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Briefings on Credentialing

The monthly newsletter for medical services professionals

Thinking ahead: Creating a transition plan for the medical staff office

A recent informal survey posed the question, "Does your organization have a transition plan for the medical staff office?" to the professionals who participate in "Medical Staff Talk," an online talk group sponsored by the **CRC.**

A common thread surrounding the knowledge needed by those in the field appeared: Many medical staff professionals (MSP) came to the profession because they stepped up in a time of need, often filling a void for a predecessor who left for a new position or retired. Although this common response speaks well for the motivation and mental stamina of the MSPs who stepped up, it also shows that in many organizations across the country, learning the medical staff services craft is something done on the fly rather than via a planned transition.

The results of our poll also beg the question of whether it is possible to create a smooth transition plan to avoid the stress and confusion that can occur when a medical staff coordinator or MSP vacates her or his role. Every facility must look at its own staffing situations and available resources to create a less-chaotic transition period for a new or newly promoted MSP.

Early notification

When Warren Hospital in Phillipsburg, NJ, needed to replace its medical staff coordinator, the facility faced an ideal situation—the outgoing coordinator announced her pending retirement more than a year early, and it had a willing and able replacement waiting in the wings.

Enclosed:

This month's ***Clinical Privilege White Papers***:

- Intraoperative neurophysiological monitoring and interpretation—Procedure 242
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"I started here as a medical staff secretary, handling calls, calendars, dictation, and other clerical roles," says **Vanessa Hosbach, CPCS,** medical staff coordinator at Warren Hospital. "[A] previous medical staff coordinator had been here for 31 years, and [served in that position] for 11 years, and she was fortunate enough to know when she was retiring. She let the hospital know, and I was offered the position."

Hosbach and her predecessor took advantage of the forewarning. They began training a little over a year before her retirement, beginning first with how to process initial applications.

"We started with the basics: primary source verification and license verifications," says Hosbach.

Both women were acutely aware of the time needed

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to fully learn the role of medical staff coordinator. In an effort to give Hosbach time to fully grasp her new role, the pair began swapping duties.

"When I started processing applications, she started doing my work—the call schedules, for example," says Hosbach.

Next step: reappointments. Warren Hospital performs reappointments every two years, with half of the medical staff reappointed each year, enabling a more controlled training method for the reapplication process.

"When reappointment came around, [the previous medical staff coordinator] walked me through that and took back some of the initial appointment applications to avoid a backlog," says Hosbach.

The more responsibility Hosbach took on, the more the coordinator took on Hosbach's roles. Once Hosbach was handling initial appointments and reappointments, the coordinator took over typing up meeting minutes from committees.

"The fact that we had 16 months to transition the position was so valuable," says Hosbach. "Nothing could have replaced that time. Learning [the standards] was incredibly time-consuming. She gave me a lot of time to read the standards, go through a lot of published materials, and listen to conferences."

Learning on the fly

Not every medical staff office has the gift of ample warning when it must replace and train a new MSP or coordinator. The long-time medical staff coordinator at Jackson Hospital and Clinic in Montgomery, AL, passed away unexpectedly four years ago. Not only was it a significant personal loss, but it also turned the hospital's two-person medical staff office into an army of one in an instant. **Robin Pate** was the medical staff secretary at the time, and immediately took on the role of medical staff coordinator—a week before a Joint Commission survey.

"The only training I had previously was working for a year with the medical staff coordinator, who had been here about 27 years," says Pate. "At that point, I'd been working on credentialing applications for initial appointment and reappointment, involved with ED [emergency department] call, those sorts of tasks."

With regard to understanding and running a medical staff office, though, Pate was still greatly unfamiliar.

Able to power through the survey based on her predecessor's keen preparation, she launched into learning mode. It was a time-devouring endeavor.

"I didn't see sunlight my first year," says Pate. "I've had some difficult jobs in my life, and, honestly, I had no idea the adventures this job would bring."

For Pate, forced to run the medical staff alone, time became a precious commodity. In an ideal world, she says, there would be time prior to the transition to get acquainted with what the various committees do, to

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attend meetings for background, and become familiar with these groups.

"Read a lot. Go over old minutes, try to get a feel for what the different committees did, and start studying the bylaws," Pate advises up-and-coming coordinators.

If there is one key to learning the role of medical staff coordinator, Pate and Hosbach agree that it is having sufficient time to do so.

