TH-11-1 Concurrent Session ✪ 1:30-3:00pm

Credentialing 102

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Credentialing Across the Continuum

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Learning Objectives

At the conclusion of this presentation the attendee will be able to:

- Articulate the purpose of credentialing
- Describe key elements of the credentialing and privileging process that represent 'best practice'
- Analyze complex credentialing issues
- Be able to defend a credentialing recommendation to physician leaders
- Implement at least one improvement to current processes
- Understand and internalize the importance of his/her role in ensuring patient safety

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Focus

- Why do we do what we do?
- What is credentialing
- Credentialing/privileging process
- Appointment
- Initial appointment
- Reappointment/reappraisal
- Case studies

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Key Terms & Definitions

- Physician: Medical Doctor/Doctor of Osteopathic Medicine licensed and privileged to practice without supervision; also known as LIP.
- LIP: Other Licensed Independent Practitioner who is licensed and privileged to practice without supervision (podiatrist, dentists and in some settings may be, advanced practice nurse, psychologist).
- APP: Advanced Practice Professional provides direct patient care services under a defined degree of supervision (advanced practice nurse, psychologist, physician assistant)
- Peer: Professionals of similar types and degrees of expertise (e.g. DPM=DPM, MD/DO=MD/DO, PA=PA, APRN=APRN, MD/DO can be a peer for PA and APRN)

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- Peer review: Objective case review by a peer to determine appropriateness of care (usually triggered by medical staff approved criteria).
- Focused Professional Practice Evaluation (FPPE): A process whereby the organization evaluates the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege at the organization.
- Ongoing Professional Practice Evaluation (OPPE): A screening tool to evaluate all practitioners who have been granted privileges and to identify those clinicians who might be delivering an unacceptable quality of care.
- Performance improvement: actions taken to change a process or function to positively change outcome (target is process variation).

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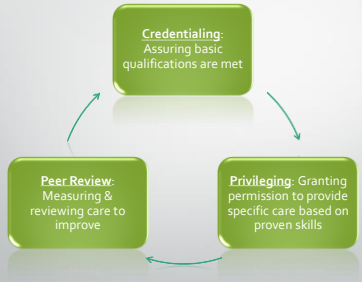
Three Mega Processes: One Strategic Priority



Why we do what we do -

- Patient safety!!!
- Regulation & accreditation compliance: TJC, CMS, URAC, AAAHC, DNV, etc.
- Healthcare entity liability/risk management: Negligent Credentialing

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#1 Reason for Credentialing/Privileging

Patient Safety

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H. H. Holmes

- Born: May 16, 1861
- Died: May 7, 1896
- New Hampshire born general practitioner
- Convicted Serial Killer
- Between 1888-1894 murdered between 9-200 (9 confirmed; confessed to 27)

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John Bodkin Adams

- Born: January 21, 1899
- Died: July 4, 1983
- An Irish-born British general practitioner
- Convicted fraudster, and suspected serial killer
- Between 1946 and 1956, more than 160 of his patients died in suspicious circumstances.

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Michael Swango aka Doctor of Death

- Born: October 21, 1954
- Date of Arrest: June 1997
- A Washington born general practitioner
- Convicted serial killer
- Between 1981 and 1997, more than 50 of his patients died in suspicious circumstances.

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John A King

- Born: August 15, 1957
- Started many residencies in various specialties; never completed any
- Multiple Adverse Actions
- Moved around frequently
- Performed unnecessary surgeries
  - Caused over 100 malpractice claims – tens of millions $$
    - For medically unnecessary surgeries
    - For procedures resulting in harm to the patient

John A. King

http://www.spartacus.blogs.com/spartacus/2005/09/Doctors_tale.html

Christopher Duntsch

- Born: April 3, 1971
- Medically unnecessary surgeries
- Injuries and deaths
- Reports of impairment
- TX Board of Medicine suspended his license in June 2013 at an emergency meeting

http://www.texasobserver.org/anatomy-tragedy/

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History

- Efforts to evaluate physicians based on their "credentials" not new.
- The early players in the physician quality movement were large private organizations such as Kaiser Permanente and Blue Cross.
- A few pioneers interested in improving performance.

