



The Medical Staff's Guide to Overcoming Competence Assessment Challenges

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HCP Pro

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Contents

About the Authors.....	vii
Chapter 1: Competence Assessment for Initial Appointment.....	1
Establishing Minimum Threshold Criteria	1
Evaluating Competence.....	4
Cross Privileges and Turf Wars.....	6
Determining Initial Competence for Low- and No-Volume Practitioners.....	8
Clinical Evaluations.....	9
Evergreen or “Forevermore” Evaluations.....	18
Competence Assessment Through FPPE After Granting Clinical Privileges	19
Common Missteps	21
Chapter 2: Assessing Competence in the Ambulatory Setting	25
Understanding Healthcare Delivery in Ambulatory Settings.....	25
Requirements of Regulators and Accreditation Agencies	28
Scope of Privileges at the Ambulatory Site.....	29
Responsibility for Privileging in an Ambulatory Setting.....	30
Medical Staff Category Versus Privileges	34
Competence Assessment in the Ambulatory Setting.....	35
Assessing the Competence of APPs in the Ambulatory Setting.....	38
Revisiting St. John Medical Center	43
Chapter 3: Temporary Privileges for Patient Care Needs.....	45
What Qualifies as ‘Immediate Patient Care Need’?	45
Developing a Temporary-Privileges Policy.....	46

CONTENTS

Pendency of an Application/Committee Approval.....	50
Temporary Privileges for Locum Tenens.....	51
Assessing the Competence of Proctors	53
Visiting Professors	54
Chapter 4: Attribution Challenges	55
Patient Handoffs.....	56
Teaching Service.....	59
Advanced Practice Professionals	59
Attribution Issues and Solutions	60
Chapter 5: Ongoing Competence Challenges and Validation at Reappointment	63
After Initial Appointment, What Are the Next Steps in Assessing Competence?.....	63
Developing Indicators for Ongoing Competence Assessment	65
Implementing OPPE and Addressing Competence Concerns	66
Addressing Competence Concerns Identified During the Ongoing Review Process	67
FPPE for Cause.....	68
Competence Assessment at Reappointment	69
Allied Health Annual Competence Reviews.....	70
Chapter 6: Assessing the Competence of APPs.....	73
Collecting Data on APP Performance.....	75
Conclusion	82
Chapter 7: How to Manage the Expanding Role of APPs	89
Training Up.....	90
Revisiting Memorial Medical Center.....	96
Chapter 8: Assessing the Competence of Telemedicine Practitioners	99
Introducing a Telemedicine Service at Your Facility	100
Defining Telemedicine	101
Who Provides Telemedicine Services?.....	103
Requirements of Regulators and Accreditation Agencies	104

CONTENTS

Effect of Telemedicine Regulations.....	104
Privileging Telemedicine Practitioners.....	106
Competence Assessment Unique to Telemedicine.....	107
Evaluation of Telemedicine by Specialty.....	109
Revisiting St. Elsewhere.....	110
Chapter 9: Assessing a Single Practitioner in a Specialty Area	113
Determining Competence With No Reference Point.....	114
Conducting Ongoing Evaluation of the Specialist.....	116
External Reviews	117
Chapter 10: New Technology, Services, and Procedures	119
New Technology, Equipment, and Procedures	119
New Techniques	126
Chapter 11: Low- and No-Volume Practitioners.....	129
Introduction to Low- and No-Volume Practitioners	131
Assessing the Competence of the Practitioner Who Is Active at Another Facility	133
Dr. Rose and Dr. Cares-A-Lot: Two Solutions to the Low- and No-Volume Challenge.....	134
Matching Privileges to Current Competence.....	139
Avoid Denying Privileges.....	142
Chapter 12: Selective Practice Affecting Competence, Privileges, and Call Coverage.....	145
Solution/Discussion.....	146
Add EMTALA-Based Language to Privileging Forms	147
ED Call Coverage for Practitioners Who Are Not Competent to Assess, Stabilize, and Determine the Disposition of Patients.....	148
Burden on the Applicant	153
Revisiting Specialized Medical Center.....	154



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She has coauthored several HCPro/Greeley books, including:

- *Core Privileges for Physicians: A Practical Approach to Developing and Implementing Criteria-Based Privileges*, Fifth Edition (2010)
- *Assessing the Competency of Low-Volume Practitioners: Tools and Strategies for OPPE & FPPE Compliance*, Second Edition (2009)
- *The FPPE Toolbox: Field-Tested Documents for Credentialing, Competency, and Compliance* (2008)
- *Core Privileges for AHPs: Develop and Implement Criteria-Based Privileging for Non-Physician Practitioners*, Second Edition (2011)
- *Converting to Core Privileging: 10 Essential Steps to a Criteria-Based Program* (2007)

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ABOUT THE AUTHORS

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Ponsioen has served on her local South Texas Association of Medical Staff Professionals as president elect, president, past president, and secretary. She has been a member of NAMSS since 2003 and has served on the Governance Management and Manpower Committee, Nominating Committee, and Audit and Finance Committee, also serving as a director at large. She has been a member of the Texas Association of Medical Staff Services since 1995. In 2007, she received the Joan Covell-Carpenter Award from NAMSS for an article she wrote in the publication *Synergy*.



