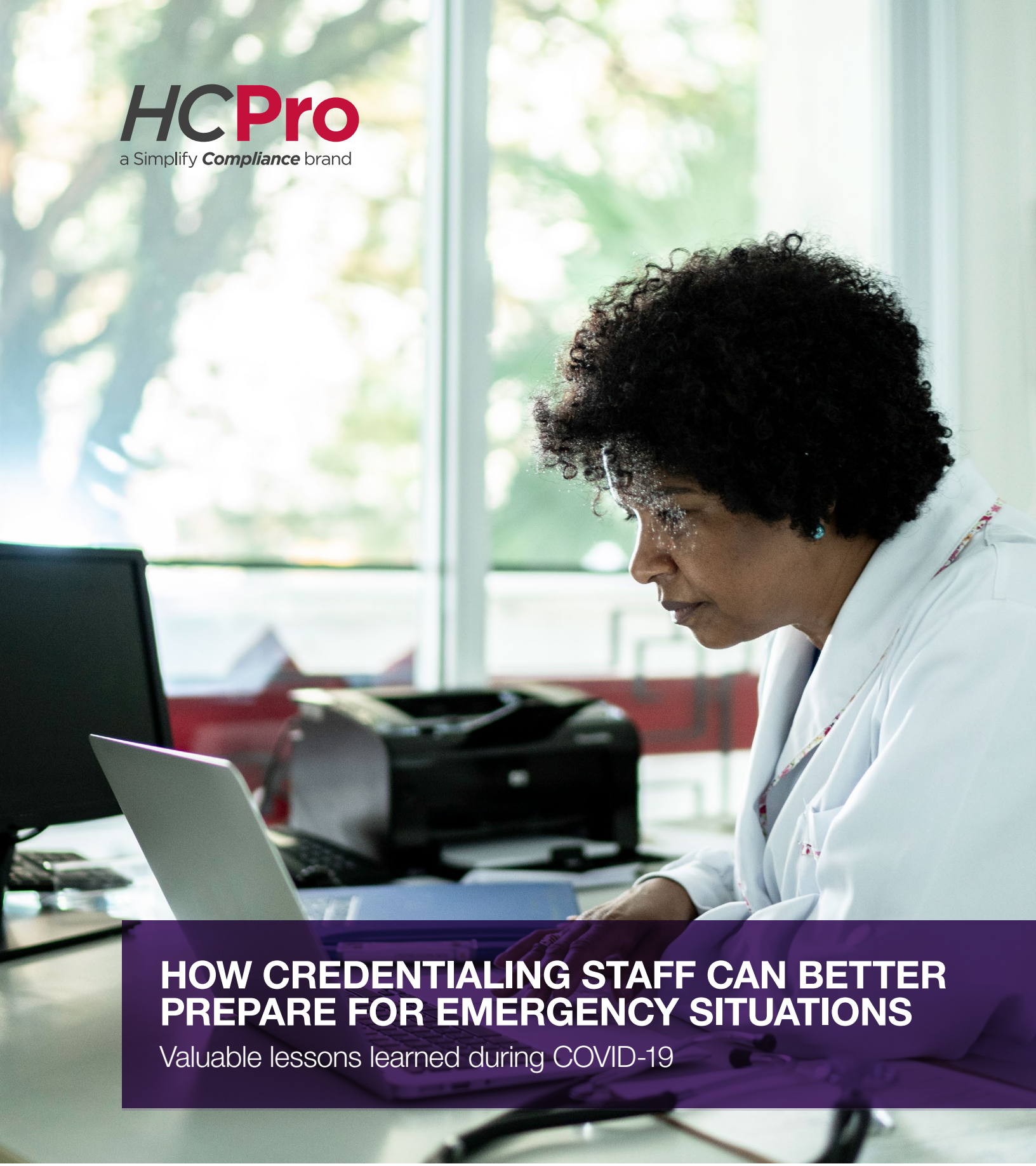

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HOW CREDENTIALING STAFF CAN BETTER PREPARE FOR EMERGENCY SITUATIONS

Valuable lessons learned during COVID-19

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How Credentialing Staff Can Better Prepare for Emergency Situations

