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GAFFEY HEALTHCARE
TECHNOLOGY. RESULTS.

Medical Staff Credentialing and Privileging

Carolyn St.Charles, RN, BSN, MBA
Chief Clinical Officer, HealthTechS3
October 9, 2020

FORTY - EIGHT YEARS OF
Building Leaders | Transforming Hospitals | Improving Care

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Areas of Expertise

Strategy - Solutions - Support

Governance & Strategy

- Executive management & leadership development
- Community health needs assessment
- Lean culture

Finance

- Performance optimization & margin improvement
- Revenue cycle & business office improvement
- AR outsourcing

Recruitment

- Executive and interim recruitment
- CEOs, CFOs, CNOs
- VP and Department Directors

Clinical Care & Operations

- Continuous survey readiness
- Care coordination
- Swing bed consulting

Interim Executive & Department Leadership

Staffing Community Hospitals since 1971

HealthTechS3

Design.Build.Optimize → High Performance Teams

- **The Right Person** – Our experience and understanding of your hospital is the key to placing the right Executive or Department Leader
- **Immediate Response** – Interim needs are typically immediate. Our bench strength allows us to find the right executive quickly to provide a seamless transition
- **Experience** – Over 49 years of supporting executives & teams in hospitals and healthcare companies of all sizes
- **Support Services** – Our business is managing hospitals more efficiently. We provide comprehensive support services to all our Interim Executives and Department Leaders

- **Our Depth:**
We support all positions including CEO, CFO, CNO, CIO, Clinic Administration and Department Leaders

- **Interim Executive Placement Services:**
"Blue Mountain Hospital District has benefited from the interim executive placement services HealthTech S3 provides. Our current CFO started as an interim placement for BMHD, prior to joining our organization in a permanent capacity. The success with this placement has motivated us to consult Health Tech with two subsequent interim executive needs." **Derek Daly, CEO BMHD**

Retained | **Contingency** | **Interim** | **Contract**

Mentoring/Support Team

Every Interim Executive and Department Leader is backed by a support team and mentor who help ensure that the team gets the right results

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Design.Build.Optimize → High Performance Teams

Operations

Neil Todhunter
President

Mike Lieb
VP - Interim Placement

Derek Morkel
CEO

Clinical

Carolyn St. Charles
Chief Clinical Officer

Faith Jones
Director of Care Coordination and Lean Consulting

John Coldsmith
Clinical Consultant

Financial/RCM

John Freeman
AVP Finance

Kevin Stringer
AVP Finance

Joy Smith
Senior Patient Financial Consultant

Retained | **Contingency** | **Interim** | **Contract**

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ALL WEBINARS ARE RECORDED

2020 QUARTER 4 WEBINARS

Medical Staff Credentialing and Privileging: The Basics and Beyond
Presenter : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Date : October 9, 2020 **Time :** 12pm CST
https://bit.ly/36kIT5G

Care Coordination Staffing Strategies
Presenter : Faith M Jones, MSN, RN, NEA-BC - Director of Care Coordination and Lean Consulting, HealthTechS3
Date : October 29, 2020 **Time :** 12pm CST
https://bit.ly/3kSmK2S

Keeping Your Swing Bed Program Survey-Ready
Presenter : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Date : November 6, 2020 **Time :** 12pm CST
https://bit.ly/2GjPHWz

The Role of a Rural Hospital's Board in a Time of Crisis: Part 2
Presenter : Peter Goodspeed, Vice President of Executive Search
Date : November 13, 2020 **Time :** 12pm CST
https://bit.ly/3l4Hogl

It's Not If, But When: Is Your Organization Prepared for the Next Emergency Event
Host: : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Presenter : Dr. Frank Mineo, FACHE, CEM, CHSP, CHEP
Date : November 17, 2020 **Time :** 12pm CST
https://bit.ly/3n13Ybo

