The updated National Practitioner Data Bank (NPDB) Guidebook was released in April and included significant changes that may have repercussions for medical staff bylaws. MSPs need to examine the revised edition closely to understand what the changes mean for their organizations.

Major changes for MSPs to consider include guidelines for:
- What constitutes an investigation
- When an investigation begins
- What is reportable
- Proctors and observation

Chapter E, which covers reporting adverse clinical privilege actions, is longer than in the prior edition of the Guidebook and includes a lot more interpretation, according to Joanne Hopkins, Esq., an attorney at law based in Austin, Texas.

The 220-page revised NPDB Guidebook stipulates that adverse clinical privilege actions that must be reported include any professional review action that adversely affects the clinical privileges of a physician or dentist for a period of more than 30 days or the acceptance of the surrender of clinical privileges, or any restriction of such privileges:
1. While the physician or dentist is under investigation by a healthcare entity relating to possible incompetence or improper professional conduct; or

We are constantly updating our library of Clinical Privilege White Papers. Here are a few of the most recently updated papers:

- Pathologists’ assistant—
  Practice area 181
- Polysomnographic technologist—
  Practice area 192
- Addiction psychiatry—
  Practice area 426
- Family medicine—
  Practice area 134
- Physician assistant—
  Practice area 165
- Medical physicist—
  Practice area 196

Download the latest papers from www.credentialingresourcecenter.com.
2. In return for not conducting such an investigation or proceeding

Adverse clinical privilege actions that must be reported to the NPDB are professional review actions, the Guidebook states. They are based on a physician’s or dentist’s professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a patient. Generally, the entity that takes the action determines whether the physician’s or dentist’s professional competence or professional conduct falls under such a category.

Actions include reducing, restricting, suspending, revoking, or denying privileges, and the decision not to renew a physician’s or dentist’s privileges if that decision was based on the practitioner’s professional competence or professional conduct. Clinical privileges actions are reportable once they are made final by the healthcare entity. Summary suspensions lasting more than 30 days are reportable even if they are not final.

Clariﬁcations

There is also a key clariﬁcation in the new edition: It addresses the specific date at which a facility starts counting summary actions/summary suspensions (the ones effective immediately before the practitioner is afforded any due process).

“The action is usually something that’s imposed by an individual, then followed up very quickly by a committee review to either conﬁrm or reverse it,” says Hopkins. “[The NPDB] clariﬁed that it is the date the action is imposed by the individual, not the date it’s afﬁrmed by the committee. That is important because this is the one you have to report after it’s been in place for more than 30 days, even though you may not have yet afforded any procedural rights of review.”

The Guidebook has also clariﬁed that, for reporting purposes, temporary privileges are no different from regular clinical privileges. But under certain circumstances, a practitioner with temporary privileges may withdraw his or her application or have the temporary privileges expire while under investigation without having to be reported to the NPDB.

“If those temporary privileges are time-limited, non-renewable temporary privileges, that would not be considered a surrender of privileges, and therefore would not be reportable,” says Hopkins. “That gives applicants and hospitals a little bit of ﬂexibility.”

When an organization sees potential problems with an applicant early in the process, the chief of staff or the
chair of credentials committee will call the applicant and tell him or her that there’s a problem. “They would make the applicant aware of the option to withdraw their application, and a lot of them do,” she says. “But what if you had granted them temporary privileges? Now we have some latitude with those, as long as they’re time-limited and non-renewable.”

Opportunities for confusion

The new Guidebook might also cause confusion, says Elizabeth “Libby” Snelson, JD, legal counsel to the medical staff, based in St. Paul, Minnesota. If the intent of the changes is to close loopholes and get more facilities to report, the new guidelines might not have that effect. “You’ve got surrender being broadened, investigation being widened considerably in terms of timeline, and it doesn’t matter whether a [physician] knows about an investigation,” she says.

Under the new guidelines, a leave of absence could count as a surrender of privileges, as could a decision not to apply for privileges, Snelson adds.

The new NPDB Guidebook states that if a practitioner does not apply for renewal of medical staff appointment or clinical privileges while under investigation by the healthcare entity for possible professional incompetence or improper professional conduct, the event is considered a surrender while under investigation and must be reported to the NPDB.

In addition, these actions must be reported regardless of whether the practitioner was aware of the investigation at the time he or she failed to renew the staff appointment or clinical privileges. A practitioner’s awareness that an investigation is being conducted is not a requirement for filing a report with the NPDB.