Valuable lessons learned during COVID-19

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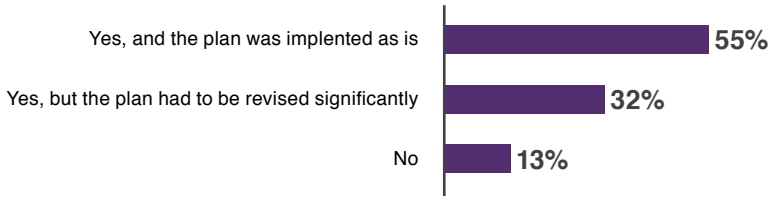
General surgeon at
Margaret Mary Health and
Decatur County Memorial Hospital

The onset of COVID-19 introduced significant credentialing challenges that healthcare organizations had not faced in prior emergency/disaster situations. What was different about the pandemic? For one, it hit a large portion of the United States all at once; for another, it has lasted much longer than previous emergencies and disasters. Both of these factors have made it difficult to expedite recruiting and credentialing of volunteer physicians using traditional emergency plans. Ultimately, healthcare organizations are finding that this pandemic requires a change in emergency credentialing practices.

In a survey conducted by HCPro in April 2020[1], 129 healthcare leaders, including VPs, chief department executives, and CEOs from hospitals, health systems, physician groups, and other healthcare organizations shared key aspects of their emergency credentialing plans prior to the pandemic, along with future revisions they anticipate making. Only 55% of respondents said they had an emergency/disaster privileging plan in place prior to COVID-19, while 45% didn't have a plan or had one that needed to be revised significantly.

"With the current public health crisis, it is becoming clear that nobody anticipated it to this level and so they were not ready for the response that was necessary," says David Welsh, MD, MBA, a general surgeon at Margaret Mary Health in Batesville, Indiana, and Decatur County Memorial Hospital in Greensburg, Indiana.

Figure 1. Prior to COVID-19, did you have an emergency/disaster privileging plan in place?



Base = 129

Welsh, who also serves as chair of the AMA Organized Medical Staff Section Governing Council for the 2018–2020 term, is participating with several AMA workgroups to streamline the general credentialing application process and address emergency situations like a pandemic that are long-lasting and have unique healthcare consequences to

1 An AMA-sponsored survey prepared by HCPro for the AMA.

both the public and healthcare providers. “Our ultimate goal is to take [credentialing] from the typical six months down to one month, which is great for routine situations, but we are also finding with emergency situations like COVID-19, it may not be quick enough,” he says.

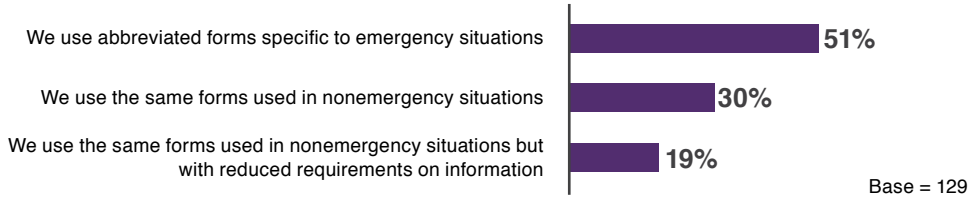
COVID-19 reveals key gaps in emergency credentialing practices

The pandemic has unique factors compared to other emergency situations that affect credentialing, according to Welsh. Number one, it has prevented some physicians from working in their own organizations due to personal sickness. Early on, test results took 14 days to get back, which impacted clinical schedules, something that doesn’t happen in a typical emergency situation such as a hurricane, he says. Travel bans also prevented physicians from serving other hospitals across state lines. Moreover, this emergency doesn’t have an end date. “The situation with the current pandemic continues to change rapidly, even several months in; some states and cities are even starting to ban elective surgeries again, which has a domino effect,” says Welsh.

