HealthTechS3 is a 45 year old, award-winning healthcare consulting and strategic hospital services firm based in Brentwood, Tennessee with clients across the United States.

We are dedicated to the goal of improving performance, achieving compliance, reducing costs, and ultimately improving patient care. Leveraging consultants with deep healthcare industry experience, HealthTechS3 provides actionable insights and guidance that supports informed decision making and drives efficiency in operational performance.

Our consultants are former hospital leaders and executives. HealthTechS3 has the right mix of experienced professionals that service hospital clients across the nation. HealthTechS3 offers flexible and affordable services, consulting, and technology as we focus on delivering solutions that can be implemented and provide a positive, measurable impact.

45 YEARS OF DELIVERING RESULTS

HEALTHTECHS^3
strategy solutions support
GOVERNANCE & STRATEGY
- Affiliation Consulting
- Executive & Management Leadership Development
- Strategic Planning & Market share Analysis
- Community Health Needs Assessment
- Compliance Consulting Services

FINANCE
- Performance Optimization / Margin Improvement
- Revenue Cycle & Business Office Operations
- Productivity & Staffing Consulting - Optimum Productivity Toolkit

CLINICAL CARE & OPERATIONS
- Continuous Survey Readiness
- Quality Assurance Performance Improvement
- Lean Culture
- Customer Experience
- Clinical Resource Management
- Care Coordination – Primary Care Practice
- Physician Practice & Clinic Assessment
- Long Term Care Consulting
- Swing Bed Consulting
- Perioperative Services Consulting

RECRUITMENT
- Executive Recruitment
- Manager and Clinical Positions
- Physician / Provider Recruitment
- Information Technology Professionals
- Interim Placement
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 6</td>
<td>12:00PM—1:00PM</td>
<td>Compliance and Ethics Programs in Long-Term Care</td>
</tr>
<tr>
<td>April 10</td>
<td>12:00PM—1:00PM</td>
<td>The Basics of Medical Staff Credentialing and Privileging</td>
</tr>
<tr>
<td>April 17</td>
<td>12:00PM—1:00PM</td>
<td>The New World of Healthcare Innovation</td>
</tr>
<tr>
<td>April 20</td>
<td>12:00PM—1:00PM</td>
<td>Using Lean in Your Revenue Cycle</td>
</tr>
<tr>
<td>April 27</td>
<td>12:00PM—1:00PM</td>
<td>The First 90 Days as a CNO Panel - TENATIVE</td>
</tr>
<tr>
<td>May 5</td>
<td>12:00PM—1:30PM</td>
<td>The Conditions of Participation for Critical Access Hospitals – About Nursing</td>
</tr>
<tr>
<td>May 10</td>
<td>12:00PM—1:00PM</td>
<td>Why An Interim Leader Might Be Right For Your Hospital Now</td>
</tr>
<tr>
<td>May 18</td>
<td>12:00PM—1:00PM</td>
<td>Creating Community Partners to Capitalize on Grant Opportunities</td>
</tr>
<tr>
<td>May 29</td>
<td>12:00PM—1:00PM</td>
<td>Leadership Competencies for the Future</td>
</tr>
<tr>
<td>June 9</td>
<td>12:00PM—1:00PM</td>
<td>Informatics – It’s Impact on Patient Care</td>
</tr>
<tr>
<td>June 16</td>
<td>12:00PM—1:30PM</td>
<td>Swing Bed – What You Really Need to Know</td>
</tr>
<tr>
<td>June 26</td>
<td>12:00PM—1:00PM</td>
<td>Transforming Patient Engagement through Family Centered Care</td>
</tr>
</tbody>
</table>

All above times are Central Time Zone

Hope you will join us!
You may type a question in the text box if you have a question during the presentation.

We will try to cover all of your questions — but if we don’t get to them during the webinar we will follow-up with you by e-mail.

You may also send questions after the webinar to Carolyn St.Charles (contact information is included at the end of the presentation).

The webinar will be recorded and the recording will be available on the HealthTechS3 web site www.healthtechs3.com.

