HEALTHCARE PURCHASING NEWS
Reprinted from April 2008

# The Wild West of vendor representative credentialing

*by David Hermann, Aspen Healthcare Metrics, a MedAssets company*

In the October 2007 issue[1], I wrote about the growing challenge of vendor representative credentialing. At that time, the market was exploding with new third-party credentialing providers and hospitals were buzzing with debates about what credentials would be required and why.

Six months later, instead of this topic stabilizing, it is getting more chaotic. The chaos and costs that are pushed onto vendors will not only increase overall costs to healthcare (since we can assume fees charged to vendors will be passed along to hospitals), but will also alienate the vendor community and frustrate even well-meaning representatives who want to comply with their customers' needs.

This situation communicates that the industry has lost focus on what the vendor credentialing craze was started to address:

- Health systems are physically and operationally complex entities with multiple entry points and often offsite purchasing departments
- New products are introduced to physicians before Purchasing knows the vendor was on-site
- Regulatory agencies and industry associations are increasing their requirements for hospitals to credential their vendors
- Patient safety demands that vendors are properly vaccinated, healthy and free from a criminal background

Due to significant requests from MedAssets' member hospitals and feedback received from my October 2007 article, Aspen Healthcare Metrics launched the Vendor Management Program earlier this year and awarded REPtrax as our business ally. We enlisted the guidance of more than 60 hospital systems to develop the program so we could meet the needs of hospitals, provide the least inconvenience to vendors, as well as to avoid the major pitfalls we saw in the market. The first of these challenges we have seen is the challenge of defining "vendor".

## The challenge of defining "vendor"

The definition of "vendor" has been a significant problem since many of the third-party vendor credentialing providers (and hospitals that have homegrown solutions) seldom provide a good definition and few definitions are consistent on a national basis. Some providers even credential at the company level and not at the rep level. An effective vendor credentialing program must have a very effective, flexible approach for both vendors and providers. It must segment the population of vendor representatives into enough categories that supports credentialing OR/Cath Lab reps differently from Blood Bank reps, differently than photocopier service techs, differently from delivery drivers, and so on.

It is also important to stress that the categories must be easily understood by the vendor community. An example of why this is important is one credentialing provider I called could not explain to me why MedAssets is in one category versus another. It just is "because the hospital assigned you to this category". When I called the hospital, the materials director explained to me that the credentialing provider recommended which bucket we were assigned to. This ambiguity and circuitous service confuses and alienates even well-meaning vendors.

Categorizing the vendor world into too few categories, such as in to one group or two (clinical and non-clinical) leads to workarounds and inconsistent results. One hospital I call on considers that I do not fall into their "non-clinical" rep category because that requires credentials from me they do not expect from the role I play there. As a result, they do not require me to register at all for the program and puts them in a position where they must manage me manually outside of their system.

## The who, what and why of required credentials

Who must provide credentials? The caterer? The architect? The snow removal guy who never enters the facility? This is another reason why most vendor credentialing programs do not succeed and result in alienating vendors. An inflexible system which requires all vendor types be treated equally is sure to receive pushback. This results in the hospital system spending time fighting with the types of vendors they should not need to focus much time on. In addition, most third-party applications/vendor credentialing providers will charge fees even for very low-risk vendors such as the photocopier repair tech and the guy who mows the grass. This can prove very expensive for vendors who are not high-risk and these fees are often charged even if the vendor has no current business (no revenue) at your organization.

An important part of any vendor credentialing program (such as Aspen's) is how the credentialing provider helps rationalize and normalize the credentials a hospital asks for within each of these categories. This helps to promote a national standard for which reps are credentialed and what credentials are required.

Some third-party credentialing providers may even be forcing your ven-

dors to submit credentials or pay for financial, legal, and other checks that your organization may never look at. Some third-party credentialing providers require that vendors pay on a per-hospital-facility basis (times approximately 5000 hospitals nationwide) to perform financial analyses in the style of Dun & Bradstreet, even though most major vendors are public and freely provide their financials on their websites. Should we require our vendors to do this? Furthermore, this begs the following questions:

- Should we expect all vendors to be saddled with expensive fees? Many of our local vendors have lower revenues and are sometimes minority- and women-owned businesses (MBWEs) which would be unduly burdened if they were required to pay the same per-facility fees as large, multinational public vendors. Especially, if the fee includes checks that we will not look at or data we will not use.
- What happens if your company of choice is untrustworthy because of bankruptcy issues? Do we stop doing business with them? We readily rely on airlines to get from point A to point B though most have been under restructuring for years.
- What happens when you are under contract with your company of choice and they do not pass your credentialing provider's test because of long-term debt challenges? Do you break contract and leave them?
- What happens when your device manufacturer gets sued? Is there an example of a device manufacturer that has not been sued? For that matter, what device manufacturer does not have an active lawsuit in some matter currently going on?

We should avoid the fear, uncertainty and doubt (FUD) as well as ignore the marketing hype and go back to the source: there are very clear existing regulations and position statements from federal and state governments, CMS, AORN, the American College of Surgeons, AHRMM, and the Strategic Marketplace Initiative. Joint Commission has not yet made public their explicit standards on vendor credentialing, but there are two patient standards and one HR standard that can be loosely interpreted to govern how we should credential reps.

## Take the time to find a quality credentialing provider

It is critical that your organization performs the due diligence in picking a vendor management program. Some are just Access databases set up in a garage. Others are put together by entrepreneurs who have no prior healthcare experience and do not understand the impact of their programs on vendors, hospital systems and healthcare in general. Some have totally missed the core reason why vendors are even credentialed: they investigate and rate the vendor company instead of tracking and credentialing the vendor rep.

If you ensure your credentialing provider has a program that meets the needs of your hospitals, provides the least inconvenience to vendors, and listens to their hospital systems to avoid the major pitfalls in the market, we can move out of the Wild West of vendor representative credentialing.

For additional information, please feel free to write me at dherman@aspenhealthcare.com. HPN

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References:

1 Hermann, David. "Vendor Representative Credentialing: The Growing Challenge". *Healthcare Purchasing News*. October 2007.

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