AMERICAN HEALTH LAW ASSOCIATION

Board Oversight of the Organized Medical Staff: Greater Rigor Is Needed

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Todd Sagin, Sagin Healthcare Consulting LLC, Governance Institute Advisor

Practitioner credentialing is one of a hospital's most critical tools for promoting the quality of patient care. While technically a collaboration between a hospital's medical staff and governing body, too many boards merely rubber stamp the recommendations for practitioner privileges they receive from medical executive committees. Time and again, as scandals regarding dangerous practitioners make headlines across the country, the public has asked why hospital leadership has failed to protect patients.

Insufficient board oversight of medical staff credentialing and peer review has become more prevalent as many hospitals have consolidated into larger, multi-campus health systems. In some systems, local hospital boards have disappeared or taken an advisory

role, leaving the task to oversee numerous medical staffs with a remote health system governing body. Such boards are less likely to have familiarity with the strengths and weaknesses of the various medical staffs, time to devote careful scrutiny to thousands of practitioner applications, or enthusiasm for diverting their attention from challenging strategic demands.

The hospital organized medical staff is an anachronism of the mid-twentieth century, which is ill-suited to a rapidly evolving twenty-first century health care environment. It is a fixture of the hospital world only because the Medicare Conditions of Participation (and often decades old state hospital regulations) keep it on life support. Nevertheless, the medical staff is assigned critically important quality and safety responsibilities and governing boards must assure they do this work assiduously. They should also challenge their medical staffs to stay current with evolving best practices, to brainstorm solutions to an array of new problems that have emerged in recent years, and to think creatively and out-of-the-box about new contemporary ways to organize themselves and approach their quality improvement duties.

Critical Areas for Collaboration

Below are some areas of critical focus for which boards, administrative leaders, and medical staffs should be collaborating to address challenges and apply greater oversight rigor to credentialing.

Aging Practitioners. The practitioner community is rapidly aging, with an increasing number of applicants seeking privileges into their seventh, eighth, and ninth decades of life. A growing body of evidence points to the dangers posed by late-career physicians, but balancing the rights of physicians to practice with the needs of patients for safe care is proving contentious. While some doctors resist retirement, the aging of baby boom practitioners is creating a growing shortage in many specialties. Where hospitals are desperate to recruit, the board must assure that they don't relax their standards and allow problematic practitioners on to their staffs.

Outpatient and Virtual Expansion, Employment, and Non-Physician Practitioners. Other relatively new concerns relate to the rapid expansion of outpatient medicine, the explosion in telemedicine, the movement of physicians out of private practice and into hospital employment, and the exponential growth of non-physician practitioners who must be credentialed.

How can boards collaborate with their medical staffs to assure the vitality of practitioner credentialing? Some boards send a member to attend meetings of the medical staff credentials committee. This practice can serve several purposes. It provides the board insight into how diligently the credentials committee undertakes its tasks, and it can reveal when there is a need to invest more resources into the education of committee members or into the support services that underpin its work. The presence of a board member also signals to the credentials committee the importance the board gives to their work and it can enhance communication between the committee and the full board. This practice can also provide the board timely information about how the medical staff wrestles with new credentialing challenges and can alert them when "turf battles" and medical staff politics distort proper privileging of practitioners.

A Rigorous Oversight Structure

- Implement a system for identifying applications that require more than cursory board attention.
- Request an annual comprehensive credentials report.
- Periodically conduct a thorough external audit of the credentialing process.

Many boards have a system for identifying which applications for medical staff membership and privileges will require more than cursory board attention. For example, it may be routine to query medical staff representatives whenever an applicant has a history of disruptive behavior, an action against privileges at another institution, more than a set number of malpractice allegations or judgments, a restricted license, and so forth.

Some boards request an annual credentials report that provides enlightening data regarding hospital or health system credentialing. Such a report might enumerate the number of applications received, the number withdrawn or rejected, statistics regarding the length of time for processing, how many applicants failed to meet criteria for requested privileges, the number of waivers granted by the board in the past 12 months, the number of corrective actions and fair hearings, and data on the growth of non-physician practitioners in the organization or the number of distance practitioners approved for privileges. The audit might also provide information on who attended internal or external training in the past year, the amount of credentialing staff turnover, or insight into how long various credentials committee members have served as a marker of experience in this complicated field.