The Critical Early Days of a New Hospital Executive - Interim or Permanent
Presenter : Mike Lieb, FACHE – Vice President
Date : December 4, 2020 **Time :** 12pm CST
https://bit.ly/3cIY4XG

Advance Care Planning: Are Your Patient's Wishes Being Communicated?
Presenter : Faith M Jones, MSN, RN, NEA-BC - Director of Care Coordination and Lean Consulting, HealthTechS3
Date : December 7, 2020 **Time :** 12pm CST
https://bit.ly/3ihndtB

National Patient Safety Goals – What's New for 2021
Presenter : John A. Coldsmith, DNP, MSN, RN, NEA-BC
Date : December 18, 2020 **Time :** 12pm CST
https://bit.ly/2GjPUJl

Instructions & Disclaimer

- 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 our team (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

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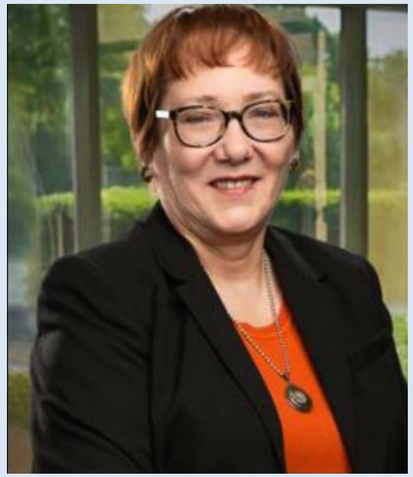
Presenter



Carolyn St.Charles,
Chief Clinical Officer
HealthTechS3

Carolyn began her career in healthcare as a staff nurse in Intensive Care. She has worked in a variety of staff, administrative and consulting roles. Carolyn has been employed by HealthTechS3 for more than 15 years and is currently the Chief Clinical Officer.

In her role as Chief Clinical Officer, Carolyn conducts mock surveys for Critical Access Hospitals, Acute Care Hospitals, Rural Health Clinics, Home Health, and Hospice. Carolyn also assists in developing strategies for continuous survey readiness and developing plans of correction.

Carolyn has extensive experience in working with rural hospitals to both develop, and strengthen, Swing Bed programs.

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Credentialing and Privileging

Credentialing: Process of assessing and confirming the license or certification, education, training, and other qualifications of a licensed or certified healthcare practitioner

Privileging: Process of authorizing a healthcare practitioner's specific scope and content of patient care services

Purpose of Credentialing and Privileging:

- Only qualified providers are appointed and reappointed as members of the medical staff
- Providers practice within the scope of their capabilities and expertise

NEGLIGENT CREDENTIALING

Negligent Credentialing

First case in US 1965: Court held that the hospital had an independent duty to ensure quality care is rendered in the hospital.

Darling v. Charleston Community Memorial Hospital, 1965
Mr. Darling, the plaintiff, broke his leg during a football game and was treated at Charleston Community Memorial Hospital by an on-call physician, who put Darling's leg in a cast.

Darling contracted gangrene afterwards, and his leg had to be amputated.

The plaintiff claimed—and the court agreed—that the hospital was negligent because it failed to properly review the work of the independent on-call physician, and because the plaintiff's nurse did not administer the appropriate tests at the point of care.

The court found that the hospital breached its duty to act as a reasonably careful hospital and protect the patient from receiving care below the standards established through the hospital's accreditation

Negligent Credentialing

Most states recognize negligent credentialing as a cause of action in litigation. Hospital has a duty to investigate, select, and retain only qualified and competent physicians, and its failure to do so can give rise to negligence.

Hospital may be found negligent if…….

- Hospital had a sound credentialing process, but failed to follow it
- Hospital followed its credentialing process, but the process was inadequate

REGULATORY REQUIREMENTS

Conditions of Participation

C-0962 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20) §485.627(a)
Standard: Governing Body or Responsible Individual

The governing body (or responsible individual) must determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.

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 to appoint new medical staff members or to continue current members of the medical staff.

