2018 ANNUAL REPORT ON

MEDICAL STAFF CREDENTIALING

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OVERVIEW:

Medical Services Professionals (MSPs) are the gatekeepers of patient safety for healthcare organizations, proclaims NAMSS (National Association Medical Staff Services), the professional organization comprised of 6000+ MSPs. What does this gatekeeper role mean in the healthcare industry? Credentialing and privileging are designed to assess the competency of providers who deliver healthcare services to an organization's patients. Most MSPs would say that their involvement in the credentialing, privileging and re-credentialing of providers (physicians, dentists, podiatrists, psychologists and additional advanced practice professionals such as nurse practitioners and physician assistants) is the critical factor in making MSPs the gatekeepers of patient safety. Patient safety is compromised when processes that enable excellent credentialing and privileging are not in place.

MSPs obtain data about providers, verify and assess the information and then manage the decision-making process of the medical staff leadership and governing body. The decision-making process determines the provider's membership (credentialing) and specific services (privileging) that may be delivered within the healthcare system. This behind the scenes work is essential when a patient is treated in a hospital emergency department or admitted for a surgical procedure or other type of treatment. Most patients don't know that this activity goes on—but they do rely on the healthcare organization to assure that when they are seen and treated, it is by currently competent providers. When patients are not happy with their treatment, lawsuits, including negligent credentialing, may be filed.

Credentialing and privileging of providers has been performed by healthcare organizations for decades and has evolved from one page applications (in the 1970's) and very rudimentary verification to today's voluminous applications, privilege delineations, verification of each provider's education/training and background, and other requirements. For years, the hospital credentialing process took a minimum of six months—and it was not unusual for the process to take nine months to a year. It didn't matter because most providers received temporary privileges almost as soon as they asked for them. Today, credentialing and privileging is heavily regulated, by the state in which an organization is located, by the Centers for Medicare and Medicaid Services (CMS), and by accreditation bodies, such as The Joint Commission (the organization that accredits the majority of healthcare organizations) and the National Committee for Quality Assurance (the organization that accredits managed care organizations and has heavily influenced the hospital credentialing process). The granting of temporary privileges has been significantly reduced or eliminated in most organizations over the past ten years, and if it takes three months to get a provider credentialed, that is too long in the opinion of the organization's leaders.

In the early days, MSPs were typically clerical positions. They worked in a Medical Staff Office, where the position included not only the credentialing and privileging processes, but also coordinating medical staff organization committees and taking minutes of those meetings. Much more is expected of today's MSPs. The position has become complicated partially due to the proliferation of regulatory and accreditation requirements and additional activities that have become the responsibility of the Medical Staff Services Department or Medical Staff Office (MSO). However, credentialing and privileging remain the activities that are the most visible and consume the most resources.

In today's healthcare organizations, there may be a MSO or a CVO (a centralized verification office that performs credentialing on behalf of multiple facilities within a health system). A CVO may provide credentialing services to multiple MSOs within a health system—as well as to an enrollment department, where processes are put in place to enroll providers with multiple payers. The landscape is changing rapidly with evolving questions of the MSOs or CVOs such as: Do MSPs have the right skill sets to address current responsibilities? Are MSPs successful in keeping up with today's challenges? Are today's MSPs able to take advantage of technology to streamline credentialing and privileging—and to also provide data considered to be the source of truth from the provider software to other business applications within the healthcare organization? Are today's MSPs able to credential and privilege faster—because of the need of most organizations to get their employed/contracted providers working as soon as possible?

The results of the survey conducted in December 2017 – January 2018 will provide some of those answers. This survey

was conducted independently by Verity™, A HealthStream® Company. The previous survey, conducted in 2016 and published in 2017, was performed cooperatively with NAMSS. You will see how responses changed from the previous survey to this survey. In the current survey, we also added some metrics about the credentialing process that the industry badly needs and has requested.

You'll see that organizations are still working hard to improve their credentialing processes, but there is still much to be accomplished.

Verity™ hopes that the information provided in this report will be valuable to healthcare industry leaders and help to determine future directions for their improvement efforts.

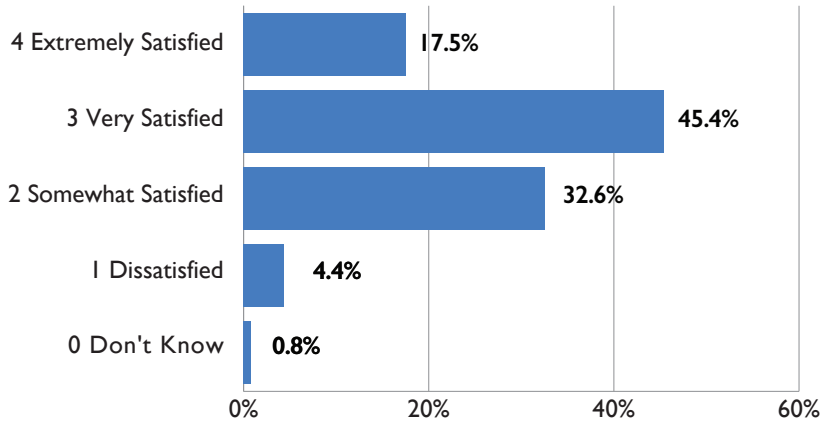
10 KEY FINDINGS:

The information in this section is based on responses from 683 medical services professionals surveyed by Verity™ in December 2017 – January 2018. Following are 10 key observations from this recent research:

1 Similar to findings in 2017, most medical services professionals in the 2018 survey are "extremely" or "very" satisfied with the quality of the credentialing and privileging processes at their organization, but many still indicate there is room for improvement.

When respondents were asked about their overall satisfaction with the quality of their credentialing and privileging processes it was found that nearly two-thirds (62.9%) were either very satisfied or extremely satisfied. However, more than a third (37.0%) indicated that they were dissatisfied or only somewhat satisfied.

Overall, how satisfied are you with the quality of the medical staff credentialing and privileging processes provided by your organization? (Base = 661)



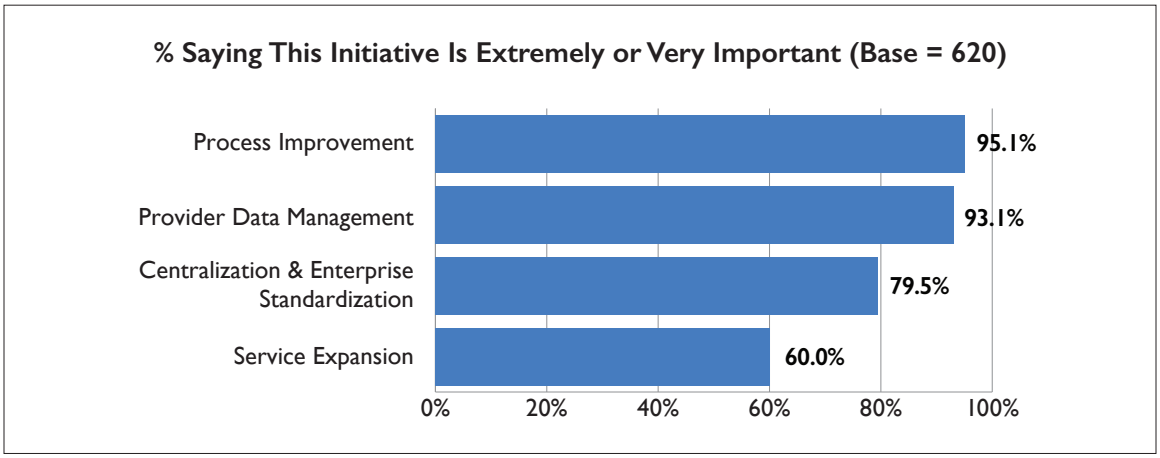
Findings for this question did not change substantially from the 2017 to 2018 surveys.

	2018	2017
Extremely Satisfied	17.5%	17.4%
Very Satisfied	45.4%	46.2%
Somewhat Satisfied	32.6%	31.8%
Dissatisfied	4.4%	4.3%
Don't Know	0.8%	0.3%

2 In both 2017 and 2018, almost all medical services professionals listed "process improvement" and "provider data management" as highly important initiatives.

Respondents were asked to rate the importance of four initiatives. When combining the Extremely Important and Very Important ratings, it was found that all four initiatives were perceived as important. However, two initiatives, Process Improvement and Provider Data Management, were found to be the relatively most important (95.1% and 93.1% respectively).

The third most important initiative, Centralization & Enterprise Standardization, was rated at 79.5%. Sixty percent of the respondents indicated that the fourth initiative, Service Expansion, was extremely or very important.



The "Centralization and Enterprise Standardization" initiative was considered slightly more important in 2018 compared to 2017.

	2018	2017
Process Improvement	95.1%	95.2%
Provider Data Management	93.1%	90.5%
Centralization & Enterprise Standardization	79.5%	74.4%
Service Expansion	60.0%	58.4%

3 Internal resource constraints and competing priorities were mentioned as the most common impediments to progress across the four initiatives.

When respondents were asked to identify the biggest impediments at their MSO or CVO to the four initiatives, some consistency was found. Approximately 25-30% of respondents indicated that internal resource constraints were the largest impediment. About 25% of respondents indicated that the second largest impediment across the four initiatives was competing priorities.

The third and fourth most challenging impediments were somewhat mixed across the initiatives—vendor/software limitations and political resistance from internal stakeholders ranged between 11-20%. Outside of the "other" category, lack of vision from leadership was the lowest relative impediment across the four initiatives with percentages ranging from 9-12%.

Provider Data Management Initiative	Process Improvement	Data Management	Centralization & Standardization	Service Expansion
Internal resource constraints in our organization	25.7%	26.6%	25.5%	29.9%
Competing priorities in our organization	24.3%	26.0%	24.9%	27.2%
Vendor/software limitations	20.0%	18.3%	14.2%	12.2%
Political resistance to change from internal stakeholders	12.6%	11.3%	18.4%	12.3%
Lack of vision from leadership in our organization	10.3%	11.9%	9.3%	9.9%
Other	7.2%	5.9%	7.7%	8.6%

4 In 2018, ten of the 27 activities monitored had been fully or partially successfully implemented by more than 50% of survey respondents. Of these ten, there were three areas (noted in yellow) in which the percentage of respondents indicating full or partial implementation had increased.

Process Improvement	2018	2017
Reducing initial and re-credentialing time frames through automation	78.3%	79.8%
Implementing an automated, paperless process for primary source	71.6%	69.7%
Implementing an automated, paperless process for online provider applications	63.6%	59.2%
Implementing electronic, paperless credentialing files for your providers	63.1%	71.2%
Implementing an automated, paperless process for delineation and tracking of privileges	57.5%	61.4%

Provider Data Management		
Implementing a single, master provider database for your enterprise that is the single source of truth for provider data	76.2%	72.9%

Centralization & Standardization		
Implementing a single online application for your entire organization	61.9%	59.5%
Standardizing privileging criteria, forms, and core privileges across the enterprise	57.6%	51.6%
Updating medical staff by-laws to reflect enterprise processes and standards	56.2%	55.1%

Service Expansion		
Managing the Provider Directory for your "Find the Doctor" functionality on your website	55.8%	53.3%

The following table shows a full list of the activities included in the study and the degree they have been fully or partially successfully implemented. Subsequent tables and narrative will explain implementation in more detail.

Process Improvement	
Reducing initial and re-credentialing time frames through automation	78.3%
Implementing an automated, paperless process for primary source verifications	71.6%
Implementing an automated, paperless process for online provider applications	63.6%
Implementing electronic, paperless credentialing files for your providers	63.1%
Implementing an automated, paperless process for delineation and tracking of privileges	57.5%
Implementing a paperless process for your committee reviews and decisions	42.8%
Automating OPPE performance profiles and workflow	33.9%
Automating the peer review process	32.4%

Provider Data Management	
Implementing a single, master provider database for your enterprise that is the single source of truth for provider data	76.2%
Integrating your provider data with downstream applications including EMR, laboratory, pharmacy, billing, payer and marketing databases	45.1%
Managing, updating, and validating data on referring providers	44.1%
Creating new data roles within your MSO or CVO including Director of Provider Analytics, Database Administrators, Data Scientists, or others	25.8%
Adding data to your provider database including CAHPS data, social media information, and information that reflects patient input	13.5%

Centralization & Standardization	
Implementing a single online application for your entire organization	61.9%
Standardizing privileging criteria, forms, and core privileges across the enterprise	57.6%
Updating medical staff by-laws to reflect enterprise processes and standards	56.2%
Implementing a centralized or regional CVO separate from your MSO	46.1%
Integrating your Provider Enrollment activities within your MSO(s) or CVO	42.8%
Implementing a centralized or regional MSO to support multiple facilities	39.2%

Service Expansion	
Managing the Provider Directory for your "Find the Doctor" functionality on your website	55.8%
Handling Delegated Credentialing services	49.7%
Developing an integrated provider onboarding process across multiple departments	48.8%
Managing the Provider Enrollment process for your providers by requesting their participation in a health insurance network as a Participating Provider	40.5%
Providing and tracking Continuing Medical Education (CMEs) for your providers	38.2%
Handling network management and managed care responsibilities for the payer and ACO entities within your organization	30.9%
Managing or coordinating graduate medical education programs	26.6%
Non-provider credentialing services for employees including nurses and other staff	22.1%

