How is your medical staff broken down? Does your organization have a multitude of departments? Are you limited to medical and surgical departments only, with smaller breakdowns within those departments? Or do you have something in between?

Now ask yourself what would you do if your organization needed to make a major change to its structure. What if you needed to eliminate an entire department and absorb its components into other departments? Where would you begin?

This is exactly the challenge one Washington hospital faced when it discovered its existing medical staff structure was causing more problems than it solved.

Yakima Regional Medical Center & Cardiac Center had, until this year, a three-department system: medicine, surgery, and cardiology. This structure had existed since 1996, created at the request of the medical staff. The cardiac and thoracic surgery physicians had pushed for their own departmental structure, and the organization worked with them to set it up.

“We have a significant heart program here,” says Rita Murphy, CPCS, CPMSM, medical staff services manager for Yakima Regional. “Our lead cardiothoracic surgeon had wanted to develop a department
Quick Hits

Hospital groups question medical staff rule from CMS

Several hospital groups are objecting to a CMS proposal that would “remove the ability of hospital systems and their medical staffs to make their own determinations about the optimal medical staff framework” and prevent integration of medical staffs in multihospital systems. The groups released an April 8 letter asking that CMS provide a convincing reason for the necessity of the policy. The groups argue that individual hospital systems are best able to determine whether to have an integrated medical staff or to have separate medical staffs at each facility, and that CMS should not regulate this.

Source: Medical Staff Leader Insider (www.hcpro.com/MSL-291243-871/Hospital-groups-question-medical-staff-rule-from-CMS.html).

NAMSS asks CMS for clarity on privileging, staff questions

The association calls on CMS to consider hospital registered dietitian privileges and more in its final policy.


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more on a service line basis with a team orientation. He worked to create a cardiopulmonary department to exist alongside our regular medicine and surgery departments.

Challenges began to arise, however, due to a disconnect between departments in key areas such as privileging, proctoring, policy development, and development of service lines.

“It became exclusionary of interdepartmental discussion,” says Murphy. For example, the hospital didn’t take into account how some of the changes that affected the cardiopulmonary department would affect the medicine or surgery departments.

Over time, the cardiopulmonary department stopped appearing to be in alignment with the rest of the medical staff.

“They had kind of siloed themselves,” says Murphy. The medicine and surgery departments were initially fine with the split, as long as their own activities and actions were not negatively impacted. As time went on, though, that impact began to be felt. The pivotal moment came with anesthesiologist privileging.

“Our cardiology anesthesiologists were separated from general anesthesia, and not part of general surgery,” says Murphy. This turned into a huge turf battle—it was the straw that broke the camel’s back and created medical staff dissension.

“It was beginning to impact the OR, particularly the scheduling of cases because of conflicts between cardio and surgery,” says Murphy.

So the problem was noted, but what was the next step?

Dissolving a department 101

Murphy began researching how other medical staff departments had gone about the restructuring process.

“It’s not something that you just suddenly do,” she says. “I wanted to see what other facilities had done.”

However, there weren’t many examples for her to draw from, and although Murphy found examples of restructuring due to insufficient staff—low department membership requiring a small department to be absorbed into a larger department, for one—she had a more difficult time finding examples that dealt with restructuring due to conflicts.

“Our was more because of the political environment,” she says. “What we had was rather unique.”

Fortunately, hospital leadership was on their side. “We worked really closely with medical staff leadership, letting them know what the bylaws are, what the [medical executive committee (MEC)] is allowed to do as well as the board, and what revisions would look like,” says Murphy. “What are the positive sort of benefits that would accompany a departmental restructuring? That was our role.”

Not only was the problem unique, the setup of the departmental structure was unique as well—the organization did not use a traditional departmental layout.

“Part of a new program we are doing at the hospital is providing leadership education to incoming officers—I think it is extremely pivotal to help empower them with knowledge for their role,” says Murphy. “Prior to having this program, it was a lot of just filling the role without fully understanding it.”