---

HealthTechS3 hopes that the information contained herein will be informative and helpful on industry topics. However, please note that this information is not intended to be definitive. HealthTechS3 and its affiliates expressly disclaim any and all liability, whatsoever, for any such information and for any use made thereof. HealthTechS3 does not and shall not have any authority to develop substantive billing or coding policies for any hospital, clinic or their respective personnel, and any such final responsibility remains exclusively with the hospital, clinic or their respective personnel. HealthTechS3 recommends that hospitals, clinics, their respective personnel, and all other third party recipients of this information consult original source materials and qualified healthcare regulatory counsel for specific guidance in healthcare reimbursement and regulatory matters.
Regional Chief Clinical Officer

Carolyn began her healthcare career as a staff nurse in Intensive Care. She has worked in a variety of staff, administrative, and consulting roles and has been in her current position as Regional Chief Clinical Officer with HealthTechS3 for the last fifteen years.

In her role as Regional Chief Clinical Officer, Carolyn St. Charles is the lead consultant for development of Community Health Needs Assessments. She also conducts mock surveys for Critical Access Hospitals, Acute Care Hospitals, Long Term Care, Rural Health Clinics, Home Health, and Hospice.
WHAT WE’LL COVER

1. Definitions of Credentialing and Privileging
2. Regulations for Credentialing and Privileging
3. Application Process
4. Privileging Process
5. Determining Quality of Care
6. Appointment & Reappointment Profile
7. Telemedicine
8. Negligent Credentialing
Credentialing & Privileging
Is There A Difference?

**Credentialing**

- Verification of a practitioner’s credentials
- Considering and establishing the professional education, experience, and other requirements for medical staff membership
- Determines eligibility for membership on the medical staff

**Privileging**

- Documentation and evaluation of the applicant’s experience and training to perform safely and competently the actual patient care, treatment or services that they will provide
- Determines qualifications to be granted clinical privileges
CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs / CfCs. (Source CMS.gov)

**Hospitals:** Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

**Critical Access Hospitals:** Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs
The governing body (or responsible individual) decides whether or not to approve medical staff bylaws submitted by the medical staff. The medical staff bylaws and any revisions must be approved by the governing body (or responsible individual) before they are considered effective.

The governing body must: Approve medical staff bylaws and other medical staff rules and regulations.
The governing body (or responsible individual) must ensure that the medical staff is accountable to the governing body (or responsible individual) for the quality of care provided to patients.

The governing body must: Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;
CoPs

CAH C-0241

Criteria for selection of both new medical staff members and selection of current medical staff members for continued membership must be based on:

- Individual character;
- Individual competence;
- Individual training;
- Individual experience; and
- Individual judgment.

Hospital A-0050 & A-0341

The governing body must:
§ 482.12(a)(6) Ensure the criteria for selection are

- Individual character;
- Individual competence;
- Individual training;
- Individual experience; and
- Individual judgment.
CoPs

CAH C-0241

It is the responsibility of the governing body (or responsible individual) to appoint, with the advice of the medical staff, the individual practitioners to the medical staff. After considering medical staff recommendations, and in accordance with established CAH medical staff criteria and State and Federal laws and regulations, the governing body (or responsible individual) decides whether or not to appoint new medical staff members or to continue current members of the medical staff.

Hospital A-0341

The medical staff makes recommendations to the governing body for each candidate for medical staff membership/privileges that are specific to type of appointment and extent of the individual practitioner’s specific clinical privileges, and then the governing body takes final appropriate action.
Organizations with Deemed Status

Know the Rules

• The Joint Commission (TJC)
• Det Norske Veritas (DNV)
• Healthcare Facilities Accreditation Program (HFAP)
• Others.............
State Regulations
And - Hospital Requirements too

- Governing Board Bylaws
- Medical Staff Bylaws
- Medical Staff Rules & Regulations
- Medical Staff Policies
- Hospital Policies (i.e. moderate sedation)

A-0048 & C-0241: The governing body must: Approve medical staff bylaws and other medical staff rules and regulations
Application Process
Application

- Complete
- Timely
- Legible
- Any Gaps explained
- All Malpractice claims disclosed & explained

Denver, Colorado: Fake surgeon pleads guilty to operating on dozens of victims Hernandez Fernandez’s Clinics (NOT A HOSPITAL!)
Verification of Individual Elements

- Licensure
- Education and Training, including Board certification
- Experience, Work History, Competency
- OIG Excluded Provider List
- National Practitioner Data Bank (NPDB)
- Peer References

The AMA Physician Profile can be used as primary source verification of medical school, internship(s), residency(cies), and/or fellowship(s) where applicable.
Verification of Individual Elements

• Past affiliations

• Liability Coverage
  – In amounts required by the Hospital

• Current health status and ability to perform privileges as requested
  – Attestation
  – Physical Exam
  – Peer References

