develop proposed credentialing criteria.

"We're currently working on what we believe is our final draft of recommendations and have sent these out for final comment and approval [from the group members]," says Perner. Information about the final criteria will be available on AORN's Web site. (See "AdvaMed updates *Code of Ethics*" on p. 3.)

AORN's goal is to have proposed criteria—not to be confused with established criteria—to help hospitals and other healthcare organizations sort through the credentialing process, Perner says. Once established, the criteria will be subject to regular reviews, similar to AORN's position statements.

Low- and no-cost solutions

MSPs seeking to manage the burden of vendor credentialing may opt to work with a CVO. There are a several such organizations that specialize in credentialing vendor representatives for hospitals. Some of them charge the device manufacturer a fee for their services, but not the hospital.

Atlanta-based Vendormate (www.vendormate.com) is one such company that offers free credentialing services to hospitals in exchange for a signed contract stating that the hospital will encourage its vendors to participate in the program.

The company sets up online portals for hospitals to manage their vendor representatives and companies. "There are two areas of vendor credentialing that kind of converged to create this market," says **John Harper**, marketing director at Vendormate. "One is the health-care industry representative [who] comes on-site and has patient access. The other is the vendor company itself."

At the vendor representative level, the individual needs to be credentialed to ensure compliance with immunizations and hospital training requirements. These requirements will vary based on the level of patient-vendor contact.

MSPs who credential their organization's vendor rep-

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representatives may find the company level more complex. At the company level, the organization must be checked to see whether it:

- Is on any CMS or Office of Inspector General sanction lists
- Has liability insurance
- Has agreed to the hospital's gift and gratuity policy
- Has met all of the other standards

The biggest difference between the credentialing requirements for practitioners and for representatives, other than sanctions lists, is that the latter are not set by the government, says Harper.

Beyond CMS requirements, hospitals generally look to four main organizations for guidance when drafting their vendor policies:

- The American College of Surgeons
- AORN
- The Joint Commission
- The Centers for Disease Control and Prevention

Once Vendormate establishes a relationship between a hospital and a device manufacturer, it continues to act as a communication hub.

"From a hospital's point of view, they have departments like the ethics organization, they have the cath lab, they have the OR management team that are collecting pieces of information from vendors, but there's not a central place where it all ties together," Harper says. "What we provide is that central place."

An example of this communication model in practice is the process for maintaining ethics compliance.

Vendormate accomplishes this by sending the hospital's ethics policy to the vendor representative and company to sign their agreement to it.

If the hospital updates its policy, Vendormate contacts the representative and the company to alert them of the change, and again requests their compliance. If a vendor falls out of compliance for some reason, Vendormate alerts the hospital.

If a hospital wants to work with a vendor company

that does not have a relationship with Vendormate, it is allowed to do so under the terms of its contract.

"We certainly don't recommend it, because the point of this is to get everything centralized and manage it in an automated fashion," says Harper. However, "the goal isn't to block access between the vendors and the hospital; the goal is to make sure that all parties have all the content and information that they need."

Meeting the goal of information gathering at your hospital can be made easier by identifying your allies in the process. ■

AdvaMed updates Code of Ethics

The relationships between medical device manufacturers and healthcare professionals will be subject to new restrictions beginning July 1 when Advanced Medical Technology Association's (AdvaMed) revised *Code of Ethics on Interactions with Healthcare Professionals* goes into effect.

The new Code is designed to eliminate even the appearance of impropriety in medical device manufacturers' interactions with healthcare professionals.

The revised AdvaMed Code:

- Prohibits providing entertainment or recreation to healthcare professionals
- Prohibits gifts of any type, including all noneducational, branded promotional items
- Provides guidelines for proper consulting and royalty agreements between medical device manufacturers and healthcare professionals
- Sets parameters for providing demonstration and evaluation products
- Addresses the provision of objective reimbursement, coverage, and health economics information to healthcare professionals
- Includes a section under which a list of companies that certify their adoption of the Code will be available for public review on AdvaMed's Web site (includes contact information for the company's compliance officer and hotline)

Source: <http://blogs.hcpro.com/epharmaceuticals>.

Sample welcome letter to vendor company

Editor's note: The following is a letter that MSPs can send to a vendor company that has expressed an interest in developing a working relationship with the medical staff. It should be customized to reflect your organization's policies before implementation.