“The basic tenet is fine; however, the latest Guidebook says investigation begins whenever the hospital begins a query about a specific individual,” Snelson says. So, “whenever there is any kind of inquiry into an individual physician’s practice, that is an investigation.”

Furthermore, the investigation need not have anything to do with privileges being surrendered. If there’s a simultaneous investigation at the time of non-renewal, that’s reportable.

What constitutes an investigation

The definition of investigation is critical because if a physician resigns in lieu of or during an investigation, that resignation is reportable to the NPDB, according to Michael Callahan, JD, MBA, senior partner in the Health Care Practice Group at Katten Muchin Rosenman, LLP, in Chicago. This section of the Guidebook generated the most comments during the review period, he says.

The NPDB wants to include for-cause FPPE under what constitutes an investigation, to redefine how it considers when a practitioner is under investigation, Hopkins says. “The new guidance on that is clearly intended to [include] for-cause FPPE. There are some real policy considerations here, because if it’s considered an investigation every time you put a physician under for-cause FPPE, the physician cannot give the privilege up without getting reported to NPDB.”

Most hospitals and medical staffs have a narrow interpretation of when an investigation is triggered vs. standard peer review activities, Callahan says. For example, if the department of surgery tracks postop infections as part of OPPE or the initial FPPE for new physicians, a routine review that applies to every surgeon, it is not treated as an investigation. On this point, the NPDB agrees. However, if a surgeon is spiking a higher than normal rate of postop infections, he will be under closer scrutiny as per peer review procedure. If, for whatever reason, he then decides to resign—even though no one has taken away a privilege and he is not on a specific FPPE plan, for whatever reason, the NPDB now considers that to be an investigation if it is a precursor to a professional review action.

“At this early stage of a typical peer review process, most hospitals and medical staffs would not be thinking about, much less taking steps toward professional review action which might adversely affect a physician’s membership or privileges. Therefore, if the physician does resign, which is an unlikely event, the resignation would not be reportable,” says Callahan. “When you now focus on an individual based on issues of quality and competency, it will be important to identify in the bylaws or policy when you are simply conducting standard peer review procedures or are instead conducting an investigation or other activities as a precursor to a professional review action.”

During a recent program where the NPDB presented for the benefit of American Health Lawyers Association
attorneys, NPDB personnel stated that they will defer to how the hospital describes and defines when is an investigation mode and what constitutes a professional review action, but that it is not bound by the hospital’s position, Callahan says. During the program, the NPDB officials said they will look to the facts and circumstances of the particular matter and make their own independent determination.

Proctoring

The previous edition of the Guidebook provided that if a professional review action involved assignment of a proctor who had to approve the physician’s exercise of clinical privileges for more than 30 days, that was reportable. However, assigning an observer wasn’t considered a professional review action that adversely affected the physician’s privileges “because all we were asking was that somebody be in the room to watch,” Hopkins says.

However, the new Guidebook states that if a physician cannot perform certain procedures without proctor approval, or without the proctor being present and watching the physician, for more than 30 days, that is reportable.

If physician leaders had a question about a physician’s competence, they might request another physician be present and observe, and fill out an evaluation. Now, that will be considered reportable. “It’s going to change the reporting implications of some of the things that peer review committees do,” Hopkins predicts.

MSPs will need to educate themselves on these changes because peer review committees will have questions. “Peer review committees may now have some hesitation to take that kind of action or require an observer to be present during surgery if that now is going to result in a Data Bank report,” she says. “Generally, if it’s something that’s going to cause a Data Bank report, we’re going to afford a hearing first.”

Guidelines, not regulations

The Guidebook states that the NPDB is meant to be one of many tools that healthcare entities use as they make licensing, certification, hiring, credentialing, contracting, and similar decisions.

No facilities would make credentialing or personnel decisions based solely on NPDB reports, according to Snelson. The danger is in NPDB reports becoming less credible as the NPDB casts a wider net for reportable actions.

Further, the new guidelines aren’t laws, say Callahan, Hopkins, and Snelson. “Hospitals will have to decide: Are they going to strictly adhere to the Guidebook on all of the guidance and interpretation?” says Hopkins. The medical staff, peer review committees, and MSPs will have to discuss what would be best for effective peer review.