Competence Assessment for Initial Appointment

Anne Roberts, CPCS, CPMSM

CASE STUDY

Dr. Jones has just relocated to the area and joined a large plastic surgery group. He has submitted his application for membership and clinical privileges at the hospital and has requested that the process be expedited so he can provide coverage for his new partners, one of whom will soon be retiring. The practice manager has contacted the CEO of the hospital to ask for assistance in getting Dr. Jones' application pushed through as quickly as possible. As the plastic surgery group produces a lot of revenue for the hospital, the CEO contacts the medical staff services department and reiterates that the application needs to be expedited. These political motivations to expedite an application can often pressure medical services professionals (MSP) to rush through the credentialing and privileging process and push paper rather than performing a thorough quality review of the applicant's education, qualifications, current clinical competence, and prior practice history.

Establishing Minimum Threshold Criteria

During the initial credentialing process, organizations must verify a practitioner's education, licensure, prior practice history (to identify if there have been prior competence concerns), and current clinical competence. The medical staff bylaws and associated policies should clearly delineate the minimum threshold criteria for applicants who apply to provide services at an organization. For practitioners, the minimum threshold credentialing criteria typically includes:

- Graduation from an accredited medical/dental/osteopathic school
- Successful completion of an accredited residency program and additional training in a subspecialty program (if applicable)
- A current, unrestricted state medical/dental/osteopathic license

CHAPTER 1

- A comprehensive criminal background check free of red flags
- Professional liability insurance coverage with minimum limits as required by the organization's governing board
- Documentation of current clinical competence (as described throughout this chapter)

Once a practitioner submits an application, MSPs, who work in the medical staff services department, then verify directly through the primary source (e.g., the medical/dental/osteopathic school, the state licensing board, etc.) all minimum threshold criteria for education and any other credentialing requirements established by the organization. Other criteria for credentialing may include but are not limited to verification of:

- All education, training, and academic appointments
- Status at all prior and/or current hospital or other clinical affiliations
- All prior and/or current employers
- All prior licenses
- Current state and/or federal narcotics registration
- Current peer references
- Claims history
- Review of reports to the National Practitioner Data Bank (NPDB)
- Review of sanctions from the Office of Inspector General

In addition to the minimum threshold criteria for credentialing, organizations must also develop a comprehensive privileging system and establish minimum threshold criteria that a practitioner must meet to prove current clinical competence for each privilege he or she requests. The decision to grant privileges must be an objective, evidence-based process, and the hospital (based on recommendations from the organized medical staff and approval by the governing body) must establish criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) that he or she requests.

COMPETENCE ASSESSMENT FOR INITIAL APPOINTMENT

The first step in developing minimum threshold criteria for clinical privileges is to first identify what privileges the organization will offer in each of the specialty or subspecialty areas. Prior to granting privileges to any practitioner, the organization must determine that the resources necessary to support the requested privileges are currently available or will be available within a specified time frame. Essential information, such as financial resources, equipment, space, and types of personnel necessary to support the requested privilege, must be evaluated as part of the process for establishing minimum threshold criteria.

Once the privileges are established, each department chair recommends to the credentials committee the minimum threshold criteria (i.e., level of education, training, experience, etc.) that are required for applicants to demonstrate that they have the current skills and clinical competence to exercise the requested privileges.

In addition to the minimum threshold criteria, the appropriate department chair must determine the core set of clinical activities that any practitioner with the minimum training required by the organization should be competent to perform. If the organization requires residency training and board certification in the applicable specialty area, the department chair should also evaluate what other criteria the applicant must submit to determine that he or she has the experience needed to demonstrate competence. Some examples include:

- Completion of subspecialty fellowship training (e.g., cardiac anesthesia fellowship, hand surgery fellowship, etc.)
- Documentation of successfully performing X number of specialty-specific procedures in the past X months (e.g., documentation of at least 25 cardiovascular procedures successfully performed within the past 12 months in which the applicant functioned as the primary surgeon)
- Documentation of appropriately treating X number of a specified type of patient in the past X months (e.g., documentation of appropriately treating at least 25 pediatric oncology patients in an inpatient setting within the past 24 months)

Many organizations have also revised their initial case log requirements for applicants who have completed an Accreditation Council for Graduate Medical Education or American Osteopathic Association–accredited training program in the past few years, as the applicant will likely have significant recent clinical experience, which his or her training program director can attest to.

In the case study described at the beginning of this chapter regarding Dr. Jones, the plastic surgeon requesting that his application for membership and clinical privileges be expedited, the organization likely already

CHAPTER 1

has the threshold criteria established, and the medical staff services department just needs to review his request to ensure he meets the minimum threshold criteria. If so, the medical staff services department would then begin gathering and verifying the data to confirm current clinical competence. If the applicant, in this case Dr. Jones, does not meet the minimum threshold criteria, the medical staff services department should notify him that he is ineligible for the requested privileges and that his application for membership and request for clinical privileges cannot be processed. Keep in mind that this is not the same thing as denying privileges, which would afford Dr. Jones due process.

Other practitioners to whom your organization grants clinical privileges or permission to provide services (such as allied health professionals or advanced practice professionals) should be treated in the same manner. The organization should outline minimum threshold criteria for each privilege, and the individual should be responsible for providing documentation that proves that he or she is qualified and competent to provide the services requested.