• Identity
  – Passport
  – Drivers License
Verification of Individual Elements

• Include a picture of the applicant

• For competency evaluation Include the privileges requested

• For peer references and review of competency include review of:
  – Medical Knowledge
  – Technical & Clinical Skills
  – Communication Skills
  – Interpersonal Skills
  – Professionalism
<table>
<thead>
<tr>
<th>Checklist</th>
<th>YES</th>
<th>NO</th>
<th>NA</th>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Complete</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government Issued ID</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education and Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affiliations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State License</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OIG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPDB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malpractice Insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affiliations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer References</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information to support privileges requested</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Privileging Basics

• Don’t include procedures on your privilege list that are not performed at your Hospital (facility)

• Don’t grant privileges for procedures not performed at your Hospital (facility)

• There must be criteria established by the medical staff for granting privileges

• There must be evidence that the applicant “meets the criteria” for the privilege granted, including minimum volume requirements
Criteria Examples

• minimum number of admissions within the last 12 months

• minimum number of emergency department patients within the last 12 months

• minimum number of deliveries

• evidence of specific course / training / test
Those Pesky Volume Numbers? Who Decides?

**YES** Medical Staff

**YES** Governing Board

**NO** Medical Staff Coordinator

Achieving minimum volumes can be tough in small hospitals - Other methods of determining competency may be required

You are responsible for ensuring volume and/or evidence of competency is available to the MEC and Board at both appointment and reappointment and that information is specific to the criteria established by the medical staff.

However...
Core Privileges Example

INTRODUCTION OF CORE PRIVILEGES

Family medicine is the medical specialty which provides continuing, comprehensive health care for the individual and family. It is a specialty in breadth that integrates the biological, clinical and behavioral sciences. The scope of family medicine encompasses all ages, both sexes, each organ system and every disease entity.

Core privileges within the department of family medicine should reflect the core curriculum and training offered in accredited family medicine residency programs. The categories and core privileges listed are based on the “Program Requirements for Graduate Medical Education in Family Medicine,” a publication by The Accreditation Council for Graduate Medical Education (ACGME) (http://www.acgme.org/acWebsite/downloads/RRC_progReq/120pr706.pdf), and the “Recommended Curriculum Guidelines for Family Medicine Residents” endorsed by the American Academy of Family Physicians (http://www.aafp.org/x16524.xml). Resources for family physicians and hospitals for special non-core privileges can be found at the AAFP website at aafp.org, including the AAFP position paper on colonoscopy found at http://www.aafp.org/online/en/home/policy/policies/c/colonoscopypositionpaper.html.

ELIGIBILITY - Initial Privileges

To be eligible to apply for privileges in family medicine, the applicant must meet the following criteria:

Current certification or active participation in the examination process leading to certification in family medicine by the American Board of Family Medicine or the American Osteopathic Board of Family Physicians AND/OR

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited post-graduate training program in family medicine.

AND

Required current experience: Provision of care, reflective of the scope of privileges requested, for at least ____ inpatients as the attending physician during the past 12 months or successful completion of an ACGME – or AOA accredited residency or clinical fellowship with in the past 12 months.
Core Privilege Example

Renewal of privileges: To be eligible to renew privileges in family medicine, the applicant must meet the following criteria:

Current demonstrated competence and an adequate volume of experience, inpatients, with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applications for renewal of privileges.

FAMILY MEDICINE CORE PRIVILEGES

Core Privileges: Family Medicine

REQUESTED: Admit, evaluate, diagnose, treat, and provide consultation to patients of all ages, with a wide variety of illnesses, diseases, injuries, and functional disorders of the circulatory, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric, integumentary, nervous, female reproductive, and genitourinary systems. May provide care to patients in intensive care setting in conformance with unit policies. Assess, stabilize, and determine disposition of patient with emergent conditions consistent with medical staff policy regarding emergency and consultative call. The core privileges in this specialty include the procedures on the attached procedures list and such other procedures that are extension of the same techniques and skills.

INITIAL PRIVILEGES: Education and training as for family medicine core privileges.

AND

Required current experience: Demonstrated current competence.

Renewal of privileges: Demonstrated current competence.
Core Privilege Example

CORE PROCEDURE LIST
This is not intended to be an all-encompassing procedures list. It defines the types of activities/procedures/privileges that the majority of practitioners in the specialty perform at this organization and inherent activities/procedures/privileges requiring similar skill sets and techniques.

To the applicant: If you wish to exclude any procedures, please strike through the procedures that you do not wish to request and then initial and date.

