The medical staff and credentialing outlook for 2017

The New Year’s dust (or confetti, as the case may be) has settled, routine is restored, and 2017 stretches ahead. For MSPs, medical staff leaders, and quality personnel, there’s no better time to take stock of last year’s professional developments, applying lessons learned to current approaches and future plans. To fuel this reflection, CRCJ asked the following credentialing and privileging experts to share their predictions, focuses, and advice for 2017:

- **Bill Cors, MD, MMM, FACPE**, chief medical officer at Pocono Health System in East Stroudsburg, Pennsylvania
- **Leslie Cox, BS, MHA, CPMSM, CPCS**, senior director of Banner Health CVO in Phoenix
- **Gwen Davenport, MBA, MA, CPMSM, CPCS**, administrative director, medical staff services, at Bon Secours Virginia in Richmond
- **Robert W. McCann, Esq.**, partner at Drinker Biddle & Reath, LLP, in Washington, D.C.
- **Maggie Palmer, MSA, CPMSM, CPCS**, medical staff consultant in Dallas
- **Lisa Shea, MD**, medical director for Butler Hospital, and system

The Supreme Court of Louisiana affirmed a lower court’s judgment that negligent credentialing claims against hospitals don’t fall under the state’s medical malpractice act and therefore are not subject to its damages cap.

Review the latest headlines concerning the anti-kickback statute, HIPAA, Medicare fraud, and the False Claims Act to ensure you don’t find yourself in legal trouble.

Beat productivity killers to the punch with Maggie Palmer’s octave of career-minded resolutions for the year ahead. Recommendations include taming email sprawl, venturing out of the office, and shaking up meeting structures.

Brush up on all the expert news and analysis CRCJ and CPRLI had to offer last year with our comprehensive 2016 story indexes.

Credit: AndreyPopov. Image Source: iStock.com
What were the biggest medical staff and credentialing happenings in 2016? How did they impact MSPs and medical staff leaders, and will they continue to do so in 2017?

Leslie Cox: The greatest impact to the medical staff over the past year, from my observations, has been increased scrutiny imposed by regulatory, legal, and
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Organizational bodies. Practitioners, and physicians in particular, are held to higher standards regarding data and documents that must be submitted during the credentialing process. Examples of emerging must-have knowledge areas include specifics regarding malpractice insurance policies/prior acts coverage, physician-owned distributorships, and criminal background checks.

Other requirements beyond the usual regulatory or accreditation standards include questions on applications regarding the Provider Enrollment, Chain, and Ownership System (PECOS), Office of Inspector General (OIG) sanctions, and health (e.g., documentation of flu vaccination and tuberculosis screenings). For the applicant, this required information often generates questions and presents challenges in providing the documentation necessary to complete the process timely.

Melinda E. Whitney: Significant 2016 credentialing-related issues that are anticipated to continue in 2017 include:

- **Expansion of telemedicine**: Medical staff leaders and MSPs will continue to face credentialing and privileging changes and challenges as they adapt to the Medicare hospital/critical access hospital (CAH) Conditions of Participation (CoP) regarding credentialing by proxy. The continued growth of telemedicine specialties and practitioners generates questions from MSPs who are operationalizing the process. Hazy areas include content and delineation of telemedicine clinical privileges and state law–specific considerations such as licensure and prescribing.

- **The evolution of the traditional medical staff services department into a credentials verification organization (CVO) or the home of one**: This transformation continues to occur across the country as medical staff leaders and hospital administrators push to streamline the application process and use information provided by the physician/advanced practice professional (APP) applicant for multiple purposes (e.g., credentialing and privileging, employment, and managed care).

- **APPs’ growing presence and shifting regulatory landscape**: Changing state-specific laws, rules, and regulations continue to generate issues for medical staff leaders/MSPs related to licensure, scope of practice, and roles for APPs (e.g., advanced practice registered nurses, physician assistants) in the traditional medical staff structure. The types of nonphysician practitioners seeking clinical privileges are also increasing (e.g., dietitians, pharmacists).

- **Information sharing**: Information-sharing challenges stay in the forefront as more departments within a system—and collaborators from beyond it—demand increased transparency and/or access to privileged peer review information.

Lisa Shea: APPs and medical staff unification seemed to dominate the field in 2016. Additionally, there’s been a growing movement toward a progressive approach to addressing medical staff member conduct issues. In light of these trends, which will likely continue in 2017, medical staff leaders and MSPs must demonstrate flexibility and great teamwork to standardize and centralize credentialing and privileging processes.

Gwen Davenport: Increasingly, medical staffs must establish reasonable case criteria for OPPE. Without correct case volumes, not all providers will meet criteria for reappointment. This can leave out excellent providers who happen to have low volume in your facility. Medical staffs must also focus on improving performance in areas that impact their patients’ experience of care and their organization’s financial viability, including readmission rates and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores.

For their part, credentialing personnel must pursue excellence, and, where warranted, improvement in a number of essential and emerging domains, including the following:

- Reducing turnaround time on initial applications, from receipt to board approval
- Retaining medical staff members and MSPs
- Vetting additional disciplines—evolving state
Terry Wilson: In my world, going paperless and becoming a high-reliability organization were focal points in 2016. Physicians also continue to struggle with electronic medical records, and it surely will be interesting to see what changes are coming our way once President-elect Donald Trump takes office.

