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Briefings on
Credentialing
The monthly newsletter for medical services professionals

Future of economic credentialing in doubt

Arkansas court ruling attracts attention, but will healthcare reform take it away?

Economic credentialing has never been very popular with medical staffs. Some say it's because it favors the aggressive business practices of hospitals and demotes the importance of competency and competition for practitioners. But is economic credentialing a battle that's not worth fighting anymore?

Advocates say yes, the economic credentialing battles of yesterday are on their way out, replaced by discussions about accountable care organizations (ACO) and the importance of teamwork.

"It makes this issue less likely to be as important in the future as it is right now," says **David Simon, Esq.,** a partner with Foley & Lardner, LLP, in Milwaukee.

A recent Arkansas Supreme Court ruling, *Baptist Health v. Murphy,* shines the spotlight on the economic credentialing argument that's alive and well in some hospitals.

"Baptist wasn't alone in having a policy that really had the purpose of eliminating competition and increasing business for them," says **Robert Iwrey, Esq.,** founding partner at The Health Partners, PC, in Southfield, MI.

No one knows what the future may hold, but as for today, hospitals and medical staffs need to understand the principles of economic credentialing before deciding whether to resign it to the history books.

Baptist Health v. Murphy

These days, *Baptist Health v. Murphy* is the economic credentialing case at the forefront of many people's minds. Appellees Bruce Murphy et al. are cardiologists who were on the professional staff at Baptist Medical Center in Little Rock, AR, and partners at a competing clinic.

This month's *Clinical Privilege White Papers:*

- **Pediatric gastroenterology—Practice area 427**
- **Coronary atherectomy—Procedure 56 (update)**

In 2003, the board of trustees at Baptist adopted an "economic conflict of interest policy." When the appellees applied for reappointment the following year, Baptist denied their request because their association with the competing clinic violated the new economic credentialing policy.

The appellees took Baptist to court, alleging that the medical center's actions disrupted the doctor-patient relationship and violated the federal anti-kickback statute, among other accusations.

The Supreme Court of Arkansas ruled in favor on the appellees on September 30, effectively barring economic credentialing from Arkansas.

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HCPro

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Economic credentialing

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From the hospital's perspective

There are two sides to every issue, and economic credentialing is no different. The term itself has varying connotations to different groups.

"The way I think about it is a general acute care hospital implementing a policy that prohibits or discourages the physicians on the staff from being investors in competing specialty hospitals," says Simon.

Although he represents both hospitals and physicians, Simon does more work with hospitals and says he understands why economic credentialing is a useful tool for them. "From the hospital's perspective, the physician-owned specialty hospitals are skimming the cream; they're taking the most profitable procedures away from the hospital," he says.

This means that hospitals, whose profits are devised from a mix of high-earning procedures such as heart surgery and less profitable services, including emergency department coverage for a community, are left with a hole in their budget when a specialty hospital moves into town. However, because the hospital has an obligation to provide services to the community, it must figure out a way to continue operations with a smaller budget.

"Hospitals tend to be opposed to specialty hospitals because the perspective is that they're competing a little unfairly and are a threat to the system," says Simon.

The solution for many hospitals is to enact economic credentialing policies to rebalance the equation and maintain a robust budget for providing quality services to the community, he says.

From the practitioner's perspective

Although some hospitals see physician-owned specialty hospitals as the unfair players in the economic credentialing battle, physicians take a different perspective. They see hospitals as the bad guys, with David and Goliath elements at work.

Analyzed in the most basic black-and-white terms, many physicians claim that they simply want to provide care to more patients while hospitals use economic credentialing to grow bigger and more profitable. Although real-life cases of economic credentialing are more nuanced than that, there is a legal strategy to be built from that perspective, says Iwrey.

Like Simon, Iwrey represents hospitals and physicians. However, Iwrey primarily works with physicians and admits having a bias toward their perspective.

Iwrey says a case can be made against economic credentialing because of the national physician shortage. "How are you going to win an argument that reduces the number of available physicians to the community by saying that a hospital can prevent a doctor from practicing at that system because [the hospital with economic credentialing policies] is afraid of competition opening up?" he says.

