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Credentialing Challenges Unique to Health Systems with Multiple Medical Staffs

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Board members and senior managers often overlook the critical importance of effective credentialing to the success of their institutions. Credentialing done well ensures health systems have practitioners who can deliver safe, high-quality care. If performed improperly, the result can be liability for corporate negligence with damaging financial assessments and harm to a health system's reputation. All healthcare organizations struggle with contemporary credentialing challenges posed by the expanded use of non-physician practitioners, growth of "low-volume" practitioners, a tsunami of aging ("late career") doctors, a growing physician shortage, and tighter accreditation requirements, to enumerate just a few.

Health systems that include multiple medical staffs often find it difficult to deal with the issues listed above because of the complexity inherent in large organizations and the lack of integrated credentialing planning and execution. Furthermore, health systems have additional unique credentialing challenges that should be assessed and addressed to keep them from stepping on legal landmines or frustrating their already stressed physician workforces. These unique challenges are often eliminated where a health system unifies disparate medical staffs into a single entity. However, while the pace of medical staff mergers is accelerating, unified medical staffs across health system hospitals are still uncommon and are not always practical or achievable.

The credentialing challenges of health systems fall into several buckets. Some create increased risk of legal liability; some increase the burden on applicants and staff in ways that can be inefficient and unnecessarily aggravating to valued practitioners; and yet others can impact the ability of credentialing to promote high-quality care. The remainder of this article will describe some of these challenges in greater detail.

Credentialing Challenges and the Need for Standardization across the System

Every medical staff in a health system is responsible for establishing (with approval by the board) eligibility criteria for both membership and specific clinical privileges. Where these criteria are different across medical staffs that operate under the same system board, potential liability is created. For example, one hospital in a health system may require maintenance of board certification to retain medical staff membership, while another may not. If a patient is harmed by a practitioner in the latter hospital, his/her attorney may assert negligence by the health system board. This lawyer would argue that the board recognized the value of the higher standard (i.e., maintenance of certification) at one of its institutions but then improperly allowed a lower standard at another. This, in turn, permitted a less-qualified practitioner to harm the patient. Within a health system, it is important to promote as much consistency as possible in the eligibility requirements to serve on its various medical staffs.

Standardization of eligibility criteria is even more important when it comes to specific clinical privileges. These criteria are typically enumerated in delineation of privileges forms (DOPs). The purpose of DOPs is to make clear the minimal qualifications a hospital requires to exercise a particular privilege. It is difficult to rationalize why a board would approve stricter criteria at one hospital than another. Take a health system that has two hospitals located on opposite sides of town that have DOPs with different criteria. It is hard to explain why a doctor who satisfies applicable privileging criteria at one hospital is regarded as qualified to perform a procedure in that facility, but does not meet the criteria in the other hospital located only a few miles away. Assume a family physician who is on staff at both places is denied the opportunity to perform a C-section at one hospital because she doesn't meet the eligibility criteria to hold that privilege. If she then performs a C-section at the hospital where she does meet the criteria and there is a bad outcome, a jury is likely to believe the system improperly and knowingly permitted one of its hospitals to grant privileges under a lower standard than the board regarded as appropriate at another one of its facilities.

Health systems can face further liability when their various hospitals undertake corrective action (a restriction on medical staff membership and/or privileges) that is not synchronized. Let's say one medical staff in a system determines a physician should have privileges terminated and the board agrees. However, that same physician may hold privileges at another system hospital where the

medical staff has made no such determination and his privileges are continued. This situation leaves the health system board in a position where it has determined a physician is incompetent in one location, but somehow is assumed competent in another. Since longitude and latitude are not generally recognized as factors in a doctor's clinical competence, this circumstance is untenable. The doctor may sue claiming the "schizophrenic" position of the health system demonstrates the loss of his privileges at only one hospital was arbitrary and unjustified, or a patient may allege corporate negligence if harmed by this doctor at the site where the board allowed him to retain privileges.

Lack of standardization in credentialing policies and procedures across a health system's medical staffs can also frustrate physicians applying to multiple staffs. Allowing each medical staff to adopt its own policies and forms may result in applicants needing to fill out duplicative forms or complete applications that do not match across institutions. A doctor may need to modify privileging requests multiple times to conform to non-standardized privileging criteria, and may be aggravated by the challenge of keeping track of the requirements of disparate policies across two or more hospitals. For example, one system medical staff may have special criteria for doctors over the age of 65 while others may not. Filling out extra forms and confusing disparity in policies and requirements is not considered a "user-friendly" environment. In a time when physician recruitment and retention need to be priority activities, annoyance with the burden of credentials appointment and reappointment applications and frustration with compliance expectations and requirements set in disparate policies can contribute to burnout and disengagement.

Expectations and Actions of the Board

What should health system boards expect from the credentialing activities across their medical staffs? If the system does not utilize an internal or external Credentials Verification Organization (CVO) this is an opportunity to create efficiency and standardization in the application process. Use of a CVO involves having a single office do the basic application data gathering and verification for all system medical staffs.

If the system has not promoted standardized DOPs across its hospitals, the board should consider charging a task force of system medical staff leaders to facilitate this activity. To standardize credentialing decisions across medical staffs, the system could explore the creation of a unified credentials committee. Such a committee could also promote uniform adoption of credentialing policies that reflect best practices.

Health system boards can require that data-sharing agreements be in place that enable the transmission of individual practitioner performance information between medical staffs within a system. This will ensure that practitioner competency concerns, peer review interventions, or corrective actions in one hospital are transparent to medical staff leaders in other system hospitals.

The health system board should ask legal counsel to create medical staff bylaws language that limits the number of fair hearings a doctor can request on the same issue at multiple hospitals. Medical staff bylaws can be revised to make corrective actions reciprocal across system hospitals.

Some health systems have consolidated into a single department medical staff support office staff, credentialing professionals, personnel working in the recruitment and onboarding of employed doctors, employees doing provider enrollment and delegated credentialing for payers, and some individuals working in human resources on physician matters. This can be led by a director of physician affairs. This helps bring these related activities into a coherent management structure and avoids duplication of work, delays in processing, and unnecessary cost.

While credentialing is not a "sexy" topic, health systems should be aggressive in coordinating this activity across their medical staffs. The health system will deliver higher-quality care, be more physician-friendly, and at reduced risk of legal liability as a result.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director of Sagin Healthcare Consulting and Governance Institute Advisor, for contributing this article. He can be reached at tsagin@saginhealthcare.com.

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