Although Yakima doesn’t have a closed medical staff, it can at times feel that way—the hospital didn’t previously have a lot of new physicians coming into the community. But recently, Yakima has had an influx of new blood; these newer physicians were able to bring their experiences into the discussion, showing the staff that the existing structure had an “elite” feel to it.

“As the medical staff, there are things that they can do to improve the environment, and so having new blood with experiences and backgrounds from other successful programs meant they were able to provide examples and resources for how things were structured elsewhere,” says Murphy. “They weren’t having the same issues we were having.”

It was also a situation, the MEC noted, where the issues could not be autonomously resolved—there had been ongoing disagreements on how often departments would meet and what their privileging requirements were, and so some sort of outside mediation was required.

The MEC sat down with representatives from all the departments to discuss the situation. The credentialing committee was represented as well to discuss how the situation had impacted its role.

“It was very different to see how all the different departments weighed in,” says Murphy. “They spoke about how very directly they were affected by the department over time.”
Finally, the MEC voted to restructure the cardiopulmonary department—specifically, to reabsorb it into the medicine and surgery departments—as a way of alleviating the problems.

**Rapid change**

The pace at which the change happened was set almost accidentally, Murphy says. The discussion was presented, deliberated, and turned into a vote right at the MEC meeting rather than allowing months of discussion and deliberation. This turned out to be a blessing in disguise: Since the dissolution of the cardiopulmonary department was meant to resolve the high levels of animosity and argument, the immediate decision worked to quash the negative culture that had developed.

Restructuring for any reason, Murphy notes, tends to work better if it happens quickly.

“What I’ve heard from other organizations going through a restructuring is that it’s like taking off a Band-Aid—faster is better,” she says. “The bigger you build it up, the more talk you will have about it and the more roadblocks it creates. It grows out of control.”

It was also very important to leadership to make the change quickly so there would be more time to acclimate staff to the transition and facilitate recruitment efforts.

“They wanted to be able to build on the end of it, to spend more time helping members develop their sections and develop an identity within the department,” says Murphy.

The organization expects the restructuring will present more growing pains in the future. There are some dissenting voices who are unhappy with the change, and the alterations to communication have had an impact on nursing—who, even though they interact with physicians constantly, are not fully aware of the inner workings of the medical staff.

“It’s difficult because nursing doesn’t know the structure of the medical staff—they become concerned and nervous because there has been a large change,” says Murphy.

Yakima also expects a bit of pushback on the part of the physicians. Some have stepped forward to ask how they can reevaluate the bylaws and understand the appeals process.

“It’s interesting that we might be going through the appeals process,” says Murphy. “The Joint Commission expects you to have a mediation process if the medical staff disagrees with MEC actions.”

The primary reaction among the medicine and surgery departments, Murphy notes, has been one of relief.

“A lot of these physicians were fine with the departments the way they were as long as they left them alone—but it’s been interesting where they’re saying, ‘This is finally done, we can get back to focusing on medicine and surgery,’ ” says Murphy. “We’re all a big group rather than having this exclusive department.”

The area most impacted, of course, is anesthesia, as all anesthesiologists—cardiovascular and otherwise—are now under the same leadership umbrella.

“We’re slowly moving in the right direction and the departments are feeling freer,” says Murphy. “Everyone needs to be on board and on the same page. I’ve heard over the weeks that it’s a hospital decision, or that it’s an administrative decision, but these were elected peers, elected to represent the medical staff.”

The decision may have had the support of the C-suite, but it came from and was implemented by the medical staff itself. The executive leadership—the CEO, CNO, and COO—were not part of the discussion to restructure the departments.

“It was a sensitive and emotional decision,” says Murphy. “But as a medical staff coordinator, it was inspiring to see the physicians working together this way to improve themselves and to grow as an organization and group.”

It certainly was not a comfortable decision, either—the vote was taken in with leaders of the cardiopulmonary department in question, and there are still some issues to be resolved to get everyone on the same page in anesthesia.