"The thing I learned the most is that you need time," says Hosbach. "You need to review available resources, to attend every conference you can, to read, and to learn. Practical experience will help, but things you read, you may not think you're going to need at the time. But I can't tell you how many times I've come across something and realized I'm already familiar with it, because I came across it in my reading."

Hiring backup

In some cases, MSPs—unbeknownst to them—are hired as future managers. This speaks well for the hospital's opinion of the individual and gives them time and the tools they need to prepare for their future role.

Halina Henning, CPMSM, CPCS, manager of medical staff administration at Northwestern Memorial Hospital in Chicago, applied for the management position without having first worked as an MSP. "However, I wasn't the successful candidate," says Henning. "Two years later the number-two position [department supervisor] became available. I applied with an eye to the future. I was in that position when the manager retired."

Henning was placed in an interim role as manager while the hospital performed an external search for candidates, interviewing others in addition to Henning. Her combination of expertise, experience, and inside knowledge of the department and hospital culture won out, however, and she was promoted to manager. "They did their transition planning quite well," she says, by bringing in a capable, promotion-worthy person for the lesser role.

Henning has adopted this concept and uses it in her own transition planning. "Whenever I hire a compliance coordinator, I have confidence that they can fill the manager role on an interim basis," she says. "Should the position become available, there is ready advancement opportunity for the coordinator if he or she has demonstrated competence."

Qualities she looks for in a candidate include: decision-making, problem-solving, and analytical skills; being detail-oriented and a quick learner; and possessing a management-minded bent—in other words, top qualities for any MSP, but particularly for the successor to the manager role.

"They strike me as people—with time, development, and mentoring—who can look at becoming a medical staff manager as a goal," says Henning. Over the years, a number of her trainees have left the hospital for management positions elsewhere.

Sharing information

Although nearly everyone in the industry has a horror story about the steep learning curve MSPs and coordinators face, most medical staff offices do not have a standard policy for transition planning in place. "You would think if anybody would have a transition plan, it would be me," says Pate.

However, developing such a plan takes time, and few medical staff offices have the time to dedicate to creating a program for training the successor to the coordinator or manager position.

Although she does not have a formal policy in place, Pate is working with her assistant—whom she says is "wonderful"—to ensure that a backup plan is in place should someone ever need to step into the role.

"We have a binder filled with the daily routines, dotting the i's and crossing the t's," says Pate. In fact, the instructions in her binder are so specific that they are presented in terms such as "click this, open this, and hit 'Enter' three times," she says. Her diligence is necessary because only two people in the building know how to operate the medical staff office's computer system.

Although Pate's binder isn't meant to be an all-inclusive instruction manual, it would give a clue to someone

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filling in in an emergency. She also makes the time—again, a challenge in and of itself for anyone in medical staff services—to regularly discuss the hows and whys of the office with her assistant.

Pate's advice for other medical staff offices with regard to succession planning is straightforward: "I know everybody is busy, but take a few minutes every week [to] just sit down and discuss things. Back when I was very new, we'd discuss what to do, but not the reasons why. Because this is such a monstrous job, if you're lucky enough to have an assistant, you need to keep them in the loop—whether or not they want to be."

Pate recalls handling credentials files when she started in medical services and not knowing why she was checking license or training requirements. "It makes sense, but I wasn't aware that it was required by outside agencies," she says.

And what if you find yourself suddenly tossed into the proverbial medical staff services pool before you know how to swim? Don't be afraid to reach out for help.

"The person who really helped me was the medical staff coordinator from a competing hospital," says Pate. "I had a burning question I couldn't answer and thought, I'm going to call her. She may hang up on me, or she may not. She turned out to be a wonderful asset."

Outsiders' perspectives don't always help

How does one explain how rare training and transition planning are for incoming MSPs? Chances are it's a lack of understanding by the administration and others.

"I don't think a lot of people understand what the job entails," says Hosbach. "It's very easy from an outsider's perspective to think this job is easy. But when forced to try to replace somebody or do it yourself, you realize there's a lot to do."