At the same time, hospital credentialing emergency plans tend to be limited in scope and not well practiced, says Welsh. While all hospitals have an emergency plan as part of their accreditation process, most of those plans are designed for the short term. “They are not designed for long term and mostly address situations in which an area has been devastated by a hurricane or a tornado. The emergency plan typically covers the things you need to do to plug the leaks for a week or two.” Also, most organizations don’t routinely perform tabletop exercises that identify their weaknesses, he adds.

During the pandemic, nearly half (49%) of survey respondents used the same credentialing and privileging forms that they use in nonemergency situations (some with reduced requirements). While 51% did use abbreviated forms specific to emergency situations, credentialing teams

Figure 2. Under your plan, what type of credentialing/privileging forms are used?



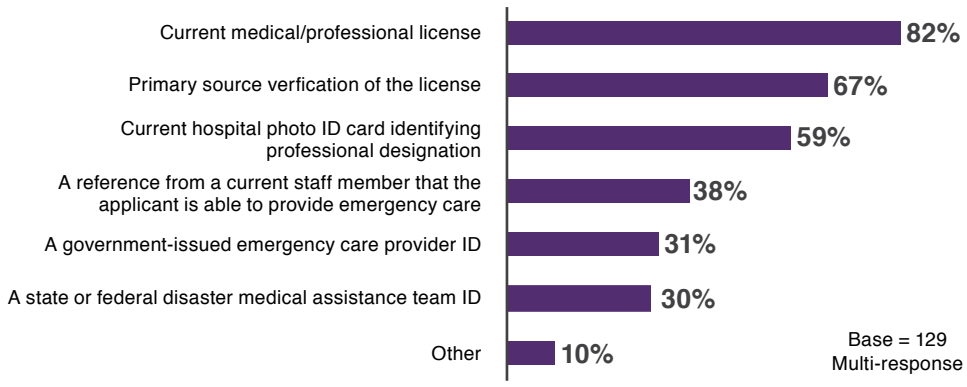
were still unable to vet physicians fast enough, especially early in the pandemic, says Welsh.

One of the main challenges is the primary verification process, which is slow because numerous pieces of information about a physician must be checked, including medical license, residency training, board certifications, and active DEA numbers. When done individually, verifying each credentialing element with the primary source in a manner that meets accrediting body requirements is very inefficient, says Welsh. A current-day solution to this challenge, he states, can be found with *AMA Profiles*. An AMA Initial Physician Profile provides all of these elements in one document that meets regulatory and accreditation requirements.

The next credentialing hurdle is making it through the review, assessment, and approval process conducted by the credentialing and medical executive committees. "These times show that the usual process is insufficient for the needs," he adds. "People were volunteering to go places, but they were serving more as aids, rather than intensivists or general surgeons, because organizations could not safely credential them in their area of expertise." In many cases, there wasn't time to get them fully vetted to practice to their level of training. "If you bring in physicians to run a floor, that is one set of requirements, but if you need an OB-GYN to deliver babies, the amount of vetting goes up dramatically," he says.

Respondents also indicated that, other than a government-issued ID, the most commonly requested forms of validation during emergency conditions are a physician's current medical/professional license (82%), primary source verification of the license (67%), and current hospital photo ID card identifying the physician's professional designation (59%).

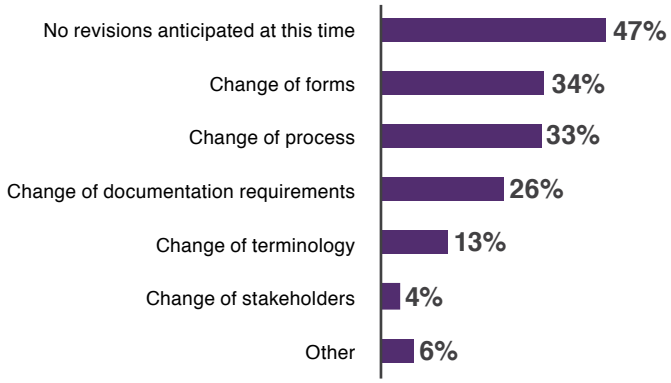
Figure 3. Other than a government-issued ID, what other forms of validation are requested?