“Now ... the leverage is there to have the anesthesia group function as one unit, with one section chair over them, holding them accountable and responsible,” says Murphy. “It will cause changes, but ultimately it will result in a smoother anesthesia service line for patients, surgeons, and quality of care.”
**Locum tenens: Minimize risks by doing your homework**

Many organizations across the country make use of locum tenens, but the role and requirements for these temporary physicians has evolved and changed over the decades. What is the best way to handle locum tenens who return for repeat assignments? How do you ensure that you retain the ability to sever ties with a locum tenens on your terms if you need to?

One organization shares its story about maximizing the beneficial use of locum tenens without tying its own hands through overly limiting policies.

“Like many communities, we episodically have needs for temporary staff in certain specialties,” says Bev Osborne, CPMSM, director of medical staff services at Providence Sacred Heart Medical Center (PSHMC) in Spokane, Wash.

Even though the best recommendation is to avoid using locum tenens as much as possible, sometimes they are necessary. So what is the optimal way to efficiently manage these physicians?

It’s possible, Osborne says, to appoint repeat locum tenens on the medical staff as associate members. “If a locum tenens physician completes an extended or repeat assignment and a high quality of care is observed, this can be an effective thing to do,” she says.

But this decision is not without its risks. If you place a physician on active or associate staff, then determine that his or her quality of care or behavior is not to the standard of the institution, you will not have the ability to terminate the relationship without a potential fair hearing. Meanwhile, most bylaws or credentialing policies will allow organizations to immediately terminate a locum tenens provider in the event that issues of quality, behavior, or compliance with policies arise.

“The locum tenens concept is inherently less stable than full medical staff membership—they are credentialed and privileged, but because of the immediate need, they may not be as deeply vetted as a permanent staff member, and while there are many quality locum tenens, our experience is that the locum tenens community at large has more issues than those recruited by one of our medical groups and applying for full staff privileges,” says Osborne. “Hospitals need the ability to sever ties with a locum tenens physician, if needed.”

**Finding the best**

Osborne notes that if you come across a particularly problematic locum tenens applicant, you should closely analyze subsequent locum tenens applicants in that same specialty.

“It appears to us that the nationwide pool of quality locum tenens applicants in specific specialties can get particularly shallow,” she says. “In one instance, we did not accept three applicants in a row in a certain specialty—one of these applicants was even under a current investigation in another state for poor patient care, poor recordkeeping, and behavior.”

But it’s also possible to find and work with excellent locum tenens—these are the ones who could potentially be considered for associate medical staff appointments.

“There are some physicians who use locum tenens work to check out different parts of the country and decide where they want to settle down and practice,” says Osborne. “For some adventuresome spirits, it’s a great lifestyle choice; I recall one who had worked in Alaska in the summer and Hawaii in the winter, with plenty of free time in between. Another reliable source of locum tenens: nearby medical school or university settings. These physicians often make excellent locum tenens candidates, particularly for episodic short-term assignments.”

Military physicians may also be a good option. They have leave time, or may be at the end of their military obligation and deciding where they want to practice, says Osborne.

“One of my family members was managed by a locum tenens military physician a few years back,” she says. “In visiting with him, I learned that he’d agreed with his wife to perform locum tenens work in the two areas they were considering to move after his separation from the military.”

After spending a few weeks in each location, the couple made the decision to live closer to the physician’s...
wife’s family, but during the physician’s time in Spokane he took great care of Osborne’s family member.

**Screening questionnaire**

“There are many good reasons that physicians elect to work as a locum tenens; however, some locum tenens applicants are seeking this avenue because, for a variety of reasons which may include quality and/or behavior, they cannot find a permanent position,” says Osborne.

After two incidents in which locum tenens applicants were not accepted in the final days before groups had hoped to use their services, PSHMC developed a screening tool that it now provides to the locum tenens agency ahead of time to demonstrate how stringent its vetting process will be.

