Granting temporary privileges and using locum tenens physicians without fully verifying their credentials verification can put healthcare organizations and their patients in danger—clinically and legally.

At the 2016 Credentialing Resource Center Symposium held April 7–8 in Orlando, Florida, Sally Pelletier, CPMSM, CPCS, advisory consultant and the chief credentialing officer for The Greeley Company; and Carol Cairns, CPMSM, CPCS, president of PRO-CON, a consulting firm in Illinois, and a senior consultant with The Greeley Company, will address these risks, as well as the best strategies to mitigate them, during their session “Two High-Risk Credentialing Situations to Manage: Temporary and Locum Tenens Privileges.”

For more information about the symposium, including the agenda of sessions, or to register, please visit the CRC Symposium event page at www.credentialingresourcecenter.com/events.

Q Can you briefly discuss some of the challenges with granting temporary privileges and using locum tenens physicians?

Pelletier: Certain influencers intensify the need for the routine use of temporary privileges or utilizing locum tenens. A challenging recruitment and retention environment as well as patient, community, and hospital needs provide understandable pressure to quickly get certain practitioners and specialties credentialed and privileged.

The use of temporary privileges (done in accordance with applicable standards) is allowed by all accrediting bodies e.g., The Joint Commission, DNV, and Healthcare Facilities Accreditation Program. (CMS Conditions of Participation are silent regarding temporary privileges.)

The function and associated tasks of granting temporary privileges takes additional resources to manage. Resources are a scarce commodity in credentialing or medical staff services departments. Additional challenges occur when the process is abused due to a lack
of real commitment to a quality credentialing process, a lack of the intestinal fortitude to slow the process down if necessary to conduct appropriate due diligence, or lack of understanding of the risk (clinical, accreditation, and legal) associated with circumventing a full credentialing process.

**Q** What are the risks organizations can face if practitioners aren’t credentialed properly?

**Pelletier:** Overuse or abuse of temporary privileges can cause havoc for the organization. In general, the vast majority of practitioners are competent and there would be no quality issues (if the risk were higher, organizations would not be likely to grant temporary privileges as often as they do); however, the bottom line is that it takes only one bad outcome by a practitioner granted temporary privileges via an abbreviated process to fuel a negligent credentialing lawsuit. Ask any medical staff leader involved in credentialing or any medical services professional and they will emphatically agree that the function and associated tasks of granting temporary privileges and/or locum tenes take additional resources to manage.

**Q** Can an organization accept information the locum agency has obtained from primary sources (e.g., references/hospital affiliation), or does it have to reach out and get that primary source on its own?

**Cairns:** It depends on what your policy requires for verifying competence and what the locum tenens agency collects. Let’s say that you have a very comprehensive peer reference document but the locum tenens agency is only asking whether the physician was a member in good standing and during what time period. Those are not comparable reference questionnaires. If you can get the locum tenens agency to supplement what it’s requesting with the type of information you normally request by expanding its questionnaire, then absolutely, you can use what the agency has already gathered for you as long as it’s pertinent and timely. If it was gathered five years ago, that information would need to be supplemented by more current evaluations of competence.

As long as the locum tenens agency is obtaining the same (or similar) information that your organization normally would obtain on a new applicant—even if it is in a different format—that would be acceptable.

It is important to outline this process in a credentials policy. I would suggest the MSP discuss this issue with the credentials committee. If the reaction is favorable, the MSP can create the policy and have it approved by the medical staff structure through the governing body.
The other thing, too, is with our electronic capabilities, all of these steps can be accomplished much more quickly and efficiently without the use of paper.

Q Is there a standard or requirement for an applicant to sign a statement accepting his or her temporary privileges?

Cairns: This has been a long-standing practice but I’m not sure where it originated.

No, there is no such standard or requirement. When I was in the trenches, we would always have the CEO sign the document along with the department chair as a paper trail that the process had occurred. Then we would have the applicant come in and sign as well that he or she understood the conditions of the granting of temporary privileges. I think it’s a good legal practice, but there is no regulatory or accreditation requirement that mandates those signatures. Attorneys would probably say “yes” to signatures, but that’s a risk management decision.

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Q What can credentialing and privileging professionals do to avoid putting their organizations at risk?