Evaluating Competence

Organizations must evaluate an applicant's ability to perform the privileges that he or she has requested. Competence criteria required by most organizations include but are not limited to the following:

- Appropriate education/training specific to the privileges requested
- Clinical peer references
- Clinical evaluations from prior department chairs and/or training program directors (see section below on developing comprehensive evaluation forms)
- Relevant and recent utilization history (e.g., activity such as admissions, consults, etc.) and quality review results (i.e., has the applicant performed the procedure recently, and what were the clinical outcomes?)
- Case logs from the past 12 to 24 months
- Ongoing professional practice evaluation (OPPE) data
- Board certification in the specialty/subspecialty in which privileges are requested

COMPETENCE ASSESSMENT FOR INITIAL APPOINTMENT

- Continuing medical education relevant to the privileges requested
- Current health status (Documentation may include the applicant's statement that no health problems exist that could affect his or her practice or an attestation from peers. If there are any current or prior health concerns that could potentially affect the practitioner's ability to perform the requested privileges, then his or her current health status should be evaluated by his or her treating provider to confirm that he or she can competently exercise their existing clinical privileges.)

Burden on the applicant

Once the minimum threshold criteria are set, all individuals requesting that privilege have to provide documentation proving that they meet the eligibility criteria. The burden lies solely on the applicant; it is his or her responsibility to prove that he or she has the current clinical competence required to perform the privileges requested. If an applicant does not meet the minimum threshold criteria, he or she is simply not eligible to apply for the privileges, and his or her application cannot be processed. Or, if the applicant fails to provide requested or sufficient documentation, then the medical staff can deem the application incomplete. Not being eligible to request the privileges or deeming an application incomplete is not a denial of privileges; denying a physician's privileges is reportable to the NPDB and state medical boards, and the practitioner may be entitled to due process if afforded in your bylaws.

Alternatives to deeming an application incomplete

If an organization requires specific case log documentation and an applicant does not meet the requirement, one option, other than deeming the individual ineligible, is to grant the privileges and require precepting. In the case of Dr. Jones, the plastic surgeon in the case study at the beginning of this chapter, if he meets all minimum threshold criteria set by the department for the privileges he has requested with the exception of providing the specified number of cases performed, the organization should determine whether he meets the criteria for precepting. For example, if the criteria for plastic surgery include a requirement to submit documentation of at least 75 plastic surgery procedures relevant to the privileges requested within the past 12 months, and Dr. Jones is able to submit documentation of only 60 cases, the organization may elect to offer precepting for the additional cases.

In general, precepting is a process that allows individuals to "train up" or receive additional training at your organization to obtain the skills and competence necessary to perform specific procedures.

CHAPTER 1

To offer precepting, an organization should have a preceptor policy in place, and the privilege delineation must clearly outline that this is an option (see Chapter 7 for more information on the precepting process and policy requirements). If the medical staff is going to offer precepting, the department chair should add this option as part of its delineation that details the minimum threshold criteria. The following is some example language:

“Applicant must provide documentation of performing 75 (X type) procedures in the past 12 months; if the applicant is unable to demonstrate the performance of 75 cases in the past 12 months, the department chair will assign an additional level of focused professional practice evaluation (FPPE) as deemed necessary to demonstrate competence and as outlined in the medical staff policies and procedures. The FPPE may include direct observation, retrospective chart review, or precepting of a specified number of cases.”

See “Competence Assessment Through FPPE After Granting Clinical Privileges” for the steps the department chair should take after the applicant has completed the initial FPPE.

Cross Privileges and Turf Wars

At times, determining the minimum competence criteria can be challenging for medical staff leaders, particularly when a privilege crosses multiple disciplines. For example, vascular rings is a procedure that can be performed by both general surgeons and cardiovascular surgeons. The organization needs to determine whether it will allow both types of surgeons to perform this procedure, and, if so, competence criteria for this procedure should be the same regardless of whether it is performed by a general surgeon or a cardiovascular surgeon.

Most larger organizations have restricted Cesarean section privileges to OB/GYN practitioners; however, some smaller organizations still allow family practitioners who practice obstetrics to request or maintain Cesarean section privileges. If these privileges are extended to both OB/GYNs and family practitioners, equivalent competence criteria for this privilege must be established.

Turf wars or cross-privileging disputes among specialists can often arise and make setting threshold criteria a difficult and cumbersome process. For example, as mentioned above, vascular rings can be performed by general surgeons or cardiovascular surgeons; some organizations have determined that this privilege should be restricted to only cardiovascular surgeons. This can cause a turf war if the general surgeons are not in agreement and feel that they should be allowed to maintain these privileges.

COMPETENCE ASSESSMENT FOR INITIAL APPOINTMENT

Or, in the other example above, many organizations have had to deal with a turf war related to no longer allowing family practitioners to perform Cesarean sections. Again, this can cause a turf war if the family practitioners feel that they should be allowed to maintain these privileges.