Date: _____

Name of vendor company: _____

Address: _____

Re: Use of [medical device]

Dear [vendor company],

We appreciate your expertise and willingness to introduce [medical device] at [hospital name]. Our medical director has reviewed and conditionally approved your request. Final approval is based on the results of a credentials review. The medical staff services department will serve as your main contact during this credentialing process.

Please find enclosed our credentialing application for vendor representatives; our hospital bylaws, rules, and regulations; our ethics and immunization policies; and a copy of our fair hearing plan and other policies relating to clinical practice in this hospital. [Insert link if available online.]

E-mail the answers to the following questions to the medical staff services department by [date due]. It will help accelerate the credentialing process.

1. Does [vendor company] work with a third-party credentialing organization that [hospital name] can obtain information from? If so, please list those credentialing organization(s): _____

2. Please list at list three other hospitals where [vendor company] has introduced [medical device], as well as the names of the practitioners who worked with your vendor representatives: _____

Thank you,

[Insert MSP's name and contact information here]

Source: HCPro, Inc.

Draft privileging criteria for vendor representatives in the OR

Minimum threshold criteria for requesting approval to be present in the operating room (OR):

- **Basic education:** Baccalaureate degree, which included biology, chemistry, and physics, as well as credits in human anatomy and physiology.
- **Minimum formal training:** Applicants must have successfully completed the following:
 - An OR protocols course, which included the following:
 - Appropriate conduct in the OR environment
 - Aseptic principles and techniques
 - Infection control practices
 - Bloodborne pathogens
 - Fire, electrical, and other safety protocols
 - Patients' rights and confidentiality, including HIPAA compliance strategies
 - Informed patient consent regarding the presence and role of healthcare industry representatives (HCIR) in the OR
 - Training in the medical system, device, or procedure for which they are seeking approval for their presence in the OR. Training must have included experience in the OR for that medical system, device, or procedure in a mentorship program supervised by an experienced HCIR.
 - Documentation of satisfactory results from a criminal background check (an explanation of satisfactory results is specified in hospital policy and procedures documents).
 - Documentation of sponsorship from an active member of the medical staff with privileges compatible to the privileges being requested by the HCIR.
 - Recredentialing for new products or devices as defined by hospital policy and procedure.

Applicants must also comply with hospital policy and procedure as defined in *Institutional Policies and Specific Procedures*.

- **Required previous experience:** Applicants must also be able to demonstrate that they have provided technical support on at least five occasions in the previous 12 months for the medical system, device, or procedure for which they are seeking approval for their presence in the OR.

Note: The **Credentialing Resource Center** recommends that applicants should present written proof of current TB testing and hepatitis vaccination and agree not to participate in the delivery of any patient care services when symptoms of any contagious disease or condition exist.

- **References:** Letters of reference must come from the director of the applicant's OR protocols training program and the director of the applicant's medical system, device, or system training program. Alternatively, a letter of reference regarding competence should come from the chief of surgery at the institution where applicants most recently provided technical support for the medical system, device, or procedure for which they are seeking approval for their presence in the OR. A letter of responsibility and sponsorship shall be provided from an active medical staff member with privileges correlating to the services requested by the HCIR.
- **Bylaws and policies:** Failure to comply with medical staff bylaws, rules and regulations, or hospital policy shall result in the termination of privileges without the right to appeal. All privileges are granted by the hospital board of trustees and may be rescinded by the CEO, on behalf of the board, at any time based on advancement of patient care and hospital policy.
- **Reapproval:** Applicants must be able to demonstrate that they have maintained competence by showing evidence that they have provided technical support on at least five occasions in the previous 12 months for the medical system, device, or procedure for which they are seeking reapproval for their presence in the OR. In addition, continuing education related to the medical system, device, or procedure for which they are seeking reapproval for their presence in the OR should be required.

Source: HCPro, Inc.'s Clinical Privilege White Paper, *Special report 1010. "Healthcare Industry Representatives in the Operating Room and Other Invasive and Special Procedure Sites."* Published January 2005.

The multifaceted medical staff

Employ cultural competency training to quell privileging discrimination claims and foster community

Cultural competency is a popular buzzword in health-care these days. From the hospital's point of view, mastering cultural competency can improve the way the organization cares for its patients. From the medical staff's point of view, mastering this competency can help reduce claims of discrimination and build an atmosphere of support for practitioners.

