THE
Medical Staff
Office Manual

Tools and Techniques for Success

Second Edition

Marna Sorensen

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Dedication

As I review this book several years after its initial publication, I am astounded anew at just how much medical staff professionals accomplish, the significant level of responsibility you carry, and, unfortunately, how underappreciated you often remain. I am so proud of you for all you do, for the kind of people you are, and for how little you complain! Rely on each other, and on your own inner strength, to continue protecting patients and supporting caregivers. Your jobs are vital, and so are you.

Introduction

When I worked in patient care as a respiratory therapist, I felt needed and useful on every shift, every day. It's tougher when you work behind the scenes, although the work medical staff professionals (MSP) do is equally important. My daughter was born at Portneuf Medical Center, members of my family have been patients here, and, as a potential patient myself, I must be able to rely on the MSPs to select only excellent providers who can provide safe, quality patient care.

However, not everyone recognizes the vital role that the medical staff services department plays in delivering high-quality patient care. It took a bad Joint Commission survey to make the leadership at my hospital understand just how important the medical staff services department really is.

That was when I learned the importance of documenting what I do, for whom, and why, and for how long, and the absolute need to be vocal and persistent about getting help and recognition. That bad survey resulted in changes in staffing and processes that stand to this day and continue to evolve and improve. The results have been gratifying. The hospital now has a full-time credentials coordinator, an electronic credentialing program, and enough resources to truly support the medical staff and allow staff to stay current in an ever-changing field, as well as the awareness to implement changes that promote efficiencies.

For the hospital, this means more time spent preventing medical staff problems rather than addressing new ones, consistent application of the excellent policies and procedures they took the time to create, and medical staff leaders who feel they are supported by the good systems that they helped to develop. Sometimes it isn't enough to knock timidly on the door—you may need to pound on it until you get what you need. And as an MSP, you will need to continually regroup rather than retreat.

That's why this book is an important resource for readers. This book is based on lessons learned the hard way or discovered while struggling through a messy situation. I encourage each of you to keep a professional journal so you can share and refine what you've learned over the years

with your peers and your future self. After all, your jobs are dynamic, not static, which is why this career is both energizing and maddening.

This book is intended to be a one-stop destination for information that you as an MSP will need every day. It has answers for your toughest questions regarding credentialing and privileging. In addition, this manual provides sample forms and templates you can download and customize to suit your organization.

It takes a certain kind of person to thrive in the medical staff services field—it seems like we either find out we love it and stay in for years, or we ship out quickly. For the individuals who love what they do (even on the bad days), I hope this book provides you with tools and insights that add to the satisfaction you're already getting from your career choice. For MSPs who are just starting out, and perhaps not sure what to make of the medical staff services department, I hope this book provides you with the information you need to better understand what this job entails and how to do it well. It's nothing less than protecting patients and improving the care they receive.

How to Use This Manual

On any given day, an MSP might be a detective, a diplomat, a reporter, a standards expert, an IT specialist, and a data analyst—often within several hours. The stakes are high, and, for many MSPs, the hours are long. Healthcare delivery certainly isn't getting any less complicated. Medical staff services departments are constantly looking for ways to save time, and a one-stop information source is a necessity. As keepers of medical staff processes, MSPs must know what information and forms are needed, from whom, and when.

With this in mind, *The Medical Staff Office Manual,* Second Edition is intended to provide the best practices, tools, and insight you need to run an organized, efficient, and effective medical staff services department (MSSD). From basic definitions of medical staff–related terms and concepts to detailed explanations, sample policies, procedures, letters, and downloadable forms, this manual is your go-to reference for successfully running your MSSD.

On paper and online

This manual is designed to be user-friendly and to help you organize and better operate your MSSD. It is divided into sections, each covering an aspect of your day-to-day responsibilities.

Chapter 1: The Organized Medical Staff discusses the general responsibilities and components of the modern medical staff, which shape the roles of MSPs. This chapter provides the "why" behind the organized medical staff, the MSSD, and nearly everything that MSPs are asked to do. You'll find discussions of service line and departmental medical staff models, as well as descriptions of medical staff leadership positions and their responsibilities.

Chapter 2: The Medical Staff Services Department takes an in-depth look at the job(s) that most MSSDs do in support of the medical staff. You'll also find job descriptions for the medical staff coordinator, credentials coordinator, and director of medical staff services. These job descriptions may also be adapted to other positions or titles within your organization.

Chapter 3: Credentialing takes a scan of one of the MSSD's most important tasks, explaining each step of the initial appointment and reappointment processes. This section provides sample letters, policies, and forms for every step—from pre-application to processing and verification— as well as descriptions of who is responsible for those activities. Information on Centers for Medicare & Medicaid Services' requirements and medical staff–related standards of accreditors are included.

Chapter 4: Clinical Privileges discusses the basics of delineating clinical privileges and provides applicable sample policies, procedures, and forms. Included are resources for temporary privileges, new technologies and procedures, an explanation of emergency privileges versus disaster privileges, as well as information and tools for privileging advanced practice professionals.

Chapter 5: Peer Review covers ongoing professional practice evaluation, focused professional practice evaluation, and their differences. Here you'll find policies and forms explaining the peer review process, proctoring and chart review, collegial intervention, corrective actions, the role of peer review in reappointment, and more.

Chapter 6: Administration includes best practices for organizing, conducting, and managing meetings. Information and forms guide readers through the basics of logistical planning, building agendas, recording attendance, taking minutes, completing follow-up, and documenting for compliance and effective medical staff management. This chapter also provides information regarding the MSSD's public relations role and information clearinghouse duties, including physician orientation.

Chapter 7: Sharing What You Know includes a collection of case histories, which are actual scenarios adapted from one organization that may look familiar to many readers. This section provides tips for alleviating the challenges of the job and tips for building a solution set to keep history from repeating itself.

Appendix provides a key to selected medical staff standards, terms and definitions, and a resource directory.

The tasks expected of the modern MSP are changing as rapidly as the rest of healthcare. It is hoped that readers will use this book both as a compendium for their own facilities, and as a place to include and share unique, organization-specific forms and additional information as these changes occur.

Important notes

Medical care is now provided by new categories of professionals and is delivered in venues ranging from acute care hospitals to ambulatory surgical facilities, outpatient surgery centers, clinics within retail stores, and other nontraditional locations. Small wonder that there are more accreditation organizations—and standards—than ever before. Individuals responsible for developing and implementing credentialing and privileging processes in any healthcare organization must have a thorough understanding of applicable accreditors' most recent standards. Discussions of standards in this manual should serve as a point of reference. The summaries provided must not be used as a substitute for firsthand knowledge of a particular accreditor's standards.

