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Inside this Issue

- 1** President's Message
- 2-3** Maine Law, Reporting of Sentinel Events
- 3** Conference Wrap Up
National Provider Identifier
MeAMSS Golden Star Award
- 4** MMA's 2004 Maine CME Award
- 5-8** Evolution of Credentialing
Part V: Managed Care and ERISA
- 9** JCAHO Teaching Tools
Credentialing Potpourri

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THE LIGHTHOUSE

The official publication of the Maine Association Medical Staff Services, published by and for the MeAMSS membership

President's Message

Kim Pelletier, CPMSM

Since the last time I wrote a president's message, life has been a whirlwind. The month of May was consumed with finalizing and attending what I believe was our best educational conference ever (which included a board meeting the day before). During the month of June, although quiet in regards to MeAMSS business, my son graduated high school, the last of my children to do so, and then participated in the national SkillsUSA competition in robotics and automation held in Kansas City. Finally, last night I finished the summer session class I was taking. I now feel a bit of freedom to start enjoying our very short summer season.

I am sure the summer is equally busy for each of you. I found the following insightful article by *Frank and Susan Pastizzo*, from *Warmup the Workplace* that I hope you find as interesting as I did. Take care and find time to enjoy the summer and make a difference!

The Person in Front of You
To affect the quality of the day, that is the highest of arts
Henry David Thoreau

At the counter of a convenience store recently, I apparently was annoying the clerk just by being there. I think summer help season has started and this young teenager was faced with the sigh-full burden of listening to me, figuring out what I needed, giving it to me, taking my money for it, and giving me change. When I asked for some extra quarters for the parking meter, her eyes rolled to a degree proportionate to

having asked her to mow the lawn with a push mower. She seemed totally in a hurry to get rid of me so she could return to her seat and continue to hate being there.

While this was clearly one of the most obvious and over-the-top exhibitions of how some find being at work distasteful, there are other, milder attitudes that people employ to show they are not happy when placed in the role of service provider.

I find it is always worth the attempt to try to connect with the person in front of you, no matter which side of the service counter you're standing on.

If we respond to our initial defense mechanisms and match or even escalate the distasteful tone, we effectively lower ourselves to the same level we find distasteful in others. This tactic might make us feel better for the moment, but does nothing to alleviate the underlying problem. A curt or sarcastic response, whether aimed at a preoccupied teen, a disgruntled adult, or anyone in between, just makes the atmosphere even more hostile. Instead, an offering of empathy: "Will you get to have any time off today?", or "Sorry, you seem to be having a really tough day" may just bring out an appreciative smile, or a small bit of friendly conversation. When people feel validated, often they feel freed up to examine their own countenance and the possible negative effect it is having on those around them. Often, this may be enough to have them *tune up* their demeanor and turn the exchange into a good-humored one.

Some might ask "Why should I make the effort to be nice when someone is acting like a jerk?" Because in improving the environment, we are making things more pleasant for everyone, including ourselves, the person in front of us, and for those that will follow. Rather than simply saying, "Have a nice day," we have taken a few simple steps to try to create one.

Maine’s Sentinel Event Reporting Law

By Lois Macias, Vice President, Ancillary Services, Maine Coast Memorial Hospital, Ellsworth, Maine

In May, 2002, the State of Maine joined the now 20 other states that responded to the 1999 Institute of Medicine’s report on medical errors by passing legislation that mandates reporting of sentinel events by health care facilities. No doubt, the motivation to be responsive to calls for public accountability is shared by all states; however, there is a variety of approaches to this complex and important topic.

Before going any further, an understanding of the definition of “sentinel event” as described in Maine hospital licensure regulations may be helpful. As one might imagine, the definition of a sentinel event varies from state to state, some more comprehensive than others. Maine regulations include a manageable, though not always easily applied, definition:

“One of the following that is determined to be unrelated to the natural course of the patient’s illness or underlying condition or proper treatment of that illness or underlying condition or that results from the elopement of a hospitalized inpatient who lacks the capacity...to make decisions:

- 1) an unanticipated death; or
- 2) a major permanent loss of function that is not present when the patient is admitted to the health care facility.”