In fact, it's such an important issue that The Joint Commission (formerly JCAHO) initiated a project in 2008 to help hospitals achieve cultural competency. From August 2008 through January 2010, the accrediting organization will work to develop culturally competent patient-centered care standards. (To learn more about this project, visit www.jointcommission.org/PatientSafety/HLC/HLC_Develop_Culturally_Compentent_Pt_Centered_Std.htm.)

Failure to master cultural competency can lead to lawsuits. In one such suit, filed in December 2008, nine cardiologists claimed racial discrimination against Regional Medical Center Bayonet Point and alleged that the Hudson, FL-based hospital revoked privileges without appropriate appeal because of the practitioners' ethnicity. Whether added on to other claims or the focal point of a lawsuit, claims of discrimination are taken seriously by juries. Medical staffs wanting to stay on the right side of the law must stay on top of current laws and best practices.

Include the basics in your bylaws

Jennifer Pizer, senior counsel at Lambda Legal in Los Angeles, says there are three essential steps that hospitals and medical staffs can take to improve cultural competency and reduce discrimination claims:

- Establish clear policies
- Conduct effective training programs
- Implement clear procedures for requesting and receiving complaints of discrimination and biased conduct

"If employers have reasonable policies in place to train and to handle complaints and they're acting in a reasonable and responsible way, that can nip trouble in the bud and limit the extent to which they can be held responsible for damages," Pizer says.

It isn't enough to include relevant state and federal laws in the medical staff bylaws. These important documents must also acknowledge what's on the legal horizon.

For example, in terms of employment discrimination, the most important law is the federal employment nondiscrimination act—also known as Title VII of the Civil Rights Act of 1964. The law protects against discrimination on the basis of race, sex, national origin, or religion. It does not explicitly cover sexual orientation or gender identity, but Pizer says courts have been finding that gender identity discrimination is covered by the sex discrimination ban and that there is fast-growing support in Congress for a bill that would cover those types of discrimination explicitly. Therefore, proactive medical staffs should include those terms on nondiscrimination documents.

Title VII applies nationwide to public and private employers, but it is not the only employee nondiscrimination law to follow when drafting policies. The federal and state constitutions have equal protection clauses that apply in public hospitals, and federal money can bring federal anti-bias rules into private settings too.

Tip: To learn more about federal discrimination laws, visit the U.S. Equal Employment Opportunity Commission's Web site at www.eeoc.gov. For more about sex and gender discrimination laws by state, visit Lambda Legal's Web site at www.lambdalegal.org/our-work/states.

Putting policies into practice

After your medical staff determines which laws and best practices to include in policies, the next step is to implement a training program. Most hospitals run a

mandatory training program during orientation for medical staff members and employees about how to handle general workplace problems. These may include conflicts of interest, bullying, and sexual harassment.

The medical staff, especially practitioners and MSPs focused on credentialing and privileging, may want to hold an additional session with a consultant or lawyer to go over specific questions.

The following are some questions the medical staff may raise in those sessions:

- ▶ Is it age discrimination to state in a policy: “Practitioners over age 62 are not required to take emergency department call”?
- ▶ Is it physical discrimination to require surgeons to take yearly eye exams and share the results with the credentials committee?
- ▶ Is it religious discrimination to require practitioners to perform procedures such as sterilization that are against their religious beliefs?

The answers may vary based on state law and the characteristics of your hospital. In addition to answering those

questions and drafting sound policies based on them, organizations must have a way to find out when those policies are broken. Hospitals should implement confidential means for requesting and receiving complaints of discrimination and other bad behavior so that people may disclose information without fear of reprisal. If an MSP suspects that a credentials or privileging committee made a discriminatory decision, he or she can use the organization’s reporting system as a first course of action. Should the need for follow-up arise, the MSP can take other steps such as filing a formal complaint or contacting a lawyer.

Another course of action is to file a complaint with the practitioner’s licensing board, Pizer says. “Those licensing standards are sometimes not as effective an enforcement mechanism as a direct lawsuit [that seeks damages] in court, but it’s important for people to keep in mind because every state has them,” she says.

Good staff policies lead to good patient policies

The culture and atmosphere a medical staff establishes ultimately trickle down to patient care and help

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Understanding discrimination terminology

Q What is the difference between gender identity and gender expression? Which is the better term to include in antidiscrimination policies?