In addition, the scope of MSSD's functions varies greatly among facilities. The individuals who are responsible for credentialing, privileging, and other medical staff processes in any organization must take into account individual requirements that may influence that organization.

Finally, the sample tools and forms in this book are intended to be used as resources to help organizations create their own medical staff– and hospital-specific documents. These tools and forms should not be adopted verbatim and without customization for the unique needs of a particular organization. MSPs and physician leaders should consult with accreditors, legal counsel, and state and federal regulatory agencies (when applicable) to ensure compliance.

Customizable versions of the forms and policies in this book are available online. These forms can be accessed at *www.hcpro.com/downloads/12691*.

If you have any questions, please reach out to me. My email address is *fournity2@gmail.com*.

Chapter 1

The Organized Medical Staff

Each hospital in the United States, regardless of type, must have an organized medical staff. The current model for most practitioners in hospital settings, often called the *traditional model*, traces its origins to the late 1800s and early 1900s. As medical knowledge and understanding of diseases grew, more citizens began to seek care and treatment in hospital settings. Medical training became more structured, with clearer guidelines for who could be considered a doctor and what each doctor could do in a given setting. In this context, trained, certified physicians now had to apply for the privilege of working in a hospital.

Much of the foundation for today's organized medical staff is regulatory. In its *Conditions of Participation* (*CoP*) for hospitals, the Centers for Medicare & Medicaid Services (CMS) requires hospitals to have an organized medical staff, with documented policies and procedures for self-governance and appointment and reappointment of practitioners.

Section §482.22(a) indicates that the medical staff must include doctors of medicine (MD) or doctors of osteopathy (DO). It can also include, in accordance with state laws (including scope-of -practice laws), other categories of physicians listed at §482.12(c)(1) (e.g., dentist, podiatrist, optometrist, chiropractor) as well as nonphysician practitioners (e.g., advanced practice registered nurses, physician assistants, registered dietitians, and doctors of pharmacy).

Standards Bodies

In addition to following the CMS requirements, many hospitals enlist one or more healthcare accreditation bodies to demonstrate to the public that their hospital provides high-quality care. Many of these accreditors base their compliance requirements on the CMS *CoPs* for hospitals, with additional standards for the structure and operation of the medical staff. Some of these accreditors are: The Joint Commission, the Healthcare Facilities Accreditation Program (HFAP), DNV GL, and National Committee on Quality Assurance (NCQA). Medical staff professionals (MSP) must know which accreditor(s) their organization works with and must know how to access their accreditors' standards.

To ensure that hospitals are providing high-quality care and following the accreditors' standards, accreditation organizations conduct surveys of the hospitals they accredit. These surveys usually occur every two to three years, although partial or complete surveys may occur outside of the regular survey cycle in response to a patient or other type of complaint. Hospitals are also subject to state surveys from CMS. Accreditation body surveys do not preclude (and in fact may trigger) a state survey.

Certain departments may require additional surveys as well. For example, if a hospital includes a trauma center, a separate inspection by the American College of Surgeons will be required. The medical staff services department (MSSD) may be involved in all surveys and, at the very least, will be asked for physicians' credentials files.

To keep up with these requirements, maintain a current table that compares various regulations and the medical staff's responsibilities for each. A cross-indexed document referring to any information a surveyor may require will make unannounced surveys much easier to handle. Continual survey readiness isn't just a phrase; it is a strong recommendation.

This book will mention the CMS requirements and Joint Commission standards most often, but it will also cite those of other accreditation organizations when applicable.

Medical Staff Structure

In the past, the organized medical staff's mission was to advocate for patient care and physician interests; fulfill federal, state, and regulatory requirements; manage peer review; and take corrective action when necessary. Today, however, the medical staff's role is expanding to accommodate the new models of healthcare delivery. The medical staff may be expected to provide support and physician leadership for achieving the organization's strategic goals, in addition to achieving continued compliance with laws and accreditors' standards, raising quality

of care and patient safety, educating the community, providing patient care in underserved areas, and accommodating increasing volumes of patients with complex and changing needs.

Remember that there is no ideal, static medical staff organization. Aside from specifying the types of practitioners who may apply for medical staff membership, neither CMS nor The Joint Commission (nor any other accreditor) specifies the structure of this organization. This is regulatory acknowledgment of the following:

1. What works from an organizational standpoint depends on the organization—for example, what works for a small rural facility in all likelihood would not be effective for a multistate hospital network

2. Medical staff organizational models will evolve as healthcare continues to change

Medical staff structures are molded by a variety of factors, including the following:

- Patient demographics
- Number of other hospitals in the area
- State regulations
- Healthcare networks and relationships with private practices

Changes in the healthcare landscape mean that these structures will, in all likelihood, need to change to accommodate further shifts. In many organizations, patient care is transitioning from a traditional hospital setting to outpatient clinics and other venues, driven by changing demographics, shifting payment models, and regulatory changes. Other facilities are restructuring due to mergers and acquisitions or due to the need to share medical skills in a shrinking physician market.

Regardless of these shifts, however, each medical staff is still responsible for upholding medical staff bylaws, collaborating with and guiding colleagues, complying with applicable regulations and standards, and advancing the organization's overall goals—all while ensuring that they provide the best patient care possible.

The medical staff hierarchy may include the chief medical officer (CMO) or vice president of medical affairs (VPMA) at the top of the chart, reporting to the hospital board of governors or top-level administration. The medical executive committee (MEC) reports to the CMO or VPMA, with department or service line chiefs and subordinate committees reporting to the MEC and representing the physicians who practice in each department or service line. See Figures 1.1 and 1.2 for possible medical staff structures.

Figure 1.1	Departmental Medical Staff Model

Practitioners in the same specialties/subspecialties are associated with each department.