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History – Cont'd

- Many motivated by case law:
  - Darling vs. Charleston (1965) – end of charitable immunity doctrine (improper supervision)
  - Purcell vs. Tucson General (1972) – hospitals assume duty of supervising competence (improper review of clinical competence)
  - Gonzalez vs Nork (1976) hospitals owe patients a duty of care (failure of peer review process)
  - Johnson vs. Misericordia (1981) – hospitals responsible for what would have been revealed (negligent credentialing)
  - Elam vs. College Park (1982) hospitals responsible for treatment rendered (improper supervision)
  - Patrick vs. Burget (1988) – Antitrust laws applied to negative peer review

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History – Cont'd

Darling vs. Charleston (1965)

Facts:

- Hospital duty to supervise physician
- 18 year old broke his right leg, went to the ER, and was treated by a general practitioner, who placed him in a cast.

Allegations:

- Hospital was negligent
  - Physician :
    - Did not update his operative procedures (continuing medical education)
    - Was not required to consult with patient after complications set in.

End Result:

- Loss of leg
- Verdict upheld for the patient
  - Noting that hospitals do more than just provide facilities for treatment, they also assume responsibilities for the care of the patient.

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History – Cont'd

Purcell vs. Tucson General (1972)

Facts:

- Improper Review of Clinical Competence
- 62 year old with colon obstruction

Allegations:

- Hospital failed to take action against attending surgeon
- Hospital knew, or should have known that he lacked the skill to treat diverticulitis.

End Results:

- Loss of a kidney and a permanent colostomy.
- Verdict upheld for the patient
  - Noting that two prior cases had been presented to the department of surgery but no action had been taken
  - A total of 4 malpractice cases has been filed against the physician and the hospital prior to this case.
  - The hospital had ample notification of concerns as to Dr. Purcell's clinical competence
  - Hospital should have reviewed his records and taken action prior to this case.

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History – Cont'd

Gonzalez vs. Nork (1976)

Facts:

- Failure of peer review process
- Gonzales was a young man injured in an auto accident in California.
- Dr. Nork performed a laminectomy

Allegations:

- Physician did not inform patient of more conservative treatment options available for his spinal injury.
  - The indication for which was questionable, resulted in complications.
  - Over the course of the previous nine years, Dr. Nork had performed 36 unnecessary or injurious laminectomies.

End Results:

- Verdict: Upheld for the patient
- Hospital has a duty to create a peer review mechanism by which it may discover inadequacies of its medical staff members
  - Hospital should have known of Dr. Nork's substandard practice and taken steps to protect other patients.

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History – Cont'd

Johnson vs. Misericordia (1981)

Facts:

- Failure of initial credentialing process
- A Wisconsin orthopedist severed Johnson's femoral artery and nerve during surgery

Allegations:

- The hospital negligently granted orthopedic privileges to Dr. Salinsky.
- In fact, no investigation was made on any of the information provided on his application form.
- His orthopedic privileges had been denied and/or restricted
- He had been denied appointment at other hospitals that he listed as active.

End Results:

- Verdict: the hospital failed to check the physician's background
  - Did not fulfill its duty "to exercise due care in the selection of its medical staff."
  - This case laid out hospitals' legal duty for credentialing physicians.

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History – Cont'd

Insinga v. LaBella (1989)

Facts:

- Negligent credentialing

Allegations:

- In this dramatically illustrative credentialing case in Florida, a fugitive from Canadian justice
  - Masquerading as a physician
  - Fraudulently secured a medical license
  - Obtained hospital staff privileges
  - Became the hospital's medical director

End Results:

- The Florida Supreme Court held the hospital responsible for failing to credential the "physician"

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What is Credentialing?

Credentialing is a three-phase process of assessing and validating the qualifications of an individual to provide services. The objective of credentialing is to establish that the applicant has the specialized professional background that he or she claims and that the position requires. An organization should

1. Establish minimum training, experience, and other requirements for physician, LIPs and APPs
2. Establish a process to review, assess, and validate an individuals' qualifications, including education, training, experience, certification, licensure, and any other competence-enhancing activities against the organization's established minimum requirements; and
3. Carry out the renew, assessment , and validation as outlined in the organization's description of the process

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What is Privileging?

Privileging is a three-phase process to determine the specific procedures and treatments that an physician/LIP/APP may perform. An organization should:

1. Determine the clinical procedures and treatments that are offered to patients;
2. Determine the qualifications related to training and experience that are required to authorize an applicant to obtain each privileges; and
3. Establish a process for evaluating the applicant's qualifications using appropriate criteria and approving, modifying, or denying any or all of the requested privileges in a non-arbitrary manner.

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What is credentialing vs. privileging?