2016 has continued in the vein of previous years, with hospitals trying to find creative ways to reduce costs to regulations may call for the credentialing and privileging of surgical assistants, first assistants, perfusionists, and other practitioners who’ve historically been authorized through HR processes.

- Educating staff on key topics, including regulatory agencies, process improvement, using current tools to their fullest potential, going paperless, and eliminating redundancies.

**Bonus insights: Big-picture considerations for 2017**

From the incoming administration to sweeping trends, regs, and reform efforts, 2017 bodes big changes for stakeholders across the care continuum. Here’s how MSPs and medical staff leaders can brace for what’s coming down the pike.

**Expect heightened ACA activity**

Healthcare reform will be front and center in 2017, according to Melinda E. Whitney, RN, BSN, BS, MS, CPHQ, CPMSM, FACHE, senior consultant of quality management services at The Quality Management Consulting Group in Columbus, Ohio. President-elect Donald Trump has selected Representative Tom Price (R-Ga.) as Secretary of the Department of Health and Human Services and Seema Verma as administrator of the Centers for Medicare & Medicaid Services. The selection of Rep. Price, an orthopedic surgeon who currently sits on the health subcommittee of the House Ways & Means Committee, signals the new administration’s intention to move forward with changes to the Affordable Care Act (ACA). The appointment of Verma, a consultant who previously worked with Vice President-elect Mike Pence on Indiana’s Medicaid program, suggests the administration may be interested in encouraging other states to implement Medicaid reform, says Whitney.

**Put safety first**

Look no further than The Joint Commission’s 2017 hospital National Patient Safety Goals for inspiration. “Six of the seven categories of safety goals are directly related to a medical staff’s provision of care to patients,” says Whitney. “Preventing infection and mistakes in surgery, improving staff communications, identifying patients, and using medicines correctly are constant challenges that every facility will face in 2017.”

**Stamp out burnout**

With physician shortages growing across the country, issues that jeopardize current practitioners’ longevity can cause systemic damage. Recognizing and addressing signs of fatigue before they morph into full-blown burnout can head off such threats, as can anticipating stressors and streamlining processes. Doing these things can also improve physicians’ engagement in medical staff affairs, according to medical staff and medical staff services leaders at BayCare Health System in Clearwater, Florida. Use the following questions, courtesy of the BayCare team, to evaluate and improve upon current approaches:

- What are integrated health systems doing to standardize credentialing processes across their organization?
- Do these systems create “standard” medical staff bylaws and privileging documents across their hospital medical staffs? What have they learned in trying to do so?
- Do they have separate processes for credentialing ambulatory physicians who no longer wish to be members of the hospital medical staff?

**Transcend the status quo**

“As we all know, change is the new norm,” says Leslie Cox, BS, MHA, CPMSM, CPCS, senior director of Banner Health CVO in Phoenix. “We must be bold, ask critical questions, be open-minded, be willing to take risks, and learn from our mistakes. These are the skills of a leader, and effective leadership is necessary when introducing and implementing organizational change.”
counteract continuous reimbursement cuts. I think that medical staff members are less willing to give of their time (even with pay) to take on leadership roles within the medical staff organization. Medical staff members’ longevity on the medical staff continues to decline (a fact that still surprises me), so our membership is constantly changing. This trend adds to our workload and decreases continuity of patient care.

More and more physicians are becoming employed, too, which makes things interesting because these practitioners must be treated as both employees and members of the medical staff, with different sets of rules to guide them in the workplace.

Maggie Palmer: HealthStream’s purchase of three major software companies (Morrisey, OneApp, and Healthline Echo), plus Symplr’s acquisition of Cactus, will likely lead to positive disruption in how we look at credentialing and privileging—routing clerical tasks away from the medical staff services department (via outsourcing or technology) and elevating MSPs’ value. But in order to gain deserved recognition for their strategic contributions, MSPs must be willing to let go of the old ways of doing things. We need to be more agile and assertive. (Editor’s note: For more of Palmer’s insights on the role of innovation—and other medical staff services musts—in the year ahead, see this month’s “The MSP’s voice” column.)

Bill Cors: An ongoing major challenge in 2016 that will certainly continue in 2017 is cultivating a well-balanced credentialing/privileging process that accomplishes the following:

- Promotes patient safety by offering a rigorous process for identifying excellent and competent practitioners
- Meets the organization’s revenue and strategic needs through a focus on timeliness, efficiency, and customer service

To meet these demands, medical staffs must figure out how to quickly adopt a bifurcated credentialing/privileging process if they do not have one already. Under this model, applications that the medical staff determines to be clean go one way, and everything else goes a more protracted route.

Fatema Zanzi: One continuing challenge is how to best credential late-career practitioners (referred to sometimes as “aging physicians”). I think everyone is struggling with the most respectful, quality-focused, and legally compliant way to roll out a policy for all medical staff members, including employed and non-employed physicians.

