**Hospitals, Accreditation, and Credentialing**

**Question 1:** What are examples of different types of hospitals?

**Answer 1:**

Hospitals include the following:

**Acute care community hospitals:** These generally provide short-term care of less than a week's duration. Patients in acute care community hospitals can range in age (from newborns to the elderly). The patients have diverse health problems and receive treatments that require ongoing assessment or monitoring of their health and/or periodic access to specialized equipment.

**Large medical centers:** Although these also function in acute care capacity, they serve as referral centers from acute care community hospitals for patients who have unusual manifestations of illnesses or patients who are not responding to traditional care. Large medical centers are often affiliated with research centers and/or physician teaching programs; consequently, patients may be exposed to more healthcare providers who may think of more possible diagnoses and/or treatments when working together as a team.

**Long-term care hospitals:** Patients can receive care in these facilities for several weeks because these patients require more than a few days to recover from their illnesses. For example, a patient may have an illness that requires the use of a ventilator, which would require comprehensive care and regular monitoring to help the patient breathe on his/her own again.

**Specialty hospitals:** These are for patients with the same area of health concern. These include mental health hospitals, rehabilitation hospitals, and children’s hospitals. Staff and physicians in these hospitals have both the special interest and the special training to care for these kinds of patients.

**Government-run hospitals:** These include hospitals of the Department of Veterans Affairs (VA) and state/local hospitals. Many government-run hospitals tend to be larger medical centers.

Other classifications include not-for-profit, for-profit, or size status (inpatient bed size). In general, the type of hospital that includes profit status, inpatient bed size, and the status of whether it is a government-run hospital will lead to different experiences for patients, staff, and the surrounding
community. Resources, technology, staff size, and specialized training for patient care will vary with the scope and type of hospital. The overall mission of a hospital will be similar to other hospitals in terms of delivering patient care, but there may be additions that reflect the distinctiveness of the setting (e.g., whether it is a research medical center or a government-run hospital). The types of programs and policies will also vary depending on the focus of the hospital. What will remain consistent among all hospitals is the focus on the financial aspect of providing healthcare within a managed care setting. The setting must have an increasing competition for dollars and an increasing need to be creative and efficient to remain financially solvent.

**Question 2:** What are the differences between not-for-profit and for-profit hospitals?

**Answer 2:**

It is generally not immediately apparent as to whether a hospital is a not-for-profit or a for-profit. The main financial distinction is how a hospital completes its tax returns. Not-for-profit hospitals are tax-exempt.

Not-for-profit hospitals typically started as community hospitals. Some not-for-profit hospitals were started by religious orders. While hospitals that start from religious orders care for those of other faiths, they do have representations of their religious order throughout the hospital. The facility may display religious icons and employ ministers who are specific to that faith. The hospital’s mission statements may include a statement of faith.

Historically, not-for-profit hospitals had a mission to treat indigent patients, and for-profit hospitals were more inclined to try to maximize their profits and avoid serving indigent patients; however, with the advent of managed care, both not-for-profit and for-profit hospitals have to be very concerned with the bottom line. While most for-profit hospital profits generally accrue to stockholders, profits from a not-for-profit hospital are generally reinvested in the hospital and in community services.

**Question 3:** What are some examples of freestanding provider organizations that provide specialized services?

**Answer 3:**
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Examples include the following:

- skilled nursing facilities (SNF)
- ambulatory care centers, such as 24-hour urgent care facilities
- community health centers providing mental health or wellness services
- hospices
- diagnostic facilities, such as MRI centers

The term freestanding merely means that the organization is not physically attached to a hospital. A hospital can still own a facility, and it may even be part of the integrated delivery system. Alternately, a corporation may own a freestanding facility as a for-profit venture.

**Question 4: What is JCAHO accreditation?**

**Answer 4:**

Joint Commission on Accreditation of Healthcare Facilities (JCAHO) is a national organization that, in collaboration with healthcare professionals, has developed standards on many aspects of healthcare delivery—ranging from inventory tracking of dated sterilized items, identifying common and/or high-risk errors in the delivery of patient care, and outlining procedures to prevent these errors from occurring.

JCAHO does not just accredit hospitals—it provides accreditation for a broad range of healthcare provider organizations. JCAHO accreditation is voluntary, but Medicare and Medicaid reimbursement is often contingent upon this accreditation. The Center for Medicare and Medicaid, the agency that administers the Medicare and Medicaid program, has certain quality standards that must be met before a healthcare provider organization can receive reimbursement. There are other quality assurance paths a healthcare organization may choose to take to ensure quality, but JCAHO has been in existence the longest and is the most common and well-known accreditation. State licensing agencies, liability insurance companies, or managed care plans may also influence selection of JCAHO accreditation over other accreditations.

**References**
Question 5: What do hospital policies and procedures address?

Answer 5:

Some policies and procedures will include areas similar to what you might find in any large business that includes general administrative procedures and human resource policies. More specific healthcare policies and procedures will help ensure staff and patient safety. For example, maternity department policies and procedures will be designed to match mothers and newborn babies to each other to prevent infant theft. Many departments will have procedures about how to manage a patient who has become violent. Certain policies and procedures will apply to patients, visitors, and staff. Large teaching hospitals may also have polices on research and clinical trials.