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.

Conditions of Participation

A-0045 (Rev. 122, Issued: 09-26-14, Effective: 09-26-14, Implementation: 09-26-14)
The governing body must:§482.12(a)
(1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;

A-0046 (Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)
The governing body must: §482.12(a)
(2) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff;

Interpretive Guidelines §482.12(a)(2)
The governing body determines whether to grant, deny, continue, revise, discontinue, limit, or revoke specified privileges, including medical staff membership, for a specific practitioner after considering the recommendation of the medical staff.

In all instances, the governing body's determination must be consistent with established hospital medical staff criteria, as well as with State and Federal law and regulations.

Only the hospital's governing body has the authority to grant a practitioner privileges to provide care in the hospital.

A-0049 (Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)
The governing body must: §482.12(a)(5)

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

Conditions of Participation

C-0962 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20) §485.627(a) Standard: Governing Body or Responsible Individual

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

Conditions of Participation

A-0050 (Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)
The governing body must: §482.12(a)(6)
Ensure the criteria for selection are individual character, competence, training, experience, and judgment; and

Interpretive Guidelines §482.12(a)(6)
The governing body must assure that the medical staff bylaws describe the privileging process to be used by the hospital. The process articulated in the medical staff bylaws, rules, or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

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

The governing body must ensure that the hospital's bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.

Conditions of Participation

A-0051 (Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)
The governing body must:] §482.12(a)(7)
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.

Interpretive Guidelines §482.12(a)(7)
In making a judgment on medical staff membership, **a hospital may not rely solely on the fact that a MD/DO is, or is not, board-certified.**

This does not mean that a hospital is prohibited from requiring board certification when considering a MD/DO for medical staff membership, but only that such certification must not be the only factor that the hospital considers.

In addition to matters of board certification, a hospital must also consider other criteria such as training, character, competence and judgment.

After analysis of all of the criteria, if all criteria are met except for board certification, the hospital has the discretion to decide not to select that individual to the medical staff.

The Joint Commission

Introduction to Standard MS.06.01.01
Credentialing and Privileging - Overview

Determining the competency of practitioners to provide high quality, safe patient care is one of the most important and difficult decisions an organization must make. The development and maintenance of a credible process to determine competency requires not only diligent data collection and evaluation, but also the actions by both the governing body and medical staff.

The credentialing and privileging process involves a series of activities designed to collect, verify, and evaluate data relevant to a practitioner's professional performance.

These activities serve as the foundation for objective, evidence-based decisions regarding appointment to membership on the medical staff, and recommendations to grant or deny initial and renewed privileges.

In the course of the credentialing and privileging process, an overview of each applicant's licensure, education, training, current competence, and physical ability to discharge patient care responsibilities is established.

While the specific information that will be collected and analyzed to make decisions about granting privileges and medical staff appointment is developed by the medical staff and recommended to the governing body, the ultimate authority for granting, restricting, and revoking privileges rests with the governing body.

The range of information collected to make such decisions is clearly defined in governance documents.

The Joint Commission Medical Staff Chapter

MS.06.01.01: Prior to granting a privilege, the resources necessary to support the requested privilege are determined to be currently available, or available within a specified time frame.

MS.06.01.03: The critical access hospital collects information regarding each practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.

MS.06.01.05: The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.
EP2: The critical access hospital, based on recommendations by the organized medical staff and **approval by the governing body**, establishes criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested.

MS.06.01.07: The organized medical staff reviews and analyzes all relevant information regarding each requesting practitioner's current licensure status, training, experience, current competence, and ability to perform the requested privilege.

MS.06.01.09: The decision to grant, limit, or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting practitioner within the time frame specified in the medical staff bylaws.

MS.06.01.13: Under certain circumstances, temporary clinical privileges may be granted for a limited period of time.

MS.07.01.01: The organized medical staff provides oversight for the quality of care, treatment, and services by recommending members for appointment to the medical staff.