BayCare Health System: We’ve seen several trends emerge or grow in 2016 that we expect to carry on in the year ahead:

- Reentry into inpatient hospital practice: Several of our physicians have requested hospital-level privileges after either retiring or practicing for several years in an office (outpatient) setting with no acute care (hospital) activity. To address this growing phenomenon, hospitals must have parameters or strong co-management practices in place to establish effective review processes for competency attestation and, ultimately, patient
safety. At BayCare, we’ve implemented a detailed policy on reentry into medicine that complies with the Florida Board of Medicine’s rules. In addition, at the recommendation of our health system’s board, we recently created an addendum to specify time frames and volume requirements.

- **Use of locums:** It’s not just prevalent at our hospitals—it’s everywhere. Medical staff leaders and MSPs must strive to obtain accurate and sufficient affiliation/practice history and avoid cutting corners. Despite the prevailing misconception, there’s no fast track for processing locums applications.

- **Negligent credentialing:** Unfortunately, these claims aren’t going away any time soon. The more education we give our medical staff leadership and providers who tend to “put the push on us,” the better they understand when we tell them “no.”

- **Stepped-up peer review scrutiny:** We’re seeing more attorneys looking at the OPPE/FPPE documentation and process.

Robert W. McCann: I see an increasing number of disputes arising with respect to decisions to limit privileges in certain traditionally open departments to physicians who are employed by the hospital. It’s an almost inevitable issue for systems that are seriously pursuing an employment model of integration. One of the legal questions that follows is whether courts will (or should) adhere to traditional legal standards for closed departments/exclusive contracts in dealing with situations where closure is based on employment.

What specific regulatory developments, events, and challenges should MSPs and medical staff leaders be on the lookout for in the year ahead?

Whitney: There are several. For those using The Joint Commission, the Healthcare Facilities Accreditation Program (HFAP), and/or the Centers for Medicare & Medicaid Services (CMS) for accreditation or deemed status, effectively gathering, evaluating, and using OPPE and FPPE data within the credentialing and privileging processes remains on MSPs’ to-do list for 2017. This is an issue with respect not only to establishing effective processes, but also to clearly defining lines between informal and formal processes to meet federal and state reporting obligations.

Given CMS’ recent decision to tamp down on hospitals’ ability to establish provider-based locations, expect the agency to ratchet up its auditing and compliance efforts surrounding existing provider-based locations. Failing to meet CMS requirements (which include a clinical integration component) can have a serious financial impact on hospitals.

Expect the OIG to continue its compliance efforts, including those surrounding medical necessity. This means that the medical staff should not only be aware of individual case issues, but also of volume issues that arise with respect to a particular provider.

Shea: The new Joint Commission survey process is an unknown. Additionally, there’s increased federal government vigilance regarding potential false claims implications.

Davenport: Keep an eye out for the following:

- More clinically integrated networks
- More in-depth regulatory surveys
- Payers initiating more penalties when specific quality measures are not met
- Medical staff leaders involved in more quality and safety initiatives
- More reduction in payer reimbursement

Cox: 2017 will likely bring additional change in our regulatory environment, and with that comes additional credentialing burdens for providers. An abundance of paperwork is costing precious time for clinicians who want to be taking care of patients. Providers are typically required to complete multiple applications, often within the same organization, and are asked to provide similar information when applying for hospital privileges, health plan participation,
employment, and insurance coverage. This duplication is not only an inconvenience for the provider; it’s inefficient for the healthcare organization.

Q What advice do you have for overcoming obstacles, improving medical staff and credentialing processes, and staying compliant in 2017?

Whitney: Don’t be caught unaware. Evaluate and challenge current processes to promote compliance with applicable federal and state laws, rules, and regulations, as well as with private accreditation standards. Prepare for change by monitoring the following on an ongoing basis:

- **Prepublication standards and other information from the hospital’s accrediting entity.** Know which medical staff standards most frequently result in citations, and learn from others’ mistakes by proactively reviewing your current processes with an eye toward compliance.
- **State law developments**, including information from your state medical and nursing boards. Stay up-to-date on proposed, impending, and emerging changes to avoid being blindsided on short notice.
- **CMS guidance and proposed changes** to the Medicare hospital or CAH CoPs and related interpretive guidelines. Remember that the CoPs for CAHs are not totally consistent with those for acute care hospitals.

Beyond vigilantly monitoring evolving expectations, review medical staff policies and procedures to determine whether each is compliant and consistent with actual practice (i.e., do you follow your policy?) and is contemporary (i.e., is your policy outdated, or does it reflect current best practice?). Get rid of redundancies and processes/procedures that add no value. Use software to the fullest (you are paying for it, after all). Update your medical staff governing documents so that you are making the best use of everyone’s time—make sure your documents serve you.

Davenport: Consider the following tips:

- **Learn from the leaders.** Don’t be afraid to reach out to healthcare organizations that demonstrate best practices.

Even more insights: Brave the medical staff and credentialing realm in 2017 and beyond

Attend the [2017 CRC Symposium](https://www.credentialingresourcecenter.com/symposium) on April 6–7, 2017, in Austin, Texas, for two days of engaging education and training taught by the industry’s top experts. During the event, MSPs, medical staff and physician leaders, and quality directors will get answers to today’s top medical staff and credentialing questions, including the following:

- In an era of increasingly difficult physician recruitment and retention, how can organizations develop a “user-friendly” practitioner onboarding process?
- Can team performance measurements be used in individual physician competency assessments?
- Credentialing, provider enrollment, and delegation: What do each of these terms actually mean, and what is the relationship between them?
- How can organizations ensure both new and late-career physicians are competent and able to practice independently?
- Can the traditional OPPE process be used for low-volume practitioners, telemedicine providers, and advanced practice professionals?
- What should organizations do if faced with a negligent credentialing legal claim?