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Hospitals might argue that they aren't reducing the number of physicians in the community, only the number of places where they can see patients. Yet if the physicians are seeing patients in a location that's easier for patients to reach or covered under a different health plan, it would be a greater challenge for the hospitals to prove they're not increasing their profits at the expense of patients' access to care. "Increased access to healthcare is pivotal to the success of healthcare reform; economic credentialing is antithetical to such access," Iwrey says.

Putting the credentialing in economic credentialing

Abstract issues aside, the Baptist case ruled in favor of a ban on economic credentialing, stating that the purpose of credentialing is to seek out competent practitioners to work at the hospital so hospitals can continue to provide services to the community.

"Economic credentialing really isn't about competency," Iwrey says, noting that competency comprises clinical quality and good behavior. "In other words, you could have somebody who's very competent—who has high quality and no behavioral issues—and you're excluding that person from the staff because of perceived conflicts of interest."

A broad-reaching precedent

Why should medical staffs care about an out-of-state court ruling?

"They should care about the ruling because the basis was, with one exception, not tied to unique Arkansas law," says Iwrey. The unique Arkansas law Baptist violated was a deceptive trade practices act.

Additionally, Iwrey notes that the Baptist case sets a precedent because there aren't many economic credentialing cases out there, and this particular case is easy for observers to learn from because it's purely about economic credentialing.

"Courts are not bound by these types of decisions, but when you have an area of law where very few decisions are made on a national level, courts routinely look to other states to see how courts rule, especially on a well-reasoned decision," he says.

It's the type of court ruling the field calls persuasive precedent. "It's not binding, it's not governing, but it's called persuasive precedent—and I would add highly persuasive precedent," says Iwrey.

Turning the page on economic credentialing

As important as it is for medical staffs to understand the issues at play in today's economic credentialing battles, it's also essential that they understand the evolution of physician-hospital relations.

There are two main factors that some predict will cause hospitals to abandon their practice of traditional economic credentialing policies:

- **Healthcare reform.** The healthcare reform law encourages the development of ACOs, which in turn encourage hospitals and physicians to work together to lower healthcare costs and share the rewards. (To read CMS' Q&A about ACOs, turn to page 4.)
- **Shifting physician priorities.** Today's physicians seek a greater work-life balance than previous generations and take less of a business interest in developing their own practices. Employed physicians, including hospitalists, are on the rise, and the hospitals satisfy their economic interests with appropriate salaries.

Taken together, these two factors paint a picture of a physician-hospital relationship based on shared goals, not economic rivalries.

"If you end up with more and more specialists who are part of accountable care organizations that are tied into an integrated healthcare service provider system, they're not going to be out freelancing," says Simon. "That model [of ACOs] is not going to occupy the whole field … but there will be fewer specialty hospitals."

Until that day comes, hospitals and practitioners would be wise to educate themselves about the latest economic credentialing court cases and implement the learning lessons they provide. ■

Q&A: CMS' accountable care organizations

Editor's note: The following is a Q&A provided by CMS about accountable care organizations (ACO). Some experts believe that the rise of ACOs will trigger the decline of economic credentialing policies.

Q What is an "accountable care organization"?

A An Accountable Care Organization, also called an "ACO" for short, is an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.

For ACO purposes, "assigned" means those beneficiaries for whom the professionals in the ACO provide the bulk of primary care services. Assignment will be invisible to the beneficiary, and will not affect their guaranteed benefits or choice of doctor. A beneficiary may continue to seek services from the physicians and other providers of their choice, whether or not the physician or provider is a part of an ACO.

Q What forms of organizations may become an ACO?

A The statute specifies the following:

1) Physicians and other professionals in group practices
2) Physicians and other professionals in networks of practices
3) Partnerships or joint venture arrangements between hospitals and physicians/professionals
4) Hospitals employing physicians/professionals
5) Other forms that the Secretary of Health and Human Services may determine appropriate.

Q What are the types of requirements that such an organization will have to meet to participate?