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

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

MS.09.01.01: The organized medical staff, pursuant to the medical staff bylaws, evaluates and acts on reported concerns regarding a privileged practitioner's clinical practice and/or competence.

GOVERNING BOARD RESPONSIBILITIES

Governing Board Core Responsibilities

The legal authority to approve, limit or deny provider credentials and privileges is a fundamental board responsibility.

The board's accountability and responsibility for oversight of medical staff credentialing exists primarily to:

- protect patients
- assure fair, thorough and consistent treatment of providers in the credentialing process

An effective credentialing and privileging process improves the quality of care that patients receive and lessens the probability of harm

Why Isn't the Recommendation of the Medical Staff Sufficient?

If the medical staff recommends the applicant.....

Why isn't that sufficient evidence for the Board to appoint or reappoint?
Why should the Board also have to review the file?

The governing board **CANNOT** delegate authority for credentialing!
The governing board assumes responsibility and liability!

The defense "*recommended by MEC*" – has been found by the courts to be insufficient.

It's Not Always Easy

Board may be uncomfortable

- *"I'm not a doctor"*
- *"I don't speak medical"*
- *"I don't really know what I'm supposed to be doing"*
- *"I was told I had to follow the medical staff's recommendation"*

Physicians may feel threatened

- *"They (board) can't tell me how to practice medicine"*
- *"Only physicians know which providers should have privileges"*
- *"The board doesn't understand medical care – it's not their job to determine who can practice at our hospital"*
- *"We do a great job of reviewing credential files – that should be sufficient"*

Different Roles & Responsibilities

Governing Board Focuses on the Integrity of the Credentialing Process

- Knowledge of and meaningful oversight of process
- Work with medical staff to assure performance criteria for appointment, reappointment and privileging set the quality and safety bar high
- Review recommendations against criteria established by medical staff and ask questions
- Verify that process is applied and consistent for all applicants
- Appoint providers to medical staff and grant privileges

Medical Staff Develops the Credentialing Process

- Ensures that the privileges reflect the type of services provided
- Develops criteria that is evidence-based
- Determines how (method) to evaluate providers
- Assesses performance
- Makes recommendations to governing board

Governing Board Review

Ask questions about **every** file:

- Is the file complete?
- Are there specific performance data required by privileges? (volume, certification, etc.) – and has the criteria been met?
- Are there any red flags?
- Have the red flags been explained to the board's satisfaction?

- ➢ Don't accept the file if it is incomplete!
- ➢ Ask questions
- ➢ Don't rubber stamp!

Governing Board Options

1. Approve the credentials and privileges as recommended by the medical staff

2. Send the file back to the medical staff for further review and clarification of questions

3. Recommend limitations, including extended probationary period, proctoring, additional education, etc.

4. Do not approve
   - If the provider is not appointed or reappointed, it is prudent to ask for a legal review since denial is reportable to the National Practitioner Data Bank (NPDB) – and usually results in an appeal by the provider

Governing Board and Medical Staff Collaboration

1. Address ALL discrepancies and inconsistencies in appointment and reappointment file

2. Keep the burden on the applicant

3. Only process complete applications

4. Review privilege request forms for every specialty in collaboration with medical staff at least every two years – or – any time a new service is added

5. Review performance and outcome measures in collaboration with medical staff at least every two years – or – any time a new service is added

6. Review the credentialing and privileging processes in collaboration with medical staff at least every two years. Work thru privileging issues before there is a problem.
   - What's working?
   - What's not working?
   - What can we improve?

7. Schedule board education at least every two years – and as part of new board member orientation

Best Practices always benefit the patient – not the practitioner!