A sentinel event is also a “surgery on the wrong patient or wrong body part; hemolytic transfusion reaction involving the administration of blood or blood products having major blood group

incompatibilities; suicide of a patient in a healthcare facility where the patient receives inpatient care; infant abduction or discharge to the wrong family; or rape of a patient.” “Major permanent loss of function” is defined as “sensory, motor, physiological or intellectual impairment that requires continued treatment or imposes persistent major restrictions in activities of daily living.”

An example of a reportable event would be a patient who commits suicide after eloping from an inpatient unit. An example of an event that may legitimately not be reported is that of a patient who is transferred to a tertiary facility after experiencing a medical error at the transferring facility. If the transferring facility was not aware that a death or major permanent loss of function occurred (secondary to the events at their facility), it is not expected to be able to report and neither is the tertiary facility.

During the root cause analysis, it will be important to answer the questions: ‘Has this happened before?’ ‘What has been done to prevent recurrence?’ and ‘Were policies followed?’

What about a patient whose death was caused by sepsis originating from a non-hospital acquired infection? The quick answer is, “No, that’s not reportable”; however, a few more questions need to be answered, such as:

1. “Did the patient receive the proper treatment?”
2. “What was the patient’s condition on admission?”
3. “Was death anticipated?”
4. “Was treatment appropriate?”

Though cliché, the expression “a case-by-case determination” describes what will need to be done in each facility for each incident. Since the reporting includes some specific requirements, briefly outlined below, it would be useful to have a single individual or group of individuals responsible for completing the report to the DHS Division of Licensing and Certification.

The responsibilities of a facility that experiences a reportable event include:

- Notifying the Department of Human Services Division of

Licensing and Certification by the next business day after the sentinel event occurred or the next business day after the hospital determines that an event occurred. Initial contact should be made with the Division by calling or faxing Bobbi Jolda, RN, HSC. If you choose to fax Ms. Jolda, it is important to call BEFORE faxing to be sure that she is available to receive it.

- Completing Phase I of the Division’s reporting form which is available at <http://www.maine.gov/bms/index.htm>
- Conducting an internal root cause analysis of the event, while cooperating with the direction of the Division.

- Submitting a narrative report within 45 days of the date the event was reported to the Division. This is Part II of the form. Sending this certified mail, return-receipt-requested will ensure no miscommunications occur. If the Division needed time to evaluate whether or not an event was reportable, the 45 days begins once the Division has determined it is reportable.

During the root cause analysis, it will be important to answer the questions, “has this happened before”, “what has been done to prevent a recurrence”, and “were policies followed”. Developing a specific action plan, evaluating that action plan for its effectiveness, and communicating the results of these activities to the Board of Trustees are essential steps in this process.

There are important and helpful features of the Maine statute and regulations that are not always

incorporated in other states' regulations. These include:

- Only aggregate data is released; individual facility, physician, or patient data is not disclosed; some states may release individual, incident-specific information to the public.
- Data are not shared with other state agencies;
- Only sentinel event reporting staff will have access to the individual facility data; if surveyors conducting routine surveys or complaint investigations discover that a sentinel event has occurred, they cannot ask if the facility has reported the event. They can only call the sentinel event staff to say, "ABC Hospital has had a sentinel event." Surveyors are not allowed to access the files of the sentinel event staff. The sentinel event staff does have the authority to mandate corrective actions in response to any regulatory breaches. Minutes of peer review discussions should contain sufficient information to understand whether or not the case being reviewed was a sentinel event. Any reviews of cases that appear to meet the reporting requirement should be immediately referred to the individual identified in the facility's policy.
- Reports of sentinel events are not subject to public access or discovery and are not admissible as evidence in any civil, criminal, judicial, or administrative proceeding.

It is important to remember that, even though Maine enjoys the above-mentioned protections, laws can be changed and your Risk Management Department should be intimately involved with the reporting of sentinel events.

Bobbi Jolda has offered to answer any questions or to meet with any groups.

Her phone number is (207) 287-9324 and her email address is roberta.jolda@maine.gov.