Click here to learn more.

Need help convincing leadership to pay your way? Click here to download a justification letter outlining the symposium’s big-picture benefits.
Case summary

Negligent credentialing claims found not to be subject to medical malpractice damages cap

Affirming a judgment by the Third Circuit Court of Appeals, the Supreme Court of Louisiana (the “Court”) concluded that claims of negligent credentialing did not fall under the purview of the Louisiana Medical Malpractice Act (LMMA) and consequently were not subject to its statutory damages cap.

The decision stems from a medical malpractice claim against Opelousas (Louisiana) General Hospital Authority (OGH); Kondilo Skirlis-Zavala, MD, an independent contractor working in OGH’s emergency department (ED); and other defendants. In June 2010, the plaintiffs, Veronica and Joseph Billeaudeau, took their adult daughter Brandi to the ED at OGH after she collapsed at home. There, Skirlis-Zavala diagnosed Brandi with a focal motor seizure and ordered antiseizure medication and a CT scan that came back as normal.

The Billeaudeaus disagreed with Skirlis-Zavala’s diagnosis, believing Brandi had in fact suffered a stroke; they asked that their daughter be given a t-plasminogen activator, a treatment for stroke victims. Skirlis-Zavala declined the request, stating that Brandi was not a candidate for it. The Billeaudeaus requested their daughter be transferred to Our Lady of Lourdes Regional Medical Center in Lafayette, which Skirlis-Zavala arranged.

Another focus that will be critical in 2017 and in subsequent years is using technology to the fullest extent possible and automating credentialing processes across the enterprise. This will improve value and efficiency, reduce cost, and increase customer satisfaction.

Cox: Open communication and inclusion of all stakeholders in a process improvement plan is critical. As healthcare organizations attempt to streamline processes, all involved departments must be at the table, as they are interdependent. Communicating the “why” behind proposed changes helps foster support and ensures a shared vision among all stakeholders.

Legal insights

Don’t be content with business as usual. Instead, strive to become a world-class organization. Ensure your current state will not be your future state by focusing on opportunities for improvement and setting short- and long-term goals.

Don’t panic. Implementing new credentialing processes doesn’t have to be overwhelming. Develop a chart with timelines for old or new credentialing processes that your organization should focus on.

Anticipate transitions. When seasoned medical staff leaders retire, will their successors be sufficiently prepared, educated, and trained to assume the mantle?

Cors: To promote effective credentialing and privileging, MSPs must learn how to strike the right customer service chords. Their stance should fall somewhere between a literal interpretation of “the burden is on the applicant,” where MSPs avoid lifting a finger to help, and total enablement, where the medical staff services department does everything.

MSPs must also leverage their credentialing/privileging software systems to promote optimum efficiency. For example, consider hosting virtual meetings—complete with electronic application review and sign-off—involving the credentials committee, medical executive committee, administration, and board. This alone can trim weeks off the processing of a clean application.

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At Our Lady of Lourdes, Brandi was given a t-plasminogen activator more than four hours after she suffered what was ultimately determined to be a stroke, which was outside the window of the treatment’s effectiveness. Although Brandi survived the stroke, she suffered irreversible brain damage.

The Billeaudeaux filed a negligence suit against the defendants, stating the hospital failed to develop and/or implement adequate policies and procedures for strokes and the administration of t-plasminogen activators, failed to provide Skirlis-Zavala with the written protocol and make sure she reviewed it, and failed to supervise Skirlis-Zavala in the ED.

As the plaintiffs in the case, the Billeaudeaux also claimed that OGH was negligent in its credentialing of Skirlis-Zavala for the following reasons:

- OGH failed to investigate Skirlis-Zavala's failure to produce evidence that she completed continuing medical education in emergency medicine, which is required by OGH’s bylaws
- When Skirlis-Zavala was granted privileges, OGH failed to follow up on a reference provided by an emergency medicine physician

The plaintiffs filed a motion for partial summary, asking the district court to determine that their negligent credentialing claim was not subject to the LMMA's terms, including its damages cap of $500,000, which was set in 1975. Citing Louisiana Revised Statute § 40:2114(E), which states a hospital must establish “rules, regulations, and procedures setting forth the nature, extent, and type of staff membership and clinical privileges, as well as the limitations placed by the hospital on said staff membership and clinical privileges for all health care providers practicing therein,” the plaintiffs argued that OGH was negligent because Skirlis-Zavala should not have been given full privileges to work in the ED based on her experience and training. This, they argued, made the case a matter of corporate malfeasance in the hiring process.

J. Michael Eisner, Esq., of Eisner & Lugli in New Haven, Connecticut: In this case, the Supreme Court of Louisiana held that a claim against a hospital for negligent credentialing fell outside of the purview of the Louisiana Medical Malpractice Act, and therefore was not subject to that statute’s cap on damages.