APPLICATION PROCESS

Application

A pre-application process is strongly recommended

1. Proof of Identity
2. Education and Training
3. Military Service
4. Professional Licensure
5. Drug Enforcement Administration (DEA)
   - Any other required by state such as state Controlled Substance Registration (name by vary by state)
6. Board Certification
7. Affiliation and Work History
8. Criminal Background Disclosure
9. Sanctions Disclosure
10. Health Status
11. National Practitioner Data Bank (NPDB)
12. OIG Excluded Provider List
13. Malpractice Insurance
14. Professional and Peer References
15. Consider – Internet and Social Media
16. Consider – Compare CV provided by applicant to actual application

And…

- Evidence that the applicant has the education, training and experience for the privileges requested
- Evidence that the applicant meets the criteria established by the medical staff for the privileges requested including minimum volumes

Initial Applicant Red Flags

- ✓ Unexplained or unaccounted time gaps in education or work history
- ✓ Discrepancies between applicant's information and verification information
- ✓ Altered documents
- ✓ Resignation or withdrawal of an application for appointment or reappointment from hospital, healthcare entity, or professional organization
- ✓ Previous adverse actions / disciplinary actions by another hospital, healthcare entity, professional organization, or third-party payor (including Medicare, Medicaid, or private insurance)
- ✓ Past, present or pending investigations by hospitals, state medical boards, professional societies, or state licensing boards
- ✓ Any claims or investigations of fraud, abuse and/or misconduct from professional review organizations, third party payers, or government entities
- ✓ Drug and alcohol abuse. Participation in last five years in any treatment or diversion program relating to drug use, alcohol dependency, or psychiatric issues
- ✓ Criminal investigations, charges, and/or actual convictions of a misdemeanor or felony

Initial Applicant Red Flags

- ✓ Cancelled malpractice insurance
- ✓ Insufficient or unverified coverage for malpractice insurance
- ✓ Settlement of any professional liability claims (whether or not they resulted in litigation) within the past five years
- ✓ Multiple lawsuits either settled or pending
- ✓ Other civil litigation relating to professional practice or qualifications (claims of sexual misconduct with patients or claims of insurance fraud)
- ✓ Frequent job changes
- ✓ Involuntary resignation
- ✓ Suspicious reference letters
- ✓ No response or incomplete response to a reference inquiry from an applicant's past affiliation
- ✓ Difficulty in verifying compliance with general requirements such as training, education, professional liability coverage, etc.
- ✓ Inappropriate internet or social media posts

Easier to say NO at the time of pre-application or application, than to remove a provider from the medical staff

Reappointment Review

Many elements are the same as the initial appointment, but should also include…

1. Continuing education
2. Attendance at medical staff meetings (if required)
3. Volume specific to procedures or disease specific privileges
4. Certification and training including training required by medical staff or hospital (antibiotic stewardship, restraints, safe opioid prescribing, etc.)
5. Clinical outcome data specific to procedures or disease (part of OPPE if TJC accredited)
6. Summary of peer review findings (part of OPPE if TJC accredited)
7. Staff / patient / peer complaints (part of OPPE if TJC accredited)
8. Chief of Staff or Department Chief review of performance

Includes tele-medicine providers

Reappointment Applicant Red Flags

Many elements are the same as the initial appointment, but should also include…

- ✓ Less than satisfactory letters of reference
- ✓ Elapsed certification (i.e. ACLS, ATLS, etc.)
- ✓ Minimum volume thresh-holds not met
- ✓ Clinical outcome data show a negative / adverse pattern
- ✓ Documentation of behavioral issues / disruptive behavior
- ✓ Patient complaints / Poor patient satisfaction scores
- ✓ Malpractice claims during reappointment period

PROVIDER PROFILE

Profile

To make it easier for the medical staff and the board to review, develop a provider profile that includes:

1. Basic profile information (license, certification, malpractice, insurance, peer references, etc.)
2. Privileges requested, specifically identify any new privileges requested since last appointment
3. Activity / volume - including minimum volumes required for specific privileges
4. Certification and Training
5. Peer Review Summary
6. Performance Indicators
7. Chief of Staff Review

Very Important
Provide the profile to EVERY board member for EVERY appointment / reappointment