General
- Performance of history and physical exam
- Arthrocentesis and joint injection
- Breast cyst aspiration
- Management of burns, superficial and partial thickness
- Excision of cutaneous and subcutaneous lesions, tumors, and nodules
- Incision and drainage of abscesses
- Performance of local anesthetic techniques
- Management of uncomplicated, minor, closed fractures and uncomplicated dislocations
- Performance of needle biopsies
- Performance of simple skin biopsy
- Peripheral nerve blocks
- Placement of anterior and posterior nasal hemostatic packing
- Removal of a non-penetrating foreign body from the eye, nose, or ear
- Suturing of uncomplicated lacerations
- Suprapubic bladder aspiration
Non-Core Privileges

Non-core privileges are requested individually in addition to requesting the core. Each individual requesting non-core privileges must meet the specific threshold criteria as applicable to the applicant.

Lumbar Puncture

**INITIAL PRIVILEGES:** Successful completion of an ACGME – or AOA-accredited residency in family medicine that included training in lumbar puncture OR completion of hands-on training in lumbar puncture under the supervision of a qualified physician preceptor.

AND

**Required current experience:** Demonstrated current competence and evidence of the performance of at least _ lumbar punctures_ in the past 12 months OR completion of training in the past 12 months.

**Renewal of privileges:** Demonstrated current competence and evidence of performance of at least ___ lumbar punctures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.
Privilege List

If you are using a privilege list that’s OK ———— However – there must still be criteria established for granting the privilege.

- Arthrocentesis and joint injection
- Breast cyst aspiration
- Management of burns, superficial and partial thickness
- Excision of cutaneous and subcutaneous lesions, tumors, and nodules
- Incision and drainage of abscesses
- Performance of local anesthetic techniques
- Management of uncomplicated, minor, closed fractures and uncomplicated dislocations
- Performance of needle biopsies
- Performance of simple skin biopsy
- Peripheral nerve blocks
- Placement of anterior and posterior nasal hemostatic packing
- Removal of a non-penetrating foreign body from the eye, nose, or ear
- Suturing of uncomplicated lacerations
- Suprapubic bladder aspiration
Professional Practice Review
Determining the Quality of Care

Process for determining if privileges should be continued / discontinued / revised

A-0340 Hospital
C-0240 CAH
TJC OPPE & FPPE
A-0340: Hospital

The medical staff must periodically conduct appraisals of its members.

- The medical staff must at regular intervals appraise the qualifications of all practitioners appointed to the medical staff/granted medical staff privileges. In the absence of a State law that establishes a timeframe for periodic reappraisal, a hospital’s medical staff must conduct a periodic appraisal of each practitioner. CMS recommends that an appraisal be conducted at least every 24 months for each practitioner.

- The purpose of the appraisal is for the medical staff to determine the suitability of continuing the medical staff membership or privileges of each individual practitioner, to determine if that individual practitioner’s membership or privileges should be continued, discontinued, revised, or otherwise changed.

- The medical staff appraisal procedures must evaluate each individual practitioner’s qualifications and demonstrated competencies to perform each task or activity within the applicable scope of practice or privileges for that type of practitioner for which he/she has been granted privileges.

- Components of practitioner qualifications and demonstrated competencies would include at least: current work practice, special training, quality of specific work, patient outcomes, education, maintenance of continuing education, adherence to medical staff rules, certifications, appropriate licensure, and currency of compliance with licensure requirements.

- In addition to the periodic appraisal of members, any procedure/task/activity/privilege requested by a practitioner that goes beyond the specified list of privileges for that particular category of practitioner requires an appraisal by the medical staff and approval by the governing body. The appraisal must consider evidence of qualifications and competencies specific to the nature of the request. It must also consider whether the activity/task/procedure is one that the hospital can support when it is conducted within the hospital. Privileges cannot be granted for tasks/procedures/activities that are not conducted within the hospital, regardless of the individual practitioner’s ability to perform them.
C-0240: Critical Access Hospital

The governing body (or responsible individual) must ensure that the medical staff is accountable to the governing body (or responsible individual) for the quality of care provided to patients. The governing body (or responsible individual) is responsible for the conduct of the CAH and this conduct would include the quality of care provided to patients.
TJC: Ongoing Professional Practice Evaluation (OPPE)

MS.08.01.03: Ongoing professional practice evaluation information is factored into the decisions to maintain existing privilege(s) to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

The process for the ongoing professional practice evaluation includes the following:

1. There is a clearly defined process in place that facilitates the evaluation of each practitioner’s professional practice.