A The statute specifies the following:

1) Have a formal legal structure to receive and distribute shared savings
2) Have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum)
3) Agree to participate in the program for not less than a 3-year period
4) Have sufficient information regarding participating ACO health care professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings.
5) Have a leadership and management structure that includes clinical and administrative systems
6) Have defined processes to (a) promote evidenced-based medicine, (b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx), and Electronic Health Records (EHR), and (c) coordinate care
7) Demonstrate it meets patient-centeredness criteria, as determined by the Secretary.

Additional details will be included in a Notice of Proposed Rulemaking that CMS expects to publish [in the future].

Q When will this program begin?

A We plan to establish the program by January 1, 2012. Agreements will begin for performance periods, to be at least three years, on or after that date.

Source: www.cms.gov/OfficeofLegislation/Downloads/AccountableCareOrganization.pdf.

Professional development = education + networking

Learn how to master the equation to make your career the best it can be

Thumbing through credentialing applications can give MSPs a snapshot of practitioners' career paths. If someone created a similar file for MSPs, what would yours look like? Would it be a series of random events, or would it be a calculated effort that led to the achievement of your highest goals?

One way to ensure that your career remains focused is to pursue professional development opportunities. These opportunities can take many forms, from informal gatherings with colleagues to formal course work for certification. Most professional development options have an educational and/or networking focus that can enhance your professional and personal life.

Say hello to the rookie

Professional development goals typically change over the course of a career. In the beginning, most professionals cast a wide net to gather the most information available to them in their chosen field. This can lead to some great and long-lasting relationships. It can also lead to a few dead ends, but knowing which sources of information aren't helpful can sometimes be as useful as knowing which sources are helpful. It's all part of the learning process.

"I was fortunate enough at the beginning of my career to have joined a [medical staff services department (MSSD)] where training was a way of life and not just an afterthought," says **Genni Koser, CPMSM, CPCS,** supervisor at the BJC Credentialing Verification Organization in Bridgeton, MO. "I started small with attending the local chapter meetings, then advanced to the state meetings, and by then I was hooked."

Having a supportive department was a great incubator for other MSPs as well. **Debi Potter,** director of medical staff services at Montgomery Regional Hospital in Blacksburg, VA, says when she initially started, she didn't even know an entity such as an MSSD existed, but that didn't stop her from hitting the ground running. "My supervisor, who was a great mentor, as well, was open to me increasing my duties from the paper credentialing aspect to taking on department meetings in the first six months. From that point on I knew that this was the field for me," says Potter.

Tip: If you're a supervisor who's responsible for setting new MSPs on their professional development paths, don't wait too long to increase their responsibilities. When people see that others have high expectations for them, they are more likely to develop a positive assessment of their own abilities and meet the goals set forth.

Aside from finding an in-house mentor, Potter recommends that new MSPs reach out to their peers at area hospitals and/or CVOs for professional advice. Most of the time, those mentorship requests will be answered.

"I find it very rare that a request for assistance from MSPs within or outside your hospital or hospital system is turned down. As a group, MSPs are always willing to advise and share forms or experiences." Potter says.

After new MSPs have gained steady footing in their career with the help of a mentor, a supervisor, or peers from nearby facilities, they are ready to pursue other development opportunities, such as membership in state and national associations and the pursuit of certification.

Joining state and national associations

Almost every state has an association of medical staff services that, along with the National Association Medical

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Answer key

Below are the answers to the quiz on pp. 8–9. You can find more details on the answers in the 2010 issues of **BOC** (the month to consult is indicated next to each answer).

1. c. (Jan.) **2.** b. (Jan.) **3.** b. (Feb.) **4.** d. (Feb.) **5.** a. (March) **6.** d. (March) **7.** a. (April) **8.** c. (April) **9.** b. (May) **10.** b. (May) **11.** a. (June) **12.** c. (June) **13.** a. (July) **14.** a. (Sep.) **15.** d. (Sep.) **16.** d. (Oct.)

Professional development

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Staff Services (NAMSS), welcomes new members with open arms.