Profile Example - Activity

Volume / Activity Type	Volume	Minimum volume thresh-hold If applicable		If volume was not met – other evidence of competency	Plan to mitigate (proctor, education, etc.)
		YES	NO		
Admissions					
Emergency Dept. Visits					
Deliveries					
Endoscopy					
C-Sections					
Ultrasound					
Laparoscopic Surgery					
Moderate Sedation					

Profile Example – Certification and Training

Certification or Training	Required for privileges requested or by hospital policy		Plan (If requirement not met)
	YES	NO	
BLS			
ACLS			
ATLS			
PALS			
NRP			
Opioid Use Reduction			
Antibiotic Stewardship			
Safe Restraint Use & Ligature Safe Environment			

Profile Example – Peer Review Outcomes

Peer Review	Number of Records Reviewed
Level 1 – No deficiency identified The clinical practice is acceptable. Management is appropriate. If this was n adverse outcome, the event was due to the patient's illness or unavoidable outcome.	
Level 2 – Opportunity for improvement Practice not necessarily routine. An event from a clinical situation, in which management, when ideal, night have avoided outcome	
Level 3 – Minor deficiency in care An unexpected event involving minor error in diagnosis, management, judgment, or technique.	
Level 4 – Major deficiency in care An unexpected event involving major error in diagnosis, management, judgment, or technique	
Total number of cases reviewed internally:	
Total number of cases reviewed externally:	

Performance Criteria Categories

1. Peer Review
2. Minimum Volumes
3. Clinical Outcomes
    - Infection Rate
    - Complications
    - Mortality
    - Readmissions
    - Other specific to practice area
4. Behavioral Issues/Disruptive Behavior
5. Patient Complaints
6. Malpractice Claims

Performance Criteria

Performance Criteria can be qualitative or quantitative (*more info included as part of discussion about FPPE and OPPE*)

- Objective
- Include ALL providers (although criteria may be different by specialty

Medical Staff and Governing Board should always receive a summary of the providers clinical outcome data at reappointment

General statement ---- "***provides quality care***" is not sufficient

Example – Performance Criteria Surgery

Performance Indicator *Applies to all specialties	Data Source	Practitioner Data	Triggers for Review
PATIENT CARE			
Mortality Rate			
Complication Rate			
Surgical Site Infections			
Return to OR			
MEDICAL KNOWLEDGE			
*CME			
PRACTICE BASED LEARNING			
*Number of peer reviewed cases classified as Level 2 or 3			
INTERPERSONAL AND COMMUNICATION			
*Validated complaints from patient / family / staff / peers			
*Patient satisfaction scores			
SYSTEMS BASED PRACTICE			
*Compliance with National Patient Safety Goals including Universal Protocol (Site Marking and Time-Out)			
H&P completed within 30 days of surgical procedure			
H&P updated within 24 hours of surgical procedure			

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Profile Example – Chief of Staff Review

Chief of Staff or Chief of Department Review	Yes	No	Comments
Medical / Clinical Knowledge: Does the information reviewed indicate that the provider 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 provider 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 Judgement: Does the information reviewed indicate that the provider provides compassionate and effective patient care as evidenced by achieving acceptable patient outcomes and using sound clinical judgement?			
Interpersonal Skills: Does the information reviewed indicated that the provider establishes and maintains professional relationships with other physicians, caregivers, patients, and patient's families?			
Communication Skills: Does the information reviewed indicate that the provider effectively communicates with the patient, patient's family and the healthcare team?			
Professionalism: Does the information reviewed indicated that the provider 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 & Regulations			
Quality of Care Does the information reviewed indicate that the provider strives to provide cost-effective quality patient care by cooperating with efforts to manage the use of resources, and by participating gin the hospital's efforts and polices to maintain a culture of safety, reduce medical errors, meet national patient safety goals and improve quality			
Litigation: Has the ligation history documentation been reviewed and found to be acceptable?			
Health: Does the provider exhibit any signs of physical or behavioral disease sufficient to impair the ability to provide patient care (Explain if Yes)			