“We ask the normal attestation questions from our standard application, such as if they have ever had privileges revoked or if they’ve had any licensing issues,” says Osborne. “By asking these questions up front as part of our screening tool, the locum tenens company will likely move on to the next candidate if they can see a poor likelihood of our accepting the candidate they are offering.”

In one of the instances where PSHMC turned down a locum tenens candidate, the applicant had repeatedly delayed providing information to the hospital. Ultimately, it was discovered that he had been terminated from a prior hospital’s staff, a fact he had not disclosed.

“In retrospect, we feel his delays were in hopes that we would not discover the facts—or that we would be so in need of his services over the Christmas holidays that we would overlook his false attestation,” says Osborne. “We do not believe the locum tenens agency was aware of this issue, but we also never assume that a locum tenens agency has fully vetted a physician to the same level we do.”

Regardless of how the screening questionnaire is answered, PSHMC still performs primary source verification of key elements in the credentialing process.

**Set your standards**

“Locum tenens companies’ primary goal is to place physicians; hospitals’ primary goals are patient safety and quality,” says Osborne. PSHMC continues to refine expectations for locum tenens. One question being debated is whether current board eligibility or certification should be a requirement for all locum tenens—a number of experienced physicians who want to scale back their work schedules wish to perform locum tenens for a few years following a full-time practice.

“We may consider accepting experienced locum tenens for a very short period following a lapse in certification. We don’t want to automatically exclude those who might prove to be a great fit for us,” says Osborne.

**The associate staff member**

PSHMC still uses the associate medical staff member concept in select instances when a repeat locum tenens practitioner has proven to be a reliable and valuable resource for the organization.

“We perform an evaluation following each locum tenens assignment; the group which has brought in the locum tenens must be a part of that evaluation,” says Osborne.

That evaluation looks at how long the practitioner was at the organization, his or her interactions with hospital and medical staff members, and patient care outcomes. That said, the organization’s policies and procedures provide a lot of flexibility. There are no set time frames or number of assignments that automatically dictate whether a physician should be made an associate medical staff member following locum tenens work.

“Sometimes you have someone who comes in solidly for three months, sometimes you have someone who is in episodically, others regularly for a week every month. We evaluate them on a case-by-case basis before considering appointment to associate staff,” says Osborne.

**Evolution of locum tenens**

The role of locum tenens has grown over the years from something relatively informal to a natural part of the healthcare industry.

“It used to be that a specialist would find a locum tenens to staff his or her practice for a much needed vacation or recovery from surgery—that’s where the name comes from, to ‘hold the place of,’ after all,” says Osborne. “But now because the industry has developed shortages in certain specialties for periods of time, we’re not just replacing one physician temporarily but augmenting the staff. The role of locum tenens has changed.”

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Locum tenens FAQ

If your healthcare organization is looking to fill a short-term need, the solution may come in the form of a locum tenens. This temporary staffing solution allows the organization to provide its community with continuity of care while undergoing an internal period of transition.

MSPs can help with this transition period by familiarizing themselves with the finer points of the locum tenens industry. Although your organization may follow a standard operating procedure when it comes to locum tenens, there are ways to improve efficiency and continuity.

Can medical residents moonlight as locum tenens?
The Accreditation Council for Graduate Medical Education (ACGME) has strict guidelines that govern the patient care activities residents engage in outside of their educational programs. ACGME uses the term “moonlighting” to describe this type of work. Residents can moonlight internally at the sites used by their educational program, or they can moonlight externally at other locations, where they may be considered locum tenens by the host facility.

If your organization’s bylaws and other documents that define qualifications for membership and privileges allow it, hospitals may find it advantageous to use a resident as a locum tenens because the organization may be in a position to bring the practitioner back in a fellowship or full-time staff member role after his or her program ends.

These practitioners can assimilate into the medical staff faster than other new hires because of their past work experience at the organization and familiarity with coworkers and policies.

Additionally, MSPs may find they can expedite the credentialing process for these practitioners because they already conducted similar checks when they processed the practitioners’ locum tenens applications.

