# Credentialing Resource Center Journal

## Get to know the speakers of the 2019 CRC Symposium

The 2019 CRC Symposium, being held in Las Vegas February 26–28, features a combination of new and returning speakers, physicians, and medical staff professionals. These speakers are experts in credentialing, privileging, provider enrollment, quality, physician leadership, and medical staff committee functions. Here, **CRCJ** introduces you to this year's lineup of speakers with a taste of the kind of insights they will provide attendees.

**Catherine Ballard, Esq.**

Ballard is a partner at the law firm of Bricker & Eckler and vice chair of its healthcare practice group. She works with clients in the areas of hospital/medical staff integration, medical staff and hospital-employed physician integration, quality assessment and performance improvement, and related peer review matters. At this year's Symposium, Ballard will speak about going through the corrective action and fair hearing processes as well as telemedicine credentialing by proxy.

*CRCJ: To engage in credentialing by proxy, must the hospital where the patient will receive telemedicine services ("originating site") explicitly recognize the option in its medical staff governing documents?*

Ballard: Yes. Your medical staff governing documents control what you can and cannot do in terms of the relationship between the medical staff and the governing body, so you need to be sure that you have a provision addressing telemedicine credentialing in there. If a document says, "Here's our credentialing process," and there's no mention of credentialing by proxy, then that route is not currently an option for you.

Whether the language goes in your bylaws or your credentials policy depends on your accrediting entity, although we are not aware of any issues related to putting this in a policy rather than your bylaws. Regardless of the chosen location, however, you absolutely need to have the option codified somewhere in your governance documents if, in fact, this is something you want to do.

**Carol S. Cairns, CPMSM, CPCS**

Cairns has more than 40 years of experience in the medical staff services profession. She is the president of PRO-CON, and an advisory consultant and frequent presenter with The Greeley Company. A recognized expert in the field, Cairns has been a faculty member with the National Association Medical Staff Services since 1990. She is an expert when it comes to setting up the structure and support to help advanced practice professionals (APP) "train up" and expand their role.

*CRCJ: What's the best approach for expanding APPs' scopes of practice? What role does the MSP play in this endeavor?*

Cairns: This is occurring across the country—APPs are expanding skills under the tutelage of their supervising or collaborating physician sponsors. Sometimes this is being done without the organization's knowledge or approval. If an organization determines it wants to allow APPs to expand their scope of practice, it is imperative that the organization/medical staff develop a process to accomplish this goal.

MSPs are at the heart of this process. They are generally the ones who identify this process is needed or is already occurring without permission. Thereafter, the MSPs and medical staff leaders must determine the next steps. Considerations include policies and procedures, privilege sets and criteria, and competence assessment processes. To prepare for such initiatives, MSPs must sharpen their researching, networking, and project leadership skills.

**Leslie Cox, BS, MHA, CPMSM, CPCS**

Cox is senior director of Banner Health's credentials verification organization (CVO). Previously, she was director of

medical staff services at Banner Estrella Medical Center in Phoenix. With over 30 years of experience in the field, Cox has a master's degree in health administration and a bachelor's degree in business administration. At the Symposium, Cox will discuss how her CVO uses a customer-service approach to succeed in its credentialing and verification duties.

*CRCJ: Besides practitioners, who would be considered the CVO's customers?*

Cox: After meeting with CVO leaders, staff, and health system executives, I quickly learned just how expansive and diverse our customer base is. Our internal Banner Health customers alone span 28 hospitals in six states, and our privileged practitioners are approximately 8,000 strong. Our primary customers within and beyond Banner Health include:

- Physicians and nonphysician practitioners
- Practitioners' office personnel (e.g., credentialing contacts, practice administrators)
- Hospital/corporate executives
- Governing body members
- Medical staff leaders (e.g., chiefs of staff, medical executive committees/credentials committees)
- Departments within our organization (e.g., recruitment, managed care, medical staff services, risk management)
- Internal CVO staff