The tort of negligent credentialing by hospitals was first recognized in *Darling v. Charleston Community Memorial Hospital*. Since then, approximately twenty-eight states have specifically recognized claims of negligent credentialing by hospitals (e.g., *Spalding v. Spring View Hospital*). Some states require expert testimony in order to establish such corporate negligence (e.g., *Neff v. Johnson Memorial Hospital*).

In my view, in spite of the various dissents in *Billeauudeau*, its reasoning is sound and is likely to be followed. Accordingly, *Billeauudeau* is important in that it should be viewed as a warning that state statutes setting caps on malpractice cases or limiting liability for problems in the peer review process must specifically reference negligent credentialing (or corporate negligence) in order to assure that your state court will not follow the reasoning in *Billeauudeau*.
Although the defendants argued that the case was simply a matter of medical judgment, the district court granted the plaintiffs’ motion, finding that the LMMA’s description of “malpractice” failed to include “negligent credentialing” despite several attempts by the state legislature to add such language.

Additionally, the district court applied a six-factor test when deciding whether the negligent credentialing allegations applied best with general negligence law or malpractice law. Ultimately, the district court found that the negligent credentialing claim didn’t constitute a medical malpractice claim and therefore was not subject to the requirements of the LMMA. This was then affirmed by the Third Circuit Court of Appeals.

The Court revisited the six-factor test, derived from the Court’s decision in the case Coleman v. Deno, to determine whether the defendants’ actions fell under the LMMA’s definition of malpractice. According to Coleman, conduct constitutes malpractice if:

1. The particular wrong was “treatment related” or caused by a dereliction of professional skill
2. Expert medical evidence is required to determine whether the appropriate standard of care was breached
3. The pertinent act or omission involved assessment of the patient’s condition
4. The incident occurred in the context of a physician-patient relationship or was within the scope of activities that a hospital is licensed to perform
5. The injury would have occurred if the patient had not sought treatment
6. The alleged wrongdoing was intentional

Legal insights

Attend the 2017 Credentialing Resource Center Symposium on April 6-7, in Austin, Texas, for expert guidance on a wide range of medical staff, credentialing, and peer review topics. For negligent credentialing insights, the following sessions may be of particular interest:

- **The Growing Threat of Negligent Credentialing Litigation:** Why has there been a rapid rise in negligent credentialing lawsuits? This session will explain the nature of negligent credentialing lawsuits, the forces that have driven their proliferation, and their most common triggers. Through analysis of landmark court cases, our expert faculty will identify key legal terms and concepts that underpin negligent credentialing claims, provide best practices and discipline-specific strategy for avoiding litigation landmines, and offer guidance on how to prepare for such lawsuits once they’re initiated.

- **Medical Staff Applications: Pink Flags versus Red Flags:** Mishandling or overlooking warning signs at initial appointment can lead to the hiring and/or appointment of undesirable candidates to the medical staff. In this session, attendees will learn to identify, investigate, and report the subtler “pink flags” on medical staff applications and peer references—a practice that fosters informed decision-making during medical staff deliberations, diminishes medical and legal risk to the organization, and promotes patient safety. Our expert faculty will provide guidance on bringing physician competence issues to the surface, dissecting peer references, and creating a plan to further investigate physician.

Using these factors, the Court concluded that the plaintiffs’ claim didn’t fall under the provisions of the LMMA. For example, the Court found that under the first factor, a claim of negligent credentialing leaned more toward general negligence than medical malpractice because the decision to hire a physician is an administrative issue and doesn’t directly relate to the treatment of a single patient or involve a dereliction of professional skill. As a result, the fifth factor also does not weigh heavily toward finding the alleged negligent credentialing to fall under the LMMA’s definition of medical malpractice.

Additionally, the Court found that the second and third factors fell in favor of finding the plaintiffs’ claim weighed toward general negligence, as the claim did not require expert medical evidence to establish a breach of care and the administrative decision to grant Skirlis-Zavala privileges didn’t involve medical assessment of a patient’s condition.

It should be noted that the Court’s decision did not determine whether the defendants in the case were negligent in their treatment of Brandi Billeaudeau or whether OGH was negligent in its credentialing of Skirlis-Zavala. The decision in this case only found that a negligent credentialing claim against a hospital was not covered by the LMMA and, therefore, not subject to its damages cap. In fact, the plaintiffs have already resolved their medical malpractice claim against the defendants.


This case was reviewed by J. Michael Eisner, Esq. (meisner@jmeisner.com) of Eisner & Lugli in New Haven, Connecticut. Case summaries are prepared for informational purposes only and should not be considered legal advice.

Legal and regulatory news roundup

Find out what’s happening in the world of federal healthcare regulations by reviewing some recent headlines from across the country.

Anti-kickback statute safe harbors expanded

The U.S. Department of Health and Human Services’ Office of Inspector General (OIG) recently issued a final rule that added new safe harbors to the anti-kickback statute, which prohibits the exchange of anything of value to induce or reward the recipient for a referral of healthcare program business. The new safe harbors are intended to protect certain payment practices and business arrangements from sanctions.