Are all practitioners with temporary privileges considered locum tenens?
No. Locum tenens is a Latin term for “placeholder” and is not one that The Joint Commission (formerly JCAHO) uses. It is typically a term recognized and used by traveling physicians who fill an institution’s need for a particular specialty or subspecialty for a specific time. All practitioners with temporary privileges are not considered locum tenens in part because temporary privileges may also be granted to new applicants who are awaiting staff appointment and privileges. Practitioners who are locum tenens usually have temporary privileges, although this is not always the case, depending on the length and frequency of their work assignment.

Did you know advanced practice professionals (APP) and hospitalists are in demand as locum tenens?
Just as more hospitals are employing hospitalists and expanding the scope of services for APPs (sometimes referred to as AHPs or physician extenders), so too are these changes reflected in the locum tenens field. Organizations find hospitalists beneficial because of the amount of time they can spend in the hospital making rounds and seeing patients.

Are locum tenens accountable for proving competency no matter how short their term?
Joint Commission standards require that organizations have plans for evaluating the competency of practitioners who are granted clinical privileges. Organizations should use the same methodologies to determine competency, such as focused professional practice evaluation and ongoing professional practice evaluation, as they do for other practitioners granted privileges.

Organizations should tailor the monitoring methods as appropriate to the locums’ time at the facility and their particular specialty area of practice. This may negate the use of direct observation for these individuals due to their limited time. The situation may lend itself to utilizing retrospective chart review, the results of which would also help to determine whether the organization would want that practitioner to return to their facility.

As challenging as this may seem, medical staffs can tailor existing requirements to fit this unique population.
Locum tenens FAQ (cont.)

For example, they can solicit more references for locum tenens than other practitioners and initiate chart review once the locum tenens begins working in the organization.

Do locum tenens staffing agencies evaluate the medical staffs with which their practitioners contract?

For a hospital’s continued success, it is important that the organization maintain a good reputation in the community with patients and providers. MSPs are used to investigating a practitioner’s credentials. At the same time, however, those practitioners are evaluating the healthcare facility, the medical staff, and even the MSP to determine whether they actually want to work at the organization.

It is not uncommon for practitioners to share their opinions about an organization with their peers. However, if these practitioners work with a locum tenens staffing agency, chances are their agency is keeping formal records of those opinions and using them as a screening tool to help decide which hospitals to work with in the future. This makes it even more important for the medical staff department to put its best foot forward.

Nevertheless, these evaluations take into consideration issues that are more substantial than whether a practitioner likes a hospital. For example, they also evaluate such factors as quality of care and how well the organization follows its own policies.

Do locum tenens staffing agencies serve as a credentialing verification organization (CVO) for the practitioners they provide?

One of the benefits enjoyed by medical staffs working with a locum tenens agency is that the staffing agency pre-selects candidates, thereby cutting back on the time the medical staff spends on candidate screening. MSPs can also reap time-saving benefits by selecting a locum tenens agency with an internal CVO. Although there may be additional fees attached to this service, it can be advantageous because the service may expedite the credentialing process and allow the MSP to focus on other responsibilities. The Joint Commission accepts the verifications conducted by this third party if certain requirements are met.

Even if a locum tenens agency does not contain a CVO, it may regularly conduct credentialing-like activities on its practitioners.

Locum tenens resources on the Web

When your organization asks you to help research its locum tenens options, the following are some websites to guide you:

- www.nalto.org. The National Association of Locum Tenens Organizations’ (NALTO) website is filled with general information about the locum tenens industry, including the most recent news and regulations. However, the most valuable resource for MSPs is undoubtedly the member contact directory, which lists email addresses and phone numbers for NALTO members. You can use this list to begin your search for a locum tenens or use the contact information to verify an applicant’s work history with one of these organizations.

- locumlife.modernmedicine.com. LocumLife is a magazine dedicated to locum tenens physicians. If your organization wants to eliminate the need for staffing agencies and contact locum tenens directly, it can place an ad in this magazine.