The best way to remedy concerns related to establishing minimum threshold criteria for cross privileges or to address possible turf wars is to ensure that the organization includes all of the individuals who are considered stakeholders in the discussions. When establishing criteria for cross privileges, all departments that will be performing the procedure need to agree on the minimum threshold criteria for competence, because the criteria must be equivalent across all departments performing the procedure. If there is a disagreement on the minimum threshold criteria requirements, the issue and recommendations from all parties should be submitted to the credentials committee and/or medical executive committee (MEC) for review and resolution.

For turf wars that cannot be resolved at the department level, such as between family practitioners and OB/GYNs, the argument/concerns and supporting documentation from all parties should be submitted to the credentials committee or MEC for review and resolution.

For both cross privileges and turf wars, the committee(s) should review the proposals in detail to determine what is considered sufficient evidence of education, training, and experience to demonstrate competence to perform the procedure(s) in question. The committees should take into consideration the recommendations and opinions of all parties and seek further clarification if needed to make an informed decision.

If the request is for a new privilege, then once the committees and the board approve the new criteria for the privilege, applicants can submit a request for said privilege and submit the required competence documentation. If the request is to change the minimum threshold criteria for an already established privilege, then the medical staff will need to review how this change will affect current staff. For example, if the competence criteria become more stringent, the organization will need to review all practitioners who currently hold the privilege to determine whether they will be able to meet the new criteria. If they are unable to meet the criteria, then they no longer qualify for the privilege and should be notified. This is not a reportable action because it is not a restriction of privileges; the practitioners merely no longer meet the established criteria.

In the examples above related to limiting procedures to specific types of practitioners, if the committees and the board approve these limitations, they should notify the practitioners who will be affected that they are no longer eligible for these privileges because the criteria have now changed. A practitioner who currently holds the privilege does not need to withdraw the privilege, as it is not optional; they simply receive

CHAPTER 1

notification from the organization of their ineligibility. Again, this is not reportable to the NPDB or state licensing board, as the practitioners merely no longer meet the minimum threshold criteria.

As noted above, these concerns can be very political and have a significant effect on an individual's practice; therefore, it is extremely important to ensure clear communication during the review process to all affected parties and to ensure that all parties have a seat at the table during the discussions. In these instances, the medical staff leaders' recommendation must be focused on what will best serve the patients. Additionally, the committees need to take into consideration when the changes will take effect, as practitioners may already have cases scheduled. The organization needs to ensure that appropriate coverage for those patients is provided by practitioners who meet the new criteria.

Determining Initial Competence for Low- and No-Volume Practitioners

Organizations should proactively identify how they will address low- or no-volume practitioners, both at initial appointment and reappointment, to ensure that they are extending privileges only to individuals who can demonstrate current clinical competence. See Chapter 11 for information on addressing competence challenges related to low- or no-volume practitioners at the time of reappointment.

If an applicant has little to no recent clinical activity and is therefore unable to demonstrate current clinical competence, the organization must determine what options best fit the applicant. Some options for low- and no-volume practitioners at the time of initial appointment include:

- Discuss the practitioner's intent to utilize the privileges requested. Perhaps a different category of privileges, such as refer-and-follow or consult-and-assist privileges, would better fit the applicant's practice. These privilege categories allow the practitioner options to interact with the care team but not serve as the primary care practitioner during a patient's hospital stay. Or, if the applicant anticipates participating only in membership activities, then he or she may not need clinical privileges and may be interested in applying only for staff membership.
- If a practitioner has been out of practice for a significant amount of time or in a private or office-based practice for many years and has no current inpatient experience, the organization may want to consider requiring the practitioner to participate in a refresher course or remedial course. The Federation of State Medical Boards keeps an up-to-date list of these types of courses that are offered across the country, many of which customize training based on need. Many times, if the

COMPETENCE ASSESSMENT FOR INITIAL APPOINTMENT

organization is willing to invest in the practitioner (for example, if a hospital has hired him or her as a hospitalist), it will pay for the course(s). Otherwise, the cost may fall to the practitioner.

- As mentioned earlier, the organization could also elect to require precepting to afford the practitioner the option to receive additional training before granting him or her privileges to provide patient care independently.

Clinical Evaluations

In the past, the only clinical evaluations that some organizations obtained as part of the credentialing process were reference letters from the applicant's peers. This was often looked at as the "buddy system," (as most people are not going to list a peer reference who is going to provide negative feedback), and therefore most organizations have determined that a more meaningful approach is necessary to evaluate an applicant's competence.

One common practice is to get a clinical evaluation from the applicant's residency or fellowship program director if he or she has recently (e.g., within the past five years) completed postgraduate training. During residency or fellowship training, the program director, along with other faculty members who provide supervision during the training program, complete routine evaluations of all residents and fellows. The program director can attest to not only the type of experience the applicant gained during training but also his or her clinical performance during training. If the applicant has recently completed training, the program director can also attest to whether the applicant is qualified and competent to perform the privilege(s) he or she has requested.

In addition to program director evaluations, it is also common practice to obtain a clinical evaluation from the department chair from the applicant's current or most recent primary admitting facility. The department chair can attest to the applicant's performance at the organization and can disclose whether there were any concerns related to the applicant's competence, behavior, or other performance issues.