As outlined by the final rule, the new safe harbors include the following business arrangements:

- Providers may offer free or discounted local transportation services to Medicare and Medicaid beneficiaries. Patients in urban areas must reside within 25 miles of the provider, while patients in rural areas must live within 50 miles. The transportation cannot be by air, luxury vehicle, or ambulance and may be provided only to established patients.
- State- or municipality-owned ambulance services may waive cost-sharing for emergency ambulance services. To fall under the safe harbor, ambulance providers must offer the cost-sharing waivers uniformly, regardless of patient-specific factors. They also cannot later claim the amount as bad debt or “shift the burden to Medicare, a state healthcare program, other payers or individuals.”

University settles potential HIPAA violations

The University of Massachusetts Amherst (UMass)
has agreed to pay $650,000 and enact a corrective action plan to settle potential violations of the Health Insurance Portability and Accountability Act (HIPAA).

According to the U.S. Department of Health and Human Services’ Office for Civil Rights (OCR), in June 2013, OCR received notification from UMass that the electronic protected health information (ePHI) of 1,670 individuals was disclosed as the result of a malware program infecting a workstation in its Center for Language, Speech, and Hearing. The disclosed ePHI included patient names, addresses, dates of birth, diagnoses, health insurance information, and Social Security numbers.

The OCR investigation found several potential HIPAA violations. Although HIPAA allows some organizations to declare themselves as hybrids—having healthcare functions that are covered under HIPAA and other functions that are not—UMass failed to designate all its healthcare components as covered, including the Center for Language, Speech, and Hearing. As a result, UMass failed to implement policies and procedures for the center to ensure it complied with HIPAA privacy and security rules. UMass also did not have a firewall in place at the center, which allowed the malware to infect the system. UMass additionally failed to conduct a thorough risk analysis until September 2015.

The corrective action plan requires UMass to conduct an enterprise-wide risk analysis, develop and implement a risk management plan, revise its policies and procedures, and train its staff on those revised policies and procedures.

Drug maker to pay $38 million to settle kickback allegations

To settle allegations it paid physicians to prescribe several of its drugs, Forest Laboratories LLC, of New York City, and its subsidiary, Forest Pharmaceuticals Inc., will pay $38 million to the federal government and state Medicaid programs, according to the U.S. Department of Justice.

The allegations against Forest state that from January 2008 to December 2011, Forest violated the anti-kickback statute by providing payments and meals to physicians connected with speaker programs about Forest drugs—Bystolic, Namenda, and Savella—to induce prescriptions of those drugs. The physicians received the payments and meals even when the programs were cancelled, had no licensed healthcare professionals in attendance, or had the same attendees attending multiple programs over a short period of time.

The settlement will also resolve a whistleblower lawsuit filed by Kurt Kroening, a former Forest employee. Under the whistleblower provisions of the False Claims Act, Kroening is entitled to a share of the recovery and will receive $7.8 million.

In a statement announcing the settlement, Principal Deputy Assistant Attorney General Benjamin C. Mizer, head of the Justice Department’s Civil Division, said, “Kickback schemes undermine the integrity of medical decisions and increase the costs of health care for everyone … Such schemes are particularly of concern when they are designed to influence drug

Sweepstakes

Win a seat at the 2017 CRC Symposium!

One lucky winner will be chosen to receive FREE registration for this year’s symposium, April 6–7 in Austin Texas.

Sweepstakes end Friday, February 17, at 11:55 p.m. PST. Enter daily to increase your chances. Winner will be announced Monday, February 20.

ENTER NOW!
Administrator for $2.5 million Medicare fraud scheme convicted

Following a two-week trial, Raciel Leon, the manager of Mercy Home Care Inc., and a billing employee at D&D&D Home Health Care Inc., was convicted of one count of conspiracy to commit healthcare fraud and wire fraud; and one count of conspiracy to defraud the United States and pay and receive healthcare bribes and kickbacks.

According to evidence presented at trial, Leon and his co-conspirators at the two home health agencies in Miami-Dade County, Florida, participated in a scheme that resulted in Medicare paying approximately $2.5 million for false and fraudulently submitted claims from October 2014 to June 2015.

During this time, they submitted false claims to Medicare based on medically unnecessary services or services that were not actually provided. The services were for patients obtained from physicians and patient recruiters who were paid illegal kickbacks by Leon and his co-conspirators.

Orthopedic medical group settles False Claims Act allegations

Jacksonville, Florida–based orthopedic medical group Southeast Orthopedic Specialists (SOS) recently agreed to pay nearly $4.5 million to resolve allegations that it violated the False Claims Act.

According to the U.S. Attorney’s Office Middle District of Florida, SOS allegedly billed federal healthcare programs for services that were medically unnecessary and unreasonable, seeking reimbursement for millions of dollars of questionable healthcare claims.

The government’s allegations against SOS include the following contentions:

- SOS certified it had met certain meaningful use standards for electronic health records despite not actually meeting those standards.
- SOS billed for certain claims using a modifier that signified a separate evaluation and management service was performed even when such a service was not performed.
- SOS knowingly billed for certain claims using a modifier that signified two procedures were billable, rather than one. This was done even when it would have been more appropriate to bill the two procedures as one.
- SOS would schedule patients’ follow-up operative visits 14 weeks following surgery instead of 12 weeks. This was done as an effort to bill for a separate visit outside the standard Medicare 90-day diagnosis-related group charge.