Figure 1.2	Service Line Medical Staff Model

Practitioners in different specialties are associated with each service line.
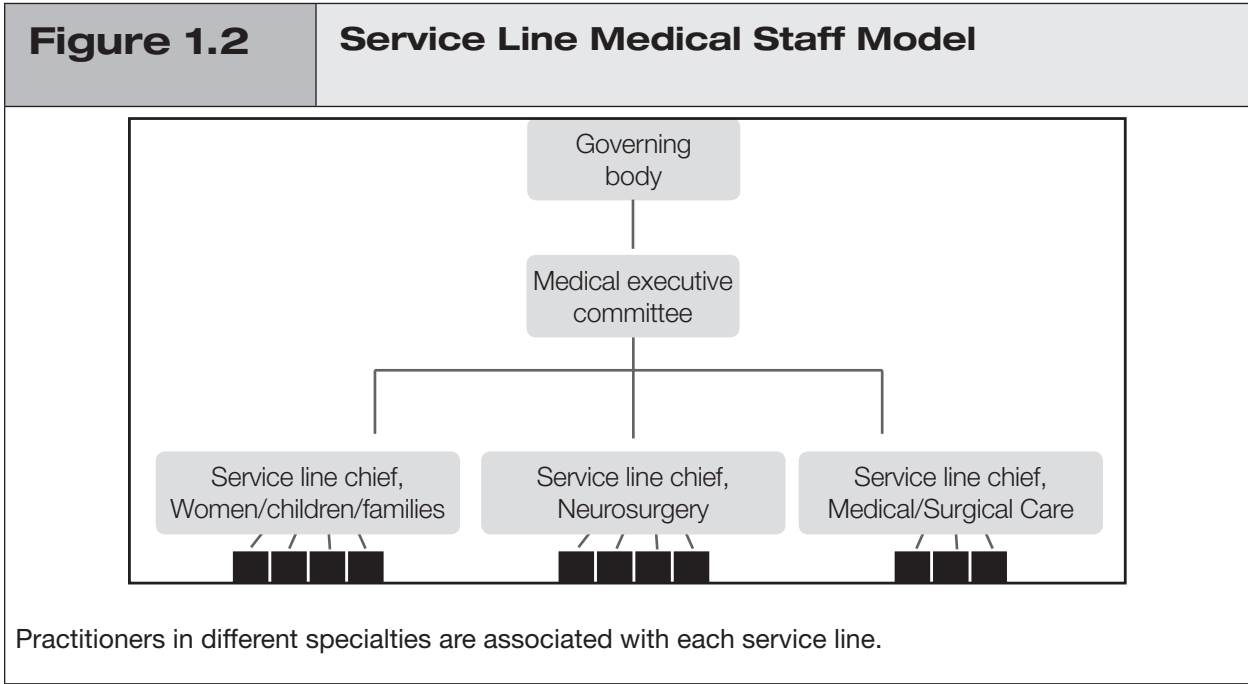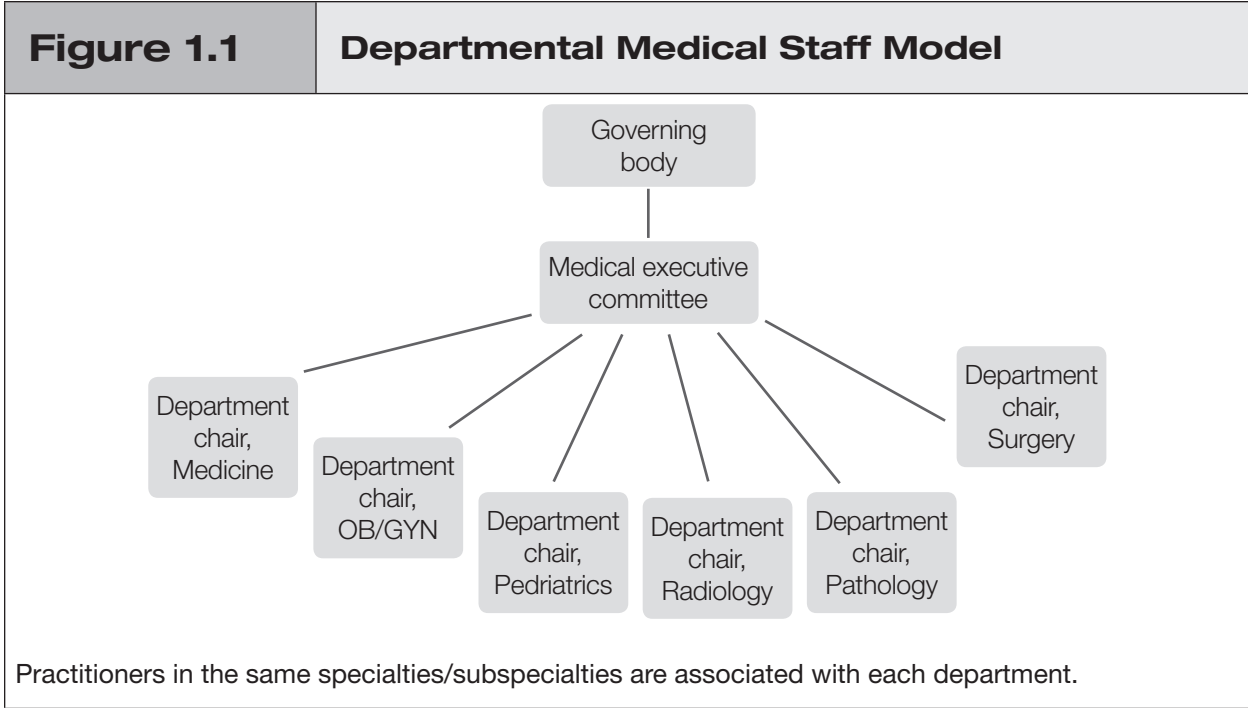
Chapter 2

The Medical Staff Services Department

The medical staff services department (MSSD) holds a unique position as a nonmedical entity that is accountable to hospital administration but may also interact with patients and families, medical staff members, other healthcare organizations, insurers, colleagues, recruiters, and physician leadership on a daily basis (see Figure 2.1). Some of the duties of the MSSD are fairly consistent across facilities—among them, credentialing, privileging, meeting and document management, administrative tasks, and reporting. These tasks will be explored further in this chapter, with more in-depth information and forms provided in subsequent chapters.

In many businesses, the functions of medical staff professionals (MSP) would land them solidly in the management pay category, but as they say, "Healthcare is different," and there are plenty of healthcare organizations in which MSPs have management titles but not management salaries (at least not yet).

MSPs' responsibilities are changing as many organizations move away from the traditional departmental model of medical staff structure (as outlined in Chapter 1). As an organization grows and new service lines are added, having separate departments for each can make administrative tasks unwieldy and difficult to complete for both the medical staff and the MSP.

