



THE LIGHTHOUSE

September/October 2003

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

President's Message

“What Noise Are You Making? ”

Can you believe how quickly the summer has passed? Though autumn is one of my favorite seasons, I am not quite ready for it to begin. I guess like age, it is useless to fight it, but instead we should embrace it for its beauty.

In June, I had the opportunity to attend the MHA Summer Forum at the Samoset Resort in Rockland. Dr. Carl A. Hammerschlag, master storyteller and internationally recognized author, speaker and physician, presented “Healthcare at the Crossroads: Sustaining our Healing Spirit”. He challenged us to think about how we will deal with the rapid changes in healthcare and not be “crippled” by them. After all, the way it *is* is not the way it *was*, *nor is it the way it will be!* If you have to know it before you do it, then you are destined to re-live the past. We simply have got to change with the times. Dr. Hammerschlag talked about his experience with Native American healers. He asked them what he needed to do to be more like them. Their response: “*I can teach you my steps, but you have to hear your own music.*” It is important to open yourself up to see “new” ways of doing the ordinary everyday tasks. If you are looking

for ways not to move, you WILL find them. Most of us only hear what we want to hear. Again, he challenged us not to be “crippled” by our preconceptions. He also said we must learn to tell the truth and stand up and deliver what we promise. Pay attention to what we feel because your heart is seldom crippled by self-doubt. We have got to *lighten up!* If we show up with “good belly” (a positive attitude) we can deal with what life throws our way. Dr. Hammerschlag emphasized that nobody makes it alone, so he encouraged us to make lots of connections. And his final words were these. The gift individuals have to share is that you *will* touch a heart and soul. Make that touch positive. Pay attention to what you know, tell the truth, and don't stay if you have “bad belly” (stressed out, unhappy, bored).

The second speaker, Ken Schmidt, former executive, Harley-Davidson Motor Company, presented “The Rise, Fall & Rise of Harley-Davidson”. He said our noise is how people describe us when we are not there. We don't want to be “like everyone else”, he said. Success is due to “making people feel good about themselves”. We are not who we say we are but what others say we are. There was no strategy behind the comeback of Harley-Davidson other than individuals with an overwhelming desire to keep the company alive and not end up in bankruptcy. They were just people working together for a common goal. He said that time spent with customers equaled increased understanding of their customers' needs. When like-minded people get together, quality of life increases. There is no need to do anything special in our lives. Just continue doing what we said we would do only better.

I believe we are those individuals. We work together for the common good, we see change all around us and we have the ability to rise and fall with it and succeed. I know I don't want to be like everyone else and I know that I do want to make people feel good about themselves. I have learned it is

important to always show up with “good belly”, to hear your *own* music, and have others hear your noise as sweet music. I look forward to seeing you at the September meeting.

Kim Pelletier, CMSC
President, MeAMSS

UPCOMING EDUCATIONAL MEETINGS DATES

Remember to invite another colleague from your organization!

September 12, 2003
Mayo Regional Hospital
Dover-Foxcroft

December 12, 2003
MaineGeneral Medical Center
Waterville

Newsletter Survey Results

A survey requesting feedback on the newsletter was distributed at the June 27 MeAMSS meeting. Seven completed surveys were returned. All respondents enjoyed reading the newsletter and have found the topics useful in their work. Below are the results of the survey:

In response to the question, ‘what topics did you enjoy the most?’ Respondents wrote:

1. Report of one facility’s survey experience;
2. Updates on new regulations, new addresses, web sites, etc., as they are found to be useful;
3. Updates, reminders, changes in regulations, helpful hints, and resources;

On the question, ‘what topics did you enjoy the least’, one respondent did not enjoy the quizzes too much but felt they were useful. (The reason quizzes are included in the

newsletter is to provide an aid to members who intend to study for certification. Some of the questions might be included as questions on the certification examinations.)

Respondents listed the following topics they would like to read in the future:

1. Practical advice, the nuts and bolts of getting the job done (Credentialing 101);
2. Letters or articles from Randal Manning or Mary Dufort, regarding changes and/or process clarifications;
3. Board activities;
4. A synopsis of previous meetings or to have a specific mailing of minutes from the last meeting. This would be very beneficial in knowing who attended and what information was disseminated.

The Board of Directors depends on your feedback. It is our intention to send the membership minutes from the educational meetings to keep you updated. If you have not been receiving these minutes, please contact Lena McDougal, Secretary.