On the other hand, “hospitals and medical staffs that don’t want to comply with clear reporting requirements are probably going to continue not complying with the reporting requirements,” she says.

"Hospitals will have to decide: Are they going to adhere to the Guidebook on all of the guidance and interpretation?"

—Joanne Hopkins, Esq.

Only 46% of all hospitals have ever reported a physician to the Data Bank, according to statistics gathered by the NPDB. Although that might sound like reports are “missing,” this isn’t necessarily the case.

“I think people try to avoid reporting,” say Callahan. "They [are] more open to monitoring, proctoring, and FPPE plans, and finding ways to get physicians back on track, encouraging the physician to acknowledge [when] a mistake was made and he or she could have done better. When there’s that realization, that’s when you can work with someone, as opposed to when someone’s in complete denial, or fears that acknowledging a mistake will lead to a loss of privileges.”

If the new guidance is intended to get more reports in the system, that might be counterproductive. The purpose of the NPDB isn’t to “gin up” more reports, it’s to improve the quality of care and provide useful information, says Snelson. “Having bad information does not help us. It complicates credentialing.”

The NPDB is open to comments and feedback, and despite the “final” status of the new Guidebook, there may be additional changes and clarification in the future. The last guide was 13 or 14 years old, and “it’s been a good refresher to take a deeper dive into the NPDB processes,” Callahan says.
DNV accreditation gains ground

HCPro’s MSP Salary Survey asks respondents to name the entities that accredit their organization. Since 2012, the percentage of respondents who have selected DNV has doubled, from 4% of respondents to 8% in 2015. DNV entered the accreditation fray in 2008, when it was granted deeming status by CMS. Currently, it accredits nearly 500 healthcare organizations in the U.S., and that number is growing.

The percentage of respondents who cite The Joint Commission as an accreditor has also risen during that time, and that accreditor holds a wide lead among survey respondents. (The survey permits respondents to give multiple answers to this question.) Therefore, the jump in DNV responses is probably not solely a result of respondents switching over from the nation’s largest accreditor.

However, some facilities are signing on with DNV after leaving The Joint Commission. 

One relatively early DNV convert was Hoag Memorial Presbyterian Hospital, a 482-bed nonprofit hospital in Newport Beach, California. In late 2009, the organization was getting ready to open a second campus in Irvine, and decided to explore a shift from Joint Commission accreditation to DNV.

The main drivers of the change were physicians who would be working in a separately licensed orthopedic specialty hospital that was in the same building in Irvine, says Marilyn Lang, RN, JD, director of safety and regulatory compliance at Hoag, in Newport Beach. The orthopedic specialty hospital had partial physician ownership, and as they made plans for their facility, some of the physicians in the orthopedic institute requested Hoag look into DNV as an alternative to The Joint Commission. At that point, DNV had held deemed status for only a year, and many at Hoag hadn’t heard of it.

Lang contacted DNV-accredited hospitals and talked to them about the processes. In addition, Hoag did a side-by-side comparison of DNV and Joint Commission accreditation. “We tried to be really objective with every aspect of the two accrediting agencies. We took that to [organization leadership] and the board.”

After that, things happened quickly: In December 2009, the board gave its okay to go with DNV. “They were quite enthusiastic,” Lang says, “but as the accreditation director, I was nervous because I didn’t know that much about DNV.”

Yearly surveys

One of the differences between The Joint Commission and DNV is the survey schedule. “We liked the idea that they come out annually,” says Lang. The three-year survey is required by CMS, but the surveys that occur in the two years between are more like checkups, she says. “They cover how you are doing and keep the momentum going. We thought that was a great idea because usually what happens is you get all revved up once every three years, then you completely collapse, then rev up again two and a half years later.”

That’s also the opinion of Kathy Thompson, CPMSM, CPCS, medical staff manager at Oklahoma Heart Hospital South, LLC, in Oklahoma City. “I think it’s better, because instead of waiting until the 30-month mark [and ramping up], you stay prepared,” she says.

The tone of the survey is nonpunitive. “When they’re here, they’re here to educate and be supportive and help you progress and improve,” says Teresa Miller, CPMSM, medical staff manager at Oklahoma Heart Hospital North, also in Oklahoma City.