What was once considered a largely clerical job has expanded into a demanding profession that requires specialty training as well as solid and continuing knowledge of the organization of the medical staff, along with mastery of accreditation standards, legal issues, medical terminology, document management, and state and federal regulations. Management and supervision skills are vital.

Structure of the Medical Staff Services Department

Until recently, the MSSD often functioned as the clerical office of physician leadership (at least, the medical staff may have thought so). However, a rising tide of regulation and care complexity has added credentialing, privileging, and data analysis/reporting layers to MSPs' work functions. As a result, MSSDs may now report to the quality improvement or risk management departments, or another group, in addition to reporting to medical staff leadership. The MSSD touches many other aspects of a hospital as well (see Figure 2.1).

Figure 2.1	The Medical Staff Service Department's Place in a Healthcare Organization

The MSSD's daily operations touch many other areas of the organization to ensure patient safety and regulatory compliance.
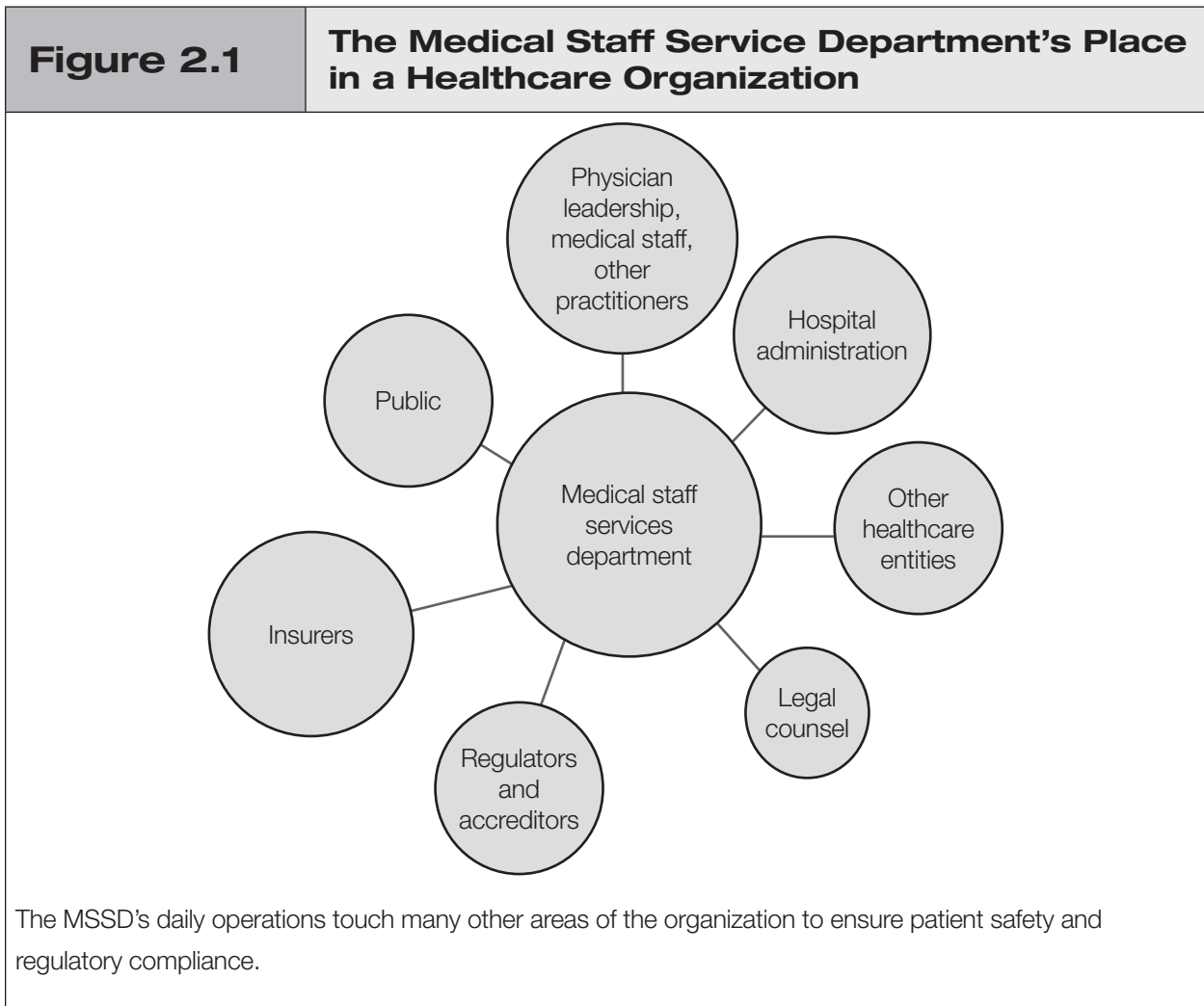
The hierarchy, size, complexity, structure, and services provided by the medical staff organization may differ, but most medical staffs share some characteristics with regard to their organization and required functions. The general responsibilities and components of the MSSD include the following:

- Providing administrative support to medical staff officers and leaders and department/service line and committee chairs

- Collaborating with other hospital departments, such as physician recruitment and retention, quality, risk management, marketing, and human resources

- Coordinating department/service line and committee meetings, including scheduling and notifications, catering and equipment oversight, preparing meeting materials, drafting the agenda, documenting proceedings, maintaining records, and ensuring follow-up on action items

- Drafting, researching, organizing, and publicizing medical staff governing documents such as bylaws, rules, regulations, and policies

- Managing the credentialing and privileging processes for physicians, allied health, medical students, and residents, including related processes (maintaining forms, policies, procedures, files, and documentation)

- Functioning as a liaison among the medical staff, hospital departments, and administration

- Managing information about current and former practitioners with membership and/or clinical privileges

- Coordinating and managing internal continuing medical education programs

- Functioning as librarian of medical staff–related documents and records

- Monitoring compliance with regulatory and accreditation standards

- Working with quality management and other departments to coordinate the clinical review processes for medical staff reappointment and reappraisal

- Working with the onboarding team to orient new staff members to their assigned department, the facility, the medical staff, and the hospital's organizational structure

In departments with one MSP, the "supervisor" is also the "coordinator" and may have no full-time equivalent (FTE) help or may share an assistant with another department. Many MSSDs with two FTEs often include one supervisor/director and one coordinator/specialist, although the titles vary widely. As with the medical staff they support, however, there is no single MSSD structure that applies to all organizations. CMS and accreditors alike have no minimum MSP staffing requirements or department configurations. See Figures 2.2–2.5 for examples.

