WORKING THE PUZZLE

Vendor Credentialing: Searching for Common Ground

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Vendor Credentialing: Searching for Common Ground

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SETTING THE STAGE

One of the most contentious issues in the health care supply world is vendor credentialing. It is hoped that this report, and the discussion that will arise from it, could be a starting point toward establishing some common ground on a topic that usually finds vendors and hospital systems miles apart.

Generally, vendor credentialing—some call it vendor registration—involves reporting requirements that vendors must satisfy to enter and conduct business in a healthcare institution. The stated goals of credentialing are to protect patient safety, keep unethical individuals out of the facility and control costs.

The requirements for vendor representatives can take a wide variety of forms, including photo IDs, proof of vaccinations, criminal background checks, conflict of interest disclosure, job performance evaluations and documentation of HIPAA compliance, among many other disclosures. Many entities also seek a great deal of information about the vendor company, including financials, legal histories, compliance and documentation, insurance limits and diversity information. Annual fees for credentials vary from $100 to $700 per individual, with the higher fee charged by vendor credentialing companies for access to more than one facility. Some health institutions do their own credentialing, while many use third-party credentialing organizations. Some healthcare systems have different requirements for vendors who enter clinical areas such as the operating suite and those that don't. Others also differentiate among vendors based on whether they access, record or transmit patient data. Some systems use a single credentialing program for all vendors.

The issues from the provider perspective are manifold. Healthcare organizations on average deal with more than 3,000 vendors each. They face daily litigation risks from healthcare-acquired infections and disease. (Anecdotally, at least one vendor rep who went through the credentialing process at one facility was found to have tuberculosis.) They also want to be able to track which vendors have been excluded from Medicare for fraud and abuse. And many IDNs, which have gone to great lengths to manage supply costs, fear the consequences of undocumented meetings between vendors and physicians and other purchasing influencers: Non-contract buying for physician preference items is one of the key contributors to unmanaged supply expenses.

Vendors, meanwhile, are upset with having to maintain multiple credentials with various facilities, with what they view as excessive charges for registering and with a lack of differentiation based on what kind of access they have to sensitive clinical areas. They wonder why someone who never goes near an operating room has to have the same level of clearance as that of a medical device rep who participates in surgeries. And they want to know where the line is drawn for needing to be credentialed. For example, why caterers don't need documentation but someone selling office supplies does.

“This one-size-fits-all approach does little to ensure patient safety,” the Health Industry Distributors Association (HIDA) said in a statement. “Indiscriminate requirements raise issues of redundancy across institutions and create compliance and risk management challenges for companies doing business with numerous hospitals with varying requirements.”

THE STATE OF CREDENTIALING/REGISTRATION

Vendor credentialing is in its Wild West phase, meaning almost anything goes. Some healthcare organizations run their own programs—which vary greatly in the amount and nature of information sought—while others turn to the growing number of third-party vendors, each with its own data requirements and information system. There are no national standards, and the federal government and accrediting bodies such as Joint Commission have so far stayed out of the arena. There are also no incentives for the credentialing firms to share data or use common information system platforms.

Within an IDN, there are a host of stakeholders influencing decision making around vendor tracking, complicating efforts to achieve common credentialing systems. In other words, even within a hospital system, there may be multiple registration processes. Compliance officers, risk managers, infection control officers, directors of surgical services, supply chain executives, formulary boards, value analysis teams and boards of directors all have an interest in how a credentialing system is conceived and carried out.

Hospitals that work with vendor credentialing companies take advantage of services they might not be able to provide on their own, including vendor visitation logs, vendor scoring and reporting capabilities. There is another significant advantage, which is that the larger credentialing platforms, such as REPTrax, Status Blue and VendorMate, work with enough hospitals and systems that vendor information and incident reports can be shared across many healthcare institutions. For vendors, that can also mean paying less in fees and having fewer lost work hours dealing with credentialing paperwork.

The counter to that rosy scenario is that there are still too many hospitals and systems with their own systems and too many credentialing firms with differing data systems and demands on vendors.

The practice of an individual hospital charging a per-rep fee of $100 or more has also raised hackles. Hospitals argue that the time and effort needed to develop tracking and framing mechanisms cost money; vendors counter that it’s nothing more than a profit center for a hospital. There is also a concern that vendors will offset the costs of those fees—and then some—in the form of higher prices.

Some credentialing entities grant “preferred vendor” status or offer performance ratings as additional services that may generate more revenue but detract from the main mission of ensuring that vendor representatives conduct themselves appropriately and don’t cause patient harm.