In this issue is an article from Mr. Manning with input from Virginia deLorimier, clarifying the issue of when advanced practice nurses must be registered with the Board of Licensure in Medicine. This article is timely because Virginia deLorimier will be discussing this at the September 12 meeting. Mr. Manning will attend the meeting to field any questions or concerns. Ms. Dufort has expressed an interest in being a contributor to The Lighthouse in the future.

Notes from the June 27, 2003 Educational Meeting Held Waldo County Hospital:

Mary Dufort, RN, BSN, M.Ed., Maine Division of Licensing & Certification,

discussed federal and state regulations and the proposed changes to the Medical Staff Chapter of General and Specialty Hospital Licensing regulations. The following topics were covered:

1. Federal quality changes and how they affect the medical staff – there is a requirement for profile data collection and this data must address patient safety, medical error reduction and prevention.

2. Sentinel Event Reporting Law – became effective May 1, 2003.

3. Proposed changes to the medical staff chapters of the hospital licensing regulations

- a. Committees/Meetings
- b. Policies
- c. Membership & Clinical Privileges
- d. Malpractice Verification
- e. Reappointments
- f. Temporary Appointments
- g. Medical Staff Quality Improvement (plan and indicators)

Members who were unable to attend the MeAMSS June meeting have an opportunity to hear about these topics in September. The Maine Hospital Association is hosting a meeting on Tuesday, September 30, 2003, in the MHA Conference Room, 33 Fuller Road, Augusta. The fee for this program is \$60 per person. Registration begins at 8:30 a.m. Check with your senior management if you have not received notice. The program is open to MHA members and their affiliates. Ms. Dufort had informed me that the planned changes to the hospital licensing regulations have not been finalized.

(Note: MeAMSS members interested in a transcript of my notes may request a copy by writing to cedwards@mainehospital.org Distribution is available by e-mail only.)

John Doyle, Vice President of Marketing,
Medical Mutual Insurance Company of
Maine, Ronald C. Hall, Vice President,

Noyes & Chapman, and Nancy R. Brandow, MS, Senior Risk Manager, Medical Mutual Insurance Company of Maine, were present to explain medical professional liability insurance.

Mr. Hall and Mr. Doyle participated in the following discussion:

Most malpractice claims result from failure to diagnose, failure to treat, failure to refer, and failure to administer the correct drug.

Malpractice (properly referred to as medical professional liability) insurance covers the cost of attorneys' fees, expert witnesses and the damage to the extent of coverage obtained.

It was interesting to learn that there is no statute or law requiring a medical health care professional to carry insurance.

There are two types of coverage: claims made or occurrence.

Claims made: This type of policy pays claims, which are first made against the insured while the policy is in force subsequent to the retroactive date. The retroactive date is the date a claims made policy becomes effective. Acts prior to the retro date will not be covered under a claims made policy.

Frequently, when physicians become disabled, retire and/or relocate to another carrier, they purchase what is called an extended reporting endorsement, often referred to as a "tail" from their insurance carrier. This affords coverage for past acts not yet reported.

Occurrence: This type of policy will cover claims that occurred during the time the policy was in effect. As an example, if one held a policy from 1998-1999 and in 2003 a claim was filed for an event that occurred during the policy period, that insurance policy will cover the claim.

The discussion evolved to what are the two elements of liability:

1. There must be bodily injury or
2. Property damage to someone else.

The injury must be unintended and resulting from an error or an omission. One has to be sued for the liability to be reported. All policies have limits of liability. Indemnity refers to the component of claim costs actually paid, or reserved to be paid, to the plaintiff. All policies have blanket defense coverage in which the company is supposed to aggressively defend the insured.

There are two different types of liability: commercial general liability (formerly known as comprehensive) and medical professional liability. There are two types of general liability: (1) premise, and (2) operations. Slips and falls would fall into these categories.

The face sheet most organizations receive is just a snapshot of coverage that was in effect at the time the sheet was issued.

A binder is a temporary form of coverage that is in effect pending the issuance of a policy. A binder should be written for 30 days.

Ms. Brandow informed the group that all MSSPs involved in credentialing are essentially the **frontline risk manager**. Two goals in medical staff credentialing:

1. to provide high quality medical care by ensuring that members of the medical staff are qualified and competent to provide specific services; and
2. to treat all individuals applying for medical staff appointment and reappointment fairly and consistently.

Essential systems that should be in place to ensure these goals are met:

1. Bylaws that provide the framework for the organization.
2. Rules and Regulations that provide the operational aspects of performing the responsibility assigned by the bylaws;

3. Policies, Procedures and Protocols that detail the day-to-day operations; and
4. Credentialing components: appointment, reappointment and privileging.