Credentialing

- Process of obtaining, verifying and assessing the basic qualifications of an applicant (licensure, relevant training or experience, and current competence) to provide patient care, treatment, and services for a health care organization
- Basis for making medical staff/network appointment/affiliation decisions
- Provides some of the basic information needed for the granting of clinical privileges to physician, LIPs and APPs

Privileging

- Process of determining competence in specific procedures.
- Based on established criteria
  - Training and/or experience in the procedure
  - Numbers of procedures performed
  - Peer references (from targeted individuals)
  - Outcomes data when available

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The Credentialing Process

- Credentialing Policy/Criteria
- Application process
- Verification (information gathering)
- Analysis (threshold criteria)
- Evaluate privileges requested against training/experience
- Analysis
- Review/Decision Making
- FPPE and OPPE
- Recredentialing / Reappraisal

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POLICY

- State your process
  - What to obtain
  - Verification process
- Define threshold criteria
  - Basics
    - License
    - DEA
    - Education
    - Training
    - Malpractice
    - Board Certification
  - Advanced
    - No patient care adverse actions against license

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Initial Application

- Basic facility services – closed medical staff/section/department, services offered, proximity of practice
- Basic threshold criteria – education/training (by approved accrediting body), board certification, licensure, etc.

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Initial Application Packet

- Cover letter
- Application
- Privilege form (specific to the specialty – should include threshold criteria)
- Bylaws
- Other
  - Policies- Code of Conduct, Health and Wellness
- Checklist of required documents
  - Completed Application
  - Certificate of Insurance
  - Life Support Certificates
  - Driver's License
  - Photo
  - Other facility specific forms (reflex testing, IT&S Access Form)
  - Provider Acknowledgement Statement

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Application Form

- Texas Standardized Application form
- Form includes:
  - Local demographics
  - Need to know information (not required under the standards)
    - Other names used
    - Email addresses
    - Visa status/number
    - Office manager name and number
  - Education:
    - Institution's name/address/phone
    - From mm/yyyy to mm/yyyy
    - ECFMG (foreign medical education

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Application Form – Cont'd

- Training/Certification
  - Institutions Name
  - Type of Program
  - Training Program Director name, address, phone number, email address
  - From mm/yyyy
  - Program completed? (if not, why?)
  - Gaps to be explained
  - Board certification/APP certification

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Application Form – Cont'd

- Licensure/Registration
  - State (current and past)
  - Disciplinary actions, sanctions, challenges (current/past)
  - DEA – check that providers DEA State of address (TX) matches your "entity" State on DEA, and has all schedules
  - CPR, BLS, ACLS, PALS – expiration date if required for privileges
- Healthcare affiliations:
  - Facility name/address/phone/fax/email
  - From mm/yyyy to mm/yyyy
  - Department/Service Chief/phone/fax/email
  - Category/Status
  - Reason for leaving
  - Gaps explained

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Application Form – Cont'd

- Peer References: What should you get?
  - Name/address/phone/fax/email
- Peer References: Who should they be?
  - Must be someone with direct/recent knowledge of current clinical competence
  - Same or related specialty
  - Policy requirements?

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Assess the Application Packet

- To determine if you can start the verification process
  - All blanks are completed?
  - All requested documents submitted?
  - Documentation necessary to comply with privileging criteria is attached?
  - Applicant responds to requests for additional information, clarification or interviews?
  - Applicant assists with obtaining written evaluations (as necessary)
- Communication is the key to efficient processing. Keep the applicant informed involved.

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Burden

Burden of a complete application is always on the APPLICANT!

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Processing the Application

- Medical licensure (PSV online State Medical Licensing Board)
- DEA (PSV online NTIS)
- Other State Medical licenses – State website or AMA
- OIG, EPLS, TX OIG
- NPDB
- Criminal Background checks – Medical staff and APP

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Processing the Application – Cont'd

- Education and Training (Institution or AMA Profile)
- Program Chair evaluation (recent graduates)
- Foreign Medical Education (ECFMG)
  - Canadian Education (Institution or AMA Profile)
- Peer References – Must be someone with direct/recent knowledge of current clinical competence. Peer reference forms should be formatted within six general competencies.
- Affiliations (online, phone or hard copy)
  - How far back? What does your policy say? Keep in mind "current clinical competence"
- Malpractice claims history

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Myth #1

- That actual paper copies of documents must be submitted and retained (i.e. copies of licenses, diplomas, certificates, etc.)
- Reality
  - No regulatory/accreditation requirements for this
  - Practice pre-dated widespread availability of online verifications
  - Risky practice is used as a substitute for primary source verification (PSV)