Many vendor reps also strenuously object to what they believe are privacy violations, such as when they have to provide home addresses and Social Security numbers, and don’t know how widely such information is being shared.

The lack of common information systems and an industry standard for credentialing has many on both sides of the debate wondering when this Wild West might be tamed. Many see the day when what they see as inevitable market consolidation among vendor credentialing firms takes place. With only two or three national firms left, vendors would only have to deal with those companies and competition among them might lead to greater standardization of the credentialing process.

If all healthcare organizations were willing to follow the lead of the retail credit industry and standardize the collection and management of vendor data, creating a unified data file as the starting point for risk assessment might be feasible. Under such a scenario, each vendor company and rep could be given a single risk score, and each healthcare system could independently assess the acceptability of that risk.

All of that may take place someday, but given the newness of the market and the unwillingness of many hospitals and systems to embrace third-party credentialing, that future seems a long way off.

Also, many healthcare facilities have enjoyed the financial and technical benefits of the competition during the request for proposal process with credentialing firms.

Finally, the adoption of a common, searchable information database across the vendor credentialing marketplace seems unrealistic. We are still far away from any semblance of a national health information technology infrastructure that would allow the exchange of even basic patient information, so why would anyone expect a common architecture for vendor credentialing to happen first? Many hospitals lack the capability to utilize such a common platform for sharing vendor data even if were to exist—an unlikely event in today's healthcare world.

ATTEMPTS AT STANDARDIZATION

All of the above issues may explain why the Joint Commission, which studied potential industry standards on vendor credentialing in late 2008 and early 2009, threw up its hands. A spokesman said that Joint Commission decided it was not in the business of developing standards of competence for healthcare industry representatives, and that it recommended that the industry turn to "professional organizations ... recommending general credentialing requirements."

Although Joint Commission demurred on national standards, it said that a number of its standards "are relevant to any individual that enters a health care organization who directly impacts the quality and safety of patient care." Among them are:

- Standard EC.02.01.01, which states that in order to protect patient safety, accredited health organizations need to be aware of who is entering their organization and what these individuals are doing in their organization.

- Standard RI.01.01.01, which states that accredited healthcare organizations need to take steps to ensure patient rights are respected.

- Standard IC.02.01.01, which states that accredited healthcare organizations need to take steps to ensure that infection control precautions are followed.

National guidelines were announced in March 2009 by a consortium of 11 organizations under the aegis of AdvaMed. The diverse group included the Association of periOperative Registered Nurses, the Medical Device Manufacturers Association, the American Association of Critical-Care Nurses and the Health Industry Distributors Association (HIDA).

The Recommended Clinical Health Care Industry Representative Credentialing Criteria emphasize the need for hospitals to accept written assurances from a sales rep's employer on matters including vaccinations, liability insurance and criminal background checks rather than carry out their own investigations.

Vendor credentialing is "an evolving area with no clear pathway" due to overlapping state privacy and employment laws, as well as federal and state health care regulations, AdvaMed said.

"In our experience, the interests of patients are not advanced by the types of credentialing policies that request (vendor rep) personal identification information: Social Security, driver's license, passport number, job performance reviews, credit checks and resumes," the guidelines state. "This is an inefficient and ineffective way to protect patient safety and it unnecessarily invades the privacy of (reps). A coordinated credentialing process, which takes place in advance of a vendor visit and encourages hospitals to institute a policy of reciprocity, saves resources throughout the healthcare system."

The groups' say that credentialing programs should be limited to:

- **Information on vaccinations:** All vendor reps should provide a statement from the employer attesting to performance on an annual tuberculosis test; showing that the Hepatitis B vaccine was offered per OSHA standard; that the rep has mumps, measles and rubella immunity or documentation of two doses of the vaccine. Privacy concerns dictate that these records should be handled and maintained by the vendor company and/or rep.

- **Information on insurance coverage:** The vendor should provide information on reps' product and/or general liability coverage, either a statement of liability insurance letter or a certificate of liability insurance. This includes limits of liability coverage and dates of coverage. No personal liability coverage, liability waiver or personal indemnity should be sought by the healthcare organization.

- **Background verification:** The vendor should provide a letter attesting that a background check was performed for each representative upon hire. Typically this includes criminal background check, healthcare sanctions, prohibited parties, sex offender registry and drug screen per state regulations. Again, those records should be handled and maintained by the vendor and/or sales rep.