Other Considerations

Tele-Medicine

Process is essentially the same as other providers – except – if you use delegated credentialing the basic information may be provided by the tele-medicine entity

The governing board must still approve the tele-medicine provider

Performance data must still be reviewed as part of appointment/reappointment process

Mid-Levels

Process for mid-level providers (nurse practitioners and physician assistants) is essentially the same as for physicians

OPPE AND FPPE

OPPE and FPPE

- Joint Commission requires Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE)

- FPPE requires a period of review when privileges are first granted – or – when issues with a provider's performance are identified
  - *Most hospitals who are not TJC accredited – still have a provisional period to evaluate competence*

- OPPE is an ongoing process of collecting and reviewing performance data for each provider based on indicators developed by the medical staff. The medical staff defines frequency – however – must be at a frequency less than annually.
  - *Periodic review is "best practice" even for non-TJC accredited hospitals*

FPPE – Provisional or Corrective Action

Performance monitoring process must be clearly defined and must include (per TJC)

- Criteria for conducting performance evaluations
- Method for establishing the monitoring plan specific to the requested privilege
- Method to determine the duration of performance monitoring
- Circumstances under which monitoring by an external source is required

FPPE – Provisional or Corrective Action

- Can include both qualitative and quantitative data
  - Qualitative: Chart Review
  - Qualitative: Proctoring

  - Quantitative: Readmissions
  - Quantitative: Surgical site infections

- Typically for a specified duration of time

OPPE – Qualitative Data

Qualitative and Quantitative Data

Qualitative Data: Data that approximates and characterizes and usually is not numerical

- Quality / accuracy of documentation
- Patient complaints
- Staff complaints
- Patient outcomes
- Peer recommendations
- Quality of medical care (Peer Review)

OPPE – Quantitative Data

Qualitative and Quantitative Data

Quantitative Data: Measurable numerical data

- Length of stay
- Readmissions
- Post-procedure infection rates
- Labor induction rates
- Required documentation (H&P within 24 hours, etc.)
- Compliance with core measures
- Complaints – *may be quantitative or qualitative. Quantitative would include number of complaints*

A FEW COMMON PROBLEMS
and
A FEW RECOMMENDATIONS

Problem: Governing Board members do not review credential file – or – summary information

Recommendations

- Consider Joint Conference Committee for credential review (Governing Board and Medical Staff)
- Appoint one governing board member to review files in detail
- Make files available on intra-net (secure site)
- Distribute "detailed" overview of credentialing and privilege request (as described) to ALL governing board members.

Problem: Summary information at time of appointment or reappointment is not complete or sufficiently detailed

Recommendations

- Develop a standardized template for summary information

- Ensure summary includes ALL requirements that have been established for privileges (volume, certification, etc.)

Problem: Core Privileges are not specific enough ---

- very general
- do not include description of procedures or types of patients

Recommendation

Review and revise privilege forms

Example

Privileges included in the core:

- ❑ Privileges to admit, evaluate, diagnose, consult, perform history and physical exam, and provide treatment for non-surgical patients without life threatening complications
- ❑ Suture of uncomplicated lacerations
- ❑ I & D abscesses
- ❑ Performance of simple skin biopsy or excision
- ❑ Removal of non-penetrating corneal foreign body, foreign body from conjunctival sac, ear, nose, skin
- ❑ Management of uncomplicated minor closed fractures and uncomplicated dislocations
- ❑ Lumbar Puncture
- ❑ Anoscopy, I & D acute thrombosed hemorrhoid
- ❑ Diaphragm fitting, Endometrial biopsy, IUD insertion and removal
- ❑ Aspiration of intra-, subcutaneous cysts, furuncles, etc.
- ❑ ETC.

Problem: Privilege requests include procedures or types of care not provided at the hospital

Recommendation

Review privilege lists at least annually with MEC or Department Chairs and revise as needed.