MSP Staffing: The 'Right' Level

The relationship between hospital size, MSSD size, and the number of practitioners credentialed isn't a direct one. Similarly, MSPs' titles and responsibilities are fluid. What is the right level of MSP staffing in a MSSD? This question is common, but there is no such thing as a typical MSSD, and there is no industry benchmark standard for staffing requirements. HCPro's annual MSP Salary Survey consistently shows that about half of the MSSDs in U.S. hospitals include one to two FTE MSPs. According to the 2018 survey, 23% have one FTE, 20% have two FTEs, and 22% have two to three FTEs. See Figure 2.6 for details.

Figure 2.6	Medical Staff Services Department Size

Source: 2018 MSP Salary Survey (503 responses)
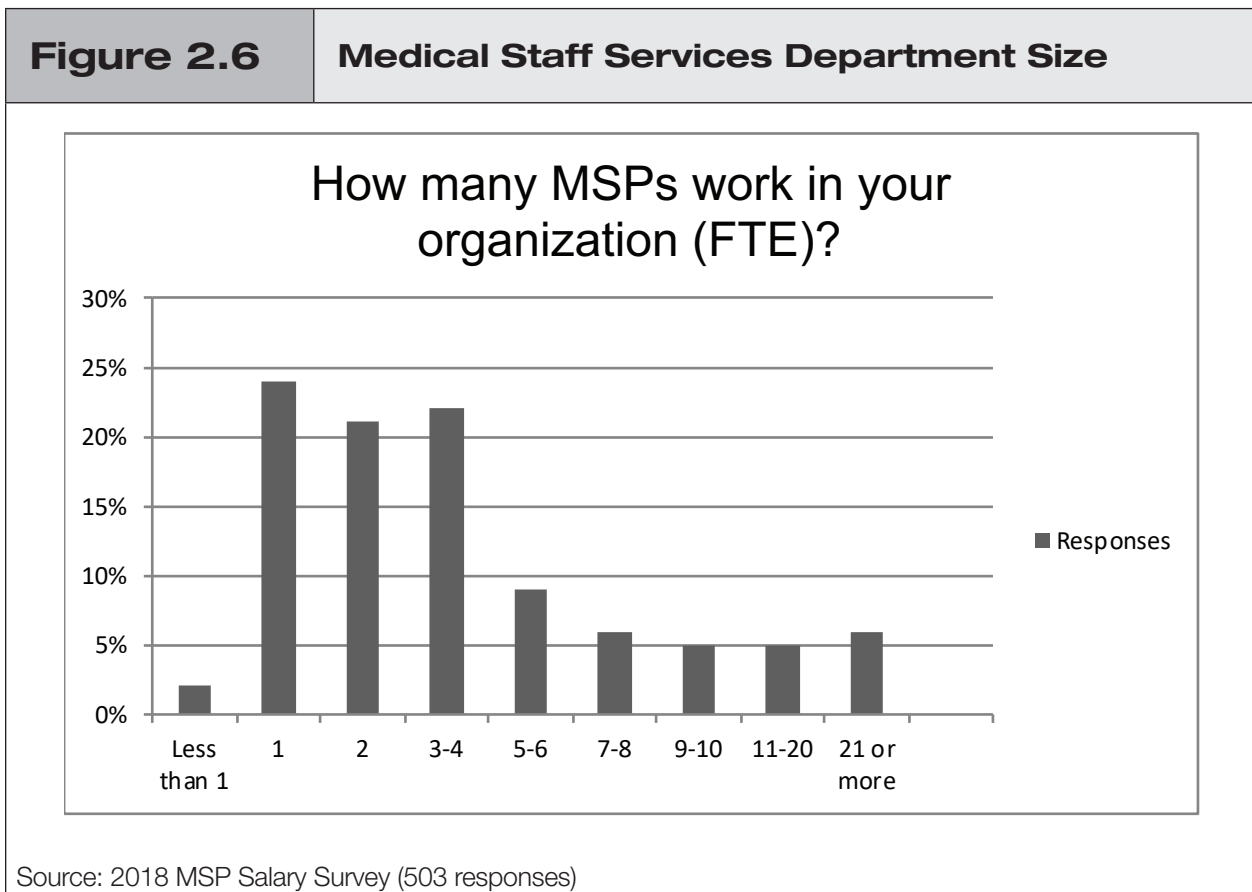
Further, the 2018 survey found that in MSSDs composed of one MSP, 24% of respondents said they credential 1–100 practitioners, 36% credential 101–200 practitioners, and 29% credential 201–400 practitioners. In departments composed of two FTE MSPs, 11% of respondents credential 101–200 practitioners, 37% credential 201–400 practitioners, and 25% credential 401–600 practitioners. Ten percent of two-person departments credential more than 1,000 practitioners, according to the survey.

Figure 2.8	**Sample Job Description: Credentialing Specialist**	
Employee Name:		
Position Title:	Credentialing Specialist	**Effective Date:** 12/2019
Department:	Quality Resources	**Last Revision:** 12/2019
Review Responsibility:	Director, Quality Resources Department	**FLSA Status:** Nonexempt

Position Summary:

Provides support to the medical staff, serves as liaison between the medical staff and [Hospital Name] administration, and ensures medical staff is compliant with applicable hospital and [Accreditor] standards.

Assists in:

» Developing, planning, and management of practitioners

» Credentialing/privilege delineation/reappointment programs that ensure the program's integrity

» Providing general administrative support to the organized medical staff regarding these responsibilities

Minimum Qualifications:

» Associate's degree from an accredited institution/program (medical staff services sciences program preferred) or other education in business and/or medical staff office procedures

» Certification as medical staff coordinator (CPCS) or eligibility to become certified

» Knowledge of basic medical terminology

» Strong workload organization and management skills

» Comfortable working with a wide variety of healthcare professionals

» Effective written and verbal communication skills

» Technical knowledge of automated support system and maintenance of the same

Essential Job Functions:

» Coordinates and provides administrative support to the practitioner initial credentialing and privilege delineation activities in accordance with the medical staff policies, bylaws, and rules and regulations so as to ensure that only qualified practitioners provide care at this hospital.

› Initiates information collection, verification, and documentation processes for completed application per established [Hospital Name] medical staff services department policies and procedures.

› Monitors adequacy and quality of potentially sensitive information; seeks additional information when necessary for effective peer review decision-making.

› Coordinates credentialing/peer review/recommendation processes per established policies and procedures.