The two facilities in the Oklahoma Heart Hospital system hold separate licenses and are physician-owned. Combined, they have about 300 physicians on staff, and the system includes a network of more than 70 cardiovascular specialists at more than 60 outpatient clinics throughout the state. The clinics are under the hospital’s license, and some are provider-based, Miller says. Oklahoma Heart Hospital South became DNV-accredited in 2011, about a year after Oklahoma Heart Hospital North.

“We went with DNV because when Oklahoma Heart Hospital acquired the clinics, The Joint Commission...
standards didn’t really accommodate the hospital’s provider-based clinics,” says Miller. “There are also cost savings.”

The transition at Oklahoma Heart Hospital North happened in less than six months, she says. “When we called DNV and said ‘we want to change over,’ they came and talked to us about their organization. Then they came back and did a survey, and then we sent The Joint Commission a letter that said we had switched, and we were DNV.”

A year later, South Hospital made the switch, and the experience has been positive there as well, according to Thompson. “It’s really been a wonderful thing—not necessarily because the DNV survey and accreditation process is easier. I don’t think anybody would tell you that,” she says. “It’s just that they strictly go by the CMS standards ... It seems to be a much clearer standard set.”

No ‘gotchas’

DNV’s approach gets thumbs up from many hospital personnel, Miller says, including quality managers and directors. “I think the nurses and people believe it on the floor—the surveyors go out and talk to people, and everybody’s more relaxed.”

The survey process itself is similar to what The Joint Commission does: surveyors conduct tracers, visit various departments, talk to hospital personnel, and review documents. “That part isn’t different, but we did feel like DNV was a lot more pleasant about it,” Lang says. “When they do their closing session [and] tell you what your nonconformities are, they also give you kudos for what you’re doing well. ... They want to see your successes and not check off the boxes.”

The move to DNV has also resulted in some organizational changes at Hoag. DNV requires an overall quality management system and one entity that has oversight of quality for the whole organization. Hoag created a performance excellence council. As part of improvement in the medical staff area, Hoag has established a multidisciplinary peer review committee. “We still have individual departments doing peer review, but we have started to shift to multidisciplinary reviews—special cases come to that committee,” she says.

Start with core measures

DNV’s medical staff requirements and processes are similar to The Joint Commission’s, with the exception of OPPE and FPPE, according to Thompson.

“We do something totally different [for practitioner evaluation]: We go by core measures and we look at the things that CMS wants you to look at. When Oklahoma Heart Hospital South was Joint Commis-

**DNV medical staff requirements**

Hospitals are certified through DNV’s accreditation process, the National Integrated Accreditation for Healthcare Organizations (NIAHO). In addition to meeting NIAHO requirements, hospitals are encouraged to become ISO-9001 compliant within three years of certification.

DNV accreditation requirements follow the CMS Conditions of Participation (CoP), and the survey process includes an annual survey and a CMS-required triennial survey. Following the CoPs, DNV-surveyed facilities are required to have a peer review process and document the measures they follow to gauge physician competence.

Medical staff bylaws must include criteria for determining privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges, according to the DNV’s MS.12 Standard Requirement (SR) #1.

Core privileges for general surgery and surgical sub-specialties are acceptable as long as the core is properly defined.

DNV-accredited facilities are also required to have a mechanism outlined in the bylaws to ensure all individuals provide services only within the scope of privileges granted. Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years.

Individual practitioner performance data must be measured, utilized, and evaluated as a part of the decision-making for appointment and reappointment. Although not specifically stated, this would apply to the individual practitioner’s respective delineation of privilege requests.
sion-accredited, the information we presented didn’t always reflect what the physicians were really doing,” she adds.

The DNV medical staff chapter, Section 9, covers performance data, and includes a requirement that 11 elements must be evaluated for practitioners, when these elements are applicable.

Practitioner-specific performance data must be evaluated and analyzed, and appropriate action taken as necessary when variation is present. Performance is to be collected periodically within the reappointment period or as required as part of the peer review process, according to the section.

The 11 elements to be evaluated include blood use, prescribing medicine patterns and trends, errors and appropriateness, surgical case review appropriateness and outcomes, anesthesia and moderate sedation events, readmissions, and unplanned returns to surgery. Other elements, such as timely and legible completion of records, are applicable to everyone. “This was an area that was a challenge and a success for us,” says Lang.

“DNV would come out and give us a nonconformity on [performance data], saying ‘you’re not quite there yet.’ But a nonconformity isn’t necessarily a bad thing. It just means you need to keep improving.”