Risk Management Alerts from 2002/2003

Ms. Brandow informed the audience that the Risk Managers at Medical Mutual have found the following to be problems uncovered during risk reviews:

1. Inconsistent documentation and inconsistent practices in the credentialing process.
2. Lack of evidence that the medical staff was involved with the risk management function.
3. Lack of evidence of quality oversight with the temporary privileging process.
4. Lack of minimum information present for granting of temporary privileges.
5. Lack of consistent documentation and management of the peer review process to assure the maintenance of no discoverability.
6. The emergence of issues regarding professional liability coverage and the hospital employed physician.
7. Inconsistent or lack of defined oversight of allied health practitioners in medical staff rules and regulations, policies and procedures.
8. Granting privileges for services not provided at the facility.
9. Performing services without granted privileges.
10. Questions of credentialing and telemedicine.

DISCLAIMER: Please note that the above-referenced information was taken from the editor's notes. They are not intended in any way to provide legal advice or supplant the need to individually research these topics. They are intended to provide you with an overview and to be educational only.

Claudia Edwards, CMSC

WHY AND HOW TO REGISTER APRN DELEGATION

from Randal C. Manning, BOLIM, with input from Virginia deLorimier, MSBON

A few questions still arise regarding why and how to register physician delegation of medical acts to an Advanced Practice Registered Nurse (APRN). For our discussion APRN refers only to Nurse Practitioners (NPs) and Certified Nurse Midwives (CNMs). I shall attempt to clarify.

Why delegate?

The purpose of delegation is to allow the physician to expand the reach of his/her practice using qualified professional assistants such as Physician Assistants and APRNs. The physician may delegate, based on the authority of the medical license issued by the Board of Licensure in Medicine (BOLIM), as they choose, irrespective of the APRN's authorized scope of independent practice. NOTE: prescribing schedule II medications is not legal while the APRN is under delegation unless specifically authorized by BOLIM. The APRN is working under a delegated scope of practice, not the APRN scope as defined by the Maine State Board of Nursing (MSBON). (See MSBON Rule Ch 8.)

If your organization's by-laws or rules of privileging require physician supervision of an APRN in order to work in your facility, or if the APRN will be performing any medical acts outside their defined scope, the supervising physician must register the delegation with BOLIM.

How to register delegation: In order to register delegation, the delegating physician must provide BOLIM a signed registration Form C, the appropriate fee, a copy of the Plan of Supervision for the delegative relationship, and a copy of the APRN's letter of authorization to practice from The

Maine State Board of Nursing (MSBON). (See BOLIM Chapter 3 Rules)

Why not have the APRN sign and provide the forms to the medical board?

Simply, because BOLIM has no jurisdiction over the APRN. The Maine State Board of Nursing at all times retains regulatory authority over the APRN. It is the physician who is registering a supervisory relationship with the medical board.

Why must the physician provide the medical board with the APRN's letter of authorization from the Nursing Board?

First, because the physician should know the APRN's authorized nursing scope of practice, since delegation may include medicine outside the APRNs specialty training (which is legal if the physician chooses to do that). Second, the physician must confirm that the APRN may legally accept delegation of medical acts before attempting to register with BOLIM.

When can an APRN not accept delegation?

- State law requires Nurse Practitioner (NP) candidates to work for 24 months - based on a 40-hour work week - under the "supervision" of a physician, before being allowed to practice independent of supervision. During that first two years the physician only "supervises": No delegation of medicine is legal. The NP candidate registers this supervisory relationship with MSBON.

There are four (4) categories of APRN, two of which cannot work under delegation. The Clinical Nurse Specialists (CNSs) and Certified Registered Nurse Anesthetists (CRNAs may not practice under delegation - See MSBON Rule, Ch 8.

REMINDER

Beginning January 2004, registration fees at educational sessions will increase by \$5:
Member fees- \$20; Non-member - \$30

Over the next several issues of [The Lighthouse](#) we will discuss the evolution of credentialing and highlight landmark cases that have been instrumental in formulating changes to regulations, standards, and policies that impact on the credentialing of practitioners. We hope you will find these articles of interest. Some of the information contained therein might be included on the certification examinations.

THE EVOLUTION OF CREDENTIALING

Part I

In 1919 the American College of Surgeons were the first to look at a formalized approach to assessing the competence of physicians by establishing a voluntary standard. ACS-approved hospitals were required to have a definite medical staff in order to create an organized method of assessing the quality of surgical services. Three centers of authority and power emerged; i.e. the governing board, physicians and the executive management.