Future plans for the sentinel event reporting program include the mandated, public report of all sentinel events. This report will be published annually and will include only aggregate data. Other plans from the Division include offering educational programs, both statewide and facility-specific as requested. These programs will feature corrective methods used to address the various events. Other forums for communication among the providers and the Division are being considered.

It is apparent that the intent of these regulations is to balance public accountability with the intent of fostering a non-punitive reporting environment. Only in an environment where health care facilities feel supported and protected in their reporting efforts will a sharing of experiences lead to improved patient care. Disclosing *individual* patient events should be done between the patient, facility, and involved practitioners, and not to the public. Public sharing of experiences in an *aggregate* format will serve to educate health care providers and will promote candid discussions within the industry that will enhance patient safety.

Please refer to the *Regulations for the Licensing of General and Specialty Hospitals* effective February 01, 2004 and the statute 22 MRSA, Chapter 1684 § 8756.



Conference Wrap Up

MaryCarol Rumsey, CPMSM

The MeAMSS biennial conference, "Climbing the Mountain of Credentialing: Avoid the Slippery Slopes" was held at the Grand Summit Hotel and Conference Center in Sunday River, May 13 and 14. There were 45 attendees, 89% attended the first session; 76% attended the second.

Overall, the conference feedback was positive. The Program Committee has taken into consideration your comments and will incorporate them for future educational sessions.

We are pleased to announce that the conference was profitable and should enable our Association to plan another outstanding event for Conference 2006 (MeAMSS' 10-year anniversary) by allowing us the necessary funds to secure nationally and regionally recognized speakers. It also allows us the option of paying an honorarium, should the need arise, to secure speakers for some of our quarterly meetings. Topics that were discussed at a recent Program Committee meeting were: Medical Staff Office Management and Public Speaking, which can be offered either at the biennial conference or one of the quarterly meetings.

Conference - Continued on Page 4

National Provider Identifier

CMS (Centers for Medicare & Medicaid Services) recently announced that it is requiring health care providers to use a National Provider Identifier (NPI) for all their electronic transactions effective May 23, 2007. The NPI is mandated by the Health Insurance Portability and Accountability Act (HIPAA) and applies to providers, payers and clearinghouses conducting HIPAA standard electronic transactions.

Eligible providers will be able to submit their applications beginning May 23, 2005. Covered health care providers that are assigned an NPI must furnish any updates to their required NPS data to CMS within 30 days of the changes.

Why do we need to know this? It is more important than ever to obtain this information on our medical staff applications, as it will affect your hospital's bottom line.

For more information, go to www.hipaadvisory.com/news/2004/0122cms.htm

Golden Star Awarded to MaryCarol Rumsey, CPMSM

By Patricia O'Connor, MS, MeAMSS Past President, Nominating Committee Chair



The Maine sky is filled with stars - the many medical staff services and credentialing specialists who work year round to ensure that quality physicians meet the needs of patients. Each year, the Maine Association Medical Staff Services gives special recognition to one of those stars - a member who has exhibited outstanding service to the organization and has demonstrated excellence in the field of medical staff/credentialing services. The Nominating Committee determines the winner from member nominations.

Please join us in congratulating MaryCarol Rumsey, CPMSM, who was presented with the Golden Star award at the Maine Hospital Association Summer Forum Recognition Luncheon held June 24 at the Samoset Inn in Rockport, Maine. This article summarizes the many fine compliments she received from her nominations.

MaryCarol was chosen this year for her many years of dedicated service to the MeAMSS Board. She is a founding member and has served in many positions. When an unanticipated opening occurred, she volunteered to return when the Board was desperately in need of her wisdom and counsel. Not only that, but she took on the position that many consider to be the most challenging one on the Board - Education Chair. Her diligence and vision in that position have resulted in many quality programs that reflect current industry issues and an excellent regional conference she coordinated this year. MaryCarol will be the first to say "I didn't do it alone", but her team members recognize that her commitment and expertise are what galvanized them into a synergistic and successful committee.

Her quiet demeanor belies the dedication she has given to this organization as she works behind the scenes to help us accomplish our goals. She takes on assignments graciously, and we know that the job will be done in an exemplary fashion.