The organization has created individual physician profiles around the required elements, and additional elements if the medical staff wants to include them. Each physician has a profile, and physicians’ performance data for these elements are part of the reappointment process.

The Oklahoma Heart Hospitals’ leadership asked the medical staff offices what was needed. “We got the ball rolling with physician report cards—what we wanted to put in them and look at. The recommendations went back to the medical staff, but it’s always a work in progress,” Thompson says.

The ISO connection

DNV-accredited facilities are encouraged to become ISO-certified. ISO is a quality management system with roots in manufacturing, and applying its principles to healthcare doesn’t happen overnight: “You have to learn what ISO is, then integrate ISO principles into your organization and your quality management processes,” says Lang. Challenges included fostering buy-in among skeptical physician leadership and getting documentation under control, she says.

Buy-in took time, but eventually the ISO certification drive caught on with the medical staff. Preparing for the ISO survey is challenging, but the book of standards is slim—approximately 50 pages, according to Lang. The focus is on reducing redundancy and waste.

“A nonconformity isn’t necessarily a bad thing. It just means you need to keep improving.”
—Marilyn Lang, RN,JD,

“Document control is a big part of ISO,” she says. You want your processes to be uniform, and you want to get rid of nonconformity. If you have a nonconformity, you want corrective action. The goals are the same as in any quality process or program, but it’s more formalized and specific [in ISO]. DNV has added the ISO component to enhance the promotion and integration of quality throughout the organization. By quality, DNV doesn’t mean just clinical quality—it’s quality in registration, in engineering, in housekeeping, all throughout the facility.”

At Oklahoma Heart Health Hospital, getting ISO certification was a lot of work, says Miller. “But it’s kind of revamping what you’re already doing, and making it flow along the ISO framework.”

Both Oklahoma Heart Health Hospitals are now ISO-certified.

Prove and improve

There is a saying throughout the DNV and ISO communities: “Say what you do, do what you say, prove it, and improve it,” Miller and Thompson say.

“It’s consistent with all quality initiatives,” says Lang. “Your organization needs to show it has written processes and established policies that show you know what you’re supposed to do; you do that; you prove you’re doing it by analyzing your data and looking at documentation; and you continue to improve it.”

For organizations that might be thinking about going with DNV, accreditation “is well worth any issues you might encounter,” says Miller. “They’re there to help you improve and make things better.”
**Manage the entire locum tenens process**

Littleton (New Hampshire) Regional Healthcare relies on locum tenens physicians to augment its permanent medical staff. The facility doesn’t have much choice, says Julie Hatley, CPMSM, CPCS, manager of medical staff services at the 25-bed critical access hospital. “We’re a small hospital and small staff, and when there’s a vacancy we don’t have the option NOT to fill it: Our patients need to be taken care of, so it has to be filled.”

The key to successful locum tenens credentialing is managing the entire process, from contracting through evaluation, Hatley said during a presentation at the recent Massachusetts Association Medical Staff Services Educational Meeting.

Locum tenens practitioners present unique challenges: They might have an extensive work history or, in the case of physicians right out of residency, they might have less independent clinical experience. Peer evaluations of current clinical competence may be scarce. Physicians not practicing full time and doing only locum tenens may not be able to document sufficient recent experience to meet minimum threshold criteria for privileges.

There’s also the short duration of the affiliation—often, these physicians work under a privileges-only arrangement; they won’t be members of the medical staff and won’t attend committee meetings.

Nevertheless, these physicians’ competency must be assessed. Hatley offered the following tips to optimize the experience for MSPs, locum tenens practitioners, and hospitals alike.

- **Be a manager of this process, more than just a credentialing coordinator.** The MSP must be at the table as both a manager and a leader, rather focusing only on the credentialing part of the process. Hatley related her own experience with this. She says she “did a lot of begging and pleading for more lead time” to process the locum tenens applications—which account for the majority of applications credentialed through the medical staff office at Littleton Regional Healthcare—and reminding her superiors that insufficient lead time could result in bad credentialing.

- “The impression that I was leaving with my managers was that I was being an obstructionist. I continued to focus only on my need [for more lead time], but time and time again I was finding myself with just a few weeks to credential someone before they came on board,” she says.

Then a situation occurred when the credentialing process identified issues that might require more detailed follow up, but there were only a few days until the physician was assigned for duty. The hospital found itself in the awkward position of making last-minute arrangements for other coverage after canceling the candidate’s assignment.