In 1951 the JCAH, now the Joint Commission on Accreditation of Healthcare Organizations or JCAHO, required accredited hospitals to have organized medical staffs responsible for overseeing the clinical practice and quality of care provided by physicians at the hospital. While the governing board is ultimately responsible for patient care within a hospital, the responsibility in effect has been delegated to the medical staff.

Governmental regulation of hospitals was limited until the advent of the government payment programs in the 1960's. Judicial decisions resulted in added regulations.

Darling v. Charleston Community Memorial Hospital

Dorrence Darling II was an active teenager who fractured his leg while playing football and presented to Charleston Community Memorial Hospital for treatment on November 5, 1960. Dr. John R. Alexander, who was on emergency service call, applied traction, with the aid of hospital personnel, and placed the leg in a cast and heat cradle applied. Not long after, the patient experienced great pain. His protruding toes had swollen and turned dark in color, eventually becoming cold and insensitive. On November 6 Dr. Alexander notched the cast around the toes. On November 7 the cast was split three inches up from the foot. On November 8 Dr. Alexander split the sides of the cast with a Stryker saw and cut the patient's leg on both sides. The seepage and blood from the wounds were foul smelling. Mr. Darling was hospitalized until November 19 and was subsequently transferred to another hospital. An orthopedic surgeon found that the leg contained a large amount of necrotic tissue probably due to the lack of circulation of blood and/or hemorrhaging that occurred while the leg was in the cast. The leg could not be saved and was amputated eight inches below the knee.

The father brought legal action against both Dr. Alexander and the hospital. Prior to going to trial Dr. Alexander was dropped from the suit because of a covenant not to sue and settled for \$40,000. The jury returned a verdict against the hospital in the sum of \$150,000. The Appellate Court for the Fourth District reduced the judgment to \$40,000, the same amount settled with the physician. The case was appealed to the Supreme Court of Illinois.

Court History:

Plaintiff argued that:

1. the hospital was negligent in permitting Dr. Alexander to do orthopedic work of this type and that the hospital did not require the physician to keep his skills current. The hospital was negligent, through

- its medical staff, of not exercising adequate supervision over the case and that consultation was not obtained when complications arose.
2. it was the duty of the nurses to monitor patient's condition and to report complications, particularly when the toes changed color, temperature and movement. Circulation should have been checked every 20 minutes; documentation revealed nurses checked on circulation only a few times a day.
 3. the hospital is a licensed and accredited hospital and the hospital failed its duty by violating licensing regulations, accreditation standards and its own bylaws to provide quality patient care.

The hospital claimed it did not practice medicine (the law stipulates that only an individual properly educated and licensed may practice medicine) and thus the hospital should not be found negligent. The hospital further argued:

1. it owed a duty to exercise reasonable care, skill and diligence as the patient's known condition requires to the same degree of care used by other hospitals in the community.
2. it should not be liable for the torts of its nurses, if the nurse was executing the orders of the physician, unless the order is so obviously negligent.
3. it had a duty to use reasonable care in selecting medical doctors. When nothing indicates that a physician so selected is incompetent or that such incompetence should have been discovered, more cannot be expected of the hospital administration.

The issue addressed by the court was not one of duty but the standard of conduct that must be done in order to satisfy this duty. Plaintiff argued that the concept that the hospital does not treat the patient through its

doctors and nurses but procures them to act upon their own responsibility is no longer a fact. Any patient admitted to the hospital expects to be treated and cured by 'the hospital', not by nurses and employees who act on their own responsibility. The court accepted the JCAHO standards as evidence against the hospital.

Another contention of the hospital was that the \$110,000 should be reduced to \$100,000, the limit of its liability insurance because its insurance is its only nontrust fund asset. The appellate court disposed of this on the ground that the defendant's allegations failed to establish that other nontrust funds did not exist. Moore v. Moyle qualified the doctrine of charitable immunity by permitting recovery against nontrust funds of a charitable corporation, specifically an insurance policy. The court cited other cases:

1. Parks v. Northwestern University wherein defendant argued that the theory of charitable immunity should be invoked based on the theory that the payment of funds is a diversion of educational funds to an improper purpose. Many writers have pointed out that the payment of damage claims is not improper use of funds.
2. Molitor v. Kaneland Community Unit District: Kaneland argued that damages should be limited to the amount of liability insurance carried by the corporation (whether or not they will be liable for their torts). The court stated whether or not particular assets of a charitable corporation are subject to exemption from execution in order to satisfy a judgment does not determine liability. No issues arise until liability has been determined.