2. The type of data to be collected is determined by individual departments and approved by the organized medical staff.

3. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).
Determining Quality of Care

• Define indicators:
  – Rate (statistic)
  – Review (case review)
  – Rule (accepted practice)

• Be measurable

• Be based on reliable and attainable data

• Utilize internal and external benchmarks

• Measure / monitor standard of care

• Have relevant volume information

• Monitor low volume, high risk, high volume, and problem prone procedures
Types of Indicators

Rate indicators
This type of indicator identifies cases or events that are aggregated for statistical analysis prior to review by the appropriate committee or administrative function. This type of indicator may be expressed as a percentage, average, percentile rank, or ratio. A target range should be established for each indicator. It may be based on best practice from benchmark data, statistical variation from the average, or internal targets, e.g. mortality or complication rates for surgical procedures.

Rate indicators
- Returns to ER within 24 hours
- Readmissions within 30 days
- Severity Adjusted Mortality Rate
- Severity Adjusted Complication Rate

Review indicators
This type of indicator identifies a significant event that would ordinarily require analysis by practitioner peers to determine cause, effect, and severity, e.g. intra-operative death or postoperative stroke.

Review indicators
- Intra-operative Death
- Mother / Infant Death
- BUT ALSO MAY INCLUDE
  - Transfers

Rule indicators
Rule indicators identify a practice or general rule of medicine that physicians should follow. If a physician does not follow these rules, he or she should be educated about the standard of practice, even if a patient has not been harmed. This feedback process allows you to encourage physicians to follow established best practices.

Rule indicators
- Core Measure compliance
- Medical Record Completion
Other Examples

Rate

- Unplanned Returns to ER within 24 hours
- Readmissions within 30 days
- Unplanned Returns to OR
- 2nd / 3rd degree laceration after delivery
- Induction Rate
- C-Section Rate
- Failure to Extubate
- OP median time to fibrinolysis more than 30 minutes

Review

- Transfers from ER
- Transfers from ICU
- Ventilator support more than 48 hours
- Use of reversal agents
- Trauma

MEDICAL STAFF DETERMINATION OF CASES THEY WILL REVIEW
Major events (sentinel events) should ALWAYS be reviewed.

Review indicators may be converted to rate indicator OR
Rate Indicators may be converted to review indicator
..., the revised credentialing and privileging standards have been informed throughout by the six areas of “General Competencies” developed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative.

**Patient Care:** Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, during and at the end of life.

**Medical Knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and application of their knowledge to patient care and the education of others.

**Practice-Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate and improve patient care.

**Interpersonal and Communication Skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and members of the health care team.

**Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession and society.

**Systems-Based Practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.
<table>
<thead>
<tr>
<th>Indicator – Specific to specialty</th>
<th>Data Source</th>
<th>Volume</th>
<th>Practitioner Data</th>
<th>Trigger</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENT CARE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality Rate Index</td>
<td>Premier</td>
<td>#</td>
<td>≤ 1.0 ≥</td>
<td>&lt;1.25 ≥</td>
</tr>
<tr>
<td>Complication Rate Index</td>
<td>Premier</td>
<td>#</td>
<td>≤ 1.0 ≥</td>
<td>&lt;1.25 ≥</td>
</tr>
<tr>
<td><strong>MEDICAL KNOWLEDGE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CME</td>
<td>Provider</td>
<td>NA</td>
<td># Credits</td>
<td>≤ 20</td>
</tr>
<tr>
<td>Core Measure Compliance</td>
<td>Quality</td>
<td>#</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>PRACTICE BASED LEARNING</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># cases referred to peer review</td>
<td>Quality</td>
<td># referred</td>
<td>2</td>
<td>≥ 5</td>
</tr>
<tr>
<td># cases classified as Level 2 or 3</td>
<td>MEC</td>
<td>#</td>
<td>0</td>
<td>&gt; 2</td>
</tr>
<tr>
<td><strong>INTERPERSONAL &amp; COMMUNICATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal orders not signed</td>
<td>HIM</td>
<td>#</td>
<td>0</td>
<td>&gt; 5</td>
</tr>
<tr>
<td>H&amp;P ≥ 24 hours after admission</td>
<td>HIM</td>
<td>#</td>
<td>0</td>
<td>&gt; 5</td>
</tr>
<tr>
<td>Lack of compliance with restraint documentation</td>
<td>NSG</td>
<td>%</td>
<td>6%</td>
<td>≥ 10%</td>
</tr>
<tr>
<td><strong>PROFESSIONALISM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Validated complaints from Patient / Family / Staff</td>
<td>Admin.</td>
<td>#</td>
<td>0</td>
<td>&gt; 2</td>
</tr>
<tr>
<td>Response time to the ER ≥ 30 minutes</td>
<td>ER</td>
<td>#</td>
<td>0</td>
<td>&gt; 2</td>
</tr>
<tr>
<td><strong>SYSTEM BASED PRACTICE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of compliance with NPSGs</td>
<td>Quality</td>
<td>#</td>
<td>0</td>
<td>&gt; 2</td>
</tr>
<tr>
<td>Severity adjusted LOS</td>
<td>Premier</td>
<td>≥ 30 admissions</td>
<td>≤ 1.0 ≥</td>
<td>≤ 1.25 ≥</td>
</tr>
</tbody>
</table>
TJC: Focused Professional Practice Evaluation - FPPE