- www.jointcommission.org. Although The Joint Commission does not use the term “locum tenens,” its website provides locum tenens–related information, including topics such as temporary privileges and healthcare staffing services.

When the RFNA is also an APN
Determining appropriate credentialing processes

by Patricia A. Furci, RN, MA, Esq., and Samuel J. Furci, MPA, of Furci Associates, LLC, in West Orange, N.J.

As we have noted in a prior article, there are multiple midlevel practitioners crowding around the operating room table, with one profession standing out amid these often confusing and blurred roles—the RN first assistant, otherwise known as the RNFA.

An RNFA is an experienced perioperative (operating room) nurse who has completed advanced education and performs within a specific scope of practice in order to optimize quality care for patients undergoing surgery. However, sometimes the RNFA may also be an advanced practice nurse (APN), so how does the medical staff office handle the processing of his or her application?

Background
According to Brown and Draye, authors of “Experiences of Pioneer Nurse Practitioners in Establishing Advance Practice Roles” (2003), a central theme in their research of pioneer nurse practitioners was that of building on existing autonomy and making a difference in patient care. APNs who desire to practice in the role of assistant at surgery are likely to have these essential intentions. Clearly, the nurse who acts as first assistant takes on a role of autonomous decision-making and critical thinking.

While the nurse is working under the guidance of a surgeon, the knowledge and skills required of the first assistant are not subservient to or always at the order of the operating surgeon. There is an inherent expectation that the RNFA, whether an APN or experienced perioperative nurse, be educated to not only know the steps of the surgical intervention, but to also know, for example, the anatomic location of critical structures, physiologic consequences of various methods of handling tissue, hemostasis, and how to anticipate needs without instructions or direction.

Clearly, to assume such a knowledge-based and technically challenging role, APNs without any operating room experience need to acquire fundamental knowledge and skills to safely perform as a first assistant.

The role of the RFNA doesn't change
According to the Association of periOperative Registered Nurses (AORN), the RNFA is an experienced operating room nurse who has completed additional formal education. When an APN is requesting to become a member of a hospital's medical staff as an RNFA, the role doesn’t change. This unique position encompasses all phases of surgical care—from the time the patient enters the hospital until the time of discharge.

The role of the RNFA in surgery and the delineation of privileges (DOP) may include assisting for all types of surgical procedures, working in collaboration with the surgeon as the surgical assistant, and assisting anesthesia and nursing. The presence of an additional license may permit other APN privileges to be included or added to the DOPs, but only if allowed by hospital policy, department chair approval, or other mechanism identified in the medical staff bylaws or rules and regulations.

No matter what the formal education, the RNFA also applies principles of asepsis and knowledge of anatomy, physiology, and operative technique. The RNFA assists with patient preparation, positioning, prepping, and draping. In collaboration with the surgeon, using knowledge, skills, and judgment, the RNFA provides exposure of the surgical site with the use of retractors, suction, and sponges. The RNFA can handle tissue, maintain hemostasis, and perform wound closure.

It is important to review state law to see what level of licensure the APN RNFA will be held to when strictly practicing as an RNFA. In most states, the licensee is held to the highest license he or she possesses.

After surgery, the RNFA helps to transport the patient and communicates pertinent patient information to the post-anesthetic care unit (PACU), ICU, or other areas. The RNFA performs postoperative nursing assessments and wound surveillance, educates the patient or family with discharge planning, and is involved with patient follow-up care. In addition, the RNFA may participate in nursing and medical research projects.
**Credentialing and privileging the RNFA/APN**

The minimum qualifications to practice as an RNFA include certification in perioperative nursing (CNOR), successful completion of an RNFA program that meets the AORN’s “Standards for RN First Assistant Education Programs”; compliance with all statutes, regulations, and institutional policies relevant to RNFAs; and a baccalaureate degree, with the exception that RNFAs practicing prior to January 1, 2020, may continue to practice at their existing level of education. If the RNFA also has a master’s or doctorate degree and is licensed as an APN, then all of those credentials must be included in the application packet.