Hosbach did ED administrative duties before coming to the medical staff office, and she was surprised at the level of complexity the MSP job entails. "When I watched [my predecessor], she made it look easy," says Hosbach. If there is one benefit to the struggles of the previous generation's MSPs in learning the job, it is empathy—something that has many thinking ahead to who will follow in their footsteps. " I promised [the hospital] that if I ever leave, I will do the same for them: [Give them] a year or so to do the same kind of training," says Hosbach. ■

Leadership and management skills for the next generation

The first group of baby boomers turns 65 years old in 2011. As they and their fellow boomers leave the work force, it is anticipated that job vacancies will outnumber available workers by 4.3 million. Healthcare, already feeling the strain of significant personnel shortages, will need educated, skilled workers in great numbers. These conditions will make it more important than ever to have highly qualified professionals in the healthcare arena.

Soft skills

Training and education on so-called soft skills are a top priority now and will continue to be so in the future. These skills are closely related to any organization's business goals and objectives. How patients and other customers are treated; the ability to communicate; dealing with workplace violence; recognizing, preventing, and coping with sexual harassment; and enhancing understanding among cultures all contribute to the success or failure of all businesses.

A culture of learning

Organizations are beginning to understand the value of establishing a culture of learning. An organization that supports a culture of learning believes that education is essential for the professional development of all employees and for the continued improvement of patient-care services.

Source: A Practical Guide to Staff Development: Tools and Techniques for Effective Education, *by Adrianne E. Avillion, DEd, RN, published by HCPro, Inc.*

Texas college offers medical staff services degree online

For most medical staff professionals (MSP), learning the trade is a matter of hands-on experience and self-directed studying of available resources. Formal degrees are rarely required to enter the field, and only a few colleges and universities offer a formal medical staff services program. Is there a value to such a degree? El Centro Community College in Dallas, whose medical staff services program is still going strong in its seventh year, believes so.

"We started out in 1995 or 1996 trying to get a program started on campus in Dallas, and never had enough students," says **Cindy Gassiot, CPMSM, CPCS,** consultant, instructor, and founder of the El Centro program.

When the numbers were not working out in El Centro's favor, Gassiot says, the community college decided to pursue a distance-learning program.

"Cindy did the majority of the work on the syllabus, creating different courses," says **Christina Giles, CPMSM, MS,** president of Medical Staff Solutions in Nashua, NH, and an instructor since the program's inception. "She came to me at the beginning of the process and asked whether I'd be interested in instructing."

Giles, who has an undergraduate degree in education, was very interested. In fact, she had spoken in the past with a New England university about starting a medical staff services program, but the perception was that the program could not draw enough students every semester to justify dedicating the resources to it.

The move to online courses proved to be a much sounder plan, although it had its challenges.

"All of the courses needed to be rewritten for online instruction," says Gassiot.

Questions? Comments? Ideas?

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Also, instructors who were trained in face-to-face teaching, such as Giles, had to train themselves for a new experience in the virtual classroom.

"The learning curve to teaching online is pretty great. Teaching online is totally different," says Giles. "You have to really reach out to the students in various ways, because many of them tend to 'hide' behind the computer—they don't communicate with you as much as they would in person."

Once converting to an online program was completed, the school offered its first class in January 2000. The class began to fill very quickly. For each of the next five semesters, an additional medical staff services course was added.

The curriculum covers all of the basic education courses for the college, the medical staff services–specific programs, and such topics as medical terminology, anatomy and physiology, and pathophysiology. "It's an associate of science degree, a true science degree," says Gassiot.

Not just for rookies

The program draws a steady core of students every year. "Our grads have all been successfully placed in jobs," says Gassiot. And it's not just fresh faces to the medical staff services field who are taking advantage of the program. Veteran MSPs are returning to school to supplement their existing knowledge, as well.

"Many of our students are working in the field, taking part in the program while working full-time to get a formal education or assist them in their jobs," says Gassiot.

In fact, when the program began, its base was made up of medical staff services veterans.

"At first, it was mostly professionals in the field," says Gassiot. "Now the majority are just starting out. They are individuals who became interested in medical staff services after reading about the program."

"The majority of the students in my classes have been in the field," says Giles. "But in every class I have

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Online degree

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someone trying to learn about it because they think they want to break into the profession."

Hands-on component

The final semester is the clinical or directed study. Students are placed in a medical staff office or department and spend 20 hours per week working under the eye of an MSP. If the student is already working in medical staff services, he or she completes the directed study on the job.

The majority of the students come from the Dallas area, and the Dallas hospitals have been very supportive of this effort, allowing students to perform their clinical studies at their facilities.