If the applicant has held a faculty appointment at a university, the medical staff services department can also seek a clinical evaluation from the applicable department chair from the university. A university department chair typically is responsible for overseeing the faculty's overall performance, including not only clinical competence, but also performance as employees, educators, and/or researchers.

CHAPTER 1

Peer reference letters and clinical evaluations must be comprehensive and ask the right questions to cover all pertinent information. Clinical evaluations should include not only questions that solicit information related to utilization or recent clinical experience, but also whether the evaluator is aware of any possible health concerns, behavioral issues, or any other performance concerns. The organization may opt to also include as part of its clinical evaluations an assessment of the six general competencies developed by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties and adopted by The Joint Commission:

- **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, and care at the end of life.
- **Medical/clinical knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences and the 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 practices.
- **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 other members of healthcare teams.
- **Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding of 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 healthcare is provided and the ability to apply this knowledge to improve and optimize healthcare.

If your organization elects to incorporate the six general competencies into its evaluation forms, MSPs should work with their medical staff leaders to draft several questions that fall under each general area. Please see Figure 1.1 for a sample form using the six general competencies.

COMPETENCE ASSESSMENT FOR INITIAL APPOINTMENT

FIGURE 1.1 PROFESSIONAL REFERENCE QUESTIONNAIRE

This sample questionnaire may be adapted for a variety of professional references, such as residency/fellowship director, previous healthcare affiliations (e.g., clinical service/department chair), peer recommendations, etc.

[Bracketed information is intended to be instructional to users and therefore should be removed from the form before use.]

Section I

[To be completed by organization requesting the reference]

Name of reference: _____

Professional evaluation concerning: [Applicant's full name, including any other name(s) used]

Specialty/subspecialty:

**Attach
or scan
applicant's
picture here**

We have received an application from the above-named and pictured individual stating that he/she: (indicate as applicable)

- completed a residency, internship, fellowship (requesting entity: circle as applicable) at your institution from
___ / ___ to ___ / ___ (MM / YY– MM / YY)
- was a staff member at your institution from
___ / ___ to ___ / ___ (MM / YY–MM / YY)
- has named you as a professional reference.

CHAPTER 1

FIGURE 1.1 PROFESSIONAL REFERENCE QUESTIONNAIRE (CONT.)

The reference should check the accuracy of the information above, and change or complete as appropriate.

Section II

[To be completed by the individual providing the reference]

Present professional position: _____

My responses are based on (check all appropriate responses)

- direct observation.
 review of accumulated information and reports about the practitioner's performance.

I know the applicant (check the most accurate response)

- very well. well. casually. personally. professionally.
 I do not personally know the applicant. (If checked, please skip the remaining questions in this section (Reference's relationship with the applicant) and go directly to Section III (Professional knowledge, skills, and attitude.)

Please answer the following questions based on your personal knowledge and direct observations. Your candor is greatly appreciated.

REFERENCE'S RELATIONSHIP WITH THE APPLICANT

- 1. How long have you known the applicant?** _____
- 2. During what time period did you have the opportunity to directly observe the applicant's practice of medicine?** _____
- 3. In what setting(s) did you observe the applicant (e.g., office, hospital, residency program, etc.)?**

- 4. Was the applicant active in your organization?**
 Yes No

How frequently did you observe the applicant?

- Daily Weekly Monthly Infrequently

Comment:

COMPETENCE ASSESSMENT FOR INITIAL APPOINTMENT

FIGURE 1.1
PROFESSIONAL REFERENCE QUESTIONNAIRE (CONT.)

5. Was your observation done in connection with any official professional title or position?

Yes No

If so, please indicate title and organization:

What was the applicant's title or position?

6. Were you previously, are you now, or are you about to become related to the applicant as family or through a professional partnership or financial association?

Yes No

If yes, please explain:

Section III

PROFESSIONAL KNOWLEDGE, SKILLS, AND ATTITUDE

If you do not have adequate knowledge to answer a particular question, please indicate Unable to evaluate (UE)

1. For each aspect of performance below, please place an X at the place on the scale between poor and excellent that best describes this provider's typical level of performance:

<i>Medical knowledge</i>	<i>Excellent</i>	<i>Poor</i>	<i>UE</i>
– Basic medical/clinical knowledge			-----
– Knowledge in specialty	-----		-----
– Technical and clinical skills	-----		-----
<i>Clinical judgment</i>	<i>Excellent</i>	<i>Poor</i>	<i>UE</i>
– Basic clinical judgment			-----
– Availability and thoroughness of patient care	-----		-----
– Appropriate and timely use of consultants	-----		-----

CHAPTER 1

FIGURE 1.1
PROFESSIONAL REFERENCE QUESTIONNAIRE (CONT.)