Also, once an accreditation is obtained, policies and procedures must be in place to maintain compliance with those standards. A special challenge in implementing policies and procedures is ensuring that policies and procedures associated with accreditation requirements are kept in the forefront of the staff’s awareness and are regularly followed. Compliance activities in anticipation of a JCAHO survey generally increase just before the survey. Starting in 2006, JCAHO surveys will be unannounced; however, because surveys are done at least once every 3 years, there is still a possibility that after a survey is complete, compliance with accreditation policies will lag. It is incumbent upon management to integrate these into daily activities so that they do not become episodic activities.

Question 6: What is involved in the hospital credentialing physicians to be on staff?

Answer 6: Before a physician can be on staff at a hospital, which means the physician will be authorized to admit patients to that hospital and/or
order/perform tests and treatments, the hospital must assess that the physician has the qualifications to provide these services. There may be limitations placed by the hospital on what kinds of patient care services the physician may authorize or provide based on the physician's qualifications. Physicians will complete a state-specific application asking for background information. In general, a hospital credentialing staff will verify the physician's medical education, state licensure, DEA certificate (a license to prescribe controlled drugs overseen by the Drug Enforcement Administration), work history, education history, and any board certifications the physician states he/she has. Additionally, the staff will use the National Practitioner Data Bank to search for previous medical malpractice payments, licensure, or clinical privileges problems. Credentialing can take place on a recurring basis.

Question 7: What is a physician-hospital organization?

Answer 7: A physician-hospital organization (PHO) is an organization formed by a hospital and a group of physicians—generally physicians on the medical staff of that hospital. Although it is typically hospital-driven, both the physicians and the hospital own the PHO. A main benefit is the creation of a larger organization that has more power to negotiate with managed care plans to get better rates. There are a number of ways to set up the PHO contract and to subsequently contract with managed care organizations. The skill and knowledge of the organizers can affect the financial success of the PHO. PHOs have been met with mixed success in terms of managing costs because this skill and knowledge varies and because the factors involved are complex.

Question 8: How does communication work in a hospital?

Answer 8:

The organizational structure of hospitals is comparable to that of any large company. A hospital has a board of directors that has oversight of all hospital activities. The board will determine the mission, verify the strategic plan, monitor financial activity, and make strategic business decisions when needed to achieve financial goals. The management staff is responsible for operational details, and the senior management staff is responsible for broadly implementing the board’s directives. Other management staff is
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responsible for determining and implementing policies and procedures for all departments within a hospital.

As with any large company, the flow of communication from top to bottom and back again is often a major challenge in a hospital. Communication challenges within departments are exacerbated because hospitals are open for 24 hours with activity happening around the clock. Many hospitals will have newsletters or bulletin boards in strategic locations to inform the staff about key hospital activities. Departments may have a change of shift protocols, some more defined than others, to communicate relevant issues. For example, nurses have time set aside at the end of each shift to give a report to the oncoming shift about patients on the unit. Patient transfers among units and outside of units as well as patient tests generally slow down or stop during these transition times.

Question 9: What hospital issues are related to nurse staffing?

Answer 9:

Some hospitals and skilled nursing facilities (SNFs) would like to see an expanded role for unlicensed assistive personnel (UAP). The term generally means a nurse’s aid and denotes someone who is not independently licensed like a registered nurse (RN), but it is someone who works under the direction of an RN. If UAPs could have a more expanded role without being under the direction of an RN, a hospital or SNF would be able to have fewer RNs on staff and save money. However, the current position of nursing authorities is that a UAP does not have the knowledge or education to safely deliver patient care without the direction of an RN. The role of a UAP is a regularly recurring issue in nursing staffing concerns.

Some states have legislation pending that would mandate a certain nurse-to-patient ratio. This issue has arisen because of concern that when hospitals try to cut costs by eliminating nursing positions, patient care suffers. Set ratios may mean hospitals will have increased labor costs if they must expand their RN staff. There is some risk of not being able to fill positions due to a nursing shortage. Nurses want to ensure that there are adequate RNs to deliver safe care; however, depending on a set ratio of RNs in a unit, many would prefer to work with the hospital administration to make sure that patients’ needs are met. Another approach hospitals may use to regulate
nursing staffing is to require mandatory overtime by nurses. Nurses are concerned about their fatigue and ability to deliver safe patient care; hospitals are concerned about nursing labor costs and nursing shortages. Legislation is pending in a number of states to avoid mandating that a nurse must work overtime. Those in the nursing field generally feel it should be a decision that the professional nurse makes, not an organizational requirement.

**Question 10:** What are some benefits to the integrated delivery system (IDS)?

**Answer 10:**

With an IDS, a variety of healthcare provider organizations may be connected under the same organizational umbrella. For example, a healthcare organization may own a hospital, nursing home, outpatient diagnostic facilities, and a home health agency. An IDS is an example of vertical integration.

The belief is that the participating provider organization members of an IDS will work more efficiently together because they are all part of the same organization working toward the same goal. Healthcare organizations hope that the IDS will help decrease costs and provide more efficient services because of this. An IDS also helps keep patients and revenue within the same system. Patients may feel more comfortable staying within the same delivery system.

As you might imagine, trying to coordinate services across a continuum of care and delivering the right mix of healthcare services to consumers can be a challenging balancing act. It takes a lot of persuasive skill and savvy financial knowledge to accomplish this desired efficiency. IDSs have had mixed success doing this.

An IDS is yet another way that hospitals and healthcare organizations are trying to cope creatively and efficiently in the world of managed care. The financial stakes and repercussion upon patient care are high.