MaryCarol embodies our vision and mission statement. She is a true professional providing leadership and expertise not only for the betterment of her colleagues but for the field of medical staff/credentialing services as well.

I'm sure you will share in our pride and good wishes for MaryCarol. We congratulate her as our 2004 Golden Star.

Conference - Continued from Page 3

The Program Committee has created a survey that will soon be sent to the membership. We need your feedback in order to bring you educational offerings that will assist you, not only directly in your every-day job duties, but also in your career. We need you to "think outside the box" and send us your suggestions that will attract you, or a colleague, to our educational sessions. A drawing will be held of the names of those respondents who return the surveys. The prize is a MeAMSS canvas bag. If you were at the Conference, you know what a beautiful gift this is.

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MMA's 2004 Maine CME Award

Paula Freeman and Cindy Hutchison are proud of their colleague, Cathy Hopler, as she is the reason Penobscot Bay Medical Center was awarded the Maine Medical Association's 2004 Maine CME Award!

Richard J. Kahn, MD, Chairman of

the Medical Staff Education Committee and Ethics Committee of the Penobscot Bay Medical Center credited Kathy Hopler at the Annual CME Awards Banquet: "... I would like to thank Cathy Hopler for her 16 years of dedicated work at our hospital. It is due to her organizational skills and hard work...that Penobscot Bay Medical Center has been awarded the Maine Medical Association's 2004 Maine

CME Award. Cathy's work has always focused on facilitating high quality education programs for the staff. In recent years the criteria for CMEs has become far strict and the ethical issues related to the medical staff, medical education, and pharmaceutical industry have become more complicated. We are pleased to honor Cathy Hopler's hard work..."



THE EVOLUTION OF CREDENTIALING Part V: Managed Care and ERISA

By Claudia J. Edwards, CPMSM

Congress enacted the Employee Retirement Insurance Security Act (ERISA) in 1974 as a means of bringing uniformity to benefit and pension plans. ERISA requires employer-provided health insurance to comply with ERISA’s fiduciary, reporting and disclosure requirements. Any civil actions brought to enforce the terms of a plan must be filed in the federal courts. ERISA’s preemption clause (which the Supreme Court has held can be interpreted broadly) provides that ERISA supersedes all state laws that pertain to employee benefit plans. Where there has been a violation of ERISA, the beneficiary is ordinarily entitled to recover only contractual damages, not any damages for malpractice. However, ERISA also provides for “other appropriate equitable” relief, and it is under this area of the Act that lawsuits have attempted to break down the barriers of ERISA.

Critics of managed care argue that cost control has predominated at the expense of quality and thus caused dangerous and unjust consequences for the persons enrolled in these plans. While physicians and other health care providers have faced liability for the consequences of their own malpractice, managed care has enjoyed immunity from malpractice suits due to the language in ERISA that exempts employee benefit plans from state law provisions.

One important feature under managed care is the “gatekeeper” method of containing costs. Under this requirement, a primary care physician is charged with the responsibility for ordering ancillary services such as lab and medical imaging exams as well as procedures. Only they can refer

patients to more expensive specialists. The goal is to reduce visits to specialists thus reducing costs. Managed care plans also restrict hospitalization by directing physicians to perform more procedures on an outpatient basis by limiting the amount of time they permit patients to remain in the hospital. These plans also have been known to include “gag clauses” that place restrictions on provider-patient communication and can interfere with the physician-patient relationship if they result in a lack of information being conveyed to the patient about other more expensive, noncovered care.

The following two cases showcase the difficulties of seeking damage relief from harm perceived to have been caused by a managed care plan:

Wickline v. California

This is a landmark case that held third-party payors could be found liable if their decisions caused harm.