Of the settlement, OIG Special Agent in Charge Shimon Richmond said, “Obtaining tax dollars which Medicare providers are not entitled to impacts our entire healthcare system, and the OIG will hold healthcare providers accountable who misrepresent services to boost profits.”
Eight professional to-dos for 2017

by Maggie Palmer, MSA, CPMSM, CPCS, a medical staff consultant in Dallas

Happy New Year—we made it! In 2016, I experienced some highs and lows, but I learned that even a bad experience can be a great learning opportunity. While consulting and doing interim work over the past year, I met many MSPs and marveled at how they expertly manage their workloads and responsibilities. As it turns out, this skill can be both a blessing and a curse.

Today’s MSPs are taking on larger volumes of work and scopes of responsibility than ever before, often without seeing equivalent gains in respect and standing. At the same time, many are still struggling with decades-old issues, such as integrating peer review into the credentialing and privileging process, verifying primary sources effectively, and avoiding procedural pitfalls that can fuel legal action. Challenging the status quo can be difficult without sufficient time, resources, and influence.

Given these obstacles, how can MSPs reach their full professional potential, both individually and collectively? Sometimes, it’s the little changes that make the biggest impact. This is my list of to-dos for 2017 (because I won’t lose those last 10 pounds). I encourage you to consider, adapt, and add to these resolutions in the year ahead.

1. Embrace change

Avoid reinventing the wheel and resist the “we’ve always done it this way” attitude. Drawing on other organizations’ accomplishments can save money, time, and your sanity.

When MSPs look beyond their organization’s walls for best practices, they tend to set new standards of excellence that can propel their department—and career—forward. Adapting field-tested approaches also removes the uncertainty of developing a brand-new process from scratch.

2. Let go

To make way for innovation, consider outsourcing credentialing and privileging tasks to an NCQA-accredited credentials verification organization (CVO). Yes, I just said “outsourcing”! Some MSPs fear that shifting tasks off their plate means relinquishing control over the practitioner vetting process and, by extension, jeopardizing patient safety. This is not the case.

When partnering with a CVO, the medical staff services department retains decision-making power while realizing several additional benefits. For example, handling fewer clerical tasks in-house frees up time for value-adding activities, such as drafting and revising bylaws, policies, and privileging forms. It also allows MSPs to focus on achieving compliance in an ever-changing regulatory world. Stepping up involvement in such high-profile processes can improve professional recognition and dispel any lingering misconceptions that MSPs are merely secretaries.

3. Measure performance and drive success

It’s important to show leadership that you have goals and performance data that speak to your progress in achieving them. Possible focus areas include:

- **Turnaround**: Measure the time it takes to process an application. Be sure to track three or four metrics and account for any third-party delays. Potential metrics include submission and receipt...
The MSP’s voice

of applications; request and receipt of quality data; request and receipt of peer reference responses; and application preparation for the department chair’s sign-off and the board’s final approval.

- **File volume**: Track volume by month to identify any notable trends—good or bad—and adjust your approach accordingly. For example, if application rates tend to spike in July and August and fall off by October, request temporary staff during the summer months.

- **Expirables compliance**: Demonstrate that you’re adhering to regulatory requirements, as well as providing a valuable service to practitioners. (You are obtaining all the information you can online before reaching out to the physician, right?)

Use evidence-based leadership evaluation tools, such as report cards and 90-day action plans, to prioritize goals. Select one project or competency to work on for the next 90 days, and develop an action plan with your supervisor or senior leader to master this skill. Potential focus areas include listening, providing negative feedback, mentoring, delegating tasks, and executing other leadership activities. See Figure 1 for a 90-day action plan template.

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**Figure 1: Sample 90-day action plan template**

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**Objective**

1. Understand
   - Interview customers, partners, and internal stakeholders to learn the business. Goal is to accelerate the learning process to make effective contribution faster.

2. Assess
   - Perform an audit of the team, key processes, and the performance of core initiatives. Goal is to identify opportunities for short-term and long-term improvement.

3. Optimize
   - Implement one key process or program change to demonstrate improvement. Goal is to make the one change that will have the biggest impact on performance.

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**Agenda**

- Objectives
- 30 days—Understand
- 60 days—Assess
- 90 days—Optimize
- Plan
- Measurement

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**30 days—Understand**

Goal is to accelerate the learning process to make effective contribution faster.

- Understand
  - Gaining insight to fuel rapid growth
  - Identify quick wins

- Assess
  - Critical thinking and decision-making
  - Identify long-term challenges

- Optimize
  - Implementing changes to demonstrate improvement
  - Commitment to improve

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**Figure 1: Sample 90-day action plan template**

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4. Cut through the email clutter

Although a necessary business evil, email is probably the worst way to communicate—and the most time-consuming. In 2015, professionals around the globe sent and received an average of 125 business emails per day, according to a study by The Radicati Group, Inc. For those who work eight-hour days, that’s 15 emails every hour, one email every four minutes, and a third of the workweek! With this incessant back and forth, when is the actual work getting done? Here are some tips to reduce the email glut:

- **Think before you click.** Imagine that every email you send is interrupting someone’s workday, because it probably is.

- **Make it snappy.** Email isn’t a good medium for conveying lots of information and context. Think about what I call the “iPod view”—the portion of the message that can be read without scrolling or adjusting window sizes. Emails should be short and specific with clear calls to action.