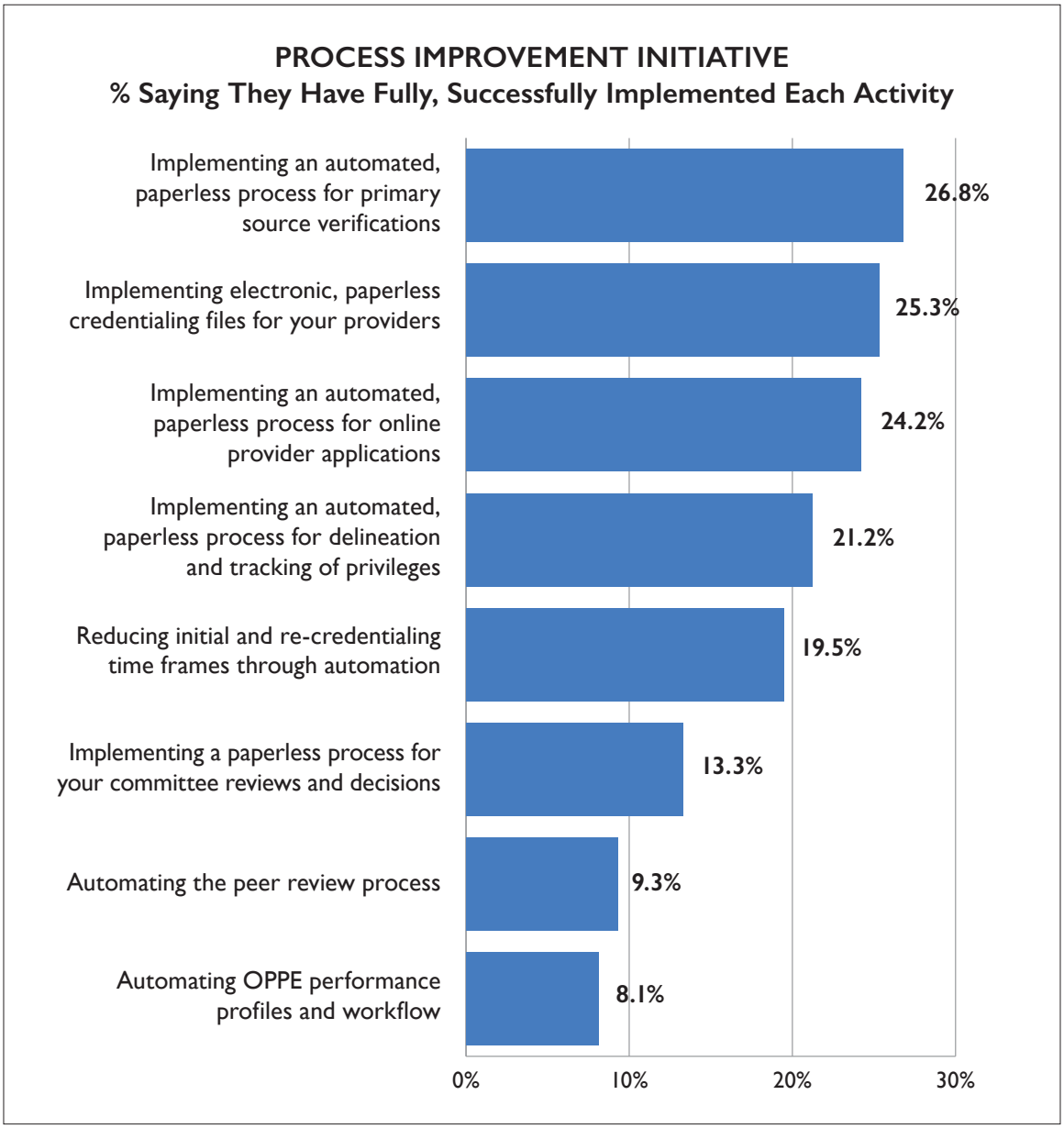
NOTE: Text in orange indicates items that are most closely related to improvement of each of the four initiatives based on a step-wise regression analysis of the results. These items should be prioritized for improvement as they are most predictive of respondents' overall ratings of that initiative.

5 The vast majority of survey respondents have been unable to FULLY, successfully implement the eight activities within the Process Improvement Initiative; however, a much higher percentage have been able to at least PARTIALLY implement many of the activities.

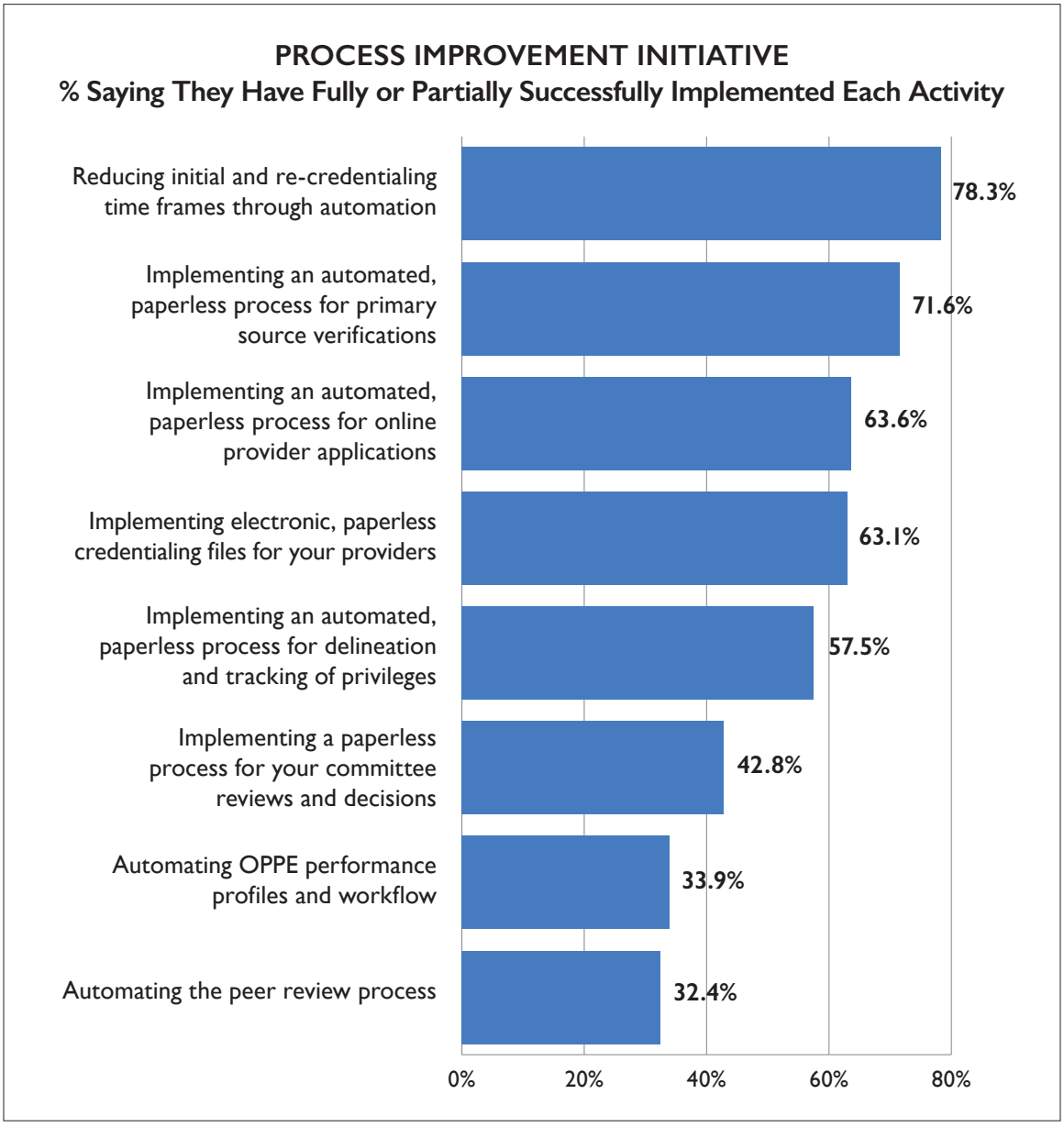
Most of the activities associated with Process Improvement initiatives related to implementing automated processes which eliminate paper.

The top four fully implemented initiatives were automating primary source verifications (26.8%), credentialing files (25.3%), online provider applications (24.2%), and delineation and tracking of privileges (21.2 %). Reducing initial and re-credentialing time frames through automation was rated as being fully and successfully implemented by 19.5% of respondents.

The remaining three initiatives fell below these with percentages ranging between 8-13% with automating OPPE performance profiles and workflow lagging all others.



When considering initiatives that have been fully or partially successfully implemented related to Process Improvement, similar results were discovered with one exception. The top four initiatives mentioned above that were fully implemented were found in the top 5 in the table above. Outpacing those four was reducing initial and re-credentialing time frames through automation. That initiative was successfully (partially to fully) implemented above all others at 78.3%.



The following table shows the range of responses that relate to the degree that each Process Improvement initiative has been successfully or unsuccessfully implemented. According to respondents, the most unsuccessfully attempted initiatives were automating committee reviews and decisions (11.4%), OPPE performance profiles and workflow (11.7 %), and the peer review process (10.9 %). Interestingly, respondents rated the same three initiatives as those most commonly going unimplemented (no attempt at implementation—ranging from 34-40%).

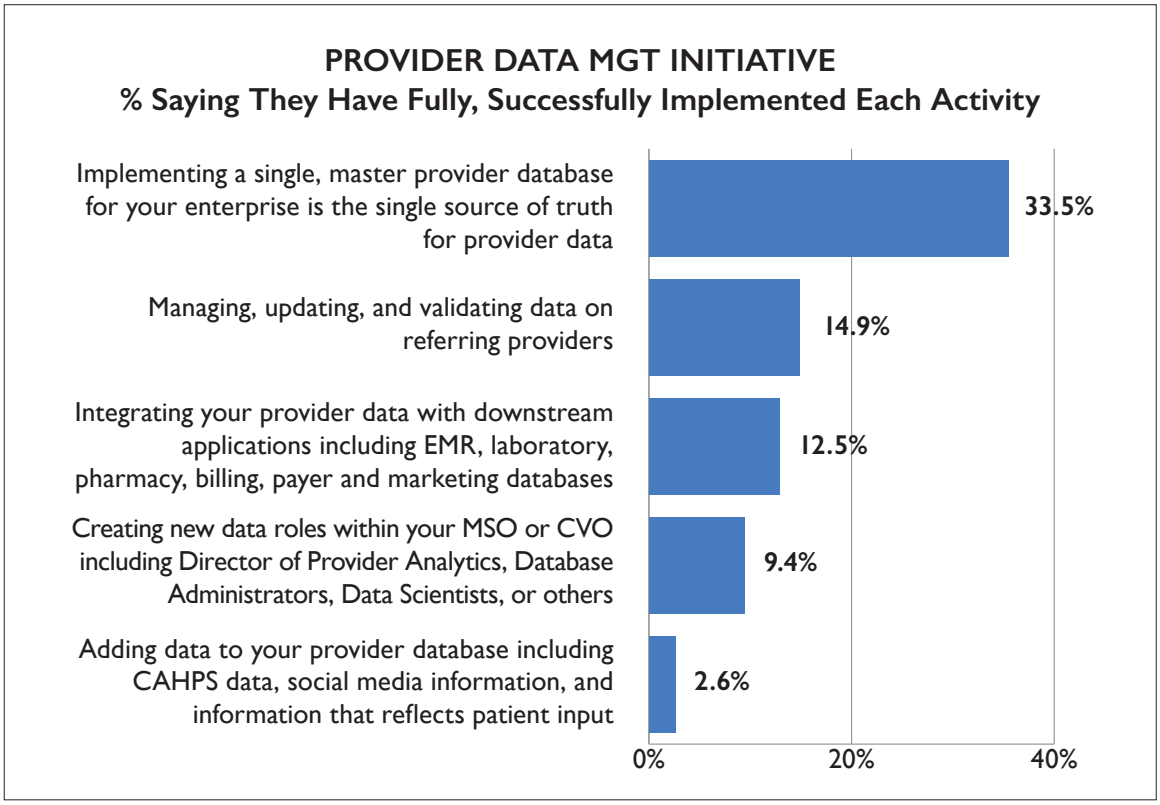
Process Improvement Initiative					
	Fully, Successfully Implemented	Partially, Successfully Implemented	Unsuccessfully Implemented	No Attempt at Implementation	Don't Know/Not Applicable
Implementing electronic, paperless credentialing files for your providers	25.3%	37.8%	8.3%	26.3%	2.3%
Implementing an automated, paperless process for primary source verifications	26.8%	44.8%	4.7%	19.8%	3.8%
Implementing an automated, paperless process for delineation and tracking of privileges	21.2%	36.3%	9.7%	26.9%	5.9%
Reducing initial and re-credentialing time frames through automation	19.5%	58.8%	6.2%	12.1%	3.5%
Implementing an automated, paperless process for online provider applications	24.2%	39.4%	7.9%	25.3%	3.2%
Implementing a paperless process for your committee reviews and decisions	13.3%	29.5%	11.4%	40.0%	5.8%
Automating OPPE performance profiles and workflow	8.1%	25.8%	11.7%	33.5%	20.9%
Automating the peer review process	9.3%	23.1%	10.9%	39.6%	17.1%

NOTE: Text in orange indicates items that are most closely related to improvement of the overall PROCESS IMPROVEMENT initiative based on a step-wise regression analysis of the results. These items should be prioritized for improvement as they are most predictive of respondents' overall ratings of the PROCESS IMPROVEMENT initiative.