**Continued competency**

The RNFA, regardless of whether he or she is an APN, must demonstrate behaviors that progress on a continuum from basic competency to excellence and maintain CNOR status. He or she is also encouraged to achieve and maintain RNFA certification when educational and experiential requirements have been met.

**Clinical privileging for the RNFA**

The facility in which the individual practices should establish a process to grant clinical privileges to the RNFA. This should include mechanisms for verifying the RNFA’s qualifications with the primary sources, evaluating current and continued competency in the RNFA role, assessing compliance with relevant institutional and departmental policies, defining lines of accountability, incorporating peer and/or faculty review, validating continuing education relevant to the RNFA’s practice, and verifying the RNFA’s physical ability to perform the role.

**Activities and privileges**

The list of activities defined by AORN may be superseded by a list of activities defined in the nursing scope of practice for each state.

RNAs practicing as first assistants in surgery are functioning in an expanded perioperative nursing role. First assisting behaviors are further refinements of perioperative nursing practice and are executed within the context of the nursing process. These behaviors include certain delegated medical functions that can be assumed by the RNFA. RNFA behaviors may vary depending on patient populations, practice environments, services provided, accessibility of human and fiscal resources, institutional policy, and state nursing regulations.

The medical staff office personnel need to consult with their state’s board of nursing to determine if there is a definition of the RNFA role or a description of accepted activities within the state’s nursing scope of practice. The amount of detail varies from state to state, with some states, such as Hawaii, Kansas, Indiana, Maryland, Missouri, Minnesota, Michigan, Utah, and Pennsylvania, remaining silent. This may make things difficult in privileging the RNFA who is also an APN. It is imperative that RNFA DOPs are used for primary privileges and that additional privileges are added as needed or determined by hospital policy, department chair, or state law.

The medical staff office at every facility needs to be sure it has a clear credentialing process that involves the chief nurse executive since the RNFA and APN remains under the jurisdiction of the board of nursing in every state. Moreover, the DOPs need to reflect AORN and/or state law regarding what the RNFA may perform in that specific facility.

According to AORN, RNFA behaviors and privileges in the perioperative arena include but are not limited to the areas of preoperative, intraoperative, and postoperative management. Preoperative patient management may occur in collaboration with other healthcare providers while performing focused preoperative nursing assessments. Intraoperative performance may include surgical techniques such as using instruments and medical devices, providing surgical site exposure, handling and/or cutting tissue, providing hemostasis, and suturing. Postoperative patient management includes collaboration with other healthcare providers in the immediate postoperative period and beyond, such as participating in postoperative rounds, assisting with patient discharge planning, and identifying appropriate community resources.

**Conclusion**

Understanding the RNFA scope and qualifications to practice permits a clearer view of the face of this midlevel practitioner, even when the applicant presents with an APN license.
Maximizing your interviewing skills

Represent yourself in the best possible light

by Kathleen Tafel, manager of medical affairs and professional credentialing at St. Clair Hospital in Pittsburgh

Credentialing and medical staff services professionals are found in a diversified and vast number of environments: insurance, hospitals, physician offices, surgical and ambulatory care centers, and more.

Each one of these environments exposes the credentialing professional to a wide variety of potential job tasks. Some may only require a fraction of the professional’s credentialing skill set: perhaps just licensure, education, and databank searches. Other positions might task the professional with a full complement of duties, which could include all regulatory requirements as well as several “office” tasks, such as call schedule development, accreditation standard interpretation and implementation ...

When interviewing, as the applicant, you will want to represent yourself and your qualifications in a way that matches up with how the entity delegates its credentialing responsibilities, as well as the role that you will play in day-to-day tasks if accepted for the position.

As such, it’s paramount to consider the experience you’ve already had and the experience you desire when searching for a position that’s right for you.