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Myth #2

- That everything in a practitioner's history must be verified
- Reality
  - Regulatory/accreditation requirements are specific to current, relevant qualifications and abilities
  - Use evidence-based approach to define requirements and establish credentialing procedures

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Myth #3

- That three peer references are needed
- Reality
  - No regulatory/accreditation requirement for a specific number
  - Required for all new applicants
  - For renewal of privileges when OPPE data is available, no peer references are needed

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Myth #4

- That the best way to learn about adverse actions or information is to query all previous and current facility affiliation
- Reality
  - No regulatory/accreditation requirements for this
  - Most facilities return only a "good standing" letter or do not respond at all, so huge work effort for little return on investment
  - Adverse actions must be reports to the NPDB – accessed there
  - Don't go back any further unless you identify a need to do so because of other factors

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Myth #5

- That it is important to gather information about gaps in work history for entire professional career
- Reality
  - No TJC or CMS requirements for this
  - NCQA standard:
    - Work history – for five years (no PSV required)
    - For gaps greater than 6 months but less than 1 years – verbal or written explanation
    - For gaps greater than 1 year – written explanation

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Privileges

- Privileging is a continuous process that includes: establishing the need for a privilege, determining the privilege criteria, applying the criteria to applicants for the privilege and monitoring of competency

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Privileging

Most facilities use one of two types of methods for delineation of privileges (DOPs)

1. Laundry list – a list of specific services or procedures a Provider can perform within his/her specialty
   - Risks: can never be a complete list, is impossible to maintain the form or to demonstrate competency line by line item
2. Core privileges – scope of practice that any well-trained, "active" Provider in the specialty would be competent to perform.
   - Complex, high risk privileges are pulled out from the core--separate eligibility criteria is required for these "special request" privileges; applicants must provide evidence of additional training, experience and current competence to apply for these 6-8 privileges.

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Privileging Tips

1. Don't make the core too broad – make sure it reflects what the majority within that particular specialty are currently performing at your facility
2. Link your definition of the core to the scope of training typically covered in approved residency programs
   - Resource: the AMA's *Graduate Medical Education Directory* (the "Green Book")
3. Ensure that everyone can answer the question: Does this doctor have privileges to do XYZ?
   - Each core privileging form should include a back-up list of "sample" conditions and procedures included in the core
     - The sample list should include a statement like: The core includes the following conditions and procedures and such other conditions and procedures that are an extension of the same knowledge and skills.

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Privileging Tips

4. Criteria for privileges should be on the privilege form itself – the risks in separating criteria from the form, is they may be missed and not applied
5. There should be a method for the applicant to request only certain items in the core if he / she does not want the full set of core procedures (CMS requirement)
6. Include language to meet the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) requirements that hospitals with Emergency Departments must offer:
   - Evaluate patients presenting to their ED to determine whether an emergency condition exists
   - If an emergency condition is found to exist, stabilize the patient
   - Determine disposition

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Common Sense Privileging

1. There should be no blank lines on the form – use the additional privilege process when a Provider is requesting a privilege that is not already offered on the Specialty DOP
2. To determine competency, there must be some clinical activity in a particular area -- setting a threshold requirement for clinical activity is necessary
3. If the Provider is not clinically active at your facility, require a clinical activity report from the facility where he/she works

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Temporary Privileges

- The use of temporary privileges (done in accordance with applicable standards) is allowed by all accrediting bodies, e.g., The Joint Commission (TJC) and AAAHC. The CMS Hospital Conditions of Participation (CoPs) and Ambulatory Surgery Center Conditions of Coverage (CoCs) are silent regarding temporary privileges. The accreditation standards of TJC describe two situations in which temporary privileges may be granted:
- **Complete application** and there are **no concerns**. This reason for temporary privileges also includes a practitioner who is already on staff, and who has applied for a new privilege or an increase in privileges.
- When the services of the practitioner are needed in order to meet an **immediate patient care need**. These should be very rare situations.