6 Implementing a single, master provider database was the activity garnering the most attention in the Provider Data Management Initiative. More than one-third reported they have fully, successfully implemented this activity, while 76.2% said they had either partially or fully successfully implemented a single, master provider database.

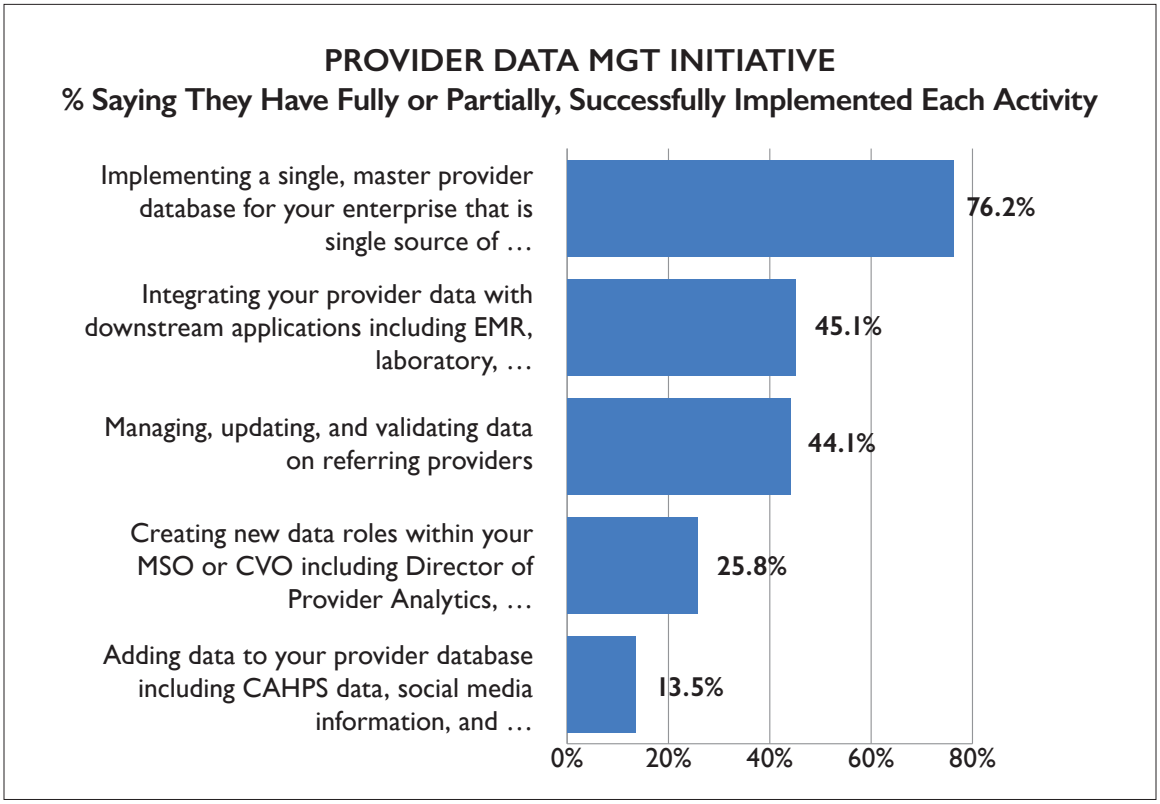
Respondents rated the degree to which Provider Data Management Initiatives have been fully and successfully implemented. Slightly over one third (35.5%) indicated that they had fully and successfully implemented a single, master database.

Other initiatives trailed substantially behind the implementation of this master database. For example, managing, updating and validating data was the next most fully implemented initiative at 14.9%. This was followed by the implementation of integrating provider data with downstream applications at 12.5%. The implementation of the creation of new data roles trailed the integration of provider data with other applications at 9.4%. Adding other types of data such as CAHPS and social media information was last at 2.6%.



Furthermore, when considering the partial or full successful implementation of Provider Data Management Initiatives, the order of successful implementation remained nearly the same for each initiative—the percentages of successful implementation, of course, increased.

For example, the implementation of a single, master provider database percentage rose to 76.2%. Integrating provider data with downstream applications and managing, updating and validating data were nearly the same at 45.1% and 44.1% respectively. Successful implementation of the creation of new data roles (25.8%) and adding other kinds of data to the provider database (13.5%) rounded out the remainder of the initiatives.



The following table displays the full range of responses relating to the successful implementation of various Provider Data Management Initiatives. At this point, it is of interest to identify the percentage of unsuccessful implementations and percentages in which there were no attempted implementations.

The range of percentages identified with unsuccessful implementation was rather narrow. For example, percentages of unsuccessful implementation varied from 5-8% across all provider initiatives. When considering the percentages associated with no attempt at implementation it was found that two initiatives stood out. The percentages associated with creating new data roles and adding other types of data to provider databases were substantially higher than that of the other initiatives at 41.8% and 51.9% respectively.

Provider Data Management Initiative					
	Fully, Successfully Implemented	**Partially, Successfully Implemented**	**Unsuccessfully Implemented**	**No Attempt at Implementation**	**Don't Know/Not Applicable**
Implementing a single, master provider database for your enterprise that is the single source of truth for provider data	35.5%	40.7%	6.3%	9.6%	7.9%
Integrating your provider data with downstream applications including EMR, laboratory, pharmacy, billing, payer and marketing databases	12.5%	32.6%	8.3%	26.5%	20.2%
Managing, updating, and validating data on referring providers	14.9%	29.2%	6.6%	22.7%	26.6%
Creating new data roles within your MSO or CVO including Director of Provider Analytics, Database Administrators, Data Scientists, or others	9.4%	16.4%	4.9%	41.8%	27.5%
Adding data to your provider database including CAHPS data, social media information, and information that reflects patient input	2.6%	10.9%	5.3%	51.9%	29.3%

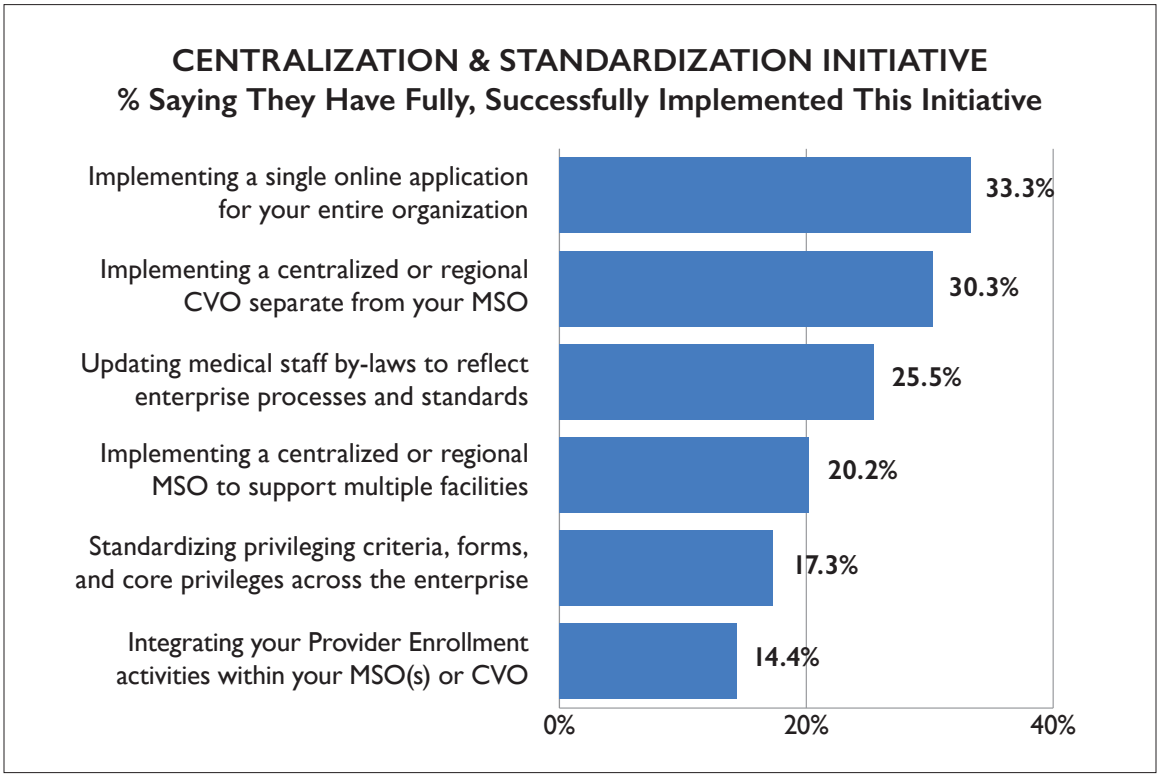
NOTE: Text in orange indicates items that are most closely related to improvement of the overall PROVIDER DATA MANAGEMENT initiative based on a step-wise regression analysis of the results. These items should be prioritized for improvement as they are most predictive of respondents' overall ratings of the PROVIDER DATA MANAGEMENT initiative.

7 None of the Centralization and Standardization activities have been FULLY, successfully implemented by more than one-third of the medical services professionals participating in the survey. Respondents reported more success in FULLY or PARTIALLY implementing three activities—implementing a single online application, centralizing privileging activities, and updating medical staff by-laws.

When considering the Centralization and Standardization Initiative it was found that two initiatives outpaced the others in regard to full, successful implementation. Implementing a single online application for the entire organization was perceived as being a fully successful endeavor by 33.3% of the respondents. Similarly, 30.3% of respondents indicated that implementing a centralized or regional CVO separate from your MSO was fully successful.

Updating medical staff by-laws was seen as the third most successful implementation (25.5%) while implementing a centralized or regional MSO to support multiple facilities (20.2%) was the fourth most successful.

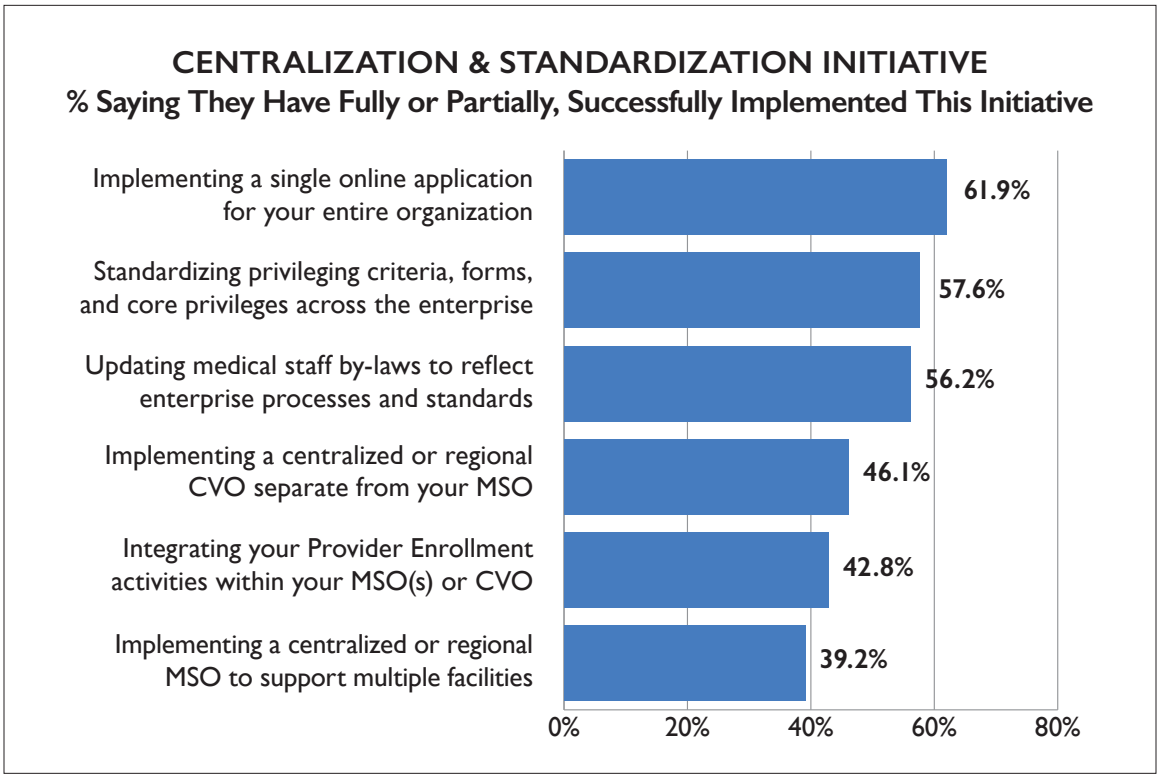
Standardizing privileging criteria and forms and integrating provider enrollment activities were seen as relatively less fully successfully implemented with percentages of 17.3 and 14.4 respectively.



When considering respondent ratings when full or partial successful implementation had been accomplished, a slightly different picture was seen. Implementing a single online application was perceived as being successfully implemented (either fully or partially) by 61.9% of respondents.

Most were also successful in standardizing privileging criteria and forms along with updating medical staff by-laws (57.6% and 56.2% respectively).

Respondents indicated they were less successful at implementing a centralized or regional CVO (46.1%), integrating provider enrollment activities (42.8%), or implementing a centralized or regional MSO (39.2%).