Lois J. Wickline sued State of California (Medi-Cal, California’s managed care Medicaid program) for harm from its cost containment program. The facts of the case are as follows:

In 1976 Mrs. Wickline, a woman in her 40’s with limited education, sought medical treatment for intermittent claudication. She was initially treated by a general family practice physician, Stanley Z. Daniels. Patient failed numerous outpatient therapies including physical therapy. She was referred to a vascular specialist, Gerald E. Polonsky, who after consultation determined she suffered from arteriosclerosis obliterans (thickening of the walls of the arteries), with occlusion of the abdominal aorta (Leriche’s Syndrome which is obstruction of the terminal aorta. Note: The aorta is the main artery of the body, carrying blood from the left ventricle of the heart to the

arteries in all organs and parts of the body.) Mrs. Wickline’s occlusion was located just above the point where the aorta divides into two common iliac arteries which descend into each leg. Although immediate surgery was recommended, under California Medi-Cal statute, the patient had to be discharged home to await approval for surgery.

On January 6, 1977, Mrs. Wickline was readmitted after receiving approval for hospitalization and underwent a Teflon grafting procedure on January 7. Post operatively she began to experience circulatory problems and it was determined the graft had clotted. She returned to the operating room at which time Dr. Polonsky reopened the incision in her groin, removed the clot and resealed the graft. She had a stormy post-operative course, experiencing a lot of leg pain and spasms (spasms stop the outflow of blood from the vessels thus causing the blood to backflow to the grafted site creating a high risk of more clots). On January 12, Mrs. Wickline was taken back to the OR this time for a lumbar sympathectomy, another major operation in which a section of the chain of nerves that lie on each side of the spinal column is removed. This procedure paralyzes the blood vessels in the patient’s lower extremity in “a wide open position” and is intended to relieve the spasms. Assisting Dr. Polonsky in these surgeries was Dr. Leonard Kovner. Dr. Daniels, her primary care physician, was present for both surgeries as well.

Mrs. Wickline was scheduled to be discharged January 17, 1977. Since the patient was not doing well, on January 16, Dr. Polonsky determined that Mrs. Wickline required an additional eight days of hospitalization as she was medically unstable and at risk for infection and the development of more blood clots. Statute required the attending physician to request the additional



days; the hospital was required to prepare and file the precertification paperwork for the additional days by obtaining relevant medical information from the physician.

Now, we enter the crucial part of this claim:

Medi-Cal’s representative, Doris Futerman, RN, was the “on-site nurse” for the hospital (and other hospitals as well). Her duties involved reviewing requests for extensions of hospital stays. Although she had the authority to approve extensions, she did not have authority to approve fewer days so the case was referred to the Medi-Cal consultant physician, William Glassman, a practicing general surgeon until 1975. Based on the information provided on the request, Dr. Glassman approved an additional four days, not the eight as requested. Factors that led Dr. Glassman to only approve four days were lack of documentation of the following: patient’s temperature (assumed then to be normal), diet, and bowel function. The form requesting the additional days included information that the patient was able to ambulate and that whirlpool treatments were to begin immediately. Dr. Glassman assumed patient was seriously ill, not critically. Those involved with Mrs. Wickline’s care contend that supporting documentation was provided to the reviewer including complete medical diagnosis, history, clinical status and a detailed treatment plan. The section of the form that requires reason for denial was left blank. It was evident that Dr. Glassman had not consulted with any of the specialists employed by Medi-Cal that were available to the physician consultant for guidance in areas beyond his expertise.

At the end of the four extended days, Dr. Polonsky discharged Mrs. Wickline (patient protested against being discharged). Mrs. Wickline’s husband was instructed by Dr. Kovner about her care which consisted of administering antibiotic

powder to the incisional site, medication, warm water baths and bed rest. A few days post discharge Mrs. Wickline began experiencing right leg pain and thought this was normal, related to her recovery.

On post-op day 3, Mr. Wickline contacted Dr. Kovner to inform him of his wife’s worsening condition (right leg was now grayish in color). Mr. Wickline was advised to give his wife additional pain medication. Mrs. Wickline’s condition worsened and finally after contacting Dr. Kovner again (leg was now blue), she was advised to emergently present to the hospital on January 30 (9 days post operatively). The operative site was infected and surgeon could not reopen the operative incision, as there was too much risk of spreading the infection. Initial treatment consisted of anticoagulants, antibiotics, strict bed rest, whirlpool baths, and pain medications. All were unsuccessful and on February 8 Mrs. Wickline underwent amputation below the knee. She did not heal and subsequently underwent another operation on February 17 for above-the-knee amputation.