“That was my opportunity,” says Hatley. “I said, ‘Let me help you on the front line, looking at the CVs.’ By presenting a solution to the senior leadership, rather than complaining about the problem, I was able to position myself at the front end of the process, and manage it proactively. Now I am provided with the vacancies that need to be filled, and I reach out to the agencies and do the initial screening of the candidate CVs. An experienced MSP will tell you that they can often tell from a CV alone if a candidate will present a credentialing challenge. The time frame for credentialing a locum tenens physician is too short to work with a candidate that will present obvious challenges in the credentialing process.”

- **Partner with the other players in the process, starting with the agencies.** A good business relationship with the agencies increases your chances of success in finding the right candidates.

- **Look at the quality of your agency.** “I look for National Association of Locum Tenens Organizations (NALTO) members. They have a code of ethics, and they adhere to that code of ethics,” Hatley says.

- **Limit the number of agencies you work with to one or two.** “If I work with just two agencies, then I give them a lot of business and they’re anxious to please me … that won’t be true if you are spreading your business across 10 different agencies. Not to mention that different work teams for each specialty and each role (credentialing, scheduling,
licensing), and keeping track of all of those contacts can be a lot of work,” she says.

Furthermore, locum tenens physicians often work with multiple agencies. “If you get a physician’s name from one agency, chances are good you’ll get it from others as well, so working with multiple agencies doesn’t necessarily ensure more candidates,” she adds.

- **Build personal connections with the agency’s teams.** Get to know the agency’s scheduler, recruiter, and credentials professional.
- **Look closely at agency contracts.** “Before we get into a contract with [an agency], I want to know, what are my options if at the last minute this person can’t be credentialed or there are doubts about the candidate’s competency or work history? Also, what am I going to have to pay for? How soon do I want them to come in, how many days do they want to spend on orientation? If you know the contract, then you’re helping to manage the process,” Hatley says.
- **Check references.** Call around to other hospitals and see if they have worked with an agency and what their experience was.
- **Send a practice description to the agencies you use.** “The agencies will send me their practice description form, but they might not know what questions to ask, so I send them my practice description form,” notes Hatley. “It gives them a sense of what’s unique about Littleton Regional Healthcare and our community. In order to place the right candidate for our position, the agency and locums physician need to have a clear sense of what our organization provides for healthcare services, and what our expectations are for the candidate.”
- **Send your bylaws and privileges.** That way, if board certification is a requirement, the agency won’t send candidates who aren’t certified. The agency must also know what criteria the physician will need to meet in order to be credentialed in that specialty.
- **Partner with the people who use the locum tenens.** These can be the physician practices, office managers, practice managers, physicians, and recruiters. “You’ve got to be part of their team, you need to know what drives them,” says Hatley.
- **Get involved early with scheduling.** Littleton Regional’s location in northern New Hampshire means an increased volume of vacationers and a lot of seasonal activities that may require extra staff to be on board during those peaks. Winter is ski season, so an uninterrupted schedule of orthopedic coverage is important.

“The orthopedic physicians staffing may need to be supplemented during February vacation,” Hatley observes. “So I know I’ll need orthopedic locums the third week of February. You do not want to be without an orthopedist when you’re at a critical access hospital that is in close proximity to ski areas!”

- **Orient the physicians.** Every hospital is different. A good orientation program for locum tenens goes a long way toward minimizing complaints from nursing staff, from the agency, and from the physicians. “They really need to hit the ground running, and you don’t have three or four days to get them oriented,” says Hatley. “You need to make sure they know how to do the job that you’ve brought them on to do, so make your orientation program complete but efficient.”

During orientation, provide the following:
- The organization’s code of conduct.
- Key contact information. At Littleton Regional Healthcare, these include the CEO, the chief nursing officer, the manager of the day, and the medical staff office.
- Discussion of the local culture. “We talk to them about what we typically see in our community that we’re comfortable keeping,” Hatley notes. “It’s important for physicians to know what we can do, the scope of services we provide, and the handoff process at the conclusion of their assignment.”
- **Get everyone’s input for evaluation.** It’s important to inform the agency about your organization’s experience with a candidate. Reach out to the physicians, surgeons, or other colleagues that might have interacted with the locums physician. Ask how the locum tenens physician did: Was he or she comfortable with their work here? Would you want to see this person back? What do your nurses think? While the nurses can’t necessarily be clinical peer references for physicians, they certainly know how the practitioner is doing as part of the healthcare team, and it’s important to give that feedback to the agency, Hatley says. If the agency scheduled this physician well, and
made the right match, it can use that knowledge in the future to send qualified candidates.