Centralization & Standardization Initiative					
	Fully, Successfully Implemented	Partially, Successfully Implemented	Unsuccessfully Implemented	No Attempt at Implementation	Don't Know/Not Applicable
Implementing a centralized or regional MSO to support multiple facilities	20.2%	19.0%	6.1%	30.6%	24.2%
Integrating your Provider Enrollment activities within your MSO(s) or CVO	14.4%	28.4%	6.5%	28.0%	22.7%
Implementing a centralized or regional CVO separate from your MSO	**30.3%**	**15.8%**	**4.4%**	**24.7%**	**24.8%**
Updating medical staff bylaws to reflect enterprise processes and standards	25.5%	30.7%	5.4%	18.5%	19.9%
Standardizing privileging criteria, forms, and core privileges across the enterprise	17.3%	40.3%	8.6%	22.5%	11.3%
Implementing a single online application for your entire organization	**33.3%**	**28.6%**	**8.6%**	**20.6%**	**8.8%**

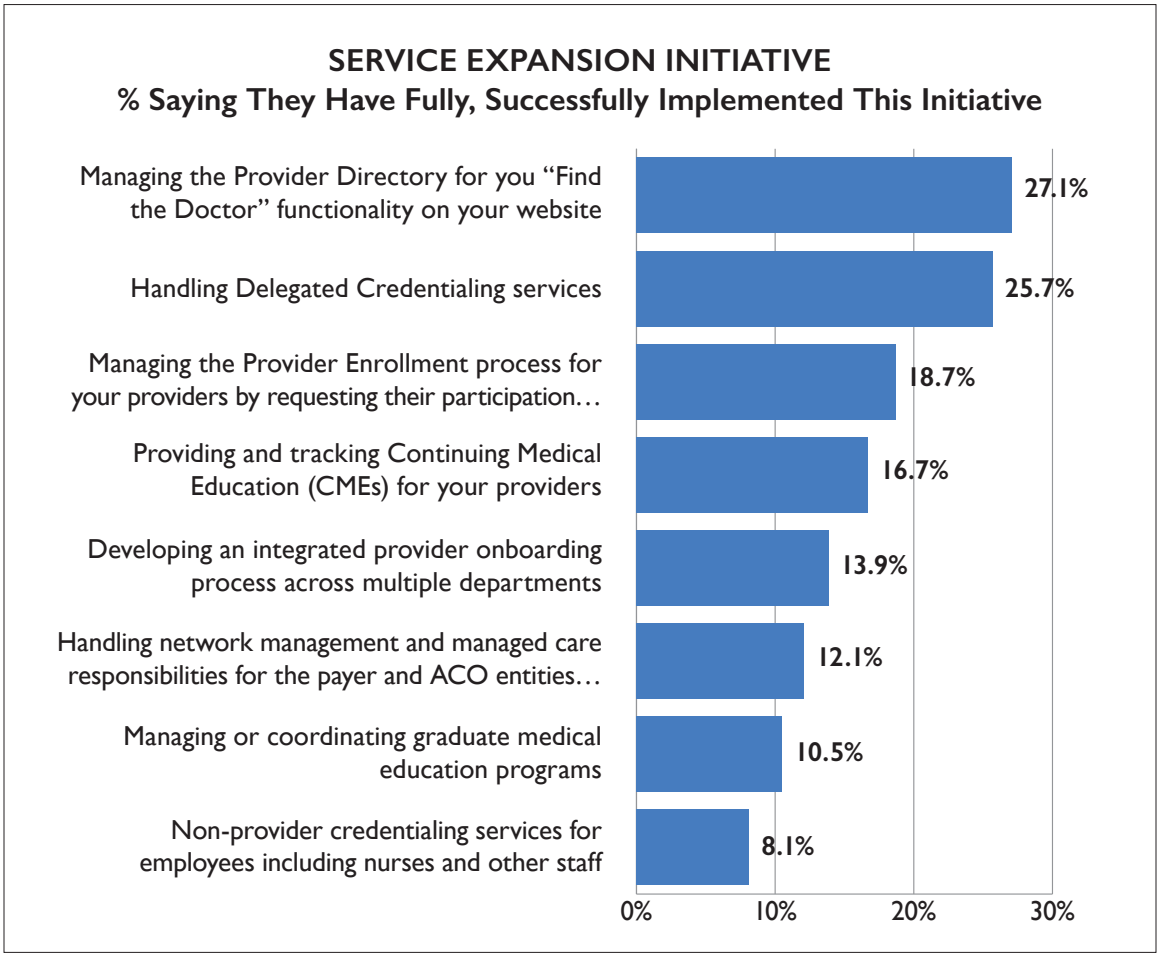
NOTE: Text in orange indicates items that are most closely related to improvement of the overall CENTALIZATION & STANDARDIZATION initiative based on a step-wise regression analysis of the results. These items should be prioritized for improvement as they are most predictive of respondents' overall ratings of the CENTALIZATION & STANDARDIZATION initiative.

8 As with the other initiatives, most medical services professionals indicated they had not been able to FULLY, successfully implement any of the Service Expansion activities, but more than half have been able to FULLY OR PARTIALLY implement the management of their Provider Directory.

When considering the Service Expansion Initiative, only a little over a quarter of respondents indicated that managing the Provider Directory for "Find the Doctor" functionality and handling delegated credentialing services were fully and successfully implemented.

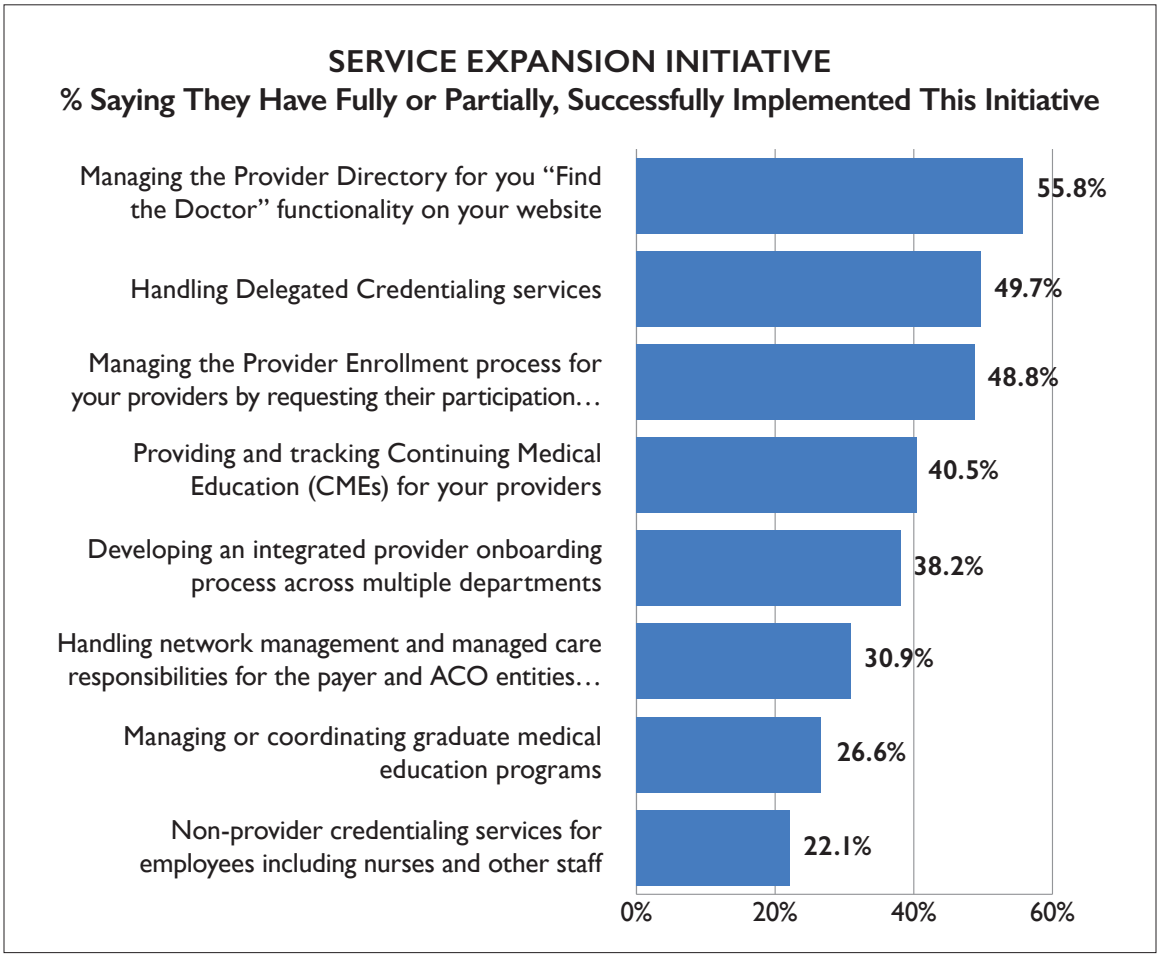
Full and successful implementation of three other initiatives were indicated by percentages ranging in the teens (14-19%)—they were managing the provider enrollment process, providing and tracking CMEs, and developing an integrated provider onboarding process.

Percentages of successful implementation for three other initiatives were the lowest of the group and ranged from 8-12%. These were handling network management and managed care responsibilities, managing or coordinating graduate programs, and lastly, non-provider credentialing services.



When combining the ratings of full or partial successful implementation, the percentages went up. Several ranged in the forties to fifties. These included managing the Provider Directory (55.8%), handling delegated credentialing services (49.7%), developing an integrated provider onboarding process (48.8%), and managing the Provider Enrollment process (40.5%).

The remainder of the initiatives clustered together with lower levels of success that ranged from 22-38%. The non-provider credentialing services percentage of successful implementation was the lowest of the cluster at 22.1%.



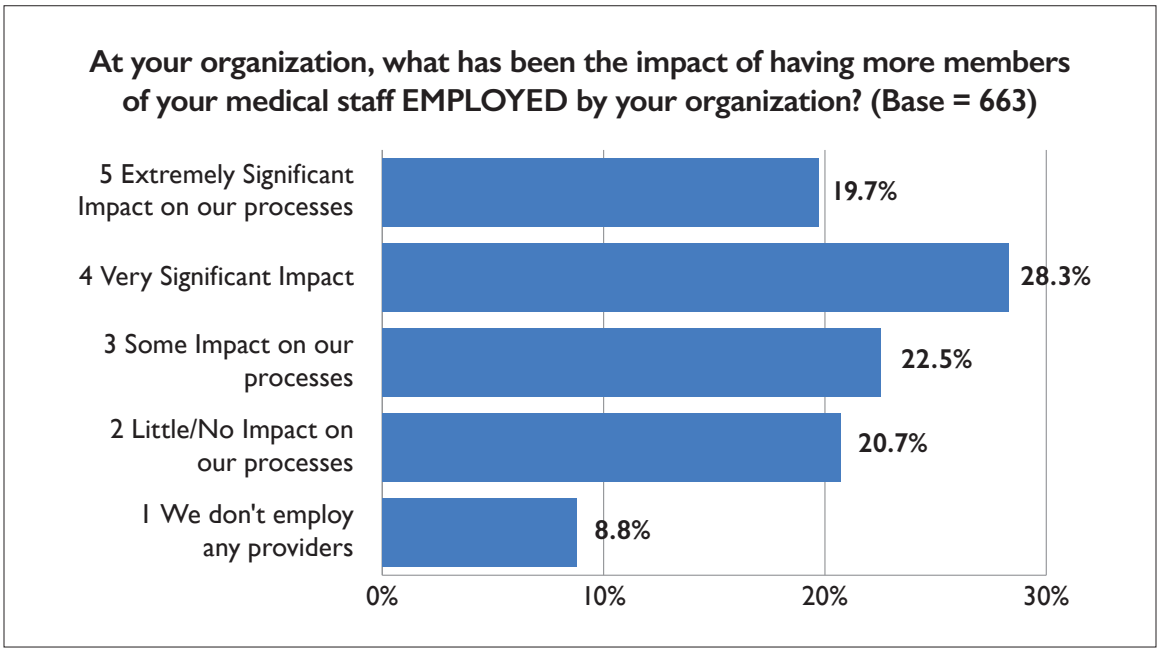
The following table displays the full range of percentages of successful implementation of all Service Expansion Initiatives. Ratings of unsuccessful implementation were low ranging from 3.4-10.6%. Developing an integrated provider onboarding process across multiple departments was highest at 10.6%.

Percentages of non-attempted initiatives were considerable and ranged from 16.9-45.3%. Nearly half (45.3%) of respondents indicated that the non-provider credentialing services initiative was not attempted. Thirty percent of respondents indicated that two other initiatives were not attempted. These were providing and tracking CMEs for providers and managing or coordinating graduate medical education programs.

Service Expansion Initiative					
	Fully, Successfully Implemented	Partially, Successfully Implemented	Unsuccessfully Implemented	No Attempt at Implementation	Don't Know/Not Applicable
Non-provider credentialing services for employees including nurses and other staff	8.1%	14.0%	3.6%	45.3%	29.1%
Handling Delegated Credentialing services	25.7%	24.0%	4.2%	24.2%	21.8%
Managing the Provider Enrollment process for your providers by requesting their participation in a health insurance network as a Participating Provider	18.7%	21.8%	3.4%	26.1%	30.0%
Handling network management and managed care responsibilities for the payer and ACO entities within your organization	12.1%	18.8%	3.7%	26.7%	38.8%
Developing an integrated provider onboarding process across multiple departments	13.9%	34.9%	10.6%	21.6%	19.0%
Managing the Provider Directory for your "Find the Doctor" functionality on your website	27.1%	28.7%	5.0%	16.9%	22.3%
Providing and tracking Continuing Medical Education (CMEs) for your providers	16.7%	21.5%	4.3%	30.0%	27.4%
Managing or coordinating graduate medical education programs	10.5%	16.1%	2.7%	30.2%	40.5%

NOTE: Text in orange indicates items that are most closely related to improvement of the overall SERVICE EXPANSION initiative based on a step-wise regression analysis of the results. These items should be prioritized for improvement as they are most predictive of respondents' overall ratings of the SERVICE EXPANSION initiative.