› Ensures integrity of all paper and electronic practitioner files in accordance with medical staff bylaws, policies, and procedures.

› When applicable and in accordance with medical staff bylaws, policies, and procedures, notifies all appropriate parties of any action taken.

Figure 2.11	Medical Staff Support	
Type of report	**Recipient**	**Purpose**
Credentialing reports	Medical director, department chairs, and credentials committee	Provide details on practitioner compliance with bylaws and credentialing and privileging criteria.
Audit and status reports	Medical staff services manager	Identify credentialing status and what information is needed to complete credentialing/recredentialing processes.
Practitioner profile reports	Practitioner	Detailed information for use at reappointment or other times as needed.
Management reports	Administration, board	Information important to administration and/or the board for strategic planning, marketing, and public relations. Includes summaries of key characteristics of the medical staff, such as specialty/subspecialty distribution, age of practitioners, board certifications, hospital affiliations, and compliance with privileging criteria.

Software rollouts and updates can disrupt operations in any office before they begin to save time and improve or expand capabilities. Your best bet is to learn as much as possible about the new systems—go in and use them as often as you can. Once you're on the other side of the learning curve, you can share shortcuts you've found and trouble-shooting experience with your colleagues. If the software works as planned, you'll have more time for other medical staff services duties.

Chapter 3
Credentialing

As stated in Chapter 2, credentialing and privileging are two of the medical staff services department's (MSSD) primary functions. The definitions of these functions are fairly straightforward:

- **Credentialing** is the process of obtaining, verifying, and analyzing the qualifications of a practitioner to provide care or services at the hospital.
- **Privileging** is the process whereby the hospital authorizes the specific scope of patient care services (or clinical privileges) for each properly credentialed practitioner.

Beyond these succinct definitions, though, things may start to sound confusing. By most definitions, a credential is a qualification, achievement, or aspect of a person's background that indicates that he or she is qualified to do something. The job of the medical staff professional (MSP) is not to bestow credentials on practitioners, however. In the context of the medical staff, credentialing refers to the entire process of obtaining *evidence* of those qualifications—usually in written form—to ensure that an applicant for clinical privileges has the necessary authority, status, and right to privileges, and to confirm that these credentials are true, accurate, and justified. (See Figures 3.1 and 3.2.)

The purpose of credentials verification is to substantiate, validate, and authenticate the information that the applicant provides. In doing so, MSPs put potential patients first, last, and always. Credentialing is vital because when it comes to knowledge of practitioners' background and training, patients often might as well be blindfolded. Patients can ask a physician questions about treatment outcomes, training, and board certification, but they do not have access to the breadth

of information that the MSSD does. Nor do patients necessarily have the means to interpret such information.

The MSP is responsible for taking patient protection seriously, and for ensuring that patients are safe from frauds, fakes, and flakes. The best way to do that is through a strong and thorough verification process outlined in the hospital's policies, rules, and bylaws.

As you begin the verification process, understand that you're not trying to achieve a specific goal. The MSP's job is not to fill a vacant space, to yield to pressure from any source, or to achieve a specific outcome—other than to bring a qualified, competent, caring professional to the hospital and the community.

The ultimate question

As you work through the credentials verification process, the ultimate question is: Would you let this person take care of your family? Open your mind and answer that question only.

Gathering information is critically important, but it's not the most vital part of the credentialing process. Critical analysis and comparison of information from all sources is the most crucial step. As you spend more time on the job, you'll sharpen your ability to effectively analyze information provided on an application and to both ask and answer questions, such as the following:

- Is the applicant who he says he is?
- Is this applicant's statement true?
- Do these dates provide a complete history, with no gaps?
- Are all of the blanks (both literal and figurative) filled in, all questions answered, and all doubts resolved?
- Are there inconsistencies between what the applicant stated and what other sources reveal?

Physicians and advanced practice professionals (APP) are credentialed using the same basic process. For all practitioners who are subject to this process, your organization's medical staff bylaws should provide definitions, categories, and scopes of practice. This information lays the ground rules for the credentialing process, and the MSSD uses it to determine whether a practitioner's credentials are valid and whether he or she is qualified to seek or expand privileges.

1. Practitioner credentialing exists to protect the patient, not to "pass" accreditation surveys (refer to The Ultimate Question on page 52). When done effectively and consistently, credentialing also protects the organization and its credentialed providers.

2. Processes must be followed exactly in all circumstances, not hurried along in order to meet arbitrary deadlines.

3. The MSP does not make medical staff membership or clinical privilege decisions—this responsibility belongs to the medical staff leadership. However, the MSP does provide as much information as possible for those who will make the final decisions regarding medical staff membership/clinical privileges.

4. Excellent credentialing processes require clear, consistently applied criteria, and if your processes are functioning properly, not all applicants will meet those criteria.

5. An application that is stopped during the verification process due to missing or conflicting information is not a denial.

6. Medical staff membership/clinical privileges are not automatic, and the burden is on the applicant throughout the credentialing process. Therefore, it is up to the applicant alone to answer all questions to the satisfaction of those involved in the credentials process.

Avoiding credentialing errors

There are two main types of credentialing errors: information errors and decision errors. Either can result in a fair hearing or a lawsuit.

- An **information error** occurs when information that could affect a credentialing decision isn't provided or discovered during the credentialing process. A lack of vital information can result in an uninformed decision by the MEC or credentials committee, so it's imperative for the MSSD to have processes in place that allow MSPs to collect and disseminate the information necessary to prevent this type of error.
- A **decision error** occurs when all necessary information was provided but a poor decision was made.

MSPs play a vital role in preventing both types of credentialing errors by diligently following verification procedures, identifying and addressing inconsistencies and information gaps, and reporting their findings. Following correct procedures takes time and is absolutely necessary to safeguard patients. Figure 3.3 is a sample credentialing timetable that will help MSPs, applicants, and physician and hospital leaders understand the time and duties involved in bringing a practitioner through the credentialing process.

A facility that is considering outsourcing the credentialing process must carefully consider at least the following:

- Quality control
- Confidentiality
- Flexibility
- Liability issues
- Efficiency
- Customer service
- Hidden costs
- Communication
- Dedication
- Loyalty

What is the role of the MSSD in this case? Although primary source verification may be completed by an external company, the MSSD is still responsible for shepherding each file through the review and approval process, in addition to everything else outlined in this manual. Credentialing is not mechanical or rote; it requires critical thinking, personal interaction with and observation of each applicant, and careful oversight of the process.