	<i>Excellent</i>	<i>Poor</i>	<i>UE</i>
– Quality/appropriateness of patient care outcomes	----- ----- ----- -----		-----
– Appropriateness of resource use (e.g., admissions, procedures, length of stay, tests, etc.)	----- ----- ----- -----		-----
– Thoroughness of medical record documentation	----- ----- ----- -----		-----
<i>Communication skills</i>			
– Overall communication skills	----- ----- ----- -----		-----
– Verbal and written fluency in English	----- ----- ----- -----		-----
– Legibility of medical records	----- ----- ----- -----		-----
– Responsiveness to patient needs	----- ----- ----- -----		-----
<i>Interpersonal skills</i>			
– Ability to work with members of healthcare team	----- ----- ----- -----		-----
– Rapport with patients	----- ----- ----- -----		-----
– Rapport with families	----- ----- ----- -----		-----
– Rapport with hospital staff	----- ----- ----- -----		-----
<i>Professionalism</i>			
– Timely documentation of medical record	----- ----- ----- -----		-----
– Participation in medical staff organization activities (e.g., committees, leadership positions, etc.)	----- ----- ----- -----		-----
– Participation in continuing medical education	----- ----- ----- -----		-----
– Demonstration of ethical standards in treatment	----- ----- ----- -----		-----
– Maintenance of patient confidentiality	----- ----- ----- -----		-----
– Fulfillment of emergency department call responsibilities	----- ----- ----- -----		-----

COMPETENCE ASSESSMENT FOR INITIAL APPOINTMENT

FIGURE 1.1
PROFESSIONAL REFERENCE QUESTIONNAIRE (CONT.)

2. Upon review of the applicant's request for clinical privileges and criteria, as applicable, (enclosed), do you find the privileges requested to be appropriate and in keeping with your knowledge of the applicant's experience and clinical activity at your organization?

Yes No

If no, please explain:

3. Have you ever observed or been informed of any physical, mental, emotional, or behavioral issues the applicant has or had that could potentially affect his/her ability to exercise all or any of the privileges requested or to perform the duties of medical staff appointment?

Yes No No information

If yes, please explain:

4. To the best of your knowledge, have any of the following ever been denied, challenged, investigated, terminated, reduced, not renewed, limited, withdrawn from or resignation submitted, suspended, revoked, modified, placed on probation, relinquished, or voluntarily surrendered, or do you have knowledge of any such actions that are pending?

- | | | | |
|---|------------------------------|-----------------------------|---|
| • License or registration | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> No information |
| • Clinical privileges | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> No information |
| • Hospital appointment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> No information |
| • Affiliation with any healthcare organization | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> No information |
| • Professional status | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> No information |
| • Employment arrangement with any healthcare facility | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> No information |
| • Employment arrangement with a physician group | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> No information |

**FIGURE 1.1
PROFESSIONAL REFERENCE QUESTIONNAIRE (CONT.)**

If yes, please explain:

5. Do you know of any malpractice action instituted or in process against the applicant?

- Yes No No information

If yes, please explain:

Section IV

SUMMARY

I have reviewed the clinical privileges requested and my recommendation concerning the specific clinical privileges requested is as follows:

- I recommend granting all privileges as requested by the applicant.
- I recommend granting privileges as requested by the applicant with the limitations specified below:*
- I recommend not granting the applicant the privileges listed below:*
- I recommend not granting any privileges requested by the applicant:*

*Please explain any reservations or concerns regarding any specific privilege/services requested by the applicant.

COMPETENCE ASSESSMENT FOR INITIAL APPOINTMENT

FIGURE 1.1 PROFESSIONAL REFERENCE QUESTIONNAIRE (CONT.)

I have reviewed this practitioner's application for appointment/affiliation and my recommendation concerning this practitioner's application for appointment/affiliation is as follows:

- I recommend the applicant.
- I recommend the applicant with the reservations listed below:**
- I do not recommend the applicant. **

**Please explain any reservations or concerns regarding the applicant's request for appointment/affiliation.

Please use this section for any additional comments, information, or recommendations that may be relevant to our decision to grant appointment/affiliation or specific clinical privileges/services to the applicant.

If you would like to discuss this applicant with someone from our organization, please call _____
at _____ and a mutually convenient time for a phone conversation will be arranged.

Reference provided by: _____

Signature: _____ **Date:** _____ **Field of practice:** _____

Telephone: (____) _____ **ext.** _____ **E-mail:** _____

Evergreen or “Forevermore” Evaluations

As noted above, an important part of initial competence verification is obtaining a clinical evaluation from the department chair at a hospital or university where the practitioner practiced. Often, when MSPs attempt to obtain this evaluation, the individual who was in that role while the practitioner held privileges there is no longer in that role, and the new department chair is unable to attest to the individual’s competence or prior performance. One way to ensure that your organization is able to disclose thorough credentialing and competence information to other organizations is to complete evergreen (also commonly referred to as “forevermore”) evaluations when a practitioner leaves your organization.

An evergreen evaluation incorporates the affiliation verification and clinical evaluation into one form. For the affiliation verification, your medical staff services department can complete:

- The practitioner’s dates of affiliation at your organization
- The department that the practitioner was assigned to
- Staff category (e.g., active, affiliate, associate, etc.)
- Privileges the practitioner held at your organization
- Recent utilization history/volume (e.g., case logs)

If the practitioner had no disclosable actions, include a statement that indicates that while the individual was on staff, he or she met all requirements of staff membership and had no clinical or other performance concerns. See the “Common Missteps” section at the end of this chapter if the practitioner has disclosable actions, such as restrictions to privileges, sanctions, or disciplinary action.

For the clinical evaluation section of the evergreen verification, the organization should include a statement at the beginning of the form that indicates that the evaluation is being completed on X date by the current department chair. The statement should indicate that the information is valid through that date and is a representation of the individual’s performance only while affiliated with your organization.