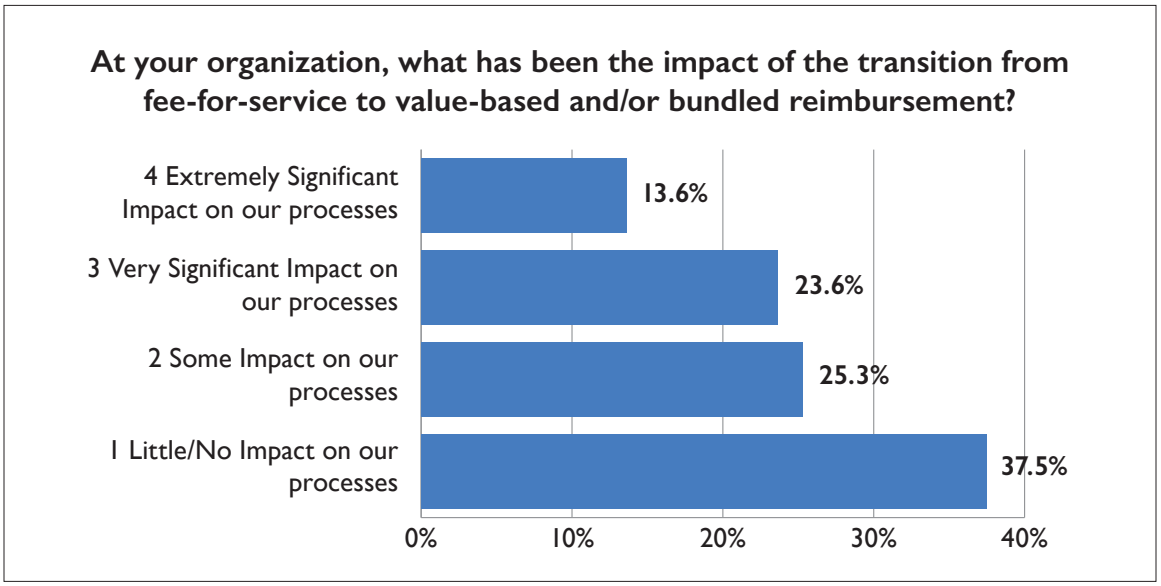
9 Compared to 2017, medical services professionals were more likely to say their organization was absorbing an "extremely" or "very significant" impact due to having more employed physicians in 2018.



Almost half of respondents (48.0%) to the 2018 survey reported that increasing numbers of employed physicians were having an extremely or very significant impact on their organization. This percentage is up from the 42.5% who said this in 2017.

	2018	2017
Extremely Significant Impact on our processes	19.7%	15.7%
Very Significant Impact on our processes	28.3%	26.8%
Some Impact on our processes	22.5%	24.6%
Little/No Impact on our processes	20.7%	17.5%
We don't employ any providers	8.8%	10.0%

10 Just over one-third of medical services professionals reported that the transition to value-based care was having a significant impact on their organization. This percentage remained consistent from 2017-2018.



Some 37.2% of survey respondents said the transition to value-based reimbursement had an extreme or very significant impact on their processes in 2018 compared to 35.4% in 2017.

	2018	2017
Extremely Significant Impact on our processes	13.6%	10.4%
Very Significant Impact on our processes	23.6%	25.0%
Some Impact on our processes	25.3%	28.2%
Little/No Impact on our processes	37.5%	36.4%

KEY FINDINGS RELATED TO METRICS:

The 2018 survey included credentialing data/metrics not previously collected. This data resulted in very interesting information (note that all metrics are included in the appendix).

Years worked in the credentialing industry: One of the more interesting results was the number of years worked in the credentialing industry. Some 43.4% have worked in the industry for 16 years or more. The number of coordinator responses was 40.7% and the number of manager/director responses was 43.4%. Another 16.8% have worked 11-15 years. Only 7.7% of the respondents have been in the profession for less than 3 years. Clearly, the industry is staffed with veterans. Perhaps some of these veterans are reluctant to adapt to the changes needed to implement and support the type of credentialing and privileging system needed today? If that is true, organizations will need to find new talent that have the skills to effectively use technology to manage credentialing and privileging and train them on the elements of credentialing and privileging to get them up to speed. Some veteran staff may be transitioned to performing file closure/quality analysis (review of files to identify missing elements, red flags, etc.), in order to compensate for the inexperience of the new talent. Alternatively, veteran MSPs may need to adapt to the changing environment by embracing the automation current generation software provides, and focus themselves on emerging, value-added tasks in areas like provider data management and analytics.

Electronic credentialing: One-fourth (25.3%) of survey respondents have fully implemented paperless credentials files, but 37.8% are in process, 8.3% tried and failed – and 26.3% have made no attempt. The most successful process improvement initiative has been implementation of automated primary source verifications, but still, only 26.8% have fully and successfully implemented, 44.8% are in process, 4.7% failed and 19.8% have made no attempt.

Electronic decision-making process: Over half of the organizations included in this survey have either made no attempt or have failed at implementing a paperless process for committee reviews and decisions—which means that credentialing in many organizations is still a morass of paper.

Provider data integration: Integration of provider data with downstream applications, including the EMR and other databases remains a point of discussion and opportunity. More than one-third (35.5%) of respondents say that they have implemented a single, master provider database that is the source of truth for provider data—but it is noteworthy that only 12.5% of these organizations have integrated their provider data with downstream applications. The value of the "source of truth" data is exponentially increased when it can be exported to other business applications. We found it interesting that just 9.5% of the organizations have created data related roles within their organization and wonder if credentialing data integrity will suffer in the longer term without them. We anticipate that some organizations will need to go back to the drawing board to determine the source of truth for address/location information for their providers who are enrolled with payers. CMS audits of data related to public-facing provider directories (address, telephone number, etc.), have revealed this data to be incorrect over 50% of the time. Very often, some or all address/location information is received by enrollment from the credentialing database. This will continue to receive scrutiny, and organizations will be seeking processes to streamline and assure correct data. We believe that one of the reasons for this problem is that the responsibility for the accuracy of address/location has not been assigned. Everybody's job becomes nobody's job—and the organization suffers the consequences of incorrect data (which results in billing write-offs when a provider is scheduled to work where he/she has not been enrolled to work).

Onboarding: Only 13.9 of organizations claim to have successfully implemented an onboarding process across multiple departments. Some 31.2% have either not tried or have failed. Almost 50% of organizations acknowledge that the impact of having more employed providers has an extremely or very significant impact on the processes of the credentialing and privileging department.

Non-required verifications: The degree to which verifications are performed that are not required by state licensing, CMS or the accrediting bodies is another area that is thought-provoking. Examples: verification of claims history with insurance carriers is performed by 80% of the survey

responders. Of those who verify claims history with carriers, 14% verify claims history with all current and previous carriers since completion of training. 94% of those who verify claims history do so for at least the past five years. 97% verify hospital affiliations. 35% verify all hospital affiliations since completion of training. For some providers, this could literally be hundreds of previous affiliations. (Note: a few states require some verification of current/previous affiliations, but we are not aware of a state that requires verification of all previous affiliations). Additional time and staff is required whenever an activity is performed in the credentialing process—particularly those activities that cannot be electronically verified, but require letters, follow-up due to slow or no response, etc. Organizations will need to be able to demonstrate that performance of non-required credentialing activities leads to better credentialing decisions or consider eliminating non-value added tasks.

How are applications provided to applicants: Another item of note is the response to the question related to how an application is provided to applicants. Nearly half of the 656 respondents (46.5%) state that the application is provided via email (rather than by providing a link to an online application). Another 42.1% provide applications via a link and almost 10% still mail out applications. The problem with emailing applications is that in most cases, they must be printed, completed and then either mailed back to the organization or scanned/faxed back. This then requires manual data entry which prolongs the onboarding process, and introduces greater opportunity for data error. We suspect that some organizations that believe their credentialing process is electronic are really not as electronic as they could be when they employ this method of providing applications.

CONCLUSIONS:

This report portrays an industry in the throes of change. Some organizations have clearly been successful in implementing process improvements such as reducing credentialing time frames through the use of automation, implementing paperless primary source verifications, implementing online provider applications, etc., but overall, only about 25% of organizations purport to have fully and successfully achieved their goals.

DOES IT REALLY MATTER IF CREDENTIALING IS ELECTRONIC AND PAPERLESS? A resounding yes! Organizations that have implemented electronic processing are able to reduce turn-around times dramatically (critical when organizations hire or contract with a provider and need the provider to be able to start bringing in revenue as quickly as possible) and reduce the staff that it takes to support the credentialing and privileging processes (staff is usually redirected to functions that have long been under-resourced). Another result—admittedly anecdotal, but coming from a number of organizations that have fully embraced electronic processing and decision-making—is that physicians responsible for making credentialing and privileging recommendations are less likely to miss important credentialing information when they review an electronic file. They are able to make more informed recommendations. This makes sense—most physician leaders do not like wading through piles of paper.

This survey, like the previous one, also identifies that there are huge opportunities in automating OPPE performance profiles (ongoing professional practice evaluation—a Joint Commission requirement) and the peer review process. The smallest percentages of organizations have successfully automated these processes (8.1% for OPPE and 9.3% for peer review). We suspect that MSPs will work on this after they have successfully implemented electronic credentialing and privileging. Success with each of these activities will involve increased engagement with other organizational departments such as those responsible for coordinating/managing quality and peer review. Those functions will need to be integrated with credentialing and privileging processes and will necessitate successful implementation with OPPE. Peer review will likely require a closer, more engaged working relationship between MSPs and their quality department colleagues in the future.

The mergers and acquisition activity over the past year—anticipated to continue—has significantly impacted credentialing and privileging. When a new healthcare facility is merged into a health system, the migration of the credentialing and privileging data and processes must be carefully assessed and managed to ensure accurate "clean" data is maintained upon completion of the migration. In many instances, the health system has different software than the facility being merged and months are needed to get that provider data successfully integrated into the system provider database.

A lack of standardized privileges on the part of the health system adds a further layer of complexity. Many systems are working towards standardized privileging across their enterprise. However, most continue to have different privilege forms for each hospital within their health system. Only 17.3% of health systems have successfully implemented standardized privileges across their enterprise.

Health systems are also more likely these days to centralize not only the credentialing process, but also support for privileging. Although this is not mainstream, it is increasing. In the past privileging support has come from the Medical Staff Office in each facility. It is difficult to find MSPs with expertise in privileging and a number of health systems are finding individuals with clinical backgrounds (typically nurses) to support privileging across the system. We anticipate that there will continue to be a focus on standardizing privileges in a health system and that staffing that effort centrally will lead to not only support for credentialing and privileging centrally, but centralized management of credentialing and privileging. That means that instead of a health system having a CVO, and managing only the obtaining of an application and performing primary source verification, that the CVO services will expand to also manage the decision-making process within each facility.

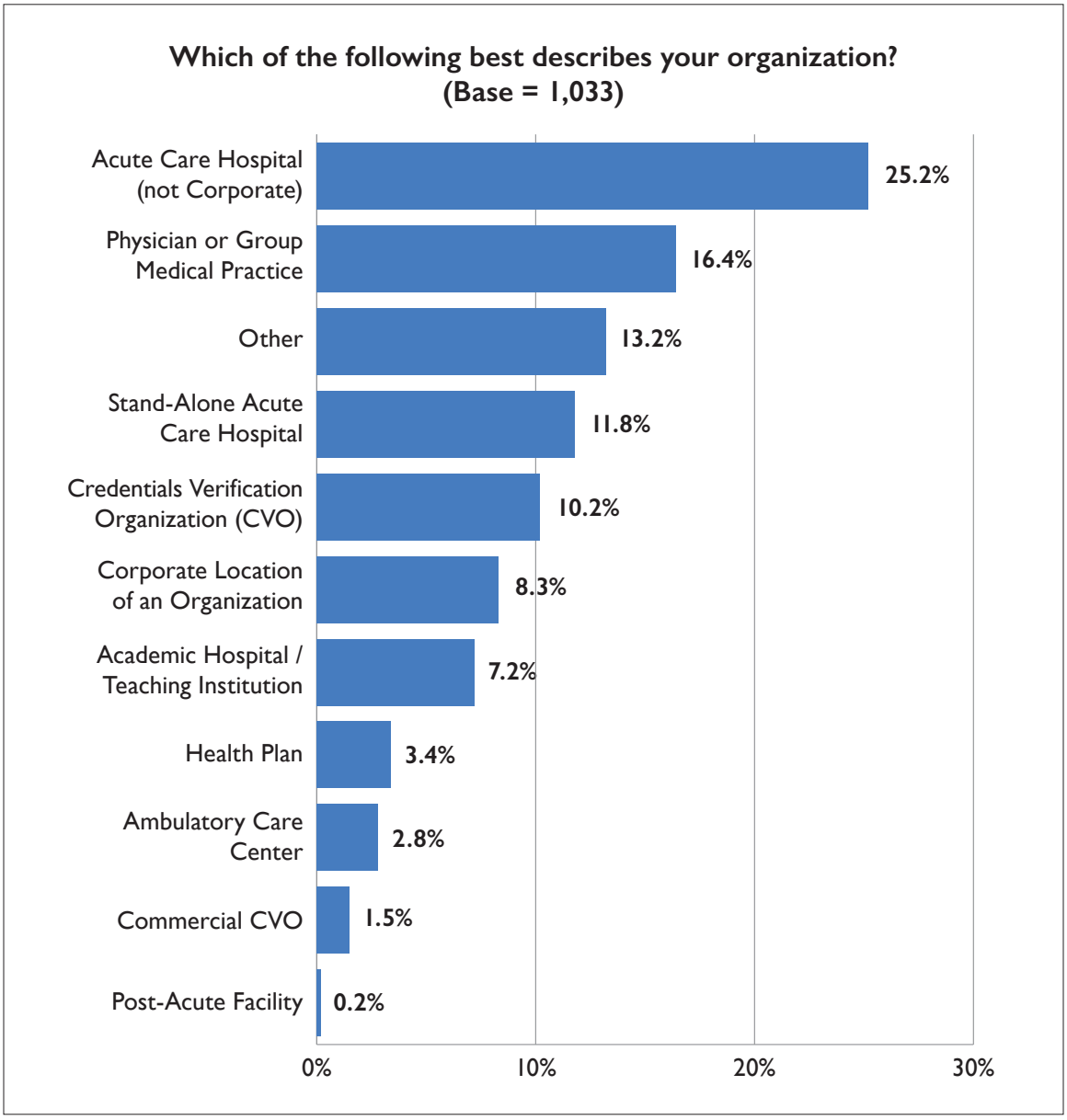
Technology now facilitates this process. Standardizing privileges makes it more likely to occur. This will change the role of the MSO in each facility in the future. This will be particularly true of health systems that are made up of critical access hospitals, micro hospitals, etc. In those types of settings, it makes sense to manage credentialing and privileging centrally—i.e., a "physical" MSO may not exist but services will be provided virtually.