Pelletier: It’s all about process. It should go without saying that no practitioner should be allowed to provide patient care until he or she has successfully satisfied the requirements of a stringent qualification, or disqualification, process. Begin by collecting the appropriate information (i.e., formal education, training, and certification). Then verify that information through primary sources to ensure that what the practitioner provided is valid.

There’s no place for complacency. Since the ultimate goal of any provider is to deliver the best patient care possible, healthcare organizations must take whatever steps necessary to develop a sound credentialing and privileging process and to revisit and reevaluate it regularly to ensure optimal results. Screening incoming physicians and assigning appropriate privileges can be a time-consuming task even under the best circumstances. The more streamlined your processes are, the sooner you’ll have the appropriate physicians caring for patients whose conditions fall within their specialties.

It’s also hugely important that your physician leaders, committee members, senior management, board members, etc. all understand the complexities of credentialing and privileging and the importance of implementing the processes necessary to get it right. Obtaining their buy-in at the beginning will kick off your process improvement initiative on the right foot and improve your chances of success.

Join us at the 2016 CRC Symposium

The Credentialing Resource Center Symposium on April 7–8 in Orlando, Florida, will deliver two days of valuable education and training for medical staff professionals and physician leaders.

Refine and strengthen your medical staff policies and procedures with guidance from experts Hugh Greeley; Carol S. Cairns, CPMSM, CPCS; Sally Pelletier, CPMSM, CPCS; and Todd Sagin, MD, JD.

In-depth sessions, inspiring keynotes, and engaging rapid fire question-and-answer sessions address a spectrum of topics, including:

• Credentialing and peer review in the outpatient world
• Privileging advanced practice professionals and physician assistants
• Running an effective credentials committee
• Managing disruptive practitioner behavior
• Focused professional practice evaluations (FPPE) and ongoing professional practice evaluations (OPPE)
• Top industry concerns and pain points

Register by February 4 to take advantage of early bird pricing!

Check the Credentialing Resource Center website (www.credentialingresourcecenter.com/events) for more information or to register.

Wanted: Guest columnists for Credentialing & Peer Review Legal Insider

Credentialing & Peer Review Legal Insider is looking for MSPs, lawyers, or consultants interested in writing guest columns. If you have any advice or ideas you’d like to share with our readers, we’d like to hear it.

Please email Associate Editor Son Hoang at shoang@hcpro.com if you would like to contribute a column or just have a story idea for a future issue of the newsletter.
**Case summary**

**External peer review reports protected from discovery**

The Second District Court of Appeal of Florida (the “Court”) has held that external peer review reports are not discoverable because they do not fall within the scope of the amendment of the state’s constitution that preempts Florida’s peer review privilege. Approved by Florida voters in 2004, article X, section 25, of the Florida Constitution, otherwise known as Amendment 7, preempts the statutory discovery protections for the peer review process: “[P]atients have a right to have access to any records made or received in the course of business by a health care facility or provider relating to any adverse medical incident.”

The plaintiff filed suit against Bartow (Florida) Regional Medical Center, a surgeon, nurses, and other hospital personnel (the “Hospital”) for medical malpractice after her common bile duct allegedly was severed during gallbladder removal surgery. The plaintiff sued based on allegations of apparent agency, vicarious liability, negligent hiring, and non-delegable duty.

Citing Florida Constitution Amendment 7, the plaintiff served the Hospital with a request to produce documents related to the review of the surgeon’s care and treatment of all of his patients during the five years prior to her surgery. The patient also requested all documents pertaining to the Hospital’s investigation or review of her care and treatment.

In response, the Hospital stated that certain reports related to an attorney-requested external peer review were privileged because they didn’t fall within the scope of Amendment 7. The Hospital’s argument was that the external peer review reports were not made in the course of business—a requirement of Amendment 7, and that they were protected by the attorney-client privilege.

The circuit court determined that the documents were privileged, but Amendment 7 preempted the privilege for any documents that were related to adverse medical incidents. Those documents, the circuit court concluded, were discoverable. The circuit court also conducted an in camera inspection to determine if any of the documents did not fall within the scope of Amendment 7.

After inspecting the documents, the circuit court issued an order for the Hospital to produce all documents related to the Hospital’s peer review of adverse medical incidents involving the surgeon, which circumstances, it must be in the context of active attorney involvement. Here, the attorney defending the case ordered an external peer review.