MS,08.01.01: The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner’s professional performance.

1. **A period of focused professional practice evaluation is implemented for all initially requested privileges.**

2. **The organized medical staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified.**

3. The performance monitoring process is clearly defined and includes each of the following elements
   - Criteria for conducting performance monitoring
   - Method for establishing a monitoring plan specific to the requested privilege
   - Method for determining the duration of performance monitoring
   - Circumstances under which monitoring by an external source is required

4. **Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff.**

5. **The triggers that indicate the need for performance monitoring are clearly defined.**

6. **The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a practitioner’s current clinical competence, practice behavior, and ability to perform the requested privilege.**

7. **Criteria are developed that determine the type of monitoring to be conducted.**

8. **The measures employed to resolve performance issues are clearly defined.**

9. **The measures employed to resolve the performance issues are consistently implemented.**
FPPE Tips

1. FPPE is consistently applied

2. System is in place for notifying MEC when an indicator is outside of the established thresh-hold

3. System is in place for monitoring FPPE as determined by the medical staff (i.e. chart review, proctoring, etc.)

4. If FPPE not completed in the time specified --- MEC is notified
Quality of Care

Every provider must have evidence of the quality of care they provide at least every reappointment period.

If you do not utilize OPPE and only refer cases that meet pre-selected criteria for physician review ---- you MAY NOT be able to demonstrate that you are monitoring the quality of care.

CAH C-0241
The governing body (or responsible individual) must ensure that the medical staff is accountable to the governing body (or responsible individual) for the quality of care provided to patients.

Hospital A-0049
The governing body must: Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients
## Appointment & Reappointment Profile

<table>
<thead>
<tr>
<th>Volume / Activity Type</th>
<th>Volume within last 24 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td></td>
</tr>
<tr>
<td>Admissions/Observation/Swing Bed</td>
<td></td>
</tr>
<tr>
<td>Inpatient Surgical Procedures</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgical Procedures</td>
<td></td>
</tr>
<tr>
<td>Endoscopy</td>
<td></td>
</tr>
<tr>
<td>Emergency Department Patients</td>
<td></td>
</tr>
<tr>
<td>Deliveries Vaginal</td>
<td></td>
</tr>
<tr>
<td>Deliveries C-Sections</td>
<td></td>
</tr>
<tr>
<td>Anesthesia cases</td>
<td></td>
</tr>
<tr>
<td>(Anesthesia providers only)</td>
<td></td>
</tr>
<tr>
<td>Moderate Sedation</td>
<td></td>
</tr>
<tr>
<td>Invasive Imaging Procedures</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Volume / Activity Type</th>
<th>Volume within last ____ months</th>
<th>Was minimum volume thresh-hold met?</th>
<th>If no – other evidence of competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endoscopy</td>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Deliveries C-Sections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultrasound</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Sedation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appointment & Reappointment Profile

<table>
<thead>
<tr>
<th>Certification</th>
<th>Required for Privileges Requested</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

| BLS            |                                   |                 |
| ACLS           |                                   |                 |
| ATLS           |                                   |                 |
| NRP            |                                   |                 |
| Other          |                                   |                 |