Sometimes new MSPs choose to join their state associations before the national association because the state offers lower fees for joining and provides conferences that are closer to home.

Potter says that she began as an MSP around the same time that her state association formed, and she quickly became a member.

"That was my first real oppertunity to meet other people who knew what I was doing and [helped me to] ensure that what I was doing was appropriate," she says.

Looking for a direct Web link to your state organization's site? Visit *www.namss.org/StateAssociations/StateWebsites/tabid/86/Default.aspx.*

"Being involved in your state and local associations just makes such a difference."

State and national associations typically offer:

- Conferences and webinars that provide continuing education credits
- Networking opportunities with other MSPs
- Updates on developments in universal credentialing applications and regulatory standards

Specifically, the networking opportunities at conferences are a big draw for many MSPs who join these associations.

"So much of what we learn comes from talking to other medical staff professionals about the processes in their organizations," says **Thora Healy, CPMSM, CPCS,** director of medical staff services at Anna Jacques Hospital in Newburyport, MA. "Attending conferences such as NAMSS gives you an opportunity to network with your counterparts."

Koser agrees with Healy on the benefit of conferences. "It is imperative that I keep up to date and current on standards, statutes, and best practices. By attending conferences, whether they be national, state, or local, assists me to keep abreast of new, more efficient, streamline processes and procedures," she says.

And it's not just MSPs who ultimately benefit from these professional development opportunities. "We serve as a resource for physician leaders and hospital administration. Attending [a conference] is a way to stay on top of industry trends and regulatory requirements—which is essential to be effective," says Healy.

Tip: If it's a challenge for you to convince your organization to allow you to attend educational events, point out that these events not only benefit you, but also the medical staff as a whole because you'll pass on the best practices you learn. Another way to gain permission is to write a formal request letter outlining which presentations you'll attend and how you'll use the information you gather to improve the MSSD.

Setting your sights on certification

One of the most tangible forms of professional development that MSPs seek out is certification. NAMSS offers two certifications (for more information, visit *www.namss.org*):

- Certified Provider Credentialing Specialist (CPCS)
- Certified Professional Medical Services Management (CPMSM)

"In the beginning, I was trying to gain as much knowledge as I could, and my goal was to achieve certification." says Healy.

"Now, my development has evolved, but still includes activities to maintain my certification."

Healy's not the only MSP who set her sights on certification as a career goal, but for others, it takes longer for that goal to come into focus.

"Halfway through my career I felt that … if you knew the job, why did you need the title," says Koser. "I can't believe how wrong I was. Being a part of the many certified professionals is an awe-inspiring experience that you cannot find anywhere else in the field."

Some of the reasons MSPs seek out certification are:

- A sense of professional achievement
- Negotiating power when requesting a wage increase
- Marketability to find a position at a new organization

Picking up the phone and hitting the road

Professional development opportunities exist in a variety of settings, from virtual and live conferences to online message boards. However, sometimes an MSP's preferred type of professional development opportunity has to take a backseat to financial realities and time constraints.

"My preferred way would be to go to live conferences; however, with all the cutbacks, I think Web conferences are really great [as an alternative] because people can listen and learn without having to go and incur a major expense," says Potter.

Tip: Looking for deeper discounts on your professional development opportunities? Think outside the box. Ask your state and local associations what opportunities exist to buy bulk registrations to conferences. Or, rather than driving miles and booking a conference room for your next networking meeting, try a virtual meeting.

Potter says that beyond the medical staff services world, MSPs can gain professional development experience by taking public speaking courses and classes on leadership training.