The court dismissed the doctrine of charitable immunity, established the doctrine of corporate negligence against hospitals and affirmed the other sum of

\$110,000 in its judgment rendered September 29, 1965.

In summary hospitals could no longer hide behind the shield of charitable doctrine. They were found to have a duty to ensure those medical staff professionals practicing at their facilities are competent and qualified.

This case significantly impacted hospitals in terms of requiring the selection of competent medical staff practitioners, establishing mechanisms to oversee and review the quality of the medical staff's care, and carrying enough liability coverage.

The duties imposed under corporate negligence include:

1. Duty to monitor and supervise current staff;
2. Duty to select and retain competent staff;
3. Duty to maintain adequate and safe facilities and equipment; and
4. Duty to formulate, adopt and enforce adequate rules and policies.

The primary purpose for credentialing practitioners is to protect healthcare organizations and institutions from legal liability that could result from care rendered by unqualified practitioners. Patients have an expectation that, when they avail themselves of a hospital's services, qualified professionals will treat them.

Claudia J. Edwards, CMSC
Editor

Sources:

Excerpts were taken from the following:

Medical and Public Health Law Site: *Classic Hospital Liability for Medical Staff Member Liability – Darling v. Charleston Community Memorial Hospital*, 33 Ill.2d 326, 211 N.E. 2d 253, 14 A.L.R.3d 860 (Ill. Sep 29, 1965)

HcPro's Credentialinfo.com, *Legal Issues in Credentialing and Privileging*

amda.com (American Medical Directors Association website), article: *Credentialing & Privileging: One Size Doesn't Fit all* www.bassberry.com/resources: *Health Care, V. MCO liability under corporate negligence*

Article: *The Two-Side Coin of PA Credentialing*

From Greeley's Credentialing Tip of the Week, August 14, 2003:

Tips for verifying military credentials

Mr. Greeley suggests asking for a physician's Officer Record Brief when writing to verify military history. Different branches of the military keep credentials files for various times. He cites the Army as keeping them only one year before they are moved to AR-PERSCOM (Army Reserve Personnel Command) in St. Louis, MO. He suggests contacting the commander of the base on which the physician served as a good starting place. Here are the web sites of each branch of the service where you can find all the hospitals and clinics. Please note Marines are covered by the facilities listed in the Navy's web site.

www.armymedicine.army.mil

<http://navymedicine.med.navy.mil>

<http://airforcemedicine.afms.mil/medicalfacilities.html>

Our thanks to MaryCarol Rumsey, CMSC, for submitting Mr. Greeley's article.

From FAQ of JCAHO web site:

Documenting Work Experience:

Q: Is there a time limit as to how far back a practitioner's work experience must be verified?

A: No. The standards require verification of relevant work experience. The organization is required to make a reasonable attempt to verify all work experience that is relevant to the privileges being requested. In many cases this

may be many years ago if the practitioner has been in practice for a long period of time.

Documenting CMEs

Q: Are copies of the certificates of attendance at continuing education programs (CME) required to be obtained and placed in the credentialing files as proof of attendance?

A: Documentation of attendance can be done in several different ways, including but not limited to:

- Obtaining copies of program certificates
- Obtaining a copy of the information submitted with a license renewal application when CMEs are required by the state
- Obtaining an attestation statement from the LIP which attests to his/her attendance at CME programs that relate to their area of practice, with the stipulation that proof of attendance and program content will be submitted upon request.

For more information or if you have questions, contact them at cvsonline@ecfmg.org

The following individuals have submitted articles or results of networking questions this year to date and are eligible for a drawing to be held at the September meeting. The prize is a free one-year membership to MeAMSS:

Lucille Bois, CMSC; Claudia Edwards, CMSC; Cindy Hutchison, CMSC; Judy O'Mara, Medical Staff Coordinator; Kim Pelletier, CMSC; MaryCarol Rumsey, CMSC; Cheryl Schilke, RN, CMSC; and Pat Stack, RN, CPCS

Anyone wishing to submit an article to *The Lighthouse* should send it to cedwards@mainehospital.org



Have you visited the MeAMSS website yet? The address is www.meamss.org.

Do you have comments/suggestions/ideas for the website?

If so, please contact Allison Meyer, CPCS, Media Chair allisonm@martinspoint.org

EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES has developed a web-based program for Certification Verification Service. To use this new program specific information must be submitted to ECFMG and you must pay by credit card or prepay an amount equal to one year's worth of requests. An account administrator must be selected.

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