"Six students who have not yet graduated are already working, either full-time or part-time, in the area, so that's been tremendous," says Gassiot. "We're very grateful to the Dallas-area MSPs for their support."

Out-of-state students also attended the program, though their numbers have decreased somewhat in recent years.

"They were the majority when we started," says Gassiot. Others take medical staff services–specific courses through El Centro and take other required courses through community colleges in their home states. El Centro requires 30 credits to graduate, but some courses and credits from elsewhere can be transferred.

The classes are typically made up of 20 students to optimize the interaction between student and instructor. The current trend is approximately six or seven out-of-state students, with the rest from Texas.

"The courses will greatly assist them in understanding what they do," says Gassiot. "My students already working in the field always tell me how much new information they walk away with."

The prototypical student MSP

Because the courses do not take place in a classroom setting, the students need to be self-regimented and disciplined, says Giles. "It's a program for self-starters," she says. "There are specific requirements of the student. Not everyone learns in this mode."

When in a classroom setting, there is a certain pressure to know the material in order to participate in the live discussion. The online courses require participation by every student in discussions posted on a discussion board, which—although carrying the same weight in terms of workload as a classroom setting—might fool a student into thinking he or she can catch up at the end of the semester by posting frequently in a short period.

"We tell them they need at least two comments on each discussion. That's the only place they really have to interact," says Giles. "Every semester one or two students don't get on the discussion boards and try to add their two cents to each conversation at the last minute, and it really isn't supposed to work that way."

A live classroom setting also lends itself to building camaraderie between student and instructor. This camaraderie is still possible with an online course, though it takes a slight change in perspective for both student and teacher to get used to the format.

"There are lots of additional coaching requirements to stay on top of those who aren't being responsive the way they should," says Giles.

To do this, Giles makes her contact information readily available to her students, encouraging them to both e-mail and contact her by telephone. "People rarely call. There's a desire to do it all electronically," says Giles, who lets her students know when she is working from the road and encourages them not to rely exclusively on e-mail to interact with her.

Courses out of the ordinary

For the past four semesters, Giles has taught a course on performance improvement, designed to get off of the beaten path and expose students to a different aspect of the medical staff world. "It's a little atypical from the usual medical staff courses," she says. "It's something that

not everybody has been exposed to, even if they're working in a medical staff office currently."

The course, focusing on how to get physicians actively involved in performance improvement, breaks from the credentialing and privileging focus of the program in order to give students a taste of quality improvement tactics, as many will eventually go on to positions in which they work with the quality department on a regular basis.

"MSPs, or prospective MSPs, need to go beyond the traditional walls of the medical staff office. They need to become involved in performance improvement, understand what is occurring in the quality improvement (QI) or performance improvement (PI) office, and participate as much as possible, because the result of the QI/PI process is the basis for reappointment and reprivileging," says Giles "With The Joint Commission's ongoing monitoring and focused performance evaluation, MSPs will be heavily involved in PI and the data produced. It's food for thought. With all of the information on the Internet, required hospital reporting and physician reporting, and pay-for-performance activities, it's worth broadening your perspective."

A matter of experience

In the end, it is the individual MSP's experience that determines how useful a degree in medical staff services—or any degree at all—will be to his or her career.

"Many hospitals are not requiring degrees for this position, so part of our theory and strategy is to let people know they can be more successful with one," says Giles.

When she first came to the field, Giles worked at a university medical center that required a degree for the medical staff services position.

Only later did she discover that the majority of hospitals do not require one.

"I've had people say to me that they are happy without a degree, that they are respected in their position," says Giles.

"For me personally, I strongly encourage people to pursue a degree. Eventually, you may find yourself competing with RNs, applicants with a master's degree or JD. Bottom line, though, it should be something you want to do for yourself—you gain a wonderful sense of achievement that stays with you your whole life." ■

Editor's note: For more information about El Centro Community College's medical staff services program, visit www.ecc.dcccd.edu/Programs/HealthLegalstudies/medstaff *or e-mail Cindy Gassiot at* cgassiot@satx.rr.com.

Sloppy handwriting: Medical staffs employ new strategies to curb illegibility problems among medical staff physicians

A recent Institute of Medicine (IOM) paper at the heart of a *TIME* and CNN.com investigation reports that physicians' messy handwriting kills more than 7,000 patients annually.