A Gender identity is a term that is used to describe whether an individual identifies as female, male, both, or differently. Gender expression is a term that describes how an individual expresses that identity through hairstyle, clothing choices, and a range of other ways. Personal expression is an interesting aspect of employment law because it raises the question: “How much freedom do workers have to express themselves in a business setting?” The law in this area is evolving, but it’s a good rule of thumb that any appearance and conduct rules that are imposed on employees must not be based on stereotypes, such as all female doctors must wear earrings and all male doctors must not. As far as which term is better to use, it’s quite standard to use “gender identity or expression.”

Q What’s the difference between sexual orientation and gender identity?

A Sexual orientation refers to whether a person generally is attracted to persons of the same sex, the other sex, or both, whereas gender identity focuses on the individual’s sense of self, rather than on relationships with others.

The definitions are used in a widespread way—they are in policy, case law, and statutes—and there are set meanings for these terms.

Thirty years ago, people may have said, “These terms are confusing; we don’t know what they mean.” But that’s not the case anymore. And the established meanings can be helpful to employers.

Source: Jennifer Pizer, senior counsel, Lambda Legal, Los Angeles. www.lambdalegal.org.

Discrimination

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establish a hospital's reputation. If a patient feels hostility between practitioners, he or she is unlikely to return to that organization. However, if patients see practitioners treating each other with respect and kindness, they may recommend the hospital with friendly doctors to their friends.

Beyond enforcing antidiscrimination policies as a good business practice, it's a good patient care practice because it encourages practitioners to look beyond stereotypes they harbor and see the patient before them as a person

The AMA and NMA's intertwined history

Through the years, discrimination among practitioners has led to the founding of several professional organizations designed to protect the interest of minority practitioners. One such organization is the National Medical Association (NMA), founded by African-Americans who were not welcome to join the AMA. In summer 2008, the NMA accepted the AMA's apology for its history of racial inequality.

"We commend the AMA for taking this courageous step and coming to grips with a litany of discriminatory practices that have had a devastating effect on the health of African-Americans," Nelson L. Adams, MD, NMA's president, said in a press release. "In fact, the NMA owes its very existence, in part, to these inequities which forced African-American physicians to found their own membership organization."

Adams called on the AMA to work with the NMA on three initiatives:

- An effort to actively recruit more African-Americans into the medical profession
- A commitment to reduce health disparities among African-Americans and other communities of color
- A requirement for medical schools and medical licensing boards to make cultural competency training mandatory, with an emphasis on training for all health professions

Source: www.nmanet.org/images/uploads/Documents/NMA_Accepts_AMA_Apology.pdf.

in need of care. "I think part of the reason this is so important is because a lot of the change that needs to happen around [lesbian, gay, bisexual, and transgender (LGBT)] patients will come from LGBT healthcare professionals," says **Joel Ginsberg**, executive director of the Gay & Lesbian Medical Association (GLMA) and a member of the Expert Advisory Panel to Guide the Development of Joint Commission Hospital Standards for Culturally Competent Patient-Centered Care.

Hospitals and medical staffs can assess their employees' views about discrimination by surveying them. The results of the survey can then be used as a baseline for an antidiscrimination training program to determine what learning objectives need to be met and what knowledge staff members already have.

The GLMA worked with the Human Rights Campaign, an LGBT civil rights organization, to develop the Healthcare Equality Index (www.hrc.org/issues/hei.asp). The Index is a yearly survey that evaluates hospitals on five main policy areas: patient nondiscrimination, hospital visitation, decision-making, cultural competency training, and employment policies and benefits. Ginsberg encourages all hospitals to take the survey, even if they don't want the results published, because it is a great self-assessment tool.

Another way to improve antidiscrimination efforts is to attend conferences of organizations that represent marginalized groups. The conferences will give outsiders greater insight into the subculture, and there may be antidiscrimination training material available.

Ginsberg says that another way to support a historically marginalized culture in the workplace is to encourage them to form a group. Some hospitals have an office of diversity that is focused on building bridges among people and moving away from discriminatory behavior.

Whatever cultural competency training methods your organization employs, it's important to constantly revisit and revise them. Just as culturally acceptable practices change over time, so does employment discrimination law. ■

Credentialing Resource Center Symposium

Get laced up for credentialing boot camp



We've been counting down the days to the next **Credentialing Resource Center (CRC)** Symposium all year long on the **CRC** Web site, and if you've been counting with us, you know there's less than 100 days to go. With four tracks available—credentialing and privileging, medical staff services department, leadership, and quality—you may need a Symposium inside scoop to know which track to choose.

Mary Hoppa, MD, senior consultant for medical staff and credentialing and privileging at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, gives readers a preview of what they'll find in May at the 12th annual **CRC** Symposium in Las Vegas.