The onboarding process is another area that is likely to continue under the microscope. The increasing numbers of employed/contracted providers need a provider-friendly, efficient, integrated onboarding process—and they are not getting it in most health systems. This remains an important opportunity in 2018. In addition to the onboarding process, the escalation of employed/contracted providers also increases the likelihood that there will be a spotlight on credentialing time frames.

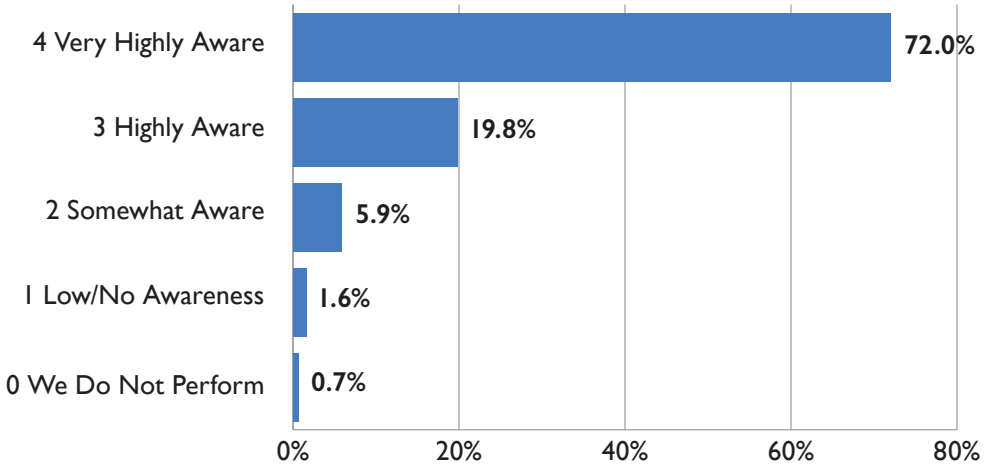
We sincerely hope that this report is helpful to credentialing leadership in identifying where there are opportunities to improve processes. We are confident that the credentialing industry will continue its improvement efforts and that automated, efficient and cost-effective credentialing and privileging will be supported by those in a position of influence and by the vendors who provide the tools and services.

APPENDIX:

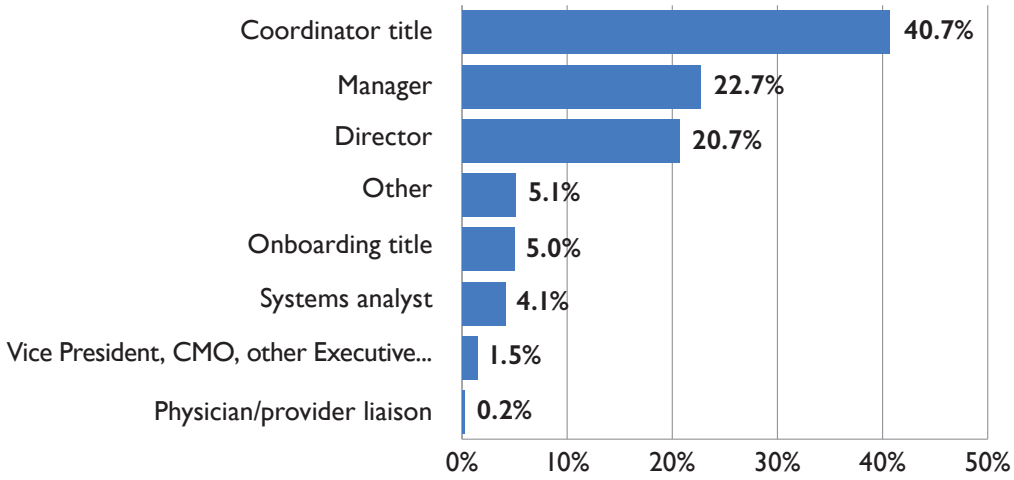
Survey Demographics and Profile Information



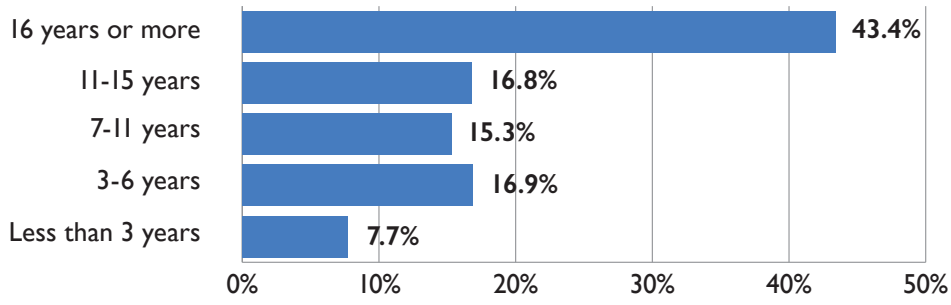
What is your level of awareness of the Medical Staff Credentialing and Privileging process at your organization?



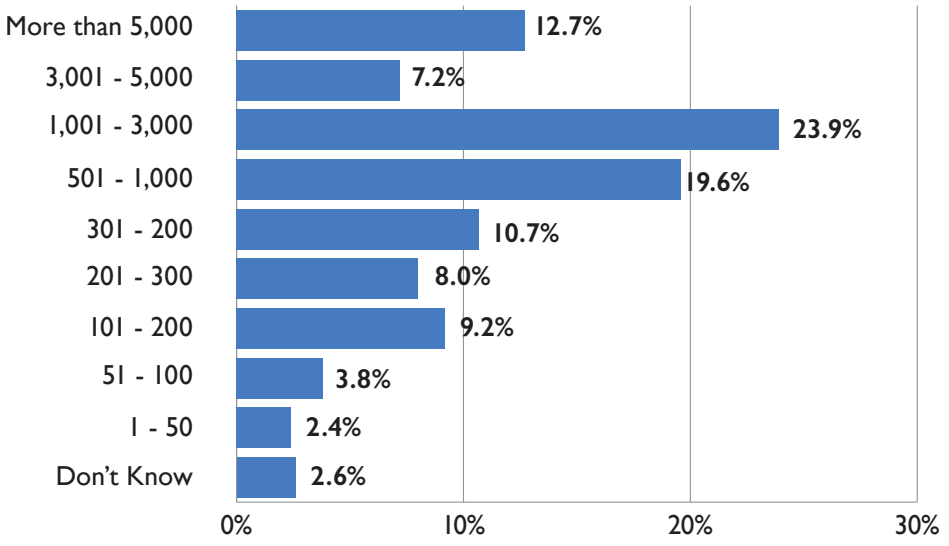
What is your current position or title? (Base = 661)



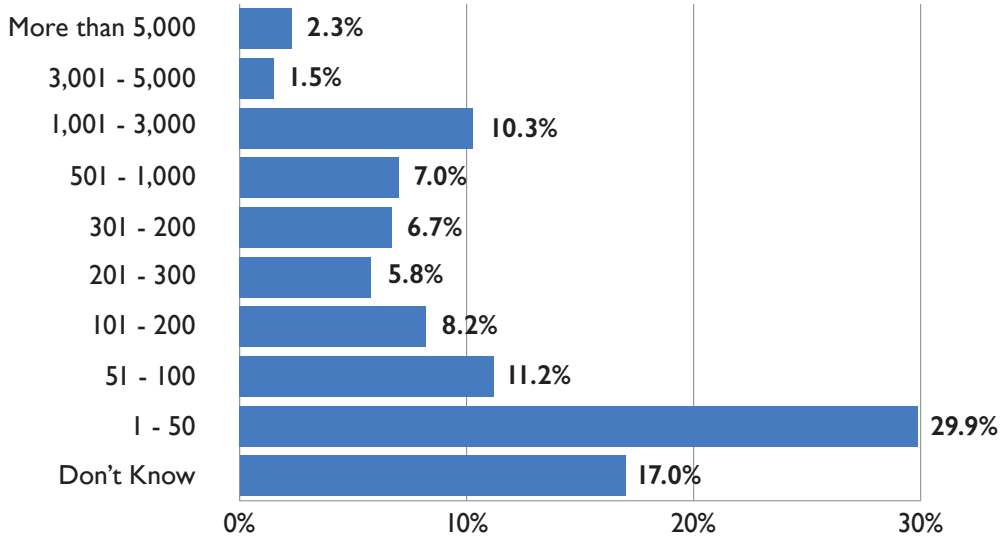
How many years have you worked in the medical staff credentialing, provider enrollment, CVO, or onboarding profession? (Base = 662)



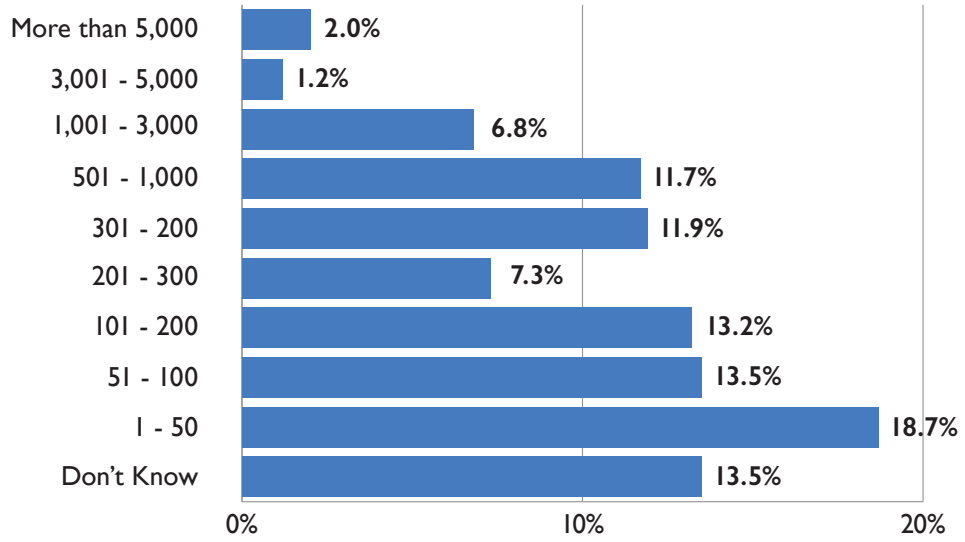
Total number of credentialed and privileged providers (i.e., physicians, dentists as applicable) at your organization as of November 1, 2017: (Base = 664)



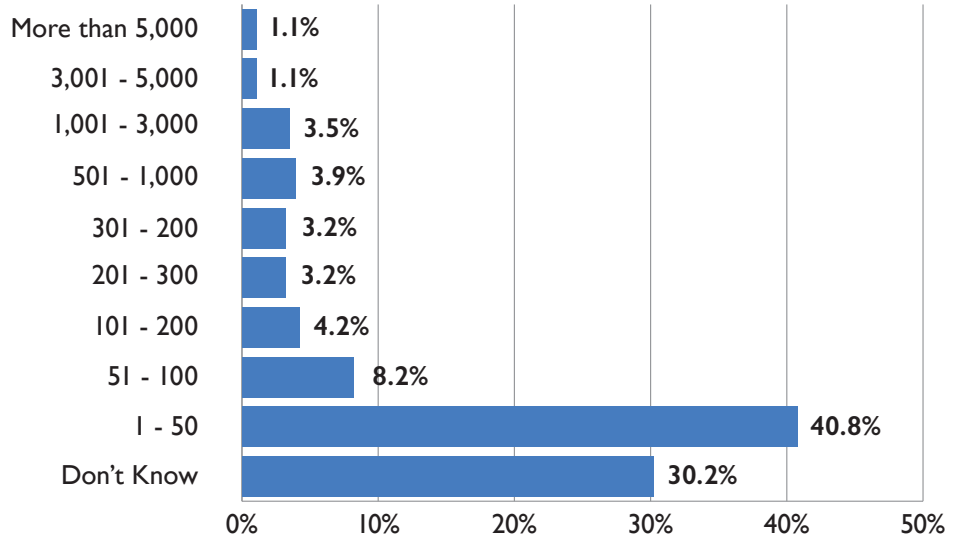
Total number of credentialed ONLY (no privileges) providers (i.e., physicians, dentists as applicable) at your organization as of November 1, 2017: (Base = 658)