The IOM report goes on to give even more alarming details. Preventable medication mistakes number in excess of 1.5 million every year. The *TIME* report states that 3.2 billion prescriptions are written every year using unclear or unapproved abbreviations or dosage indications, or containing illegible handwriting.

But there are strategies in use at some hospitals that help prevent these errors and hold physicians accountable when mistakes are made. "What we've been doing is specifically relating handwriting to medical events and medical errors," says **Dorraine Young**, assistant with the quality management services department at A.O. Fox Memorial Hospital in Oneonta, NY.

Any time someone working with the record-review process identifies something that contributed to an event

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Handwriting

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that was related to eligibility, a copy is made of the actual document. This copy is sent to the nurse practice committee and the medical staff divisions.

The files are redacted to protect patient information and hide the signature and name of the practitioner in question.

"Of course, those with poor handwriting are known by the staff, so you can't hide everything," says Young.

The committees are then asked to read the document and interpret what it says—and, separately, so is the physician.

Sample handwriting policy

The attending physician, dentist, or podiatrist shall be responsible for the preparation of the complete, current, and legible medical record for each patient. The contents of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and results.

This includes the ongoing development and reassessment/revision to the treatment plan and the recording of clinical observations. This record shall include identification data and assessment of the patient appropriate to his or her age, including chief complaint; history of present illness; past history; family history; social history; pertinent psychological history; the legal status of the patient receiving mental health services; physical examination; review of systems; provisional diagnosis; reports of consultations; reports of laboratory and radiology services; reports of treatment; operative reports; pathology reports; progress notes; diagnostic and therapeutic orders; information regarding medications ordered and given; any adverse drug responses; final diagnosis; discharge summary; autopsy findings; records of emergency treatment, including care rendered prior to arrival; evidence of known advanced directives; referrals to internal or external providers or agencies; and other reports, as mandated by New York state law.

Source: A.O. Fox Memorial Hospital, Oneonta, NY.

"It's pretty bad when the attending who wrote the order can't make it out," says Young.

It was the physicians themselves who suggested the shame approach to improving handwriting.

"Our doctors have always told me that if I embarrass them, I'll get somewhere," says Young. "I don't go to that degree unless it's really needed, however."

This tactic has worked so far to curb poor handwriting, according to Young, although it is necessary to periodically revisit the process when legibility starts lagging again. Young also keeps the hospital's physicians abreast of developments in the news that will directly affect them in regard to handwriting.

"If I see anything—such as a story I spotted recently about a physician practice cited and fined by Medicare for illegible records—I copy and present it to them to prove that people are paying attention to this issue," says Young.

Make an example of someone

Susan Sanches, a quality specialist at Espanola (NM) Hospital, found a much larger number of unap-

No cursive for prescriptions; medical records next?

Some states are taking an active role in physician handwriting. In 2006, Washington issued a ban on cursive handwriting for filling prescriptions, according to an article in the *Seattle Post-Intelligencer*.

The move was made to increase the legibility of the scripts, which contain vital information that can be easily misunderstood by pharmacists filling the orders. According to the new law, doctors must print orders via computer or write them with print lettering.

A random sampling of physician orders showed that 24%–32% were illegible, according to the report. Often, pharmacists had to call physicians to clarify an order, which delayed the administration of the medication.

proved abbreviations and illegible handwriting examples than she expected to find while auditing medical records.

She made examples into overheads—redacting the patient identifiers and doctors' names—and presented them during a medical staff meeting.

"I'd say, 'I'm going to give you some examples of legibility issues and unapproved abbreviations, and I want to see if you can find it,' " says Sanches. "I'd finish off with 'Can anyone tell me what this says?' and the docs know when they see their own writing up there. They realized after [the presentation] that a couple of people would interpret [the prescription] differently."

Sanches says the quick, gamelike nature of the presentation makes the activity more enjoyable for the staff.

"It really drove the point home, especially with unapproved abbreviations, units, and decimals that were getting used over and over," she says.

Although Sanches has carried out this sort of activity during a medical staff meeting only once, she says she would not hesitate to try it again if it was necessary.

Handwriting improved, and incidences of unapproved abbreviations dropped after the first activity.

"Now, if I catch it and point it out, they [say,] 'Oh, yeah, I'm sorry,' " says Sanches. Occasionally, they will forget to avoid using unapproved abbreviations, she says, "but if I mention it to them, they won't argue about it. The game really did stick; there's no more resistance. That's kind of the main thing—they are open to it."