### Review Outcome

<table>
<thead>
<tr>
<th>#</th>
<th>Review Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Level 1 - No deficiency identified</strong></td>
</tr>
<tr>
<td></td>
<td>The clinical practice is acceptable. Management is appropriate. If this was</td>
</tr>
<tr>
<td></td>
<td>an adverse outcome, the event was due to the patient’s illness or unavoidable</td>
</tr>
<tr>
<td></td>
<td>outcome.</td>
</tr>
<tr>
<td></td>
<td><strong>Level 2 - Opportunity for improvement</strong></td>
</tr>
<tr>
<td></td>
<td>Practice not necessarily routine. An event from a clinical situation, in which</td>
</tr>
<tr>
<td></td>
<td>management, when ideal, might have avoided outcome.</td>
</tr>
<tr>
<td></td>
<td><strong>Level 3 - Minor deficiency in care</strong></td>
</tr>
<tr>
<td></td>
<td>Questioned practice. An unexpected event involving minor error in diagnosis,</td>
</tr>
<tr>
<td></td>
<td>management, judgment, or technique.</td>
</tr>
<tr>
<td></td>
<td><strong>Level 4 - Major deficiency in care</strong></td>
</tr>
<tr>
<td></td>
<td>Questioned practice. An unexpected event involving major error in diagnosis,</td>
</tr>
<tr>
<td></td>
<td>management, judgment, or technique.</td>
</tr>
</tbody>
</table>

**TOTAL NUMBER OF CASES REVIEWED INTERNALLY:**

**TOTAL NUMBER OF CASES REVIEWED EXTERNALLY:**
Appointment & Reappointment Profile

CHECKLIST – This information for internal purposes only AND for review by Medical Staff Executive Committee and Governing Board

1. ____ Appointment Application
   Date Sent __________
   2nd req _____ 3rd req _____
   4th req _____ Date Received __________

2. ____ Privilege Request completed
   Date ______

3. ____ State License
   Expiration Date __________
   Number __________
   Primary source _____
   Verif date __________

4. ____ Licenses Other States
   Expiration Date __________
   Number __________
   Verification primary source _____
   Verification date _____

5. ____ DEA
   Expiration date ______
   Verification Date __________
| **Medical/Clinical Knowledge:** Does the information reviewed indicate that the practitioner demonstrates knowledge of established and evolving clinical practices by using evidence-based guidelines, when available, in selecting the most effective and appropriate approaches to diagnosis and treatment? |
|-------------------------------------------------|---|---|---|
| **Technical and Clinical Skills:** Does the information reviewed indicate that the practitioner demonstrates technical and clinical skills related to effectiveness and appropriateness in performing the clinical privileges as granted by achieving patient outcomes that meet or exceed generally accepted medical staff standards as defined by comparative data, medical literature, and results of peer review evaluations? |
| **Clinical Judgment:** Does the information reviewed indicate that the practitioner provides compassionate and effective patient care as evidenced by achieving acceptable patient outcomes and using sound clinical judgment? |
| **Interpersonal Skills:** Does the information reviewed indicate that the practitioner establishes and maintains professional relationships with other physicians and caregivers, patients and patients’ families? |
| **Communication Skills:** Does the information reviewed indicate that the practitioner effectively communicates with the patient, patient’s family, and the health care team? |
| **Professionalism:** Does the information reviewed indicate that the practitioner acts in a professional, respectful manner at all times to enhance a spirit of cooperation and mutual respect and trust among members of the patient care team; responds promptly to requests for patient care needs; respects patient’s rights by discussing unanticipated adverse outcomes and not discussing patient care information in public settings; and adheres to the Medical Staff Bylaws and Rules and Regulations? |
| Does the information reviewed indicate that the practitioner strives to provide cost-effective quality patient care by cooperating with efforts to manage the use of resources and by participating in the hospital’s efforts and policies to maintain a culture of safety, reduce medical errors, meet national patient safety goals, and improve quality? |
| Has litigation history documentation been reviewed and found to be acceptable? |
| Does the practitioner exhibit any signs of physical or behavioral disease sufficient to impair the ability to provide patient care? *(Explain only if answered Yes)* |
Don’t Forget Signatures!
CAH C-0196: Standard: Agreements for credentialing and privileging of telemedicine physicians and practitioners.

(1) The governing body of the CAH must ensure that, when telemedicine services are furnished to the CAH’s patients through an agreement with a distant-site hospital, the agreement is written and specifies that it is the responsibility of the governing body of the distant-site hospital to meet the following requirements with regard to its physicians or practitioners providing telemedicine services:

(i) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.

(ii) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff.

(iii) Assure that the medical staff has bylaws.

(iv) Approve medical staff bylaws and other medical staff rules and regulations.

(v) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.

(vi) Ensure the criteria for selection are individual character, competence, training, experience, and judgment.