Perhaps more valuable is a periodic board request for a thorough audit of the credentialing process. Such an audit is typically performed at intervals of three to five years by a knowledgeable outside expert in the field. The consultant will usually review all credentialing policies and procedures, confirm compliance with these P&Ps by personnel in the medical staff office and by medical staff leaders, examine privileging criteria to make sure delineation of privileges documents (DOPs) are in order and are consistent with contemporary practice, interview support staff and relevant physicians to make sure they understand their roles and are knowledgeable about both internal requirements and best practices, look to see that all accreditation requirements are being met, and, in health systems with multiple medical staffs, identify problematic variances across hospitals in their policies or privileging criteria that could lead to corporate liability claims.

The Benefits of Unifying Medical Staffs

Claims against hospitals for negligent credentialing are on the rise in most parts of the country. Large health systems are particular targets because of their deep pockets and because they frequently acquire new institutions without adequately examining and addressing medical staff deficiencies. Medical staffs are often leery of new corporate owners and system boards frequently don't want to alienate new health system physicians by imposing on their medical staff work space. Nevertheless, a system board should not accept, without clear justification, differing standards and recommendations for credentials and privileges across multiple institutions when they are all accountable to the same governing body.

Where feasible, many health systems would be well served to unify multiple medical staffs. The many advantages of such medical staff mergers include standardization of policies and procedures, adoption of uniform privileging criteria, less variance in credentialing recommendations, less overall burden on physician time to perform medical staff work, less work at the board level where fewer applications must be approved, and more efficiency in the staffing resources needed to support a reduced medical staff bureaucracy. In large health systems, it may be reasonable to unify medical staffs by region or to delay merger of some medical staffs until they have become better acclimatized to health system culture. Even where such mergers are not undertaken, multiple medical staffs in a system can agree to utilize a common credentials committee and health system boards should consider using their influence to encourage such committee consolidation.

The Importance of Robust Peer Review

Closely related to credentialing is the medical staff's accountability to the board for practitioner peer review. Few boards have a strong sense of the robustness of their medical staff peer review. They get brief glimpses on those rare occasions when they must act on the corrective action recommendations of the medical staff (e.g., a termination or restriction of privileges or medical staff membership). As with credentialing, peer review is facing new challenges as the health care environment evolves. Many staffs struggle with how to:

- Provide ongoing monitoring of practitioner performance in their hospital's growing outpatient realm
- Assess the work of non-physician practitioners
- Make best use of the growing data resources made available by electronic health records
- Adequately peer-review distance practitioners

Furthermore, few physicians are trained to assist colleagues who demonstrate inadequate performance and physician leaders often fail in collegial efforts at remediation. A hospital whose doctors feel uncomfortable with peer review rarely has a governing board whose members have the confidence to ask physicians to up their game. Legal counsel can play an important role by pointing out the legal liabilities that can emerge from inadequate peer review and encouraging the board to provide diligent oversight.

To improve peer review and meet the challenges described above, the board and medical staff should jointly explore and pursue emerging best practices. They can do this by surveying the peer review approaches undertaken by similar hospitals; using external consultants to recommend improvements to current practices; send medical staff leaders to nationally recognized educational programs on peer review; or improve receptivity to performance evaluation by promoting Just Culture initiatives. The board should also consider enhancing the hospital's ranks of physician executives so that these initiatives can be facilitated by knowledgeable physician leaders. Reliance on the traditional volunteer and transient leaders of the medical staff rarely accomplishes sophisticated, or even adequate, peer performance assessment and successful remediation.

Hospital and health system boards should be knowledgeable about the risk management concerns relating to medical staff work. Counsel should assure that trustees and directors have a clear grasp of the liability that lurks where the board and medical staff fail to work in concert to assure all privileged practitioners are competent and meeting the institution's performance expectations. The schedule of board education should periodically include training on best governance practices for credentialing and medical staff oversight. It is through this diligence that hospitals will avoid appearing in damaging headlines about dangerous doctors, build good defenses to corporate negligence claims, and promote higher quality and safer care for their patients.

About the Author

Todd Sagin, M.D., J.D. is a physician executive who has consulted with hundreds of hospital medical staffs, boards, and executive teams to assess and improve the tasks of credentialing and peer review. He is frequently asked to provide leadership education to these groups at national forums and through customized retreats, boot camps, and seminars. Dr. Sagin is an advisor and faculty member for The Governance Institute and can be reached at SaginHealthcare.com.

1099 14th Street NW, Suite 925, Washington, DC 20005 | P. 202-833-1100

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