In addition to being a creative way of getting the message across, playing this game is a good way to demonstrate standards.

"Docs hear so much stuff—they are inundated: 'You've got to do this for The Joint Commission, you've got to do this for CMS, now the board wants you to do this,' " says Sanches. "They just shut you down if you don't find a way of really getting them to pay attention. This was quick, and you aren't just saying, 'Don't do something.' You are showing them examples."

Sanches also says it is important to train pharmacists and nurses to reject orders with unapproved abbreviations and illegible handwriting as a second line of defense. ■

Tips for increasing legible records

Legibility is a difficult area to tackle, but some hospitals have had success in improving the legibility of their medical records. The following are some best practices:

- Use preprinted orders for medications. Checking boxes and fill-in orders for rates, doses, and routes can go a long way toward legible orders for medications.
- Consider promoting a state law that addresses legibility requirements for medical records. Two states—Florida and Washington—have this type of law.
- Develop a legibility policy to clarify expectations for legibility.
- Use a keyboard with computer physician order entry, a stylus and personal data assistant, or voice recognition.
- Cut out bits of poor documentation, blow them up, and post them in the health information management department. Have physicians and other hospital staff members guess the author.

Physician extenders are key to easing physician shortages, coping with duty hour restrictions at some hospitals

Nurse practitioners (NP) and physician assistants (PA) have been a part of many hospitalist practices for as long as hospital medicine has been a unique specialty, and they may be the answer to the physician shortages plaguing many hospitals.

At Brigham & Women's Hospital and Faulkner Hospital in the Boston-area Partners Health System, the work-hour restrictions forced general medicine service practitioners to care for patients in 15 beds that house staff once covered, says **Christopher Roy, MD,** associate director of the hospitalist service for the two facilities.

Now, the service has six full-time extenders working on the hospitalist service. The PAs see patients independently, do history and physicals, come up with care plans, write orders, and call consults. The hospitalists help to guide the plan.

The success of the process is aided by the fact that PAs often come to the program with four or five years of previous inpatient experience.

The extenders are introduced to patients as PAs, and the patients are receptive. "I haven't seen a negative comment on any of our patient satisfaction surveys," Roy says.

At Brigham & Women's, there are three grades of PAs, based not on their experience, but on the nonclinical responsibilities they take on in addition to their work with patients. "That gives them a growth track" and keeps their satisfaction high, says Roy.

The PAs' administrative and leadership work varies widely: Some work on continuing education programs. Another works on hospitalwide PA grand rounds. One works in patient satisfaction and has been doing quality improvement projects related to satisfaction with the PA program. Still another works on qualifications and credentialing issues.

Changing the model

The surgical services and bone marrow transplant units at Brigham & Women's have used PAs for years.

In the former, PAs keep things running on the floor while the surgeons are in the operating suites. In the latter, they are viewed as a substitute for residents in a situation with little teaching value.

At Faulkner, a community hospital, PAs have been used primarily for low-acuity patients with short lengths of stay and only a single medical problem. They care for those patients without any resident involvement, and only under the guidance of an attending physician.

However, none of these models was appropriate for the hospitalist service at Brigham & Women's, says Roy. Although the facility considered a model that used PAs in

conjunction with residents to help the physicians get out of the hospital at the end of their shifts, by taking care of the more menial tasks, Roy says it chose instead to have PAs replace residents completely.

Keep in mind that not all states allow physician extenders to do the same kind of work. Although they have a lot of freedom in Massachusetts, their practice in Ohio, until recently, has been pretty restricted, says **Michael Ruhlen, MD, MHCM, FAAP,** vice president of medical affairs at Toledo (OH) Children's Hospital and the chair of the committee on nonphysician providers at the Society of Hospital Medicine.

Currently, three PAs are working with the five hospitalists at Toledo in a 54-bed unit. The program has incorporated extenders for more than eight years, but in May 2006 it got a boost when the state legislature changed the rules to allow PAs to see new patients (and old patients with new conditions), prescribe, and write orders. Ruhlen contends that it will now be easier to incorporate PAs and NPs into the hospitalist practice.

Hindsight: Prepare for challenges

Even though extenders have been part of the practice for years at Toledo Children's Hospital, Ruhlen says every time a new group of physicians comes in, he has to explain all over why PAs are a good thing.