At trial the attending surgeon stated he was reasonably certain that had the extra days been approved, Mrs. Wickline’s worsening condition would have been treated and she probably would not have lost her leg. Initial judgment was in favor of Mrs. Wickline. However, the State appealed to the Supreme Court, which dismissed review on July 30, 1987, and remanded the case to the Court of Appeals, Second Appellate District, Division Five where the decision was overturned. The State had appealed successfully that it was not negligent as the plaintiff’s three doctors had discharged her according to prevailing standards of practice. At trial when asked why he didn’t request an additional four days, Dr. Polonsky replied that Mrs. Wickline’s condition had not changed from the time he had

requested the first extension and discharging her was in keeping with community standards. In addition, the State argued that it had absolute immunity in accordance with Government Code section 820.2. As a matter of law the Court found for the State and absolved it from liability.

The principal issue before the court was: who bears responsibility for allowing patient to be discharged from the hospital - her treating physicians or the health care payor? Medical experts for both sides agreed that it was the physicians’ responsibility in accordance with prevailing standards of medical practice in 1977.

Key Findings of the Case

1. The Court found that a patient who requires treatment and who is harmed when care that should have been provided is denied is able to recover for the injuries suffered from all who were responsible for deprivation of such care including health care payors (because of defect in plan design or implementation of cost-containment programs).
2. While it is true that Medi-Cal played an important role in this case as the payor of services for treatment sought and length of hospital care, it was not given the opportunity to override medical judgment as no appeal was made for additional days of hospitalization. A physician’s duty to the patient is not mitigated by the patient’s insurance and that physicians who comply with treatment limitations by managed care organizations without protest cannot avoid

ultimate responsibility for any injury that occurs. All physicians involved in the case agreed that Mrs. Wickline could be discharged according to prevailing standards of medical practice in 1977.

The Court warned that it was important that cost-containment programs not adversely influence medical judgment. In this case it concluded it did not. (Note: The Court might have ruled differently had the physicians appealed Medical for the additional days.)

Corcoran v. United Health Care

This case raised the issue of the limitations imposed by ERISA on claims against third-party payors.

Mrs. Florence Corcoran was a long-time employee of South Central Bell Telephone Company. She became pregnant a second time in early 1989. Her first pregnancy was medically complicated deeming this second one high risk. Her obstetrician recommended bed rest and 24-hour fetal monitoring during the final months of her pregnancy. In accordance with her benefit plan, she applied for temporary disability benefits which were denied. Her obstetrician appealed and benefits were denied a second time (even though a second opinion obtained by United Health Care indicated the company would be at considerable risk denying physician's recommendation). Utilization review felt hospitalization was not necessary and instead approved ten hours per day of home health care with fetal monitoring. The fetus died during the time the home health nurse was not on duty.

Mr. and Mrs. Corcoran filed court action at the state level claiming wrongful death; the lost love, society and affection of their unborn child; aggravation of a preexisting depressive condition; and the loss of

consortium caused by that aggravation. United Health Care immediately moved to place this action in federal court claiming preemption as allowed under ERISA. United contended that the Corcoran's claim was one of "improper handling of a claim". The Corcorans claimed malpractice. The district court granted the motion to move the action to federal court noting that the claim was related to the employee benefit because "but for the ERISA plan, the defendants (United Health Care) would have played no role in Mrs. Corcoran's pregnancy." The Corcorans filed a motion to reconsider contending the compensatory damages they sought were covered under ERISA's "other appropriate equitable relief". United claimed it was basing its decision in its capacity as a plan fiduciary and that its responsibility was to determine whether Mrs. Corcoran qualified for benefits. The Corcorans argued that preemption did not apply because United's decision was an erroneous medical decision, not erroneous claims decision. The Court disagreed holding that a beneficiary under a defined ERISA health plan cannot collect "compensatory or consequential damages for emotional distress or other claims beyond medical expenses covered by the plan." It agreed that United makes medical decisions but that those decisions are based on the availability of benefits coverage.