Remember, you will be interviewing the entity as much as the entity is interviewing you. If you have a particular interest in expanding your exposure to accreditation standards and bylaws interpretation, for example, voice your enthusiasm for these topics. On the other hand, if you are not interested in these things and the interviewer makes clear that the position will deal with them, then be honest with yourself. If you were to accept the position regardless, your work would be a daily struggle; the accountability and the scope of the position is not going to change.

All credentialing professionals bring value to their organization. We have transitioned from focusing on task-oriented skill sets and now have credentialing roles with larger, “big picture” responsibilities: partnering with managers, directors, quality professionals, and physicians to ensure an integrated process that results in the delivery of quality care.

Find and know your niche. Credentialing is a vast field—identify what you are good at doing, what you have been successful at, and what you are interested in learning more about and taking on in the future.

A successful professional transition depends upon personal honesty and introspection. Celebrate yourself by shooting for—and hopefully acquiring—the position that you determine is the best match for you.

Until next time: “Believe in what you do and do what you believe.”

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Matt Phillion
Senior Managing Editor
MS governance: Myths & misconceptions

Myth #6: The tangled web of membership and rights/responsibilities

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A tangled web is created by inappropriately intertwining stand-alone factors. Physician leaders must understand the difference between the following elements or risk unnecessary confusion:

- **Membership**: Fundamentally, medical staff membership makes one a part of the medical staff organization. It involves the part of the credentialing process that assesses and verifies current licensure, education, relevant training, character, ethics, and behavior.

- **Privileges**: Clinical privileges delineate what a practitioner can do while utilizing the services and facilities of the hospital. Additional information is collected to verify experience, ability, and current competence, which is a fundamental accreditation standard.

- **Membership and privileges**: Can you have membership without privileges or vice versa? The answer to both is yes. Membership without privileges is increasingly used to address the conundrum of low- or no-volume primary care physicians who no longer admit patients but wish to maintain a connection with the hospital for social, professional, or insurance purposes. Privileges without membership is also commonly seen in many medical staffs to address telemedicine practitioners and low-volume physicians (e.g., gynecological oncologists) who are active at another hospital and whose services are desired by the privileging hospital and its medical staff. Many medical staffs do the same for advanced practice professionals (e.g., physician assistants, advanced practice nurses), but they can just as easily have membership.

- **Staff categories**: Medical staff categories are not mandated, but they are often used to delineate the citizenship status of practitioners, including who can vote and hold office. They can also differentially assign responsibilities, such as emergency department or clinic coverage, but this practice should be avoided.

According to the famous architect, Louis Sullivan, form should follow function. The medical staff needs to decide how it wishes to function and then design the form (bylaws, staff categories, etc.) accordingly. For example, the medical staff may want to be “exclusive,” limiting voting to practitioners with both membership and privileges, or “inclusive,” extending the vote to practitioners with membership but no privileges (e.g., community primary care physicians).

Many medical staffs do not extend the vote to practitioners who have privileges without membership (e.g., telemedicine). The staff categories might not mention voting at all but simply define “active staff” (membership plus privileges plus “x” level of patient contacts) and “associate staff” (everyone else). Or, voting rights could be independent of staff categories and extended to practitioners with membership (with or without privileges). Alternatively, three staff categories could be used: “active staff” (membership plus privileges plus activity; can vote), “community staff” (membership but no privileges; can vote), and “associate staff” (privileges but no membership; cannot vote). Understanding these elements gives the medical staff flexibility to thoughtfully address function and design.

- **Medical staff rights and responsibilities**: Best practice is to have a separate section in the bylaws outlining both medical staff rights and responsibilities. Many medical staffs instead try to parse out differential rights and responsibilities through staff categories. This often leads to practitioners seeking to switch staff categories to “game the system” and shirk call or other responsibilities. A simple independent responsibility statement could be “each member of the medical staff must help the hospital meet its mission to provide emergency services by taking call in the emergency room in accordance with policies passed by the medical executive committee and the board.”

Next month, we will embark on another area of interest: the culture of safety and the high-reliability organization. Until then, be the best that you can be.