Many hospitals and physician groups mistakenly believe that cloaking something in the attorney-client privilege will keep it from discovery. Not true. The attorney must be fully and actively involved in the situation and directing what is happening. If the attorney is not actively involved, labeling something “attorney-client privilege” will fail, and the court will determine that the privilege does not apply.

Finally, it will be interesting to see if the Florida trial lawyers are powerful enough to override this decision and obliterate the attorney-client privilege as it applies to peer review.

**What does this decision mean for you?**

First, Florida appears to be the only state that has a Constitutional amendment that obviates the peer review privilege. Surely, this is a testament to the political power of that state’s trial lawyers.

Boiled down to its essentials, this case—an appellate decision and not a decision of Florida’s highest court—holds that an external peer review, conducted at the specific request of an attorney defending the hospital in a malpractice case, is not discoverable under Constitutional Amendment 7, which only applies to regular peer review conducted in the ordinary course of business.

What you need to keep in mind, however, is that if the attorney-client privilege is to apply in this, or other
included the external peer review reports. The Hospital provided the documents related to its internal review process but challenged the part of the order that required that the external peer review reports be produced. The Hospital filed a petition for the Court to review the circuit court’s decision.

In its decision, the Appellate Court agreed with the Hospital’s argument that the attorney-requested external peer review reports did not fall within the scope of Amendment 7. The Court found that the documents were not “made or received in the course of business.” Instead, the Hospital had maintained that they were made following a request from its counsel to an external peer review organization to conduct a review for the purposes of litigation.

The Court wrote as follows: “While Florida hospitals are statutorily required to establish internal risk management programs to investigate and respond to adverse incidents, they are not statutorily required to retain external experts to evaluate adverse medical incidents to determine whether the standard of care was met.”

The plaintiff argued that based on Amendment 7’s definition of “adverse medical incident,” the external peer review reports should be discoverable. According to Amendment 7, adverse medical incidents include “incidents that are reported to or reviewed by any health care facility peer review, risk management, quality assurance, credentials, or similar committee.”

Although the external peer review organization was not a healthcare committee, the plaintiff argued that it served the same function. Furthermore, she claimed that by using an external peer review organization, the Hospital had attempted to shield its peer review process from discovery under Amendment 7.

The Court disagreed with her claim on the grounds that the external peer organization did not perform routine peer reviews. “Instead, it provides an expert opinion on the standard of care on sporadic occasions when litigation is imminent.” Whether or not the external peer review reports fall within the scope of Amendment 7, depends on their substance and context. The reports do address adverse medical incidents but they also contain attorney-requested expert opinions. Applying this standard, the Court found no suggestion that the reports were obtained as part of the Hospital’s regular peer review process.

In addition, the Court rejected the plaintiff’s claims that the Hospital attempted to cloak its peer review process from discovery through the use of an external peer reviewer. The Court wrote that the Hospital had already provided documents related to its internal adverse incident reporting and peer review processes, which satisfied the disclosure requirements under Amendment 7.

The Appellate Court held that the attorney-requested peer review was protected from discovery.

Source

Peer review and the NPDB revisions

Last spring the National Practitioner Data Bank (NPDB) updated its guidelines for the first time in more than 10 years. The following questions and answers are from the recent HCPro webcast, FPPE and the Revised NPDB Guidebook: How to Address New Reporting Challenges, presented by Todd Sagin, MD, JD, national director of Sagin Healthcare Consulting, LLC, and HG Consultants, LLC.

For more information or to order this webcast on demand, go to http://hcmarketplace.com/fppe-and-the-revised-npdb-guidebook-how-to-address-new-reporting-challenges.

Q When it comes to reporting to the NPDB, can you talk about some of the differences between an investigation and a routine peer review?
A Keep in mind that if a practitioner resigns in exchange for not performing an investigation, it’s reportable. If, on the basis of a focused review, a formal
investigation and formal recommendation to remove privileges begins. If the physician resigns at that point, then you have to report because they’ve resigned in order to avoid an anticipated investigation.

Should there always be an adverse recommendation to the medical executive committee (MEC) before an investigation is begun? This is a matter of how you define investigation. My suggestion is that investigations should be triggered by a formal referral if you will from a peer review body that may have undertaken focused review or otherwise has concerns. Or it could be a referral for an adverse recommendation from a department chair or medical staff officer.