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Temporary Privileges – New Applicant/New Privilege

- **Request:**
  - New applicant's fully processed application awaiting review and approval by the organized medical staff with:
    - No current or previous successful challenge to licensure or registration
    - No subjection to involuntary termination of medical staff membership at another organization
    - No subjection to involuntary limitation, reeducation, denial, or loss of clinical privileges
- **Approval:**
  - Medical Staff President or authorized designee
  - CEO or authorized designee
- **Timeframe:**
  - For no more than 120 calendar days.
    - 4/24/16 to 8/22/16

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Temporary Privileges – Patient Care/Treatment/Service Need

- **Request:**
  - To fulfill an important patient care, treatment, or service need (e.g., the patient's care needs are unique and there is no other practitioner on staff with the requisite education, training, skills, and current competencies who is immediately available to meet those needs)
- **Process:**
  - Provider supplies defined in your bylaws or policy (such as a modified application form, CV)
    - Verification of current licensure
    - Verification of current competence
      - Current competence is obtained through relevant training, peer recommendation
- **Approval:**
  - Medical Staff President or authorized designee
  - CEO or authorized designee
- **Timeframe:**
  - Time period defined in the medical staff bylaws

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Temporary Privileges -- APPs

- The standards do not exclude APPs from being eligible for temporary privileges, but there are a few considerations :
  - *Are all conditions as required by law being met?*
    - If the APP's supervising physician is also coming on staff, the physician may not yet have staff membership or clinical privileges to cover the APP
    - the delegation agreement may not yet be in place (PAs)
      - Do not let the request get out ahead of the process for assuring that appropriate delegation agreements (PAs) and prescriptive authority, practice protocols, and supervision/back-up arrangements are in place.
- *What is the reason for the request for temporary privileges?*
  - While it is easy to understand why an APP may wish to have temporary privileges for the first purpose listed above (new applicant/new privilege), especially if needed to support his/her employing physician who is also on staff, it is less likely that an APP would qualify for temporary privileges for the second purpose (immediate patient care need). Just assure there is a sound, well-documented rationale describing the immediate patient care need. Each case would be judged based on this.

Convenience does not equate to an "immediate patient care need!"

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Additional Privileges

- Request:
  - A currently privileged provider requests new privileges
- Process:
  - Provider submits the request on the approved form
  - Can the facility support the request?
  - Yes
    - Primary source verification of the following should occur
      - Current licensure and/or certification
      - Relevant training to the privilege request
      - Evidence of physical ability to perform the requested privilege
      - Peer/faculty recommendation
      - National Practitioner Databank

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Additional Privileges, cont.

- Can the facility support the request?
  - No
    - If the facility cannot support requested privilege, notify the Provider that the privilege is not available and the process stops
- Approval:
  - The same approval process for initial appointment or recredentialing
  - Temporary privileges can be granted for the new privilege

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Analyze

- Your job!
- READ RESPONSES CAREFULLY AND CRITICALLY
- Identify and flag issues; follow-up on any unresolved questions (e.g. call peer for clarification)
- Follow-up with provider to obtain/understand any open questions

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Medical Staff Review Process

- Personally review application and significant verifications with Department/Section Chief – discuss any issues and all documentation that supports non-core privilege requests.
- Chair makes recommendation (appointment and privileging) and signs department review form.
- Application forwarded with Chair recommendation to Credentials Committee (if applicable) or Medical Executive Committee.
- Information transmitted to the Board with Medical Staff recommendations for final approval. Only the Board grants membership and privileges!

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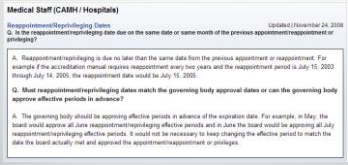
Documenting the Approval Process

- Appointment Dates
  - TJC
    - No greater than 24 months – 4/9/14 to 4/8/16



Medical Staff (CAMH / Hospitals)

Reappointment/Reprivileging Dates — Updated | November 24, 2008

Q. Is the reappointment/reprivileging date due on the same date or same month of the previous appointment/reappointment or privileging?

A. Reappointment/reprivileging is due no later than the same date from the previous appointment or reappointment. For example if the accreditation manual requires reappointment every two years and the reappointment period is July 15, 2003 through July 14, 2005, the reappointment date would be July 15, 2005.

Q. Must reappointment/reprivileging dates match the governing body approval dates or can the governing body approve effective periods in advance?

A. The governing body should be approving effective periods in advance of the expiration date. For example, in May, the board would approve all June reappointment/reprivileging effective periods and in June the board would be approving all July reappointment/reprivileging effective periods. It would not be necessary to keep changing the effective period to match the date the board actually met and approved the appointment/reappointment or privileges.

http://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=254&StandardsFAQChapterId=74

  - AAAHC
    - Every three (3) years or more frequently is state law or organizational policies stipulate

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After Approval

- Notify applicant of Board decision.
  - Include dates of appointment, copy of approved privileges, proctoring requirements, category and department assignments
- Send out internal communication regarding new appointee, including privileges to appropriate departments and post privileges on organization website created for that purpose
- Begin process of FPPE

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Provisional Category – Is it Relevant?