For MSPs, professional development never goes out of style. "Even after 23 years, I am still in awe of all the certified professionals and the total experiences they have accumulated over their years of service. Always remember that patient safety comes first, and by doing your job to the best of your ability and keeping up to date on current standards and statutes will make that happen," says Koser. "Education and experience is powerful. Take them to the limits." ■

HCPro's professional resources

If you're looking for professional development tools, check out some of the resources for MSPs available at *www.hcmarketplace.com:*

- **News updates.** In addition to **Briefings on Credentialing,** HCPro offers two other monthly publications for MSPs: **Medical Staff Briefing** and **Credentialing & Peer Review Legal Insider.**
- **E-learning.** Our library of e-learning courses includes "Overview of the Joint Commission's Standards," "Introduction to Credentialing," and "Introduction to Privileging." Complete all three to earn six NAMSS CEUs.
- **Conferences.** Our 14th Annual Credentialing Resource Center Symposium takes place May 12–13, 2011, in Las Vegas. Can't make it out West? We provide other seminars around the country throughout the year. Click on the Seminars tab on *www.hcmarketplace.com* for more information.

Credentialing year-in-review quiz

What new credentialing topics did you learn about in 2010? Take our quiz and see how closely you were paying attention.

1. How can your medical staff disclose credentialing information in a manner that is protected under the peer review umbrella?
   a. The disclosing hospital can give the information to the candidate to give to the receiving hospital
   b. The disclosing hospital can send the information to the requesting hospital via certified mail
   c. The disclosing hospital's appropriate committee or designee can arrange a meeting with its counterpart at the requesting hospital to share the information
   d. There is no way credentialing information can be protected under the peer review umbrella

2. What is the significance of a satellite clinic and a hospital sharing the same Medicare billing number?
   a. The satellite-based practitioners must exercise exactly the same privileges as the hospital-based practitioners
   b. The satellite clinic and hospital are part of the same system and likely share the same credentialing policies
   c. The satellite clinic and hospital must see the same patients
   d. The satellite clinic and hospital must have been established in the same year

3. According to a **Credentialing Resource Center** blog poll, do the majority of organizations have different controlled substance screening requirements for contracted practitioners versus noncontracted practitioners (i.e., traditional medical staff members)?
   a. Yes
   b. No

4. Which of the following techniques can MSPs use to communicate with hard-to-reach practitioners?
   a. Putting paperwork in mailboxes in the physicians' lounge
   b. Posting notes on memo boards
   c. Calling or e-mailing practitioners, depending on the practitioner's preference
   d. All of the above

5. It is a best practice to evaluate a medical staff member's potential conflicts of interest at initial appointment, reappointment, and whenever a new business development is negotiated.
   a. True
   b. False

6. In which of the following ways can the HR department assist MSPs in writing their job descriptions?
   a. Providing the organization's template for job descriptions
   b. Showing examples of job descriptions of other employees at a similar managerial level as the MSP
   c. Instructing the MSP on the approval process for the newly written description
   d. All of the above

7. Section 1921 expands the NPDB to include information on which previously excluded group of practitioners?
   a. Advanced practice professionals
   b. MDs
   c. DOs
   d. DDSs

8. According to The Delta Companies' *The Physician Recruiting Standard,* what was most requested specialty in the fourth quarter of 2009?

a. Internal medicine
b. Cardiology
c. Family medicine
d. Pediatrics

9. Which industry did researchers at the University of Buffalo and Roswell Park Cancer Institute borrow simulation technology from to create the Robotic Surgical Simulator?
a. Shipping and freight
b. Airline
c. Financial
d. Veterinary

10. What role does a residency program director perform?
a. This administrative coordinator is responsible for a specific residency program
b. This physician is responsible for the operation of the residency and/or fellowship program
c. This senior resident helps manage other residents in their programs
d. This pre-med student assists with the residency program's administrative responsibilities

11. According to a **Credentialing Resource Center** blog poll, most medical staffs take behavioral evaluations as seriously as clinical evaluations and exercise disruptive behavior policies as needed.
a. True
b. False

12. How do Accreditation Association for Ambulatory Health Care (AAAHC) surveyors differ from Joint Commission surveyors?
a. AAAHC surveyors assess organizations via phone and e-mail, whereas Joint Commission surveyors assess organizations in person
b. AAAHC surveyors are paid directly by the organization they survey, whereas Joint Commission surveyors are paid by The Joint Commission
c. AAAHC surveyors work part time, whereas Joint Commission surveyors conduct surveys full time
d. None of the above