- **Hospital unit orientation/policies and procedures:** If appropriate, the hospital should provide the rep with an orientation session regarding each procedural area he or she might be working in and document the session. If there are hospital rules and policies related to appointments, check-in processes and/or other requirements (e.g., knowledge of emergency procedures), these policies and procedures should be communicated and observed.

- **Training documentation:** The vendor should provide a letter verifying that training was successfully completed by the vendor rep in the device or procedure he or she is representing; in HIPAA/patient confidentiality; conduct policies and procedures, including letter from the vendor verifying training and/or stating that it requires a rep to be trained on policies and procedures consistent with a nationally recognized applicable industry code of ethics such as the AdvaMed Code of Ethics; and OSHA/blood-borne pathogens (and, if appropriate, sterile/aseptic control and/or radiation safety).

Meanwhile, HIDA has its own policy recommendations for achieving consistent nationwide credentialing requirements. It would categorize industry vendors into three areas:

Clinical representatives: These individuals require regular access to patient-care areas such as the operating room or catheterization laboratory. They typically demonstrate products and provide technical training and information on medical products in the hospital or laboratory setting.

Non-clinical reps: These reps don't require regular access to patient-care areas. The typical roles include: delivery, reimbursement support, administering clinical trials, research and development, and product assessment.

Administrative reps: These people do not come into contact with patients or patient-care areas. They interact with administrative managers and executive team members.

HIDA said that credentialing programs should tailor the amount of information they seek from reps based on those categories. Having a one-size-fits-all approach leads to higher costs throughout the supply chain while doing little to ensure patient safety, the association maintains.

SESSION FOLLOW-UP

Most participants at this Peer-to-Peer Learning Exchange believe that the key to managing vendor credentialing, sometimes referred to as vendor registration, is adopting a process that can be easily managed by supply chain personnel while ensuring patient safety, adherence to corporate policies and financial stewardship. The leading ideas for how to achieve this included developing industry standards which could be adhered to by either a self-managed or a third-party managed process.

Additional Discussion Topics:

- Variance in vendor credentialing programs (sometimes within the same health systems) makes it cumbersome for vendor community to adhere

- Providers need to have a means of managing vendor access, especially in patient sensitive areas such as the OR

- Expense related to fees associated with third-party credentialing organizations, typically more a concern of the supplier community

- The level of information being asked of the supplier representative, in some cases considered intrusive to an individual's privacy

- The accuracy of records flowing through third-party managed systems to providers as well as the lack of common information systems throughout the industry.

Participants mentioned three key strategies for simplifying the vendor credentialing process. The first would be to have an accreditation organization, such as JCAHO, set the standard of minimum requirements needed for a supplier representative to enter the hospital. This could include proof of vaccinations, background check, and confirmation of hospital policy comprehension and training. The second would be an industry standard which holds the company responsible for the majority of additional documentation, such as insurance coverage, as a representative of the company. Thirdly, develop a clear standard for clinical versus non-clinical representatives.

The supplier community has been openly vocal about the disparity in systems. Market trends show a reduction in the number of third-party services from just three years ago. While there remains concern of the fees associated with third-party vendors, it was pointed out this type of market consolidation would also lead to development and adherence of more standard practices. For self-managed programs, there was an overall indication from participants, the third-party managed service is a better option for supply chain personnel to manage time and resources more efficiently.

Overall, participants felt these issues ought to be explored in more detail and addressed with both accreditation and government bodies for the exploration of the potential for setting standards. The supplier community expressed its desire to see a more simplified and unified process, especially when faced with multiple IDN and regional responsibilities. Overwhelmingly, all participants agreed the privacy of an individual sales representative should not be jeopardized while serving the physicians, hospitals and patient communities.

INFORMATION RESOURCES

- "Data standards for vendor reps debatable," Healthcare Purchasing News February 2010 http://www.hpnonline.com/inside/2010-02/1002-PS.html
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- Advamed, et al: Joint Best Practices Recommendation for Clinical Health Care Industry Representative Credentialing http://www.aorn.org/docs/assets/F7198A50-E3B9-59EF-B2798C853CFEA4BE/JointBestPracticesRecommendationforClinicalHCIRCredentialingSign-onasof2009-06-02.pdf
- Health Care Vendor Credentialing: Recommendations to Ensure Patient Safety and Avoid Dangerous Cost Inflation, Health Industry Distributors Association, Nov. 2008 http://www.hida.org/Content/NavigationMenu/GovernmentAffairs/IndustryIssues/VendorCredentialing/VCfacts.pdf

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