- History:
  - A "Provisional Staff" category has been traditional in medical staff bylaws, going back several decades. The Joint Commission used to require a provisional period; the category was useful not only to allow assessment of a new staff member's performance and to provide for a period of time to acclimate him/her before "advancement" to full active status.
  - There was confusion when the FPPE/OPPE standards first became effective as to whether FPPE had to be performed on new members throughout the entirety of their appointment to a Provisional Staff category (often a year). This was never required!

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Provisional Category – Is it Relevant?- Cont.

- Fact:
  - Today, while hospitals have other choices for accreditation, all of the accrediting bodies and the CMS Conditions of Participation require ongoing and focused peer review in concept, regardless of the terminology.
  - FPPE must be done for all new grants of privileges, whether for new or current physicians, LIPs or APPs who have been granted clinical privileges.
  - Some medical staffs retain a Provisional Staff category, however, it is superfluous with the advent of focused professional practice evaluation (FPPE) and ongoing professional practice evaluation (OPPE) requirements.

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Credentialing Best Practice Pearls

1. To get the needed information, ask the right questions
2. Spot red flags in peer evaluations
3. ALWAYS place the burden on the applicant - Don't deny - defer
4. Streamline your process to obtain substantive information
5. READ and ANALYZE the information obtained
6. Tic and tie privilege criteria to Providers documented credentials
7. Follow-up on concerning information
8. Flag and call out concerns, including research outcomes for medical staff leadership review
9. Clearly document decisions in the Credentials / MEC and Board minutes
10. KEEP YOUR EYE ON THE PATIENT!

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Part II Focus

- Review and discussion of FPPE
- Review and discussion of OPPE
- Recredentialing
- Case studies
- Other Hot Topics

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BREAK!

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Focused and Ongoing Professional Practice Evaluation

In order to make the decision of privileging more objective and continuous, in 2007 The Joint Commission introduced its Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) processes. These tools were created to work together to help determine if the care delivered by a practitioner falls below an acceptable level of performance. It is important to note that neither tool on its own is capable of making an adequate assessment, but instead it is the thoughtful and judicious use of both that is required.

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Focused Professional Practice Evaluation

- Must be performed:
  - On all newly privileged practitioners (physicians, LIPs, and APPs)
  - On all newly granted privileges
  - When a question arises about competence through OPPE or other monitoring mechanisms

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Focused Professional Practice Evaluation (FPPE)

- Process is defined by the organized medical staff.
- Time period is established but may be extended and/or different process assigned.
- Process may include
  - Chart review
  - Monitoring clinical practice patterns
  - Simulation
  - Proctoring
  - External peer review
  - Discussion with others involved in the care of practitioner's patients

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FPPE – Cont'd

- Period of evaluation required for all initially requested privileges
  - New members of the medical staff
  - Current members with new privileges
  - Current members of the medical staff that have been identified as requiring specific focused review due to performance issues.
- FPPE may be tiered for different level of documented training and experience
  - Practitioners coming directly from outside residency program (unknown data)
  - Practitioner's coming directly from the organization's residency program (known data)
  - Practitioners coming with a documented record of performance of the privilege.

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FPPE – Cont'd

- No one can be excused from the process of initial evaluation
- If using time frames, time frame may need to be extended if minimum activity does not occur.
- Use six general competencies as a framework:
  - Patient care
  - Medical/clinical knowledge
  - Practice based learning and improvement
  - Interpersonal and communication skills
  - Professionalism
  - Systems-based practice

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FPPE – Cont'd

- Process is individual to Sections or Services and should be designed by them. Source: Specialty Boards may have defined criteria for performance monitoring.
- Policy should define:
  - Criteria for conducting performance monitoring with measures that are clearly defined
  - Method for establishing a monitoring plan specific to the requested privilege with definition of who will conduct the review
  - Method for determining the duration of performance monitoring
  - Circumstances under which monitoring by an external source is required
  - Results are to be used in credentialing/privileging process
  - Must be applied to ALL privileged practitioners

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FPPE – Cont'd

- All practitioners are treated equitably
- Criteria are applied as defined by the Service/Medical Staff
- Specialty-specific data/indicators for the same privilege are managed the same way for all practitioners with that privileges
- Process to be approved by Medical Executive Committee
- Follow your policy!