**John McDonald, MD, MSHM, CMQ**

Dr. McDonald has served as the chief medical officer at Medical City North Hills (MCNH) in North Richland Hills, Texas, since April 2014. A board-certified pathologist, he has also been medical director of the MCNH laboratory since 1991. Throughout his career, Dr. McDonald has held a variety of leadership roles in medical staff affairs, including chief of staff and chairman of the board of trustees. He is also the winner of the 2018 CRC Medical Staff Leader of the Year award. Dr. McDonald will share his years of medical staff leadership experience with other physicians who are stepping in to or looking for support in their leadership roles.

*CRCJ: What do you think are the main duties of a medical staff leader?*

McDonald: My main duty is to help set the tone so that our patients get taken care of efficiently and with excellent quality. That begins with credentialing and extends through all-encompassing, open, as well as fair and efficient medical staff leadership. My main goal is to be available and approachable so that I can intercede when necessary to help patient care proceed as optimally as possible.

It is always a compliment when members of the medical or hospital staff feel comfortable enough to approach me with issues that I can help work through. Most of the time that involves helping to engage various parties so that they team up and communicate better for the patient's benefit.

**Amy M. Niehaus, CPMSM, CPCS, MBA**

Niehaus is an independent healthcare consultant with more than 25 years of experience in the medical services and credentialing profession. In her current role, she advises clients in the areas of accreditation, regulatory compliance, credentialing, process simplification and redesign, credentialing technology, CVO development, and delegation. Niehaus has worked in multiple environments throughout her career, including acute care hospitals, CVOs, managed care organizations, health plans, and consulting firms. Niehaus will focus on provider enrollment and delegation at the CRC Symposium.

*CRCJ: At what point in the medical staff credentialing process can an application for enrollment be submitted to the payers?*

Niehaus: Your payers may vary a bit here, but usually 60 days is a good benchmark as this should give them sufficient time to process. Payers don't want them too early as information may go stale or because they need to focus on their current inventory of applications they already have in-house.

You should inquire as to what submission time frames your payers might be following, but it's about getting the information to them as soon as possible so that they can start their process.

Again, payers are going to vary. The hardest thing to deal with in enrollment is that there's not a lot of consistency among the payers with their processes and requirements. It's always good just to go to that source and find out how early they can accept an application, knowing that it's still going through your process. Then follow up and let

them when the provider is approved and the final approval date.

**Sally Pelletier, CPMSM, CPCS**

Pelletier is an advisory consultant and chief credentialing officer with The Greeley Company. She brings nearly 25 years of credentialing and privileging experience to her work with medical staff leaders and MSPs across the nation. Pelletier advises clients in the areas of accreditation and regulatory compliance; credentialing redesign, including change management, standardization, and centralization; medical services department operations, privileging redesign; and leadership and development training for MSPs. Pelletier is an expert in privileging—from core privileges to temporary privileges.

*CRCJ: Is it acceptable to use temporary privileges for reentry practitioners?*

Pelletier: I'm going to answer this question from a compliance perspective because CMS doesn't address the issue of temporary privileges. But The Joint Commission, HFAP, and other accreditors generally allow for temporary privileges for two circumstances. One is for specific patient care need. The other is if you have a complete clean file with no concerns pending med exec review and recommendation. Reentry physicians wouldn't really fall under either of those circumstances, so I caution against the utilization of temporary privileges. What would be outlined in your policy is that they apply for privileges under supervision or preceptorship and when they meet those particular requirements, they are going to apply for privileges to practice independently.

**Raechel Rowland, RN, BSN, CLSSBB, CPHQ, CPPS**

Rowland has 31 years of experience in clinical nursing with expertise in a variety of roles and currently works as a Lean practitioner in the performance excellence department at Ascension Borgess Health in Kalamazoo, Michigan. Rowland is known for her passion for patient safety, patient experience, employee engagement, and cultural transformation. She is also the winner of the 2017 CRC Excellence in Medical Staff Collaboration award. Rowland will discuss OPPE and FPPE through the quality perspective at this year's Symposium.