Key Findings of the Case

1. The Court found that United's refusal of services was as a provision of medical services covered under Mrs. Corcoran's benefit plan.
2. If utilization review activities were not preempted, states might develop their own standards of conduct. Plans would be tailored to local jurisdictions and run the risk of

3. The Court ignored the fact that Congress implemented ERISA in a time when it could not have predicted the medical utilization review process. The Court also acknowledged that, because of the widespread use of utilization review, perhaps a reevaluation of the provisions under ERISA should be undertaken.

Summary

This concludes my series on credentialing and managed care. My purpose in bringing this series to our members was to provide an historical perspective on credentialing, the evolution of managed care and to showcase landmark cases that impact on credentialing.

We have learned from Darling v. Charleston Memorial Community Hospital that the hospital failed to properly supervise and monitor its staff (nurses), that the hospital could not hide behind the shield of charitable immunity doctrine, and that it was responsible for the care rendered within its walls of non-employed physicians.

In Johnson v. Misericordia Community Hospital the hospital was found liable for negligent credentialing in that it failed in its initial credentialing process to investigate the orthopedic surgeon's privileges at other hospitals and his pending malpractice cases.

Elam v. College Park was another case of negligent credentialing. The medical staff office did not obtain malpractice data yet the medical records department was aware (highlights the need for proper credentialing procedures as well as improved interdepartmental communication).



Harrell v. Total Health Care, although unsuccessful because of a technicality of state law, the court found that the managed care organization had caused harm because of negligent credentialing.

We are entrusted to ensure that patients are not harmed by performing due diligence when verifying a medical staff application. We must authenticate that the applicants are who they say they are and that they are competently trained for privileges requested. As we go about the business of verifying the credentials of our practitioners, please keep in mind the following considerations:

1. Physicians are under enormous pressure to provide quality care while receiving discounted reimbursement. They risk no payment (or worse, delisting from the plan's provider panel) if they do not adhere to the terms of their contract with the managed care organizations.
2. Physicians are trying to provide quality care while dealing with patients who feel they cannot afford treatment if the services are not covered by their benefit plan, and this affects the physician's medical judgment. Patients can seek recourse by taking legal action if they are harmed by the managed care organization; but, as you can see from the cases highlighted in this series; it is very difficult because of ERISA protections.
3. Ultimate responsibility for one's care rests with the patient. Patients need to know whether or not a service is covered in their benefit plan, hence there is a need for improved education of plan beneficiaries to allow them

to make informed decisions. If they are dissatisfied with the plan, it is incumbent upon them to make their employer aware, as it is the employer who provides, and in most cases pays for, the benefit plan.

4. Physicians have a responsibility not to be intimidated by the limitations of a benefit plan and to discuss alternate treatment plans that might not be covered and to not accept a plan's limitations without protest. As we have seen, the courts have found that the physician is ultimately responsible for a patient's care and thus cannot escape responsibility for the care rendered.
5. A national data source for all of us to tap into for credentials verification would eliminate the redundant tasks we now perform.
6. Changes to the inequities of the litigation process in malpractice claims cases need to be implemented at the federal level.

Remedies to the problems and considerations noted above are beyond our ability. However, the more we learn about the complexities of the health care industry, the better we are able to understand our role. As you process that application and you find one or more malpractice claims/settlements, I would hope that you would look further into the causes and details of the case(s). After all, as we had learned at our June 25, 2003, quarterly conference, it is often cheaper for the insurance company to settle than to risk jury decisions, and these settlements do not necessary reflect on competence. But, it is important that you do investigate all malpractice claims history.

The public has the perception that the hospital is a multi-faceted health care facility with the responsibility to carefully credential its medical staff and to exercise oversight responsibility in the medical staff's responsibilities in conducting proper peer review. Because of case law, managed care organizations are also mandated to exercise diligence in verifying the credentials of the providers with whom they contract.

In addition to our credentialing activities, we can further assist our medical staff and administration by developing policies that would aid them in their mission to provide oversight for the quality of care rendered to patients in your facility.