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Ongoing Professional Practice Evaluation

- Ongoing means ongoing – not more than every six to nine months.
- Data needs to come from Quality
- MSSP manages the process

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Ongoing Professional Practice Evaluation (OPPE)

- Evaluation conducted on an ongoing basis to help identify problems early to allow for positive intervention.
- Information gathered factored into the decision to maintain existing privileges.
- Time period to be determined by medical staff – not to exceed 9 months. Annually considered periodic, NOT ongoing.
- Data collected on every practitioner

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Ongoing Performance Practice Evaluation

- Using 'triggers' increases the likelihood that all practitioners are treated fairly.
- Triggers may be:
  - Defined # of events occurring
  - Defined # of individual peer reviews with adverse determinations
  - Elevated infection rates
  - Sentinel events
  - Small number of admissions/procedures over an extended period of time
  - Increasing lengths of stay compared to others
  - Increasing # of returns to surgery
  - Frequent/repeat re-admissions or returns to surgery for the same issue

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Collection of Performance Data

- Whose job is it?
  - Requires heightened degree of collaboration between Medical Staff, MSSP, Quality Department, and IT Department
- What is currently being collected?
- Who is collecting it?
- What technology is available to synthesize the data?
- Reminder – zero data is data. Zero data can actually be evidence of good performance
- Triggers? How can they be used to simplify data collection?

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Triggers

- Patterns of unnecessary diagnostic testing/treatments
- Failure to follow approved cliical practice guidelines

TIPS:

- If OPPE is not identifying any practitioners performance issues through its process, then the indicators may not be as sensitive as they should be.
- Resource: The Joint Commission Standards BoosterPak™ for FPPE/OPPE:

http://2011.july.qualityandsafetynetwork.com/downloads/boosterPak_FPPE_OPPE_FINAL/pdf.

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Re-credentialing process

- What to re-verify?
  - All health care facility memberships and privileges?
  - Only Active?
  - Any additional training related to newly requested privileges
- Based on OPPE data and/or peer references when insufficient data is available.
- Chief signature page – make them substantive
  - "Have you observed or been informed of any physical or mental conditions, including alcohol or drug dependency, that have affected or reasonably may affect the practitioner's ability to perform professional and medical staff duties and obligations appropriately?"
  - "Any evidence of general uncooperativeness and/or inability to communicate with patients and/or staff?"

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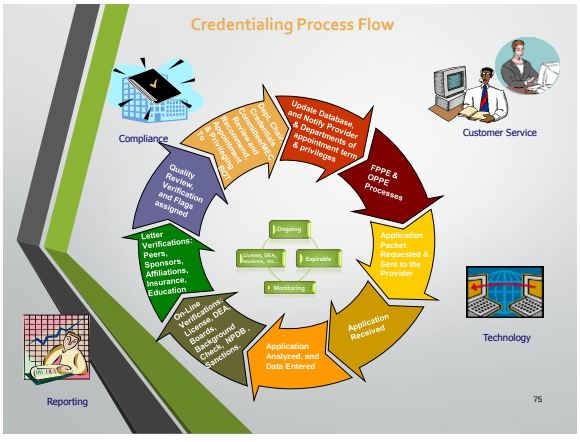

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Policies and Procedures

- Credentialing and Privileging Policy
- Temporary Privilege Policy
- Additional Privilege Policy
- Allied Health Professional (Non-LIP) Credentialing Policy
- FPPE Policy
- Peer Review Policy
- OPPE Policy

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Policies and Procedures – Cont'd

- In the absence of a policy, it is our policy to create a policy.
- Which exception to your policy is the worst? The first . . .

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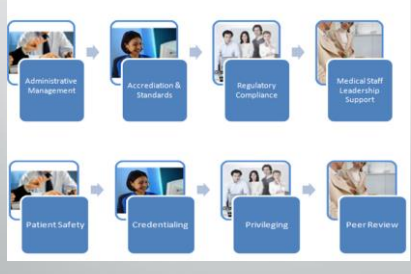
Organization Responsibilities



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Medical Staff Administration

- Facility credentialing policies and procedures
- Facilitate medical staff meetings
- Coordinate committees
- Prepare credentialing reports for medical staff leaders, committees, and the governing body
- Develop, maintain, and distribute governance documents

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Medical Staff Education

- Orientation
  - New Medical Staff
  - New Officers
  - Committee members
- Education
  - Administrators and department directors regarding MSO operations, privileging (including temporary and disaster privileging)

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Accreditation and Regulatory Compliance

- Subject matter expert regarding relevant accreditation and regulatory requirements.
- Survey liaison relative to credentialing, privileging and peer review activities and functions.
- Developing and implementing corrective action plans related to credentialing, privileging and peer review activities and functions.

