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Solving the patchwork quilt of credentialing for vendors

"Would you like to be on *60 Minutes* and answer the question as to why the supplier who had TB was allowed in the OR?" asks Tom Hughes, MBA, executive director for Strategic Marketplace Initiative (SMI), a nonprofit consortium of providers and suppliers from the healthcare supply chain. "Let's head off that question."

Vendors play a valuable role in the OR, but how can OR managers ensure staff and patients receive what they need while managing potential risks?

"We feel industry representatives have a role in training and use of equipment," says Fred Perner, MBA, JD, vice president of business development for AORN. "The question is how do you balance that with patient safety?"

One strategy is the booming business of vendor credentialing. But credentialing of vendors comes with its own challenges. A lack of standardization for credentialing requirements, the need for vendors to register for the multiple hospitals they service, and costs of the process all play a role.

In 2006, SMI took a step to help end the patchwork quilt of credentialing requirements by publishing *Management Guidelines for Vendor Access* (www.smisupplychain.com).

"We identified the need for vendor management from a safety and quality standpoint," says Hughes.

New joint best practices

AORN and the Advanced Medical Technology Association (AdvaMed), which represents medical device manufacturers, recently took another step toward consistency, releasing *Joint Best Practices Recommendations for Clinical Health Care Industry Representative Credentialing* at the AORN Congress in March 2009. The recommendations include credentialing criteria representing best practices from 11 organizations and are designed to provide guidance for streamlining vendor credentialing.

Perner says the organizations hope the recommendations will help OR managers establish a vendor credentialing policy.

"It's also important to determine how to implement the policy and communicate it to others so it's followed," he adds.

Some hospitals have used medical credentialing as a template for vendor credentialing, but Terry Chang, MD, director of legal and medical affairs for AdvaMed, says there's a difference. "With physicians, it makes sense to have primary source verification such as graduation from medical school. That kind of rigor makes sense because of the risk. But the risk [from what a vendor does] is not the same as practicing medicine."

Who's on first?

More is needed to reduce confusion. "Suppliers are asking who's on first,

who's on second," says Hughes. "What are we supposed to be doing for each system?"

Vendor credentialing requirements vary because individual hospitals interpret risk, industry expectations, and infection control practices differently.

"Some hospitals ask for vaccinations, and some don't ask for any," says John Wills, founder and president of Status Blue, LLC, a third-party credentialing verification organization (CVO). Companies like Status Blue use databases and software to manage sales rep credentialing; vendors pay an annual processing fee to be included.

Reciprocity needed

"In a perfect world, you do the paperwork once and be squared away for all the hospitals," says Wills. In essence, there would be reciprocity. Variations in hospital requirements make reciprocity difficult.

"The notion of there being a 'one size fits all' industry guideline and documentation repository sounds good in principle but is difficult to conceptualize in real-world practice," says Wills. "Best practices and industry guidelines are important, and we need more consistency with vendor credentialing, but if clinicians have to meet different requirements and medical staff expectations for each facility so they can be on staff or have privileges, why would the industry operate differently for vendors?"

The good news is most third-party CVOs allow sales representatives access to all the hospitals in a single system rather than charging the system for each hospital.

"Reps can log on and send their profile with their credentials attached to whomever they want," says Wills. "It's the equivalent of sending an email with a link." That includes other CVOs the vendor might want to register with.

The AORN recommendation encourages hospitals to "institute a policy of reciprocity," which, along with a coordinated credentialing process, could save resources. CVOs typically provide an option in case of emergencies. For example, a patient who arrives in the ED has a pacemaker from a manufacturer the hospital doesn't have a contract with, and the manufacturer's representative needs access. In cases like this, hospitals can allow the vendor entry into the OR.

"The system then badges the rep as a vendor visitor and records the visits," says Wills.

Who pays?

Who bears the cost of vendor credentialing? There are 3 options.

Hughes opposes the first option, where hospitals charge suppliers. "It's like selling shelf space. I'll give you 3 feet of shelf space if you give me a certain amount of money," he says, adding, "I get very nervous when I see money going from suppliers to providers not for goods sold."

Wills adds that this system "is not efficient," given the amount of work involved. He says hospitals typically charge $100 to $250 per sales rep, although one system charges $400 per rep.

The second option is for vendors to pay CVOs. Wills sees his and other companies as time savers for the hospital.

"Everyone is busy enough so why not log into a system that other hospitals in your area are using?" he says. "You can monitor and track visitors.

It's apparent to the staff this person isn't an employee. If they have the badge on, then it's thumbs up."

Hughes says the drawback of this option for vendors is, "an annual fee, even though 90% of work is done in the first year. It's like the Energizer Bunny for cash flow." He also worries that larger manufacturers, which can better afford the fees, have an unfair advantage over smaller companies.

"Of 3,000 manufacturers, about 20 make up 60% to 70% of business," Hughes says. "But you're still dealing with nearly 3,000 manufacturers who deserve access to present their products. It needs to be managed carefully." He also wonders if antitrust charges by smaller companies could be a possibility in the future.

Fee structure varies

The fee structure for CVOs can vary. The Independent Medical Distributors Association (IMDA) recommends the universal membership model, defined as "a single annual fee good for all installations of the same branded service solution," in which a vendor representative's membership grants access to unlimited hospitals for one fee.

CVOs deny fees are out of line, citing costs of annual updates needed to meet hospital requirements for TB testing and liability insurance, adding new hospitals, and technology costs.

"Nearly all vendors find our business model to be fair and equitable compared to alternative business models or hospitals charging individually," says Wills.

Hughes proposes a novel third option: funding by group purchasing organizations (GPOs) such as Novation, Premier, MedAssets, and others. The cost to fund credentialing would come from the administrative fee (typically up to 3% of total volume) GPOs can charge. He believes this option would lower the number of credentialing companies down to "3 or 4," also reducing the number of companies a vendor must register with.

What's next?

Perner says the recent joint recommendations are, "a living document. More organizations can join, and we welcome input."

Hughes at SMI also welcomes AORN's involvement, saying, "Their involvement is powerful. They cast a large net." He also cautions, "Guidelines are not standard; there will always be variation." The goal is to cut down on the variation, while still moving forward. "In health care everyone wants it to be perfect so they don't do anything. No matter what the solution, it won't solve everything."❖

—Cynthia Saver, RN, MS

Cynthia Saver is a freelance writer in Columbia, Maryland.

Joint Commission's perspective

On April 15, 2009, the Joint Commission posted a response on its website to a question about standards that address vendor representatives in clinical areas. The commission says it does not have specific standards or credentialing requirements in this area because accepted national standards on competence for vendor reps are lacking.

But the commission notes, "… some organizations are recommending gen-

eral credentialing requirements for these individuals" and refers readers to AdvaMed's website (www.advamed.org).

The commission also cites several standards relevant to any person who enters a health care organization and affects the quality and safety of patient care.

—www.jointcommission.org/AccreditationPrograms/Hospitals/Standards/09_FAQs/HR/hc_industry_vendor_representatives.htm

Credentialing verification organizations

REPtrax
214/222-7484
www.reptrax.com

Status Blue
866/383-2583
www.status-blue.com

Vendor Credentialing Service
281/ 863-9500
www.vcsdatabase.com

VendorClear
888/850-7484
https://secure.vendorclear.com

Vendormate
877/483-6368
www.vendormate.com

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