(vii) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society.
Telemedicine – Distant Site Hospital

(2) When telemedicine services are furnished to the CAH’s patients through an agreement with a distant-site hospital, the CAH’s governing body or responsible individual may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site hospital regarding individual distant-site physicians or practitioners. The CAH’s governing body or responsible individual must ensure, through its written agreement with the distant-site hospital, that the following provisions are met:

(i) The distant-site hospital providing telemedicine services is a Medicare-participating hospital.
(ii) The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician’s or practitioner’s privileges;
(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the CAH is located; and
(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician’s or practitioner’s performance of these privileges and sends the distant-site hospital such information for use in the periodic appraisal of the individual distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH’s patients and all complaints the CAH has received about the distant-site physician or practitioner.
Telemedicine – Distant Site Entity

C-0197: The governing body of the CAH must ensure that when telemedicine services are furnished to the CAH’s patients through an agreement with a distant-site telemedicine entity, the agreement is written and specifies that the distant-site telemedicine entity is a contractor of services to the CAH and as such, in accordance with §485.635(c)(4)(ii), furnishes the contracted services in a manner that enables the CAH to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in this section with regard to its physicians and practitioners providing telemedicine services.

§485.616(c)(4) When telemedicine services are furnished to the CAH’s patients through an agreement with a distant-site telemedicine entity, the CAH’s governing body or responsible individual may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site telemedicine entity regarding individual distant-site physicians or practitioners. The CAH’s governing body or responsible individual must ensure, through its written agreement with the distant-site telemedicine entity, that the following provisions are met:

(i) The distant-site telemedicine entity’s medical staff credentialing and privileging process and standards at least meet the standards at (c)(1)(i) through (c)(1)(vii).

(ii) The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services, which provides a current list to the CAH of the distant-site physician’s or practitioner’s privileges at the distant-site telemedicine entity.

(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the CAH whose patients are receiving the telemedicine services is located.

(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician’s or practitioner’s performance of these privileges and sends the distant-site telemedicine entity such information for use in periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH’s patients and all complaints the CAH has received about the distant-site physician or practitioner.
Telemedicine – Quality of Care

Hospital: (iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician’s or practitioner’s performance of these privileges and sends the distant-site hospital such information for use in the periodic appraisal of the individual distant-site physician or practitioner.

At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH’s patients and all complaints the CAH has received about the distant-site physician or practitioner.

Telemedicine Entity: (v) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician’s or practitioner’s performance of these privileges and sends the distant-site telemedicine entity such information for use in periodic appraisal of the distant-site physician or practitioner.

At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH’s patients and all complaints the CAH has received about the distant-site physician or practitioner.
Telemedicine

1. Ensure your bylaws have a category specifically for Tele-Medicine

2. Develop specific privilege list(s) for tele-medicine

3. Don’t grant privileges for procedures you don’t perform

4. Don’t allow providers to provide services if privileges have not been granted by your governing board as recommended by the medical staff

5. Make sure licensure, medical staff membership at distant hospital or site --- and other information is CURRENT

6. You may have to do your own OIG checks, if the tele-medicine hospital / entity does not provide

7. You can utilize quality review data from tele-medicine hospital / entity ----- but you must have evidence of quality of care provided
Negligent Credentialing

On December 12, 2012, a Worcester Superior Court judge ruled that hospitals may be held liable for negligently granting physicians privileges to treat patients at their facilities.

In identifying the basis for the “negligent credentialing” cause of action, the Rabelo Court reasoned that a hospital has a duty to its patients to safeguard them from “incompetent or careless” physicians, and that such a duty is foreseeable given that they deal with the public.

The defendant physician in Rabelo had been credentialed and re-credentialed by a Massachusetts hospital despite a number of past and pending medical malpractice cases against him and having failed multiple board certification exams, in addition to eyesight that was apparently failing at the time of treatment.

The underlying negligence action arose from a surgical procedure performed by the physician on the plaintiff. Notably, Rabelo’s broad holding contemplates liability both when a hospital knows that the physician was “incompetent” and fails to take action, and when it fails to discover this incompetence prior to credentialing.

Summary
QUESTIONS?
THANK YOU

Learning Knows No Bounds
If you are interested in information about our Medical Staff consulting or have questions about other consulting products, please contact:

Carolyn St.Charles, RN, BSN, MBA  
Carolyn.stcharles@healthtechs3.com  
Telephone 360-584-9868

5110 Maryland Way, Suite 200  
Brentwood, TN 37027  
MAIN 615.309.6053  
FAX 615.370.2859  
www.HealthTechS3.com