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Facility Credentialing Operations

- Apply the credentials evaluation process uniformly to all initial and recredentialing applications to ensure compliance with your credentialing policy and procedures.
- Verify applicant identity (initial).
- Compile and analyze any available internal data and information for an assessment of qualifications and competencies for each recredentialing application.
  - Compile internal information regarding CME credits in accordance with medical staff bylaws.
  - Compile internal data on provider's volume
  - Compile internal information related to focused or ongoing professional practice evaluations (FPPE/OPPE), performance improvement, utilization patterns, peer review, or other performance information.

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Facility Credentialing Operations (cont.)

- Facilitate review, assessment, and authenticated documentation of an evaluation of each application and request for clinical privileges by the section chief / department chairman as required.
- Facilitate review, assessment and recommendations for each application and request for clinical privileges by the Credentials Committee (if applicable to the facility) and the Medical Executive Committee.
- Summarize and prepare credentialing information, including information about flagged concerns, for the board's review and decisions.
- Actively manage provider's expiring credentials
- Update the credentialing database to reflect all board actions on a provider's application, including resignations, terminations, LOAs, denials, terminations, or withdrawals
- Manage and archive files according to facility procedures and accreditation/regulatory standards.

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Privileging

- Facilitate development of eligibility criteria for each clinical privilege.
- Facilitate the review of requests for clinical privileges using the approved eligibility criteria.
- Assess the applicability and appropriateness of clinical privileges for each specialty through periodic review.
- Maintain all up-to date-privilege content within the credentialing database (technology permitting).
- Notify Departments and coordinate access to Providers' appointment dates and authorized privileges.
- Facilitate any required regulatory agency reporting of adverse actions taken against a provider's medical staff membership or clinical privileges, as directed by facility leaders.

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Performance Improvement/Peer Review

- Coordinate with the quality department to facilitate focused professional practice evaluation (FPPE), and any related evaluation at the conclusion of FPPE.
- Coordinate with the quality department to facilitate ongoing professional practice evaluation (OPPE).
- Coordinate with facility leadership in the conduct of internal and external peer reviews.
- Complete a summary of FPPE, OPPE, and peer review results for evaluation by medical staff leaders as part of the R-RFC process as noted above, and ongoing as required by policy.

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Risk and Information Management

- Review and evaluate an applicant's claims history and NPDB or other reports regarding final settlements; review findings with Department Chair.
- Coordinate all medical staff disciplinary actions (e.g., ad hoc investigations).
- Facilitate due process in accordance with the facility's fair hearing and appeals policy as well as legal and regulatory requirements.
- Coordinate medical staff review of occurrence reports, patient complaints, close call data, and other risk management information.
- Develop and maintain a policy regarding the management, access to, and distribution of credentialing, privileging, and peer review information, in accordance with confidentiality requirements and record retention policies.
- Respond to external requests for information in accordance with policy.

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Credentialing Operations Top Risk Issues

- **Not thoroughly evaluating** all verifications received
- Inappropriate use of **temporary privileges**
- Approving an application **before file is completed**
- Believing in "**grace periods**"
- Allowing terms of membership/privileges **> 24 months**
- **Not referring** to Provider's privileges; relying on memory
- Not using credentialing database reports to **proactively manage** information
- **Not updating** information in credentialing database timely or accurately
- Not being aware of what the bylaws say or **not following bylaws**
- **Being inconsistent or letting conflict of interest influence** decisions
- **Ineffective FPPE/OPPE** to monitor and improve
- Lack of awareness of risks with "**negligent credentialing**"

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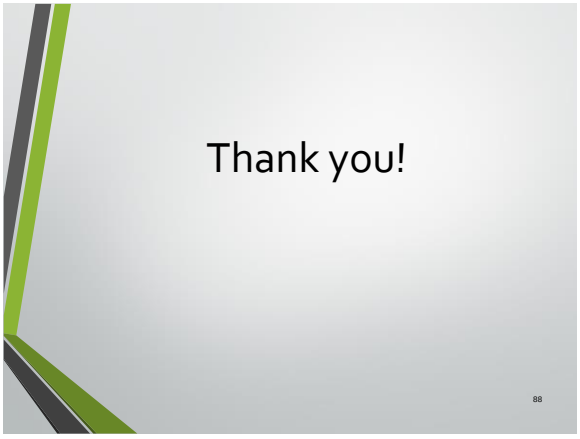
Thank you!
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