Along with Sally J. Pelletier, CPMSM, CPCS, Hoppa will be presenting the first sessions in the medical staff services department track. The presentation, "Boot Camp for Credentials Committee Members, MSPs, and New Department Chairs," (part I & II), is designed to give attendees a solid foundation in credentialing basics.

Recently, **Briefings on Credentialing (BOC)** spoke with Hoppa to learn more about the presentation.

BOC: Who should attend this boot camp? Are boot camps designed for MSPs to collect information to give to their medical staff leaders or are they for the individual medical staff leader?

MH: I would send both types of professionals. It's really geared toward doctors, but since the MSP supports the doctor in most credentialing aspects, I see it as a collaborative session. In a way, the session is similar to the collaborative credentialing process between the MSP and the medical staff leaders.

BOC: What information do attendees need to know before they show up?

MH: Absolutely nothing. At our boot camp, we assume you know very little about credentialing, so we

teach you all the basics. This gives you a good foundation for the other sessions in which more complex information is presented. Today's credentialing challenges include low- and no-volume practitioners, processing advanced practice professionals, linking competency to privileging, and evaluating competency. We allude to these in the boot camp sessions, but because they are such involved topics, you can't go into too much depth or it becomes the whole program.

BOC: Is attending the boot camps something that medical staff leaders need to do only once in their career, or do they need refreshers?

MH: You probably want a refresher course every three to five years since the area of credentialing and privileging is constantly evolving. Sally Pelletier and I will address certain things in our presentation that are topical for today's audience. For example, the area of competence is being hit much more than it ever was before. Once you get the credentialing basics down, then you can apply that knowledge to other programs. Although much of the foundation of the boot camps has evolved over time, there is definitely new material being added to it.

BOC: What drives new medical staff leaders to attend these boot camps?

MH: People coming out of residency today know they should only ask for those privileges they're competent to do. So that idea of competency is engrained in residency.

When we ask people to become medical staff leaders, many of them ask, "How can I become a medical staff leader when I don't have any competency in that area? I've not been trained to do it."

The credentialing boot camp, as is the whole **CRC** Symposium, is a tool to educate medical staff members and get them past the hurdle of saying, "I don't want to do it badly; I only want to do it if I know I can do it

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CRC Symposium

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well.” It deals with competency, which is a big-ticket item that is on the forefront of a lot of people’s minds. If your potential medical staff leaders tell you, “I don’t mind doing it if I know how to do it,” then you should point them in the direction of this boot camp.

BOC: How do you answer potential medical staff leaders who ask you how long leadership training is going to take?

MH: There’s no set curriculum for how long training takes. Leadership is a continual learning experience. Obviously, we have courses that leaders can refer to as a foundational set of knowledge that medical staff leaders should have.

Nevertheless, this information needs to be customized for your organization and will undoubtedly evolve over the years. There are certain things that some hospitals may never encounter, such as a privileging dispute between specialties, and there are other hospitals where the medical staff may come across that dispute several times and have solved it.

There’s no set time frame for mastering medical staff leadership training and there’s no one magic course that will make you a perfect leader overnight. A good rule of thumb is to start with the basics and remain open to new learning opportunities as they arise.

BOC: What are some things an MSP can do to encourage medical staff members to become leaders or to stay active as leaders?

MH: MSPs serve the vital role of sifting and winnowing information that is important to the medical staff and relaying it in a concise format. Doctors value

their time, so whatever the MSP can do to put that information in an easily digestible format is a plus to the practitioner.

This also means flagging the most notable data in a large packet of information. You can tell the practitioners, “You don’t have to scan all the literature, but the items I’ve flagged are things that pertain to us,” or “This is something big that’s happening in the area that pertains to us, and you ought to be aware of it.”

This helps put the relevant information on the practitioner’s radar. It’s sort of an early warning system, so when the medical staff is faced with an issue head-on for the first time, they have some background information available.

BOC: Do you think it’s more effective for MSPs to pass the information on to the medical staff as they get it or on a regular basis?

MH: When Sally and I receive questions like that, we usually turn it back to the MSP and ask, “How does your medical staff like to learn?” It’s important that MSPs pass information along to the medical staff in a format that works best for the practitioners.

You may have great information to share, but if you’re not effectively making a connection, the information does not get transmitted well.