What Is Managed Care?

As an important part of the management team at a hospital, MSPs must stay current not only on changes that directly affect their jobs but also on changes in healthcare in general, which will affect the hospitals in which they work.

Hospitals not only provide patient care but also work with managed care organizations to provide health insurance for their employees.

The concept of managed care was developed in the United States in the 1980s. As one of the few countries in the developed world that does not have a national health system, the two primary goals of managed care were to reduce the cost and improve the quality of healthcare.

Some of the methods by which this was to be accomplished included economic incentives for physicians and patients to select less costly forms of care, reviewing the medical necessity of services provided, mandating controls on inpatient admissions and lengths of stay, and close scrutiny of high-cost healthcare cases. In addition, managed care established provider networks that require practitioner members to meet specific quality standards and agree to pricing arrangements and mandated utilization management. The MSP is likely involved in the

Preapplications

Some organizations use a preapplication process to screen potential applicants. A preapplication form may include consent for a criminal background check and authorization for the medical staff services department to investigate basic background information. Although preapplication screening can be effective in weeding out some applicants, it also adds time to the credentialing process because prospective applicants must wait to see whether they can apply, and MSPs must process the preapplication information before that decision can be made. Organizations that don't use a preapplication will include background check consent forms and other authorizations within the application. In either case, the application process stops if basic criteria aren't met. This information is included in your organization's bylaws, policies, and procedures.

The application packet

Basic application packets are usually available electronically from the MSSD or the credentials coordinator. The application packet includes clearly articulated eligibility requirements for membership and clinical privileges, as well as consent forms for a criminal background check and authorization for the medical staff services department to investigate basic background information such as a query to the National Practitioner Data Bank (NPDB), the Office of Inspector General (OIG), the American Medical Association (AMA), the Federation of State Medical Boards (FSMB), the Drug Enforcement Administration (DEA), and state and federal licensure agencies.

The packet typically includes the following:

- Cover letter
- Consent and release from liability form
- Confidentiality and security agreement
- Conflict of interest form
- Education attestation
- Medicare acknowledgment statement
- Health Insurance Protection and Accountability Act of 1996 (HIPAA) forms
- Other consent forms as required by the facility
- Expectations of credentialed practitioners form
- Appropriate privilege form(s)

See Figures 3.4-3.12 for samples of some of these forms as well as documents MSPs can use to track the application process.

Leave of Absence

Members of the medical staff may take time off to care for children or other family members, or for other reasons. In most organizations, a medical staff member requests a voluntary leave of absence by providing written notice to the medical staff president, stating his or her reasons for the absence and the approximate period of time of the leave. The maximum length of absence is specified by the facility, and it usually doesn't exceed one year except for military service or in certain other cases permitted by the board.

While on a leave of absence, the practitioner may not exercise clinical privileges and has no obligation to fulfill medical staff responsibilities.

Reinstatement

When returning from a leave of absence, reinstatement must be requested at least 30 days before the approved term of leave ends and must be submitted in writing to the medical staff president. The returning practitioner must submit a written summary of relevant activities during the leave if the MEC or board so requests. Those returning from a leave of absence for health reasons must provide a report from their physician that answers any questions that the credentials, quality, health and wellness, or medical executive committees may have as part of considering the request for reinstatement.

The MEC makes a recommendation to the board concerning reinstatement, and applicable procedures concerning the granting of privileges are followed.

Note

If the practitioner's medical staff membership and/or privileges expire during the leave of absence, he or she must complete a reappointment application, and it must be approved in order for him or her to resume membership and/or privileges.

Without a good cause, failure to request reinstatement is deemed a voluntary resignation from the medical staff and results in automatic termination of membership, privileges, and prerogatives in most facilities. Practitioners whose membership is automatically terminated are not entitled to procedural right to appeal. Your bylaws should specify the manner in which the terminated member may subsequently submit a request for medical staff membership and how it should be processed.

The credentials committee and the MEC review requests for reinstatement of clinical privileges following a leave of absence and recommend oversight requirements and/or conditions.

Clinical Privilege Form Review

National, regional, and local standards and models of care are changing more rapidly than ever. This fact makes it even more important to review privilege forms on a regular basis and evaluate the content of core versus non-core privileges. The MSP is often tasked with tracking review dates and content changes and sending copies of privilege forms to everyone in a given specialty annually for input.

This review process should also include feedback from OR staff to ensure that verbiage is consistent with the terms used to schedule cases and that nursing and other staff understand the meaning of terms in the same way.

The medical staff services department has a multitude of external resources for privilege form content as well. Professional journals, articles, and colleagues should all be consulted to determine what is new, outmoded, or changed in each specialty area. New privileges, for example, may start out in the core and over time be incorporated into residency training. At that point, separate training and volume requirements may no longer be needed, and the privilege may be included in the core.

Take all documentation of the need for revisions to the specialists to get their feedback, develop draft criteria, and then refer the approved draft to the credentials committee. When substantive changes are made, the MSSD distributes the privilege form to appropriate practitioners for completion and approval.

Following approval by the board, the MSSD must distribute basic information regarding new applicants to hospital departments, including their clinical privileges. The board grants clinical privileges for a period of no more than 24–36 months (depending on the organization's accrediting body), but changes to privileges may be requested at any time following the processes outlined earlier.

Because the credentials committee is involved in parts of privileging, from recommending privileges for practitioners to recommending changes to privileging criteria, Figure 4.14 is a great tool to help them track status changes.

- Ask your physician about his or her experience. It is perfectly acceptable to ask your obstetrician how many C-sections he or she has performed in the past year. Even if your physician is fresh out of training, he or she will have experience. You should never be the first!
- If you find your potential physician named in a lawsuit on the internet, keep in mind that certain specialties are more prone to legal actions. Obstetrics is one of them, and it is no longer unusual for an experienced physician to have been named in a lawsuit. That said, if your physician is two years out of training and has already settled two lawsuits, keep looking.
- Patients who don't have a computer will receive excellent assistance at their local library. Older patients can also get help from the local senior citizens center.
- A great deal of information is available through hearsay and on the internet, but the best source of information is the practitioner herself. Ask what you need to know. A professional will welcome your questions. A defensive attitude is just another reason to keep looking.