What language is needed to terminate an investigation? The language is whatever you want, but formally, there should be something that is documented in minutes, somewhere, that the investigation was formally ended.

It could be by action of MEC, or a medical staff officer or CMO; it doesn’t matter how you terminate an investigation—it should be defined in your policies or in your bylaws, and there should be documentation that whatever ends an investigation actually took place. That should be documented in minutes or in a practitioner’s file, so you can after the fact establish what the parameters were of that investigation.

**Q** If direct proctoring is required for “remedial” monitoring, does this need to be completed within 30 days in order for it to not be reported, or is it reportable no matter how long it takes to be completed?

**A** If the proctoring is, in essence, a restriction on privileges, and it is if it’s remedial, if that lasts for more than 30 days, it’s reportable, less than 30 days, it’s not reportable. If it’s just observation, with no limitation at all on the practitioner, and proctor is just there to capture as much observation as possible, then it’s not reportable under any circumstance because it’s not a limitation of any kind or the practitioner’s exercise of his or her privileges.

**Q** Our hospital vice president of medical affairs (VPMA) prefers to handle peer review problems that arise with employed physicians as an HR/personnel matter and terminates problematic practitioners under their contract rather than utilize the medical staff corrective action procedures. He says this is better for physicians than having to submit a report to the NPDB. Is this appropriate and ethical?

**A** There are a couple of issues there. First, is it reportable to NPDB? Employment actions are not reportable to the NPDB even if they’re based on concerns about competence or conduct; it’s only actions against membership or privileges. If the doctor, as a result of termination of employment, automatically loses or relinquishes membership and privileges, then it is not reportable because they’re not surrendering privileges as a result of a professional review action.

If their employment is terminated, but they nevertheless are taken through a med staff corrective action process and lose their membership and privileges, then it would be reportable.

If the VPMA decides to take care of problematic behavior or competence this way, is this ethical or good practice? At some level he is doing this to avoid having to go through rigors of a fair hearing and perhaps to avoid having to file an NPDB report, which might lead to litigation against the institution.

My personal feeling is that organizations are required, as part of a good credentialing process, to query places where physicians have practiced and worked. At some point, this institution will get a query from the next place this doctor goes, and they will ask questions. Hopefully they’ll ask specific questions: Were there competence or conduct concerns? I believe it is incumbent on that organization to give an honest answer—yes, we did have competence/conduct concerns—and should give a factual recitation of what those concerns were or how they were manifest.

If both parties are engaging in the credentialing process in an appropriate fashion, the Data Bank report isn’t essential or necessary. The goal of ensuring the next employer was given notice has been served.

If the hospital doesn’t disclose its concerns that lead to the physician’s termination, and instead just verifies dates for employment, then we’ve undermined a good professional system, and have undermined effective credentialing. That’s what the Data Bank was put in place to help us address.

Let’s be clear though: Terminations of employment based on conduct or competence are not reportable to the Data Bank.

**Q** Is it reportable if there’s a recommendation from peer review or FPPE that a physician voluntarily restricts privileges, but it is not mandated?
A

It’s not reportable if the physician voluntarily restricts privileges. If the leadership suggests that a physician restrict privileges or not renew, and he or she does so, that’s also not reportable. It’s only reportable if the physician is under investigation or if he or she relinquishes privileges in return for not having an investigation done.

CPRLI 2015 index: A year in review

Looking for an article from last year but forgot what issue it was in? Browse the Credentialing & Peer Review Legal Insider story index for 2015.