- **Talk it out.** If you find yourself needing to discuss an urgent matter, laboring over an email, or writing more than a couple of brief paragraphs, pick up the phone or pop into the person’s office to discuss the issue verbally.

- **Resist instant email gratification.** Addressing emails as they come in—and expecting the same in return—is a productivity killer. Here’s a better
The MSP’s voice

dynamic: I send you my thoughts when it’s most convenient for me, and you read and respond when it’s most convenient for you. To encourage more realistic expectations and productive exchanges, I include the following message in my email signature: “I read and respond to emails from 10 a.m.–11 a.m. and from 2 p.m.–4 p.m. If there’s an urgent matter you’d like to discuss, please call me at XXX-XXX-XXXX.”

5. Critically audit your documents and processes— all of them

While working in a new position this year, I needed to create some policies and delineation of privileges (DOP) forms. I pulled ones that I had developed a few years back and was surprised by their mediocre quality. While the forms complied with necessary regulations, they didn’t follow the typical workflow or reflect current best practices. During initial development, I had thought they were strong, but armed today with a more critical eye, I must say I was a bit humbled.

It is very distressing to see some organizations continue to struggle with the basics. Though difficult, letting someone else critique your work and being open to change—even the disruptive kind—can help. I shared my DOP forms with a colleague, she passed along her own creations in return, and we provided honest feedback on each other’s work. We’re still friends.

6. Get out of the office

There is no substitute for observing operations first-hand. Rounding and asking questions can help MSPs develop a more textured understanding of hospital processes. It can also increase their visibility, allowing them to get their face in front of leadership.

Volunteering at organizational events can also put MSPs on the map. Any get-together will do, be it an employee recognition celebration, job fair, charity event, MSP week activity, or social gathering. At a previous job, we had a night at the ballpark, and I was the “get your peanuts and crackerjacks here” girl. My CEO never forgot that!

7. Be wary of simple explanations for complex problems

Sweeping excuses and quick fixes can be attractive when processes don’t work well. While it is beneficial to simplify some activities, MSPs must recognize the risks of failing to dig deep enough to find the real source of—and viable solutions for—a nuanced problem. For example, if a service issue arises with a partner CVO, give the organization a chance to conduct a root cause analysis before concluding that all of its files have a glitch. If you miss one reappointment, don’t assume that the rest are on schedule or are completely off the rails. Instead, check your data to verify their status. When a referred policy (i.e., one that’s referenced in the medical staff bylaws as the source for detailed how-to information on a given topic) hasn’t been updated recently or doesn’t match actual practice, don’t assume that all policies are bad or, conversely, that they are good across the board. Instead, ensure you have enough time and energy to perform a deeper data dive (e.g., by outsourcing time-consuming tasks).

8. Rethink meetings

Traditional meetings are another productivity killer. The best place for conversation is in the work space—not in a conference room. Recast meetings as rounds and huddles. Rounding in and beyond the medical staff services department provides MSPs with in-the-action learning and communication opportunities. Huddles, which are informal conversations lasting no more than 15–30 minutes, are usually good for checking a project’s pulse.

Of course, it’s impossible to avoid meetings completely. To mitigate the impact of formal gatherings on productivity, consider establishing no-fly zones—set windows during the MSP’s workday that are reserved for individual projects, rather than attending meetings,
The modern MSP’s influence spans more functions, facilities, and settings than ever before. Get unparalleled insight into the evolving profession with the 2016 MSP Salary Survey Special Report, a complimentary benefit for all CRC members.

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- **Telling stats and incisive analysis organized into three professional focuses.** Trace trends in compensation, job duties, and professional development.
- **Deep dives into the data that matter most.** More than 70 graphs, tables, and special features look at key professional experiences from a variety of angles. Peruse salary ranges broken down by title, education, certification, and setting. Pinpoint common ratios of credentialed practitioners to full-time MSPs. Learn which positions may call for additional education or a new professional certification.
- **Three years’ worth of comparative data.** See 2014–2016 Salary Survey trends in compensation, credentialing volumes, certification, education, accreditation, and more.
- **Practical applications for key findings.** Come away with concrete strategies for advancing career goals, propelling compensation conversations, and advocating for the medical staff services profession.

Use this report to:

- See how your experiences stack up against those of MSPs in similar professional circumstances
- Make the case for additional resources or compensation
- Identify, refocus, or advance professional goals
- Educate stakeholders within and beyond the profession on the integral role MSPs play in patient safety, quality care, risk management, and other essential healthcare functions

**Site exclusive!**

Visit the Resources section of the CRC website to download Palmer’s action plan template in its original format.

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In short, MSPs must let go of things that keep them in clerical mode. Elevate your value to your organization by being in the present but looking to the future. That is, do a bang-up job in your current role, but keep an eye out for opportunities to advance. Now that the new year is upon us, I encourage you to step outside your comfort zone and change things up!

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**Click here to download the report**
Note: The October 2016 issue of CPRLI was its last as a standalone newsletter. CRCJ and CPRLI are now one 16-page publication that reflects the hallmark insights of both classic newsletters. Click here to read back issues of CPRLI. Click here to read issues of the expanded CRCJ, as well as back issues of its 12-page predecessor.

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