- **Manage the madness.** Your time is valuable. “I can be politely brief on the phone because I don’t have time to talk about the weather [and] I don’t have time to read hundreds of emails from staffing recruiters each day,” says Hatley. Caller ID and the junk mail folder in email can help save time.

  When a CV doesn’t pass “the sniff test,” and it’s clear right away that there will be problems credentialing a candidate, stop. “Because I manage the entire process, if I get a CV like that, I’ll call the agency and say, ‘Send me another CV.’ I don’t have to say why. I don’t have an obligation to any candidate at this point.”

  Also, remember that there are no regulatory or accrediting bodies that mandate the MSP must verify all activities back to medical school, Hatley says. “I’m most interested in what have you done in the last three to five years and have you done it well.”

- **Advocate for quality.** But don’t let that advocacy become destructive. “For a while, I was part of the problem. I was right that more lead time would permit a more thorough credentialing process, but the way I communicated my message to leadership gave me an image in my organization that I didn’t want to have,” Hatley says. “I had to get down off my pedestal and see the issue from many different perspectives. I had to be collaborative.”

  Locum tenens physicians will be around as long as there is a need for them, so it’s important for MSPs to be managers and leaders in selecting the best candidates for the job.

  “There’s a difference between being a medical staff coordinator and being a medical staff director or leader. I don’t mean to downplay the importance of credentialing, but if you’re just seeing the problem as one where an application lands on your desk and you don’t have enough lead time, then you’re not really seeing the bigger organizational picture,” says Hatley.

---

**Temporary privileges**

**Test your knowledge with this MSP quiz**

CMS states that temporary privileges may be granted as allowed by state law, medical staff bylaws, and rules and regulations. The Joint Commission is more prescriptive than CMS in its standards for granting temporary privileges, specifying the reasons they may be granted, and the requirement for verifications in order for temporary privileges to be granted.

**Questions**

1. According to The Joint Commission, temporary privileges may be granted for what two reasons?
2. What are the minimum verification requirements for temporary privileges granted to a non-applicant for an important patient care need?
3. What are the differences in verification requirements for locum tenens practitioners?
4. What time limit should be placed on locum tenens temporary privileges?
5. Must temporary privileges be granted for the entire time period allowed in your bylaws?
6. What is a “clean” application?
7. What is the temporary privileging process for a physician proctor who is not on your medical staff?
8. Is the time limit for proctors’ temporary privileges granted based on the number of cases or based on a specified period of time?
9. Your medical staff bylaws allow up to 120 days for temporary privileges granted to a non-applicant. Dr. Jones comes to work with your hospitalist group in January as a locum tenens physician and is granted temporary privileges for the full 120 days. He works through the end of April and does a great job. The director of the hospitalist program would like to have him fill in for 90 days beginning in June. Is this allowed?
10. True or false: Temporary privileges may be terminated by the hospital CEO without affording the physician any fair hearing rights.
Answers

1. Temporary privileges may be granted for the following reasons:
   – To fill an important patient care, service, and treatment need
   – To allow new privileges to applicants who are awaiting review and approval through the organized medical staff

   In the past, Joint Commission standards language stated that temporary privileges could be granted for an “urgent patient care need.” However, the standard now reads “important patient care, service and treatment need.”

   Temporary privileges for new applicants include:
   – Initial applicants applying to the hospital for the first time
   – Individuals who currently hold privileges and are requesting a new privilege
   – Individuals who are currently going through the reappointment process and are requesting one or more additional privileges

   This definition has helped clarify the intent of the standard. Previously, the standard referred to “new applicants” with a clean, complete application—some medical staffs were reluctant to allow temporary privileges for physicians who were already on staff and had requested a new privilege (MS.06.01.13).

2. The minimum requirements for temporary privileges for non-applicants are that you verify the following:
   – Current licensure
   – Current competence

3. As far as CMS and The Joint Commission are concerned, the requirements are no different for a locum tenens physician than for another physician seeking temporary privileges. Locum tenens physicians are requesting privileges, but are not requesting medical staff membership.