13. What is the name of the Washington state healthcare bill designed to lower healthcare costs by establishing a statewide credentialing database?
a. SB 5346
b. SB 4653
c. WB 5344
d. WB 4655

14. A "forever more verification" is a term some people use to describe a final assessment letter written about a departing practitioner. What is its purpose?
a. The hospital has a recommendation letter on record written by an individual who personally knew the departing practitioner
b. The hospital has a recommendation letter on record written by a collective group of patients
c. The hospital has a recommendation letter on record written by the hiring HR manager
d. All of the above

15. For which of the following purposes may physician reentry programs be used?
a. When a physician returns to work after extended maternity, paternity, or family leave
b. When a physician requests new privileges for procedures he or she has not performed in several years
c. When a physician returns to work after a short retirement period
d. All of the above

16. Which accreditor's standards specifically require medical staffs to query Medicare/Medicaid sanctions at initial appointment?
a. The Joint Commission
b. CMS
c. DNV
d. None of the above ■

Getting to know Mary Baker, DHA, CPMSM, CPCS, the newest member of the Greeley credentialing team

Mary Baker, DHA, CPMSM, CPCS, joined The Greeley Company as a senior consultant in October. She specializes in regulatory compliance, credentialing and privileging, medical staff services department (MSSD) effectiveness, CVO implementation and assessment, and MSP leadership and development training.

A dedicated MSP, Baker has been a member with the National Association Medical Staff Services (NAMSS) since 1990. She has served as president-elect of the Ohio Association Medical Staff Services and as a board member of Texas Society Medical Staff Management. She received her master's degree in healthcare administration from Central Michigan University in 2000 and her doctorate in healthcare administration from the University of Phoenix in 2008.

Briefings on Credentialing caught up with Baker to learn more about her professional journey and what advice she has for the latest generation of MSPs. (***Note:*** To see photos of Baker at NAMSS and a video interview, visit *www.credentialingresourcecenter.com/blog.*)

Q How did you become an MSP?

A I started as CME secretary in 1985 at Good Samaritan Hospital in my hometown, Zanesville, OH. I also helped the credentialing coordinator with verifications, NPDB queries, which we performed back then on noncarbon paper, commonly called NCR paper. I attended meetings, took minutes, scheduled CME programs, including inviting speakers. Eventually I took on more responsibilities in that role, and I began reviewing medical records against criteria such as admissions within 24 hours with the same diagnosis, return to surgery within a certain period of time, blood usage, and participated in other medical staff projects.

Q What type of work did you do before joining Greeley?

A Most recently, I worked in Doha, Qatar, on a hospital project that is currently in the construction phase. I was responsible for developing the medical staff organization, bylaws, rules and regulations, policies and procedures, credentialing and privileging procedures, physician recruitment process, and staffing requirements for physicians and MSSD personnel. Prior to that, I was corporate director of the medical staff at Baylor Healthcare System in Dallas, where I was responsible for oversight of 12 hospitals and the CVS.

Q What was the process like of building a medical staff from the ground up in Qatar? Some people might think that it's easier to develop policies when you're working with a blank slate—was that the case?

A It is easier in the sense that you don't have the day-to-day challenges and interruptions. The difficult part is building the processes following a similar formula that we use in the U.S., with access to all the data banks and verification sites that we have, but make it fit into a culture and country that doesn't have NPDB, AMA, AOA, and related resources.

Q You've worked as an MSP in a variety of states, such as Texas and Ohio. Do the location and state laws change your work as an MSP?

A Of course organizations and some laws are different from state to state, but nothing too significant that impacted my job.

Q When you talk to other healthcare professionals, is it easier now to explain what an MSP does compared

to when you started in the profession? Do you think there's a greater awareness of the work of MSPs?

A It is much easier now to explain what we do because our roles have expanded so much, plus we MSPs have become more vocal about our expertise, knowledge, and value to the healthcare organization. There is much more awareness of the work we do thanks to bodies such as The Joint Commission, AMA, and others who promote the importance and value of MSPs.