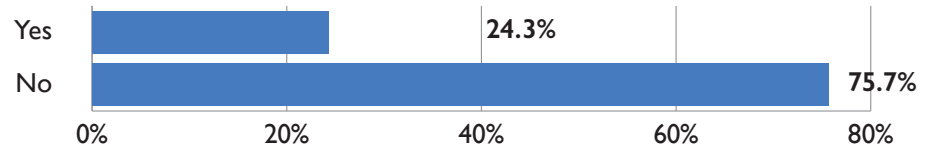
Total number of other credentialed and privileged practitioners (i.e., advanced practice nurses, RNs, LPNs, PAs, psychologists, etc. as applicable and not listed above) at your organization as of November 1, 2017: (Base = 657)



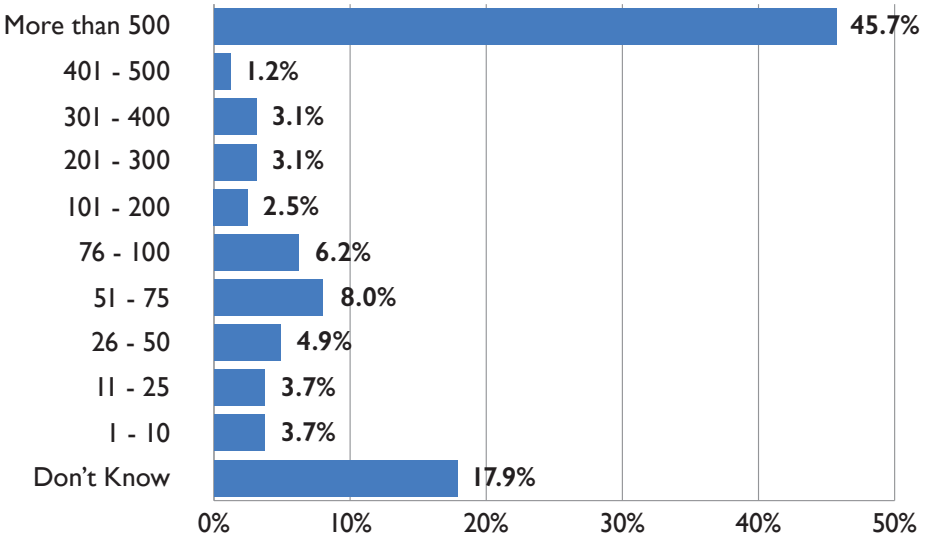
Total number of other credentialed ONLY (no privileges) practitioners (i.e., advanced practice nurses, RNs, LPNs, PAs, psychologists, etc. as applicable and not listed above) at your organization as of November 1, 2017: (Base = 663)



Does your department have any responsibility for referring practitioners (i.e., practitioners who refer patients to your organization for test/treatment but do not hold membership or clinical privileges)? (Base = 659)

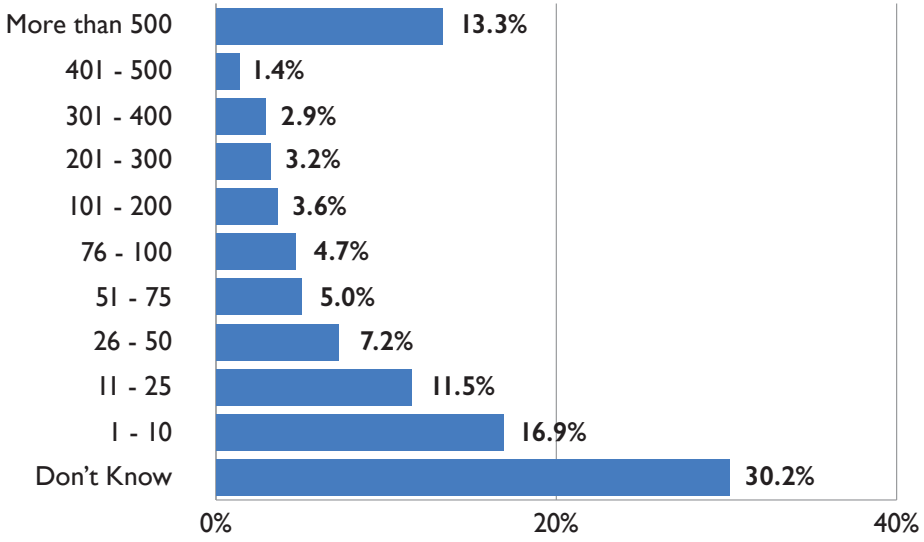


If yes, what is the approximate number of referring practitioners in your database? (Base = 162)

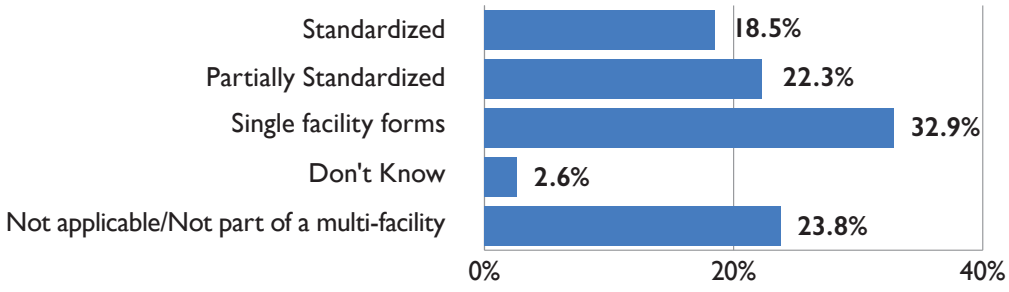


Does your organization have any responsibility for managing residents/fellows/house staff? (Base = 655)

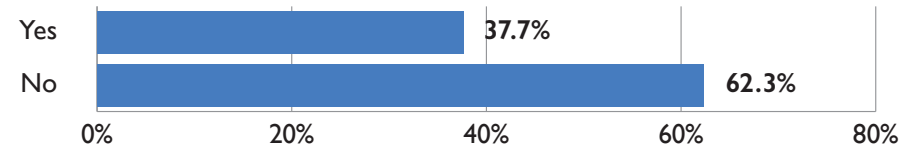
If yes, what is the approximate number of residents/fellows/house staff in your database? (Base = 278)



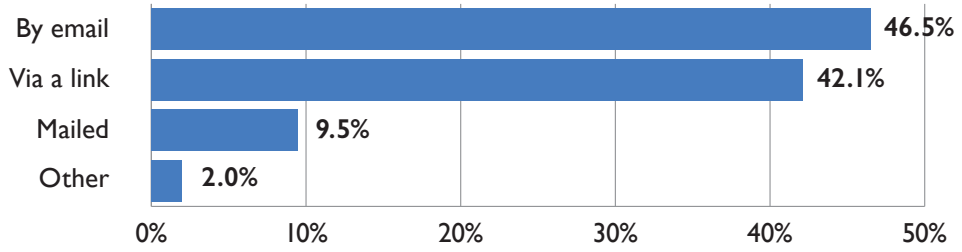
Are privileges standardized (i.e., use of multi-facility or enterprise forms) or does each facility have their own privilege delineation? (Base = 660)



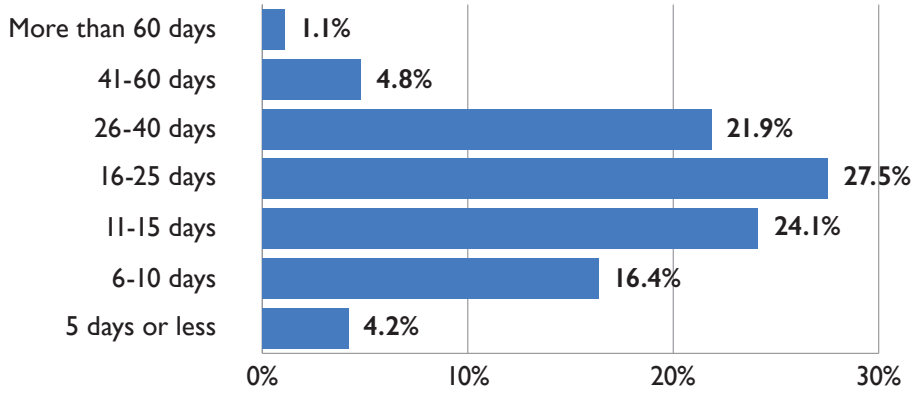
Does your organization use a pre-application to screen applicants prior to sending a credentialing application? (Base = 652)



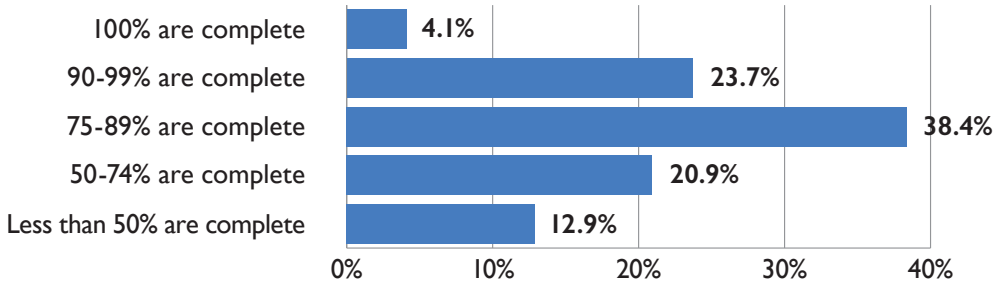
How are applications sent to practitioners? (Base = 656)



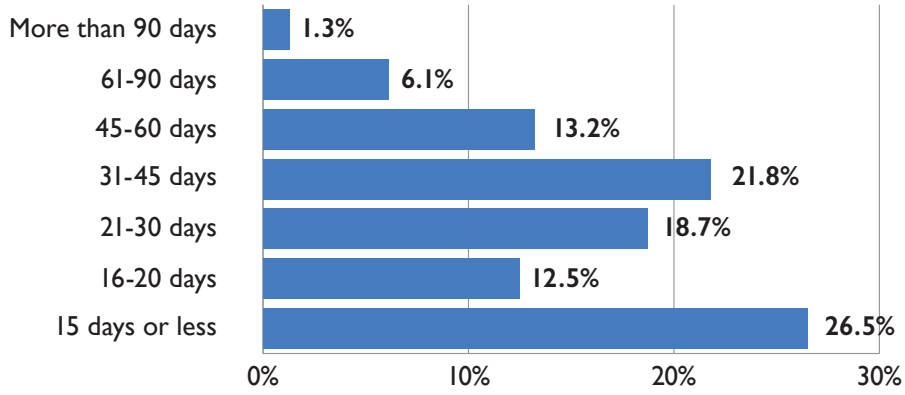
What is the average amount of time that it takes a practitioner to submit an initial application after it has been provided to him/her? (Base = 647)



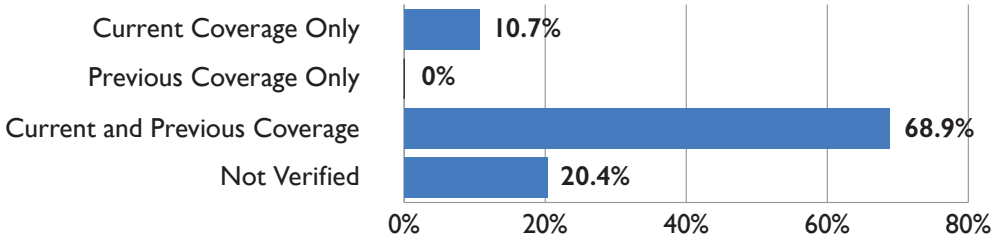
When your department receives an initial application from a practitioner, what percentage of the time are they sufficiently complete to begin primary souce verification procedures? (Base = 641)



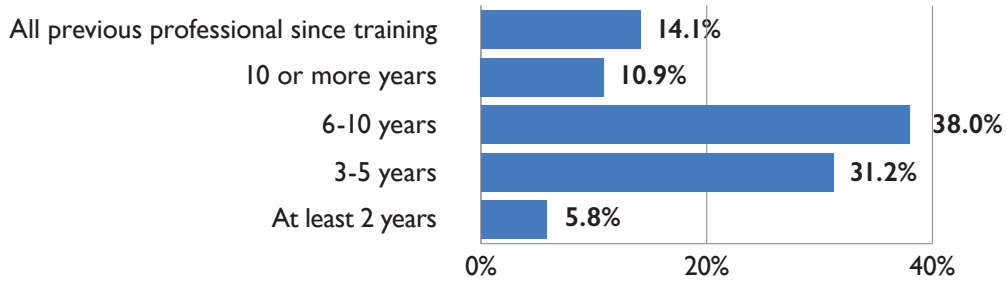
What is the average amount of time that it takes your department to complete primary source verification after the organization has received a completed initial application...? (Base = 638)