4. The time limits for temporary privileges should be spelled out in your bylaws. Your medical staff may differentiate between a locum tenens and other non-applicants, but it is not required. Bylaws language should also give your CEO the ability to grant and terminate temporary privileges.

5. Temporary privileges do not have to be granted for the maximum time allowed. If a locum tenens physician is filling in to cover summer vacations, for example, the need may cover a five-week period spanning June and July—35 days. Although your bylaws allow temporary privileges for up to 90 days, your CEO should grant privileges for the specific time period that must be covered.

6. A “clean” application is an application for which no concerns have been raised. The Joint Commission has requirements for clean applications, and your medical staff bylaws should define any additional criteria deemed appropriate for a clean application.

7. Temporary privileges for a physician proctor who is not on your medical staff may be granted through the same process as other temporary practitioners. Current licensure and current competence must be verified, and then privileges can be approved by your CEO upon recommendation of the president of the medical staff.

8. Temporary privileges for proctoring may be defined for a certain number of cases, but not to exceed a specific time limit. For example, temporary privileges might be granted for proctoring of five cases, but they are not to exceed 60 days. If the specified number of cases have not been completed within the 60 days, temporary privileges could be granted again, or extended.

9. Yes, he can, if your bylaws allow it. Most bylaws do not limit the number of times in a year that a provider can be granted temporary privileges, and neither do CMS nor The Joint Commission or other accreditors.

10. True—if this is written into your bylaws. Temporary privileges may be terminated by the hospital CEO without affording the physician any fair hearing rights. Your bylaws should include language to this effect.

EDITOR’S NOTE
Material for this quiz comes from Credentialing A to Z, a new book from HCPro. For more information, go to www.hcmarketplace.com/credentialingAtoZ.
Letting leaders come to their own conclusions

By nature, I am an easygoing person and do not like to give a lot of direction, especially to the medical staff leaders that I “coach.” I like to use the word coach because the medical staff members are the stars, and I believe that we, as medical staff services professionals, need to let them shine. After all, it’s the physician leaders whom The Joint Commission and other surveyors want to hear from, not us. They take the ball and pass it, or shoot it. We don’t. (Maybe I am using this analogy because I was watching the NBA finals as I write this column, but it makes sense to me.)

I re-learned the lesson of not giving a lot of direction recently when I revised our general surgery clinical privilege request form. The form had been a laundry list of various items for what seemed like millennia, with some asterisked privileges identified that required copies of five operative reports to demonstrate current clinical competency. It needed a change, but getting to the point where the section leader acknowledged that need took a while.

As each particular problem arose with the form, such as proctoring (is this enough?), old terminology, or what I knew should be identified as needing demonstration of current clinical competency, I would bring it to the attention of the section leader. Finally, she asked me, “Okay, Guenther, when are we going to revise the form?” Music to my ears.

When we first sat down, I asked her to think about how to make the form easier for her to complete as an applicant. Then I considered how to make it easier for her, as the section chief, to quickly evaluate current clinical competency.

We had one session just to update terminology, and another to break out bundles by subspecialty. We looked at what procedures required the use of fluoroscopy so my office could ensure that the surgeon had appropriate licensure. We then tweaked and tweaked, adding and revising volume requirements along the way.

With each meeting, the section leader was making the form better—without me saying anything. For example, in several subspecialty bundles, she was unsure what the volume requirement should be. I said it was at her discretion and that she could collaborate with her colleagues. We started some bundles at one or two years. When we met again, she upped it to five years. Then 10. Having been through this before, I had an idea from the start of what the volume numbers should be. But as she collaborated with her colleagues and thought about it, she upped the figures each time.

When our medical staff leaders come to their own conclusion—one that we have been leading them toward—they will own more than we can imagine and defend it to any surveyor.

She ended up putting in the numbers that I originally thought should be there—but she did it herself; it was her idea. She owns it, can speak to it, and can defend it.

It was a long but worthwhile exercise, and now we have a template that the surgery chief wants to use for the rest of the surgery clinical privilege request forms.

So my 2 cents is to take a breath and try not to talk too much. When our medical staff leaders come to their own conclusion—one that we have been leading them toward—they will own more than we can imagine and defend it to any surveyor. They will be engaged and make our jobs that much more enjoyable.

EDITOR’S NOTE
Baerje is director of medical staff services at Saint John’s Health Center in Santa Monica, California.