Initial Peer Review or Peer Review for Specific Circumstances (FPPE)

In the event that a decision is made by the board to investigate a practitioner's performance or that circumstances warrant the evaluation of one or more providers with privileges, the MEC or its designee appoints a panel of appropriate medical professionals to perform the necessary peer review activities, according to the organization's bylaws and policies. In many facilities, peer review may also be initiated as directed by the credentials committee, with input from the group service chief, for newly granted privileges.

FPPE should be discussed during the credentials process, and the group chair—with the assistance of the MSSD—should develop a detailed plan, which is then reviewed and approved by the credentials committee.

The FPPE plan includes the following:

- Types of cases to be proctored
- Cases to be reviewed either concurrently or retrospectively
- How long FPPE is estimated to take
- When results will be reported to the credentials committee

Standard requirements as predetermined by each specialty may be used, or a personalized plan may be developed, depending on the applicant's background and training. For example, a new graduate from a local residency program will likely be well-known to the medical staff and may require only 10 additional procedures to be proctored, along with retrospective chart review of 10% of cases for one month. A practitioner who is new to the facility may have to meet all specialty-specific requirements, plus additional proctoring or chart review for non-core privileges.

| **Figure 5.9** | **FPPE Monitoring Form** |

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Monitoring period from: _____ to: _____

Practitioner monitored: _____

I have reviewed the results of the FPPE for the above-named practitioner and make this report based on a combination of the following:

» Chart review (attached completed monitoring form)
» Direct observation
» Monitoring diagnostic and treatment techniques and clinical practice patterns
» Discussion with other individuals involved in the care of each patient
» External review
» Other: _____

❑ The practitioner is performing well and within desired expectations, and no further focused review is necessary.

❑ The practitioner has not provided an adequate volume of patient care and treatment in order to form an opinion. FPPE should continue for an additional period of _____.

❑ The practitioner is not performing well or within desired expectations and further action is necessary.

❑ FPPE to continue (list issues).

_____

_____

❑ The possibility of risk to patient safety exists. Refer to medical executive committee immediately.

Other comments:

_____

_____

_____   _____

Monitor/proctor name printed   Date

_____

Monitor/proctor signature

Date reviewed by credentials committee: _____

Chapter 6
Administration

Administration is synonymous with direction, organization, and management. The medical staff services department has an administrative role that grew, in part, out of medical staff professionals' (MSP) clerical past. Now, however, the department's "administrative" duties are intertwined with credentialing, privileging, data aggregation and reporting, and information management activities. These tasks can include administrative aspects of the following:

- Meeting management and direction
- Medical staff member orientation
- Compliance with medical staff standards
- Performance/quality improvement activities
- Hospitalwide initiatives and groups

Meeting management is an integral component of the medical staff services department's (MSSD) administrative duties and is certainly one of its most frequent tasks. The MSP typically organizes meetings; invites participants and guests; handles room, equipment, and refreshment logistics; takes minutes; tracks follow-up activities; helps prepare the meeting leader by reviewing the agenda and preparing for any contentious items; and keeps everything organized. Often, sensitive information, such as salaries, budgets, and hospital or practitioner performance, is shared during committee meetings. MSPs must therefore be both highly organized and discreet.

Organized medical staff meetings keep the lines of communication open. During regularly scheduled meetings, members of the medical staff and administration carry out assigned responsibilities and interact with various individuals or groups. Conversely, when meetings

are planned or executed poorly, they stifle communication and accomplish little while wasting everyone's valuable time, ensuring a cycle of decreased attendance and poor communication.

Meeting Management

The medical executive committee (MEC) is the only committee required for an organized medical staff, according to Joint Commission standards. Despite their arguments to the contrary, however, few modern healthcare organizations could survive with only one committee. A variety of other committees report findings and activities to the MEC and act on the MEC's recommendations. Figure 6.1 provides a look at a master calendar for meetings of various medical staff committees that report to the MEC.

Generally, a master meeting schedule lists the regular (standing) meetings of all committees that must report to the MEC. The MSSD creates this schedule and distributes it to all medical staff members and key hospital administrative staff.

Duties assigned to the MSSD in support of various departmental/service line and committee meetings can include the following:

- Taking minutes or otherwise documenting the proceedings
- Communicating follow-up actions to individuals, committees, or departments
- Reserving meeting rooms and equipment and ordering refreshments
- Preparing agendas, minutes, and relevant documents to facilitate decision-making
- Determining whether recommendations have been implemented

For effective meeting support, MSPs need to have on hand relevant organizational documents, such as medical staff policies and procedures, bylaws, medical staff department rules and regulations, and other documents pertinent to an issue. This chapter includes tools to help optimize meeting management.

Figure 6.1	Sample Master Meeting Calendar

Committees reporting to the medical executive committee and when they meet

REPORT	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Quality Committee	X			X			X			X		
Contract Services		X										
Psychiatry Residency			X									
Sentinel Events				X								
Dental Residency					X							
Reference Labs						X						
FP Residency							X					
PI Plan								X				
Pediatric Residency									X			
Study Oversight Committee										X		
UR Plan											X	
Culture of Safety												X
Wellness	X											

Getting organized

Effective meetings rely on a well-planned agenda (see Figure 6.2). Standing meetings often include the same agenda items each month, which aids the planning process; any follow-up from previous meetings should also be included (Figure 6.3). The chair of each committee must sign off on the agenda prior to each scheduled committee meeting. Getting committee chairs to review and approve the agenda can be challenging because committee chairs are notoriously busy. Persistence is required, but "the meeting before the meeting" is essential.

Because not all medical staff leaders have administrative experience, careful preparation prior to meetings is an essential component of support. The MSP can refresh the chair's memory about the previous meeting(s), particularly nuances that may not have appeared in the minutes; review the agenda; and anticipate questions or points of contention. This allows the chair and the MSP to be prepared in advance with any supporting documents or information that may be required.

THE
Medical Staff
Office Manual

Tools and Techniques for Success Second Edition

Marna Sorensen

The Medical Staff Office Manual: Tools and Techniques for Success, Second Edition is a comprehensive guide for both new and experienced medical staff and credentialing professionals. This book maps every aspect of the medical staff services department, from onboarding and orienting practitioners to querying other facilities for practitioner information and effectively collaborating with physician leadership.

This updated "must-have" training resource also provides chapters on many of the new issues MSPs are now facing, and how to apply traditional job functions to things such as expanding location and provider types.

Along with detailed information and tips from her personal experiences, author Marna Sorensen also provides quick access to accreditation and regulatory information, and job descriptions and customizable forms to simplify a constantly growing list of daily responsibilities.

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