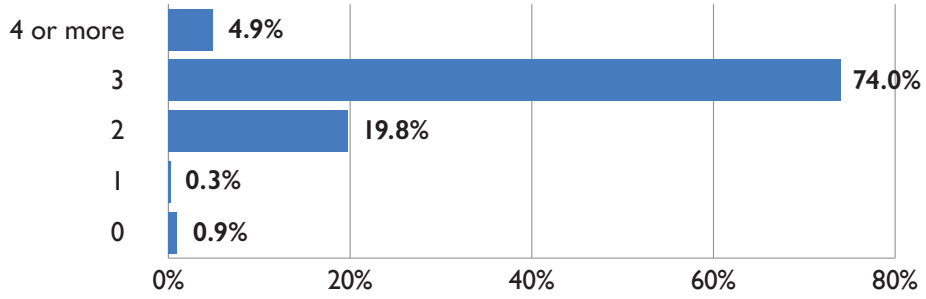
Does your organization verify professional liability claims history with the carrier? (Base = 647)



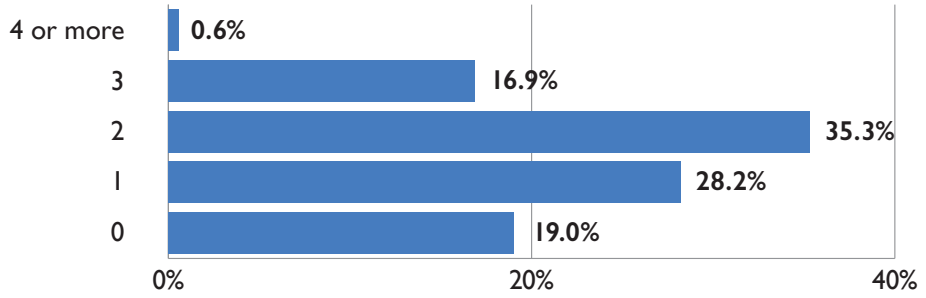
How far back do you verify professional liability claims history with the carrier? (Base = 516)



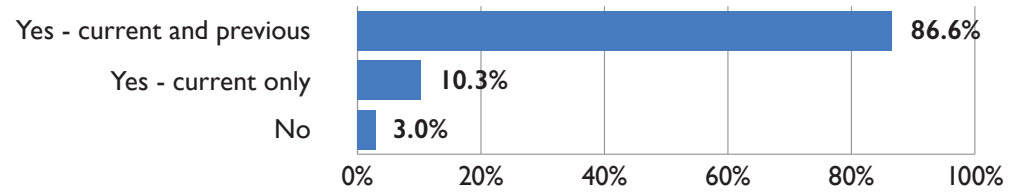
How many peer references are obtained for initial appointment? (Base = 651)



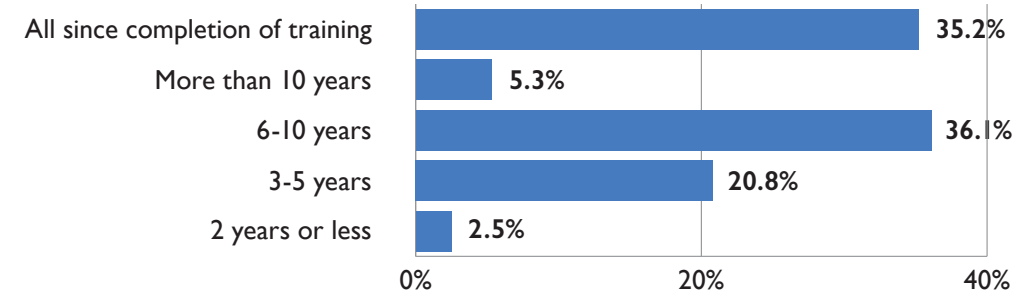
How many peer references are obtained for reappointment? (Base = 649)



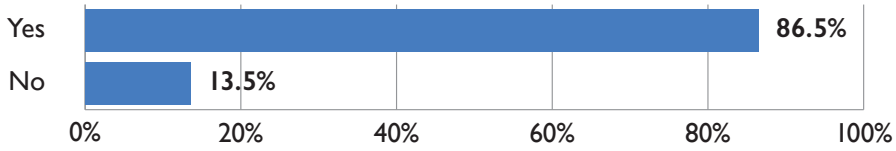
Does your organization verify hospital affiliations? (Base = 658)



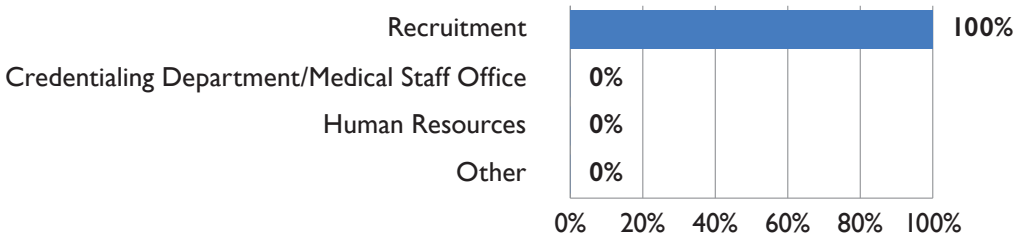
How far back do you verify hospital affiliations? (Base = 562)



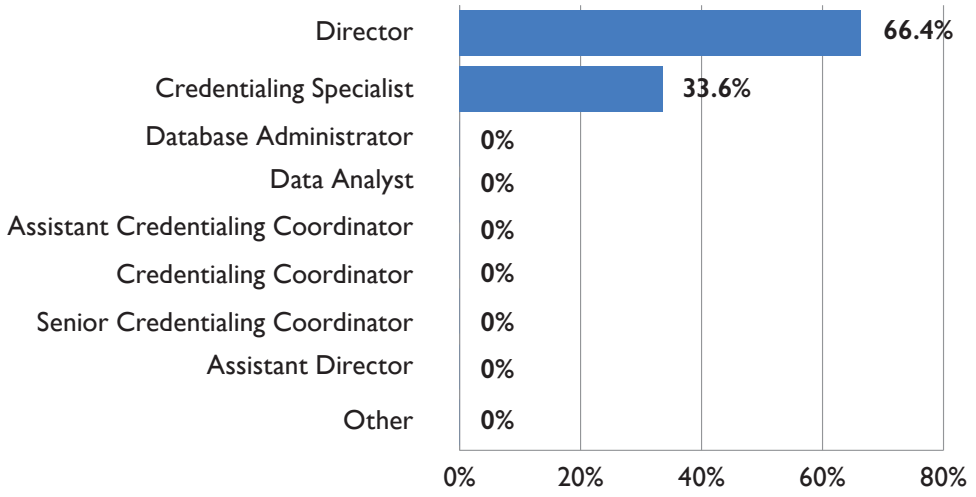
Is a background check performed on new applicants? (Base = 654)



If yes, what department obtains the background check? (Base = 569)

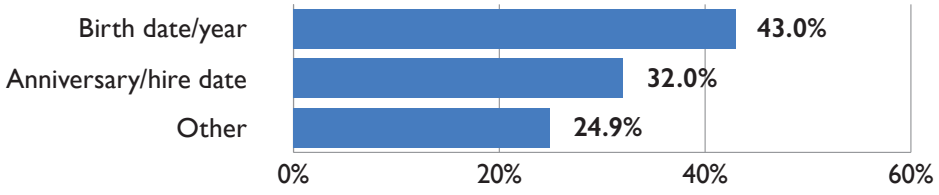


What staff titles are used within your credentialing department? (Check all that are applicable.)

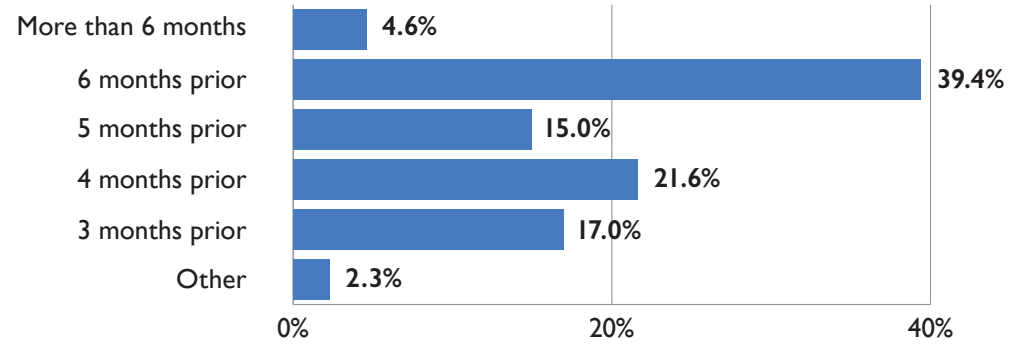


Is there a practitioner-centric re-credentialing date? (Base = 558)

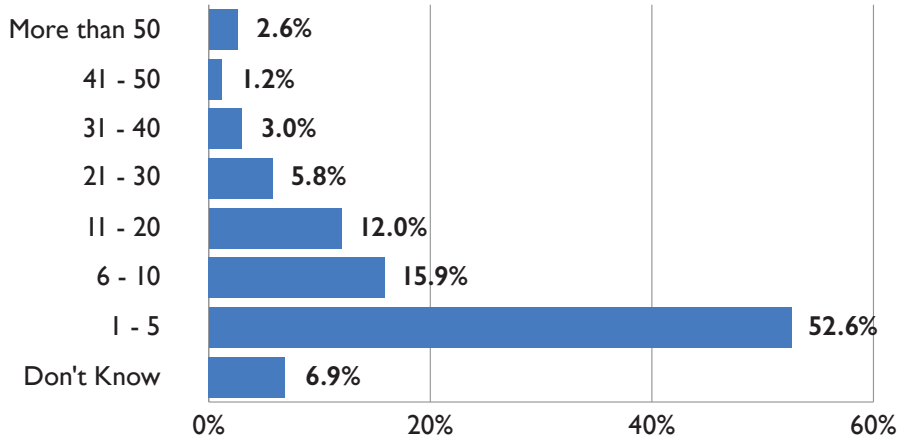
If yes, how is the date selected? (Base = 337)



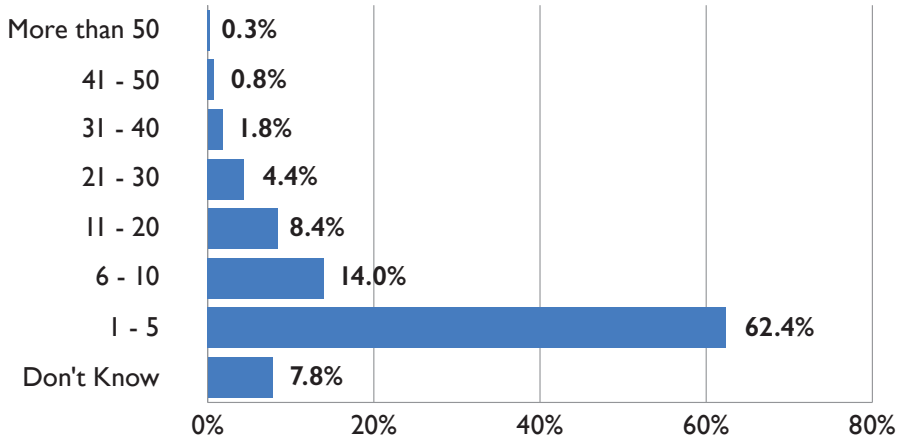
When are reappointment applications sent to practitioners? (Base = 652)



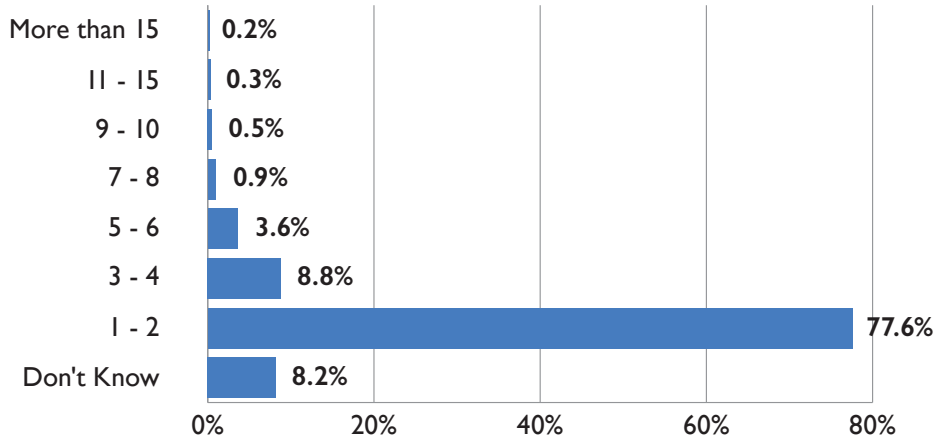
What is the total number of FTEs that work in medical staff credentialing, privileging, enrollment or onboarding activities at your organization as of November 1, 2017? (Base = 656)



What is the total number of FTEs whose primary responsibilities are in these areas: application management (send out/receive back); data entry/import; primary source verifications; file audits; management of expirables? (Base = 652)



What is the total number of FTEs whose primary responsibility is for supervising people performing tasks listed above? (Base = 646)



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Verity™, a HealthStream® Company, delivers enterprise-class solutions to transform the healthcare provider experience for healthcare organizations and providers. We currently serve over 2,400 hospitals and 1,000 medical groups in the US. Verity resulted from the merging of Echo and Morrisey, representing over 75 years of industry experience, becoming the leading credentialing, enrollment, and privileging companies in the United States. HealthStream, (NASDAQ: HSTM), based in Nashville, Tennessee, is our parent company, supporting us through innovation, investment, and the development of market-leading solutions. Verity has over 200 employees spanning headquarters in Boulder, Colorado and satellite offices in San Diego, California, Brentwood, Tennessee, and Chicago, Illinois.

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[3] Internet-based PECOS
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