How to better prepare for emergencies

It is critical that healthcare organizations and industry groups start to map out new emergency credentialing processes that address new types of emergencies and disasters, including the current pandemic. Even so, 47% of respondents do not anticipate revising their emergency credentialing plans, while others plan to change forms (34%), processes (33%), and documentation requirements (26%).

Figure 4. Given the current COVID-19 disaster environment, which future revisions do you anticipate making to your plan?



Still, says Welsh, "Folks need to recognize that there are problems and put together recommendations that outline how people can be safely and accurately credentialed, especially in light of emergency situations where you may not have the luxury of tracking down information from multiple places of training and multiple places of work activity."

To that point, Welsh says it is important that the industry create a central location where a physician's background information is easily verifiable and would count the same as primary verification. "There should be a repository or a vetting process where you can at least get basic information for credentialing. This would greatly improve the credentialing process and ensure patient safety." For example, the basics would include verifying that the physician is currently licensed, has graduated from medical school, and has completed a training program. It should also include red flags like corrective action against a practitioner during their career. While AMA Profiles currently provide full license history, education, and training, DEA and NPI information, and sanction alerts, the association is interested in exploring ways to create a single central repository of truth.

Many in healthcare who operate outside of a credentialing department or medical staff office—including physicians themselves—may

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believe that information used to credential and privilege physicians is scattered across state organizations, places of employment, and other organizations, says Welsh. But for decades, the AMA has gathered this key information from those sources and presented it all in one document: the AMA Physician Profile. “The idea is to combine all of these sources to one location and consider that information secure and verifiable,” says Welsh.

“Then you must determine what is the minimum information you want or need in disaster situations,” he says. “If you pull stakeholders together, you can have the basics that everybody agrees with.” There should be a credentialing list for physicians who are staying short term, from a few days to a few weeks. The vetting list should grow based on length of time and complexity of services required. To these points, Welsh recommends hospital credentialing departments verify at a minimum medical school completion, active licensure in that state or another, completion of postgraduate training, and any action from government programs. “Beyond that, organizations need to determine how in-depth they want to go while still putting boots on the ground within days for basic care and within weeks for more extensive needs,” he says.

Smaller healthcare organizations, such as critical access hospitals, long-term care facilities, and small physician practices, will have steeper credentialing challenges during an emergency. In these situations, healthcare associations, such as the Rural Healthcare Association, may need to step in to help, says Welsh. “Also, the American College of Surgeons has looked into sending vetted fellows, who they can vouch for, into areas of need for the short term.” Smaller organizations should also move to reduced requirements, such as allowing a physician’s home hospital to verify that the person is licensed at that hospital, he adds.

Smart partnerships

As hospitals and other healthcare organizations develop a new emergency credentialing road map, they inevitably will look across the industry for input. As the pandemic plays out, industry, government, and accrediting organizations such as The Joint Commission will be

crafting an emergency/disaster plan template for their use. Per the April 2020 HCPro study noted above, survey respondents said they would trust accreditors most (54%) to produce that template or list, followed by a health association (40%), an industry peer (37%), and a government office (27%).

"An accreditor such as The Joint Commission focuses on quality and safety, and it understands hospital frameworks," says Welsh. However, hospitals will want a seat at the table to ensure a successful partnership that includes a practical approach to future emergency credentialing plans. Ideally, a taskforce should comprise the accrediting agencies, the AMA as the unified voice of physicians, and hospital associations such as the AHA, says Welsh. "You need a diverse group who knows what is possible when developing a framework, then a broader group of stakeholders can fill in the details." ■

Figure 5. If your organization were to review your existing plan against a new emergency/disaster plan template or list of recommendations, who would you trust most to produce that template or list?

	Most trusted	Moderately trusted	Slightly trusted	Not trusted
Accreditors	54%	32%	9%	5%
Health association	40%	49%	10%	2%
Industry peer	37%	45%	15%	3%
Government office	27%	40%	20%	12%

Base = 129
* Ranked by responses for "Most trusted"

For more information on AMA Profiles please visit *amacredentialingservices.org*