"We have a multidisciplinary environment that includes family practice residents, pediatric hospitalists, pediatric residents, PAs, NPs, pharmacology, nursing, medical students, and PA students," he explains. "It's one great big lab environment to explore a lot of different relationships among disciplines."

Ruhlen says there were fears among family practice residents in particular that PAs would "take their patients and steal their jobs."

However, that's not their purpose or effect, he says. PAs function at Toledo Children's Hospital a lot like junior residents.

The longer PAs stay, the more procedures they do, such as IVs. They are not allowed to do lumbar punctures —yet—but they have plenty of other things to occupy their time, such as histories and physicals, daily progress notes, discharge exams, documentation, and contact with follow-up physicians.

They also prepare discharge prescriptions, although a physician must sign off on them.

PAs have worked in the pediatric hospitalist service since 1998, says Ruhlen. They come in on a daily basis, and often start their jobs with hospital experience.

"Ours have at least 108 months' of experience," he says. "Compare that to an average pediatric resident with eight months'experience."

They are technologically savvy, are diagnostically capable, like the hospital environment, and, on more than one occasion, have caught emergent issues with patients that no one else has.

However, there are things to consider before starting. First, some payers won't reimburse for midlevel providers. Others will reimburse at 85% of the physician level, and if the physician does enough appropriate additional documentation, that could increase to the full amount.

Some people still don't like the idea of PAs doing physician work.

"When I first became a hospitalist in 1989, I got hate mail. They thought what I was doing would destroy pediatrics. I see midlevel practitioners in that kind of state now," Ruhlen says. "They think PAs are conspiring against physicians. But that isn't the case. The enlightened physician can help them accomplish their work, and in [these days, when] pay for call is a huge issue, I think hospitalists are a natural answer, and midlevels will be a key in that. I don't think we would be functional without them." ■

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Debunking myths—or 'untruths'—about privileging

by Sally J. Pelletier, CPMSM, CPCS

Common myths abound in the credentialing and privileging field. Knowing how to expose the truth behind the myth can save time, avoid confusion, and help limit frustration in the long run. Let's take a look at some of the more frequently cited tall tales you're likely to hear in the medical staff office.

Myth #1: Clinical privileges are owned by the physicians.

Privileges are requested and then granted based on the practitioner's licensure, education and/or training, experience, current competence, and ability to perform—and information from ongoing professional practice evaluations is used to determine whether to continue, limit, or revoke clinical privileges. Clinical privileges are, in fact, granted by the governing body for not more than a 24-month period. They are not owned by physicians.

Myth #2: Clinical privileges and criteria are defined, determined, and granted by the clinical departments.

Clinical departments should certainly be asked for and should provide input regarding clinical privileges and criteria, as applicable. However, only the governing body can approve the types of procedures or services offered at the facility, grant clinical privileges, and approve the criteria needed for eligibility to request the specific privilege/procedure.

Myth #3: A physician is entitled to all clinical privileges requested, unless he or she is not sufficiently trained or qualified.

A variety of factors can come into play here as to why a physician can be refused a specific clinical privilege. Was a privilege inadvertently included on the privilege form that is not even offered at the facility? Is there an exclusive contract delineating that only a certain specialty group can provide the service?

Myth #4: There are textbook criteria available for delineating privileges.

No, unfortunately, there are not. However, there are many published guidelines and statements by various medical societies, specialty associations, and boards, but they are meant to be just that—guidelines. Each organization should take this information into account and customize these guidelines as appropriate for their facility, staff, and resources.

Myth #5: Exercising any privilege is just like riding a bicycle.

This is another misconception. Although there are some procedures that have transferable skills, there are others that the practitioner must continue to perform to maintain the skill. Decisions about which procedures need to be performed periodically to maintain the skill are best left to clinicians wearing their medical staff leader hats.

Myths about core privileges

Myth #6: There is a hidden agenda behind the organization's decision to move to core privileges.

The switch to core privileges is designed to simplify life for the medical staff and to generate a more consistent, objective, and fair version of privilege delineation.

Myth #7: The credentials committee is trying to restrict privileges by moving to core.

A practitioner will maintain current privileges as long as he or she is capable of demonstrating current competence. ■

Editor's note: Pelletier is a consultant with The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, specializing in the areas of credentialing and privileging.