*CRCJ: Do you have any advice for finding and leveraging data at your facility?*

Rowland: A big part of my role with the data and formulation of these key metrics is helping people understand how you can leverage the data. People need to know the difference between qualitative and quantitative data, which data fields in the software are discrete and which aren't, and where data can actually be pulled from. Physicians don't always understand that even if they write or dictate very comprehensive notes, we can't search dictated notes to pull data. We need to have discrete data to pull (e.g., yes, no, and numbered answers).

When physicians are not aware of that, it sometimes changes how they do their documentation or how they set up their own formatting of templates to answer questions. Core measures are often set up with discrete data fields so we can pull data for meaningful use. If you can help physicians understand how data moves electronically, it'll make better sense to them and make your job easier. We can clean up some areas of the data pool just by looking at what the answers are and how they're being documented.

**Todd Sagin, MD, JD**

Sagin is a physician executive recognized across the nation for his work with hospital boards, medical staffs, and physician organizations. He is the national medical director of Sagin Healthcare Consulting, LLC, and HG Healthcare Consultants, LLC, which provide guidance on a wide range of healthcare issues. He served for more than half a decade as the vice president and national medical director of The Greeley Company. Sagin is a practicing family physician and geriatrician who has held executive positions in academic and community hospitals and in organized medicine. Sagin often advises hospitals on supporting their medical staff leaders or restructuring medical staff committees.

*CRCJ: Is the fact that hospitals are employing physicians affecting the independence of the medical staff? Are physicians more reluctant to take on medical staff leadership roles?*

Sagin: I don't believe that the shift to employment changes the independence of the medical staff. I have found that medical staff leaders from all backgrounds undertake their roles seriously and with dedication to the welfare of patients. But there is certainly a reluctance for already overworked and stressed physicians to take on yet more burdens in the form of leadership work. It is, therefore, important to give those who do step forward the knowledge, skills, and resources to do medical staff tasks efficiently and effectively.

**Mark A. Smith, MD, MBA, FACS**

Smith is a senior consultant with HG Healthcare Consultants, LLC, a healthcare consulting firm, and the chief medical officer for MorCare LLC. He brings 30 years of clinical practice and hospital administration experience to his work with physicians and hospitals across the United States, where he provides expertise in system quality and performance improvement, peer review, ongoing and focused professional practice evaluation, management of deficient practitioner performance, criteria-based privileging, low-volume practitioners, population health management, and external focused review. Smith will tackle peer review from many angles at the Symposium, including the new challenges due to new care delivery options.

*CRCJ: What is the difference between negligent credentialing lawsuits and negligent peer review lawsuits?*

Smith: A negligent credentialing lawsuit most typically is attached to a medical malpractice case, and the plaintiff most often is a patient who sustained harm during the provision of medical care. The plaintiff files a malpractice case against the hospital and the physician. There are times when the patient only files suit against the hospital, such as when the malpractice was committed by a nonphysician provider, but most often the physician and hospital get named. Plaintiffs may attach negligent credentialing onto that to see if there is information to suggest that there was a pattern of behavior that the hospital should have known about, and therefore should have not granted the practitioner privileges. That's the most common scenario.

A scenario for negligent peer review could be a patient who files a malpractice case and believes the hospital whitewashed a practitioner because they have information to suggest that there's a pattern of behavior. It happens much more often when you see a group of cases, as in a class action suit for failure to identify the appropriateness of care (e.g., heart catheterizations that shouldn't have been done, or heart surgeries that were inappropriate). The plaintiff will tack negligent peer review onto that action.

But the more common negligent peer review action is brought by a practitioner who has sustained a negative outcome from the peer review process and feels the peer review is being used against them. A lot of times, negligent credentialing and negligent peer review cases cross because peer review feeds into the credentialing process. Often, both elements can be in a suit.