The current department chair should complete the clinical evaluation section to the best of his or her knowledge. The questions should be the same questions that the organization uses on its clinical evaluation forms (and others if deemed appropriate by the organization), and you can elect to incorporate the six general

COMPETENCE ASSESSMENT FOR INITIAL APPOINTMENT

competencies to ensure the evaluation is meaningful. You want to ensure that the department chair signs and dates the evaluation.

In the instance of practitioners who have had formal disciplinary actions and/or have been under a formal investigation, medical staff leaders may wish to consider whether the evergreen letter will be used as a response. Some organizations have determined that in these instances, they will respond only to the specific questions asked from the requesting facility (See the “Common Missteps” section at the end of this chapter for more information.) Still other organizations create a specific response given the circumstances of the practitioner’s departure. It is important for organizations to develop a routine procedure for responding to queries regarding practitioners with less than stellar performance. The routine procedure, along with the content of the responses on the individual practitioner, should be determined following the input of legal counsel.

Competence Assessment Through FPPE After Granting Clinical Privileges

Once an applicant has been granted clinical privileges by the board of directors, or after he or she has been granted temporary privileges (see Chapter 3 for verifying competence prior to granting temporary privileges), the organization should monitor the practitioner’s competence through an initial assessment. For Joint Commission–accredited organizations, FPPE is required to assess the individual’s ability to competently exercise clinical privileges using your staff, equipment, and resources. For non-Joint Commission–accredited organizations, initial competence assessment should be incorporated as best practice to ensure safe, quality patient care.

In addition to each of the department chairs, the organization’s credentials committee plays a significant role in determining what the initial competence assessment or FPPE should entail. We discussed the option to offer precepting if an applicant does not have enough current clinical competence and needs to gain additional training and experience to demonstrate current clinical competence. Some additional examples of initial competence assessment options are listed below:

- **Core privileges:** The credentials committee could indicate that all department chairs must assign a minimum number of retrospective chart reviews for core privileges. The department chair would have the option to increase the number of chart reviews, but it could not fall below the minimum set by the credentials committee. For example, if the credentials committee determines that all departments should have a minimum of 10 retrospective chart reviews for core privileges, a department chair may decide that for his or her department, 10 is too few. The department chair could set the initial FPPE criteria higher, such as 20 retrospective chart reviews for all core privileges and

CHAPTER 1

direct observation for five patients with a specific diagnosis. It is important to note, however, that the cases need to be a full representation of all privileges included in the core. For example, the proctor could not conduct retrospective chart review of 10 patients with a similar diagnosis as this would not be a representation of everything included in the core.

- **Special procedures:** For more invasive or specialized procedures or more acute patients, the department chair should carefully consider what type of initial competence assessment is appropriate. This often involves direct observation for a specified number of procedures to demonstrate competence prior to allowing the practitioner to practice independently. For example, if your organization has the Da Vinci robot, there are competence requirements that must be submitted prior to granting privileges to use this equipment (i.e., completion of appropriate training, etc.). However, initial competence assessment at your organization may include direct observation for a specified number of cases.
- **Additional requirements:** As mentioned earlier in this chapter, if an applicant does not have recent experience relevant to the privileges he or she has requested, the department chair has the option of adding requirements to the FPPE to better evaluate the practitioner's current clinical competence. For example, if the minimum criteria for core privileges in a department is 10 retrospective reviews for most applicants and the applicant does not have recent experience, the department chair could increase the FPPE requirement either in volume or by adding requirements, such as direct observation, precepting, or remedial courses.

The most important thing for department chairs to remember when developing FPPE plans is to customize the plans as needed for each individual. The department chair typically assigns the oversight or proctoring of a new practitioner to a tenured member of the department with similar privileges. Anyone assigned as a proctor must hold current clinical privileges equivalent to those that they are proctoring. After completing the proctoring (or earlier, should an issue arise), the evaluations and recommendations from the proctor are forwarded to the department chair for final review. The department chair should then make a recommendation to the credentials committee to decide whether the FPPE was successfully completed or if additional monitoring/proctoring is required. For example, if the FPPE included retrospective chart reviews, and the proctor indicated that there were documentation concerns noted, the department chair may recommend that the practitioner attend documentation training specific to the organization and assign additional retrospective reviews to ensure that his or her performance improves.

COMPETENCE ASSESSMENT FOR INITIAL APPOINTMENT

If the initial FPPE indicates that there are significant clinical care concerns, the department chair must determine what the appropriate next steps are to address these concerns. The organization should keep in mind, however, that if the action taken to address the concern involves any corrective action, it must follow the medical staff bylaws to determine whether the practitioner is entitled to due process. For example, if the department chair recommends limiting the practitioner's privileges to perform certain procedures, a limitation of privileges for competence concerns would typically entitle the individual to due process, and if limited for more than 30 days, it is reportable to the state board and NPDB.

Additionally, organizations need to also consider that recommendations for prospective proctoring may be reportable. Prospective proctoring that requires preauthorization (when the proctor is required to approve a practitioner's plan of care prior to treating a patient or prior to care being delivered) is reportable to the NPDB.