Credentialing
Avoid the pitfalls of negligent credentialing, May, p. 1
Credentialing challenges for MSPs and physician leaders, Aug., p. 6
Getting and sharing relevant data, March, p. 4
Ensuring quality care at retail clinics, April, p. 1
Games for credentialing training, May, p. 4
Illinois appellate court affirms dismissal of physician’s defamation claim, May, p. 7
NAMSS PASS aims to be the one stop for practice affiliation histories, Sept., p. 5
The case for criminal background checks for physicians, Jan., p. 1
The credentialing challenges posed by low- and no-volume practitioners, Aug., p. 1

FPPE
Conducting FPPE/OPPE for your AHPs, Oct., p. 1
Proctoring and FPPE: Doctors Hospital of Manteca, Oct., p. 8
The credentialing challenges posed by low- and no-volume practitioners, Aug., p. 1
To report or not to report: What to do about the recent NPDB Guidebook update, Sept., p. 1

Medical staff bylaws
To report or not to report: What to do about the recent NPDB Guidebook update, Sept., p. 1

Medical staff governance
Addressing aging physicians’ abilities, June, p. 5
Conducting FPPE/OPPE for your AHPs, Oct., p. 1
Minnesota Supreme Court rules on medical staff autonomy case, March, p. 1

Medical staff office
Conducting FPPE/OPPE for your AHPs, Oct., p. 1
The credentialing challenges posed by low- and no-volume practitioners, Aug., p. 1
2015 MSP Salary Survey Results, June, p. 1

OPPE
Conducting FPPE/OPPE for your AHPs, Oct., p. 1
The credentialing challenges posed by low- and no-volume practitioners, Aug., p. 1

Peer review
District Court upholds peer review privilege, May, p. 8
Does your peer review program have F-A-C-E?, Feb., p. 1
Have a policy to determine when to use external peer review, Nov., p. 3
Illinois district court rules that audit trails are not protected by peer review statute, Nov., p. 7
Michigan Supreme Court finds peer review privilege protects objective facts of incident report, Sept., p. 7
New Jersey Superior Court affirms dismissal of physician’s claims against hospital, Feb., p. 6
North Carolina federal court denies hospital request for peer review privilege protection, Feb., p. 7
North Carolina Supreme Court affirms denial of peer review privilege protection, March, p. 5
Peer review ethical and legal issues, March, p. 6
Peer review in a new environment, Feb., p. 5
Physician employment and peer review, April, p. 4
Texas Supreme Court orders hospital to turn over peer review documents, Nov., p. 6
Turning to external peer review when internal processes are not enough, Nov., p. 1
Wisconsin district court orders hospital to hand over peer review documents, July, p. 7
Physician leader

Credentialing challenges for MSPs and physician leaders, Aug., p. 6

Privileging

Illinois appellate court affirms dismissal of physician’s breach of contract claim, June, p. 7
Managing temporary and locum tenens privileges, Jan., p. 3
New Jersey district court dismisses surgeon’s lawsuit, June, p. 6
New Jersey federal court dismisses surgeon’s discrimination claims, Jan., p. 6
The credentialing challenges posed by low- and no-volume practitioners, Aug., p. 1

Quality

ABMS revises language regarding MOC, Dec., p. 4
An alternative to MOC, Dec., p. 6
Conducting FPPE/OPPE for your AHPs, Oct., p. 1
Patient safety work product privilege at center of possible Supreme Court case, Dec., p. 1
Turning to external peer review when internal processes are not enough, Nov., p. 1

Court cases

District Court upholds peer review privilege, May, p. 8
Illinois appellate court affirms dismissal of physician’s breach of contract claim, June, p. 7
Illinois appellate court affirms dismissal of physician’s defamation claim, May, p. 7
Illinois district court rules that audit trails are not protected by peer review statute, Nov., p. 7
Michigan Supreme Court finds peer review privilege protects objective facts of incident report, Sept., p. 7
New Jersey district court dismisses surgeon’s lawsuit, June, p. 6
New Jersey federal court dismisses surgeon’s discrimination claims, Jan., p. 6
New Jersey Superior Court affirms dismissal of physician’s claims against hospital, Feb., p. 6
North Carolina federal court denies hospital request for peer review privilege protection, Feb., p. 7
North Carolina Supreme Court affirms denial of peer review privilege protection, March, p. 5
Patient safety work product privilege at center of possible Supreme Court case, Dec., p. 1
Texas Supreme Court orders hospital to turn over peer review documents, Nov., p. 6
Wisconsin district court orders hospital to hand over peer review documents, July, p. 7

Forms

Sample allied health OPPE, Oct., p. 6
Sample allied health professional practice evaluation, Oct., p. 4
Sample low-volume practitioner letter, Aug., p. 3
Sample medical staff survey form, Aug., p. 4
Staff categories for reappointments and contract practitioners, Aug., p. 5

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