One our Association's missions is to foster education. Education is knowledge and knowledge is power. I hope that this series has provided you with interesting perspectives of our industry.

I shall continue to publish interesting malpractice cases because we are after all the front-line risk managers. If we do our job correctly, we reduce (cannot avoid) the possibility of an expensive legal action.

Sources:
 University of Dayton School of Law, *ERISA as a Barrier to Compensation for Injuries*, Professor Vernellia R. Randall
 Health Administration Responsibility Project
The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?
 By Barbara A. Noah,
<http://review.law.mercer.edu/old/48311.htm>

Notice

The Board of Licensure in Medicine will not be holding a monthly meeting in August.

JCAHO Teaching Tools

Donna S. Friedman, CPMSM, CPCS

The following is reprinted with permission from Donna S. Friedman, CPMSM, CPCS, of Thomas Jefferson University Hospitals, Philadelphia, PA. Ms. Friedman used this information to instruct her MEC and Credentials Committee members to prepare for survey.

Supervision of interns / residents.

Whose responsibility is it to oversee the education of interns and residents? Who supervises them? What kind of medical education program or programs do you have? How do you ensure the interns and residents are competent? How do the nurses know which procedures the residents and interns can do? Do you have computerized privileges? How is that accessed?

NPSG's

Tell me about what you know about the national patient safety goals. Asked specific questions about most of the goals. Are the nurses taking verbal orders? Do the nurses read back the verbal order to you? Do you give them the time to get the chart or enter it into the computer so they can read it back to you; because you know it's not a "repeat back" it's a "read back"? Do you have a verbal order policy?

Do you have a process for marking the surgical site? Does anyone give you trouble with complying with the site marking policy? Are you involving the patients in the marking process? Where does this get done? Before the OR suite?

How do you verify that you have the right patient? Do you perform a time-out? Do you do a verification of the procedure, the patient and the site? How is this done?

How is compliance monitored? CPOE (Computerized Physician Order Entry)

How has the medical staff leadership been involved with selecting the new computer system? When will you be starting it?

What kind of patient safety considerations are you putting into it?

You have some computer (CPOE) now, how do you like it?

Ethics

You have an Ethics Committee, are there any members here? How often do you meet? Who is the Chairman? Who is on the committee? What other disciplines are represented? Any type of interesting case we can discuss briefly?

IRB

Do you have an institutional review board? How do projects get submitted? Approved? Do you have a mechanism for getting feedback? Are the patients informed of their rights? How do you protect patients? Do you consent them?

Strategic Planning

Are you involved in the strategic planning process of the hospital? Do you feel you have a voice? Are any of you members of the board? Are you voting members? Tell me about your committee structure and how it goes up to the board.

HIPAA

How were you educated about HIPAA? How has HIPAA changed your practice? Do you have a mechanism to report issues?

Patient and Medical Staff Survey

Do you get feedback on the patient satisfaction survey? How? Does this get discussed at department meetings? Was there a medical staff survey conducted? Did you get feedback from that survey? Does this get discussed at department meetings?

CREREDENTIALING POTPOURRI

What is meant by the term, medical staff appointment?

Appointment to the medical staff implies only that the organization will permit the practitioner to announce that he or she is a member of the staff. Also, appointment of a physician to a medical staff allows the institution to expect from that physician only what has been agreed to as a condition of his or her appointment. Appointment does not imply specific clinical expertise but does imply that the institution has evaluated the practitioner's general background, education, training and professional performance and has found that he or she meets all the criteria required for appointment.

What is privileging?

JCAHO defines privileging as "the process whereby a specific scope and content of patient care services (clinical privileges) are authorized for a health care practitioner by a health care organization based on an evaluation of the individual's credentials and performance.

Must reappointment/reprivileging dates match the governing body approval dates or can the governing body approve effective periods in advance?

The governing body should be approving effective periods in advance of the expiration date. Example: In May, the Board would approve all June reappointment/reprivileging effective periods. It would not be necessary to keep changing the effective period to match the appointment/reappointment or privileges.

Sources: HCPprofessor, Credentialinfo.com, jcaho.org, FAQ