Common Missteps

The following are common missteps during initial credentialing:

- **Affiliation verification versus clinical evaluation:** Often, organizations combine the affiliation verification and a clinical evaluation into one form; however, it is more likely that they will get a quicker and more accurate response if they separate these two forms. The affiliation verification is typically sent to the medical staff services department at all current or prior hospitals where the practitioner held or currently holds clinical privileges and is completed by the MSP, as the keeper of the credentialing database. MSPs can verify dates of affiliation, staff status, type of privileges held, and whether there were any performance or quality concerns. MSPs should not answer questions pertaining to the practitioner's competence or make recommendations specific to the practitioner's request for privileges at the new organization. Rather, these tasks should be deferred to the appropriate department chair or peer references. Keeping these two forms separate helps expedite the process and ensures that your organization receives the information in a more timely manner. If you combine them, MSPs may complete the section that they are qualified to complete and return the rest of the form incomplete, as they are not qualified to answer the evaluation questions. As noted in the "Evergreen or 'Forevermore' Evaluations" section earlier in this chapter, it is efficient to combine the two when a practitioner leaves the organization, as the information will not change.

CHAPTER 1

- **Failure to ask the right questions on the medical staff application:** This is one of the most common pitfalls in credentialing. It is difficult to draft questions that cover any and all situations that should be disclosed by the applicant; however, organizations should attempt to be as thorough as possible. For example, asking if an applicant has ever been the subject of “formal disciplinary action” at any healthcare institution is rather vague. The applicant may not consider certain actions to be formal disciplinary action, and, therefore, based on the way the question is worded, he or she may not disclose pertinent information. For example, perhaps he or she was under investigation or had numerous incident reports filed against him or her that were handled at the department level through collegial intervention. Because these actions are not considered formal corrective or disciplinary action through the MEC, the applicant may not feel that he or she needs to disclose the information. However, if the application specifically asks whether the applicant has ever been the subject of any current, former, or pending complaints; the subject of a current or pending investigation or formal review; or placed on probation, suspended, reprimanded, or received any other type of disciplinary or corrective action—the applicant would be required to disclose that information.
- **Questions on affiliation verifications:** Ensuring that the questions on your affiliation verifications are thorough is just as important as ensuring that questions on your application are thorough to ensure that other organizations disclose all relevant information regarding the applicant. After receiving an affiliation verification, organizations must carefully read the questions and respond accordingly (always, of course, ensuring that the appropriate third-party form that authorizes the release of the information in good faith and releases all parties from liability in doing so, is signed by the applicant). An organization will not (and should not) disclose specific actions if the questionnaire does not ask for it. An organization must disclose information in good faith, and disclosing more than what is requested may leave the organization vulnerable to certain liabilities. For example, if an affiliation verification form asks whether there has been any disciplinary action *taken* against the practitioner in question, the organization may not disclose a *pending* action. Therefore, your organization should ask whether there have been any disciplinary actions or whether there are any impending reviews or investigations. A common mistake at the time of recredentialing is for an organization to include questions that start with, “In the past two years . . .” Just because you received an initial verification two years ago with no disclosures does not mean that something wasn’t missed. For example, perhaps two years ago, the organization’s policy was not to disclose certain actions to other hospitals, but the policy has changed. If the action occurred more than two years ago, they would not be obligated to disclose the information if your question is limited to the past two years.

COMPETENCE ASSESSMENT FOR INITIAL APPOINTMENT

- **Inadequate review of red flags:** When an MSP or medical staff leader identifies a red flag (something in the applicant's practice history that appears abnormal, such as not completing a residency program in the normal time frame, an excessive number of prior malpractice claims, significant gaps in work history, etc.), the organization should ensure that it thoroughly investigates the concern. Ensuring that all discrepancies or concerns that are noted during the credentialing process are thoroughly reviewed and followed up on is an essential part of the MSP's role.
- **Failure to thoroughly review submitted verifications:** MSPs should also closely review the responses they receive from peer references, other healthcare institutions, licensing agencies, and training programs. They need to compare the dates provided from the applicant to the dates provided by the source for discrepancies. They also need to evaluate whether the organization answered all questions thoroughly on the verification form and flag any concerns for the department chair to review. If the organization did not complete the verification form and instead provided a generalized or template response, the MSP should verify that the response includes a statement that confirms that the applicant was not the subject of formal disciplinary action or complaints and that there were no quality concerns. If the organization does not provide this information to the MSP, the MSP should put the responsibility of obtaining a clear and thorough response back on the applicant.

In summary, initial competence assessment goes above and beyond the initial credentialing process.

Organizations have many different options to not only ensure that new practitioners are clinically competent to perform the privileges requested, but to also ensure that they maintain competence through precepting or initial proctoring.

The Medical Staff's Guide to Overcoming Competence Assessment Challenges

Carol S. Cairns, CPMSM, CPCS • Sally Pelletier, CPMSM, CPCS
Frances Ponsioen, CPMSM, CPCS • Anne Roberts, CPMSM, CPCS

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- Attribute performance data to the correct practitioner
- Determine when new technology, procedures, or techniques are appropriate for your facility and successfully assess the competence of the practitioners who will be using them
- Update your medical staff bylaws, policies, and procedures to reflect changes to competency assessment requirements

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