Q MSPs may have a more defined role to play, but they still rely on medical staff members to carry out a number of projects. What are some ways for MSPs to achieve buy-in from medical staff members, especially if you're new to your role and don't really have a relationship with them?

A It is all about gaining credibility with your leaders and other staff members. That's not to say you have to know all the answers; you just have to know when you don't know the answer and have the drive to go find it. You lose credibility when you give an incorrect answer just to answer a question. There is no shame in saying, "I don't know, but I'll find out for you."

Q If MSPs are interested in going back to school to obtain a bachelor's or master's degree, in what majors do you think they would most benefit?

A The most valuable major is healthcare administration since it provides a well-rounded view of the healthcare system. Unfortunately, most of these programs do not go into great depth related to the medical staff organization and its complexities or the credentialing process.

Q On a similar note, were your peers and supervisor supportive of you pursuing your degrees?

A Well, I was a late starter to advanced education, and I didn't have to convince anyone but me that it was a good idea. I knew that if I wanted to move forward, I needed more education. I did my bachelor's and master's in what used to be a nontraditional setting. For the bachelor's, I attended school one night a week for two years, and in my master's, I was supposed to attend every other weekend, although I attended every weekend so I could finish sooner. My doctorate was done online through the University of Phoenix so I could continue to work full-time. Some people think that online degrees are easier, but I must say, you certainly have to think out of the box and be creative, be organized, and be disciplined to get your work done. It is not easy, that's for sure. I was very supported by my peers, supervisors, and especially my family.

Q Do you think there's a glass ceiling for MSPs, or is there always a new aspect of being an MSP to explore?

A I used to think there was a glass ceiling, but with the continual expansion of our job and responsibilities, I think there are always new avenues to explore. I would have never thought 25 years ago when I started in this business that I would have ended up in the Middle East working on a hospital project. I think you can go as far as you want to go and as far as your circumstances will allow you to go.

Q What's the best advice you've been given as an MSP?

A Understanding the importance of the work you do as an MSP is key.

Q If you weren't an MSP, what other type of profession would you like to pursue?

A I'd probably be working in the legal profession, specifically criminal law. I'm a *Law & Order: Criminal Intent* junky. ■

The MSP's Voice

Anatomy of an application: Processing the data

Editor's note: This is the second in a series of columns that takes a closer look at credentialing applications. The previous article, "Anatomy of an application: Red flags," was published in October.

There are numerous recipes out there for processing an application, but what is the best one? My basic recipe is below.

Sifting and clarifying

- Review each page to ensure that the practitioner completed the application and meets all qualifications. Don't spend your time chasing information that should have been provided within the application. This is the beginning of a respectful relationship between you and the practitioner, so don't be afraid to set the boundaries early.
- Ensure that all requested phone, fax, and e-mail addresses are present.
- Create a list of missing items needed from the practitioner to complete his or her application packet. This list may also include clarification questions. Send this list to the practitioner and keep a copy of the request on file.
- Contact the practitioner shortly after receiving the application to introduce yourself if you have not already done so. It is a best practice to contact the practitioner by phone so both of you can directly address any questions.

Verifying

- The first items I verify on an application are the professional liability coverage and claims history queries, the peer references, and any training that I need to verify directly from the organization. These items routinely have the longest turnaround times, so it is helpful to send the verification requests as quickly as possible.
- Don't say the request is urgent unless it really is. Don't be the little boy or girl that cries wolf because when the day comes that you really do need an urgent response, it will most likely not be given the attention it needs. If the request really is urgent, include a needed response date with your request.
- Stay on top of your requests. If you don't hear anything in five to seven working days, make a phone call. Don't simply send another fax or e-mail. The personal touch goes a long way and helps build the relationships that are necessary for our continued success.

Presenting

- Each medical staff will have preferred ways for reviewing a file. The best thing we can do as MSPs is to ensure that the file being reviewed is complete and accurate and that any red flags are clearly identified.

Is there a "best" recipe for application processing? I would say the best recipe is the one that works for you and your facility while maintaining respect and appreciation for the practitioner, your colleagues, and those responding to your requests. What is the most important ingredient? A complete application! Happy processing. ■

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