Problem: Criteria are <u>not</u> established for either core privileges or special privileges

Recommendation

Review or develop criteria for both core and special privileges. Every special privilege should have criteria

<u>Core Privilege Example</u>

- Education / Training: Successful completion of ACGME or AOA-accredited residency in family practice or foreign equivalent training
  AND
- Current certification or active participation in the examination process leading to certification in Family Medicine by the American Board of Family Medicine or by the American Osteopathic Board of Family Physicians or foreign equivalent training/board.
  AND
- Documentation or attestation of the management of general medicine problems for at least 100 inpatients or outpatients as the attending physician (or senior resident) during the past two years.

<u>Special Privilege Example</u>

- Fiberoptic sigmoidoscopy with biopsy. Criteria – 10 cases in the past two years (initial only)
- Colposcopy. Criteria: 10 cases in the past two years (initial only)
- Newborn circumcision. Criteria 10 cases in the past two years (initial only)
- No scalpel vasectomy: Initial criteria – letter from residency program documentation competency or documentation of a minimum of 5 cases. Renewal criteria – Minim 3 cases during the past two years

Problem: Lack of documentation that criteria has been met to be granted initial privileges or to continue privileges

- i.e., Chart Review
- i.e., Minimum Volume
- i.e., Training (course in laser surgery, ultrasound training, moderate sedation test, etc.)
- i.e., Certification (ACLS, PALS, ATLS, etc.)

Recommendations

- Develop spread sheet that identifies ALL criteria and if it has been met

- Submit spread sheet with credential file.

Problem: FPPE or Provisional Period requirements as determined by medical staff are NOT completed

- observation of first 2 laser surgery cases
- chart review of the first 10 cases
- Etc.

Recommendations

- Develop reliable method to both identify and track in collaboration with Chief of Staff or Department Chair

- Provide departments (surgery, emergency department, etc.) information about requirements for each provider

- Maintain a spread sheet with requirements for each provider and if they have been met

- **Ensure** that the provider is actually aware of the requirements

Problem: Low volume

Recommendation

- Consider “proxies” for volume such as ongoing professional education, proctoring, chart review, etc.

Problem: New equipment / procedure initiated outside of privileging cycle
Problem: Criteria not developed for new criteria or procedure
Problem: Provider not credentialed for new criteria or procedure

Recommendations

- Ensure communication loop between Medical Staff Coordinator and other departments (surgery, ICU, purchasing, etc.) to help identify new services / procedures

- Include medical staff privileging criteria as part of any new service review and approval

Problem: Lack of performance criteria established for mid-levels (NP, PA)
Problem: Lack of physician performance review of mid-levels (NP, PA)

Recommendations

- Ensure physicians and mid-levels are aware of requirement
- Ensure performance review is documented.
- Develop an appointment / reappointment profile for mid-levels (the same format as physicians)

Questions

HEALTHTECH S3
strategy solutions support

THANK YOU

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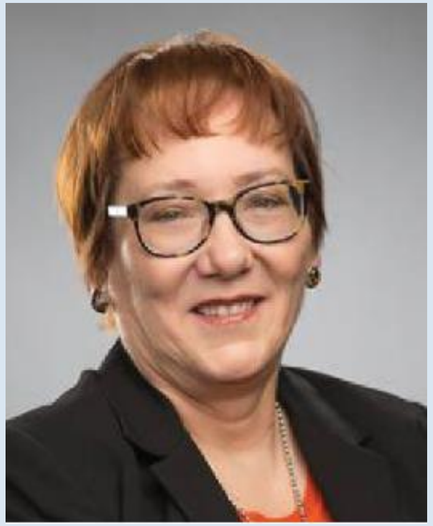
TECHNOLOGY. RESULTS.



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Chief Clinical Officer

I hope this information has been helpful! If you are interested in a review of medical staff credentialing & privileging, or a mock survey, please contact me.

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