You may deal with a medical staff that says, “Tell us when something’s important. Otherwise, we’ll just think it’s status quo.” And there are some medical staffs that say, “We do better if we have a set time, such as a half an hour before a credentials meeting when you go over this information with us.”

Different practitioners have different communication needs.

BOC: What’s the next step in the learning process for the medical staff leader after arriving home from boot camp?

MH: The next step is understanding that it’s a continual learning process. Just as you have to keep up on medical literature, you have to stay current on the latest

Correction

The American Society of Ophthalmic Plastic and Reconstructive Surgery was listed incorrectly on p. 12 of the *Clinical Privilege White Paper “Oculofacial plastic and reconstructive surgery—Practice area 419,”* published in February. The word “Ophthalmic” was inadvertently omitted. The rest of the information is correct.

medical staff leadership information. You can do this by looking at available audio conferences or Web conference training sessions or reading publications such as **Medical Staff Briefing** and similar resources that have continuing educational value.

Even if you don't think some information is pertinent to you, file it. You may need it six months down the road and you'll be glad you have it.

BOC: MSPs do a great job of networking with their peers across hospitals to gather information. Do medical staff leaders employ similar tactics?

MH: Not exactly. For MSPs, it's their job to know all these standards, and one of the ways they can do this is by exchanging information with their peers.

However, doctors frequently volunteer as medical staff leaders and they're doing this as an adjunct to their regular practice. Therefore, they may not attend the informational meetings or networking sessions with the regularity that MSPs do. Medical staffs vary: In some medical staffs, you have dedicated leaders that have been in leadership positions for 10–15 years, and these individuals have accumulated vast knowledge throughout the years.

You may also see staff members who are episodically in leadership positions over the years as their circumstances allow. Often, the training for doctors isn't as consistent or long-term because this is only a small part of their medical life.

Anything the MSP can do to help practitioners process information efficiently while they are in the leadership role will ultimately help the medical staff function smoothly. ■

*Editor's note: The 12th annual **CRC** Symposium takes place at Caesars Palace in Las Vegas May 14–15. For more details, including early bird registration discounts, visit www.greeley.com/seminars.*

PRESENTED BY THE **CREDENTIALING RESOURCE CENTER**

12th Annual Credentialing Resource Center Symposium

May 14–15, 2009
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The Next Step with Sally J. Pelletier

Advancing your credentialing & privileging practices one step at a time

Privileging software benefits

During the past few decades, advances in technology have resulted in a lifestyle that previous generations never dreamed possible. However, there are some traditional and slower methods of doing things that I won't give up.

For example, I much prefer the old-fashioned method of brewing a cup of tea versus heating up water in

When it comes to credentialing and privileging verification methods, we must be willing to let go of old-fashioned or less efficient ways of doing our work.

the microwave. Personally, part of the enjoyment and relaxation of having a cup of tea includes the ritual of putting on the teakettle,

hearing the whistle, pouring that steaming water over the tea bag, and waiting for it to brew to the desired strength. Penning a handwritten note to a treasured friend or sending a thank-you card via snail mail has special meaning when compared with sending electronic cards or e-mail.

However, when it comes to credentialing and privileging verification methods, we must be willing to let go of old-fashioned or less efficient ways of doing our work. We must decide to say out with manual processes, redundant checklists, and labor-intensive tasks, and in with efficiency, state-of-the-art reports, push-of-a-button queries, Web crawlers, and automated reappointments.

For many years, technology has allowed organizations to automate credentialing and privileging verification and reporting functions. MSPs should continuously evaluate utilization of their credentialing and privileging software to ensure that optimal benefits are embraced and incorporated into their daily world. With MSPs

being asked to do more with less, they must be aware of where they can incorporate automation whenever possible.

One of the most time-consuming and arduous projects a medical staff services department will undertake is the development and implementation of a criteria-based privileging system.

Fortunately, there are innovative electronic solutions that provide not only a mechanism to automate the dissemination of an individual practitioner's privileging information, but which also contain expertly researched and customizable content.

The plus of technology is that when we use it to our advantage, it allows us to find time to spend in more meaningful areas. Utilizing software that has been developed by experts and includes content that can be customized for your organization is a great way to increase productivity in your office. ■

Editor's note: Sally J. Pelletier, CPMSM, CPCS, is a senior consultant with The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

To learn more about criteria-based privileging systems or to receive a free credentialing software assessment tip sheet, contact credentialing editor Maureen Coler at 781/639-1872, Ext. 3741, or mcoler@hcpro.com.

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