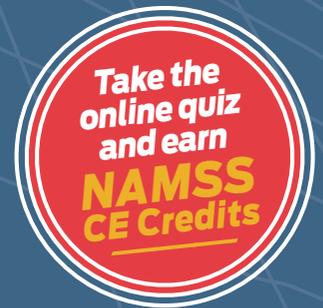


SECOND EDITION

# Assessing the Competency *of* Low-Volume Practitioners



TOOLS AND STRATEGIES FOR OPPE AND FPPE COMPLIANCE



Mark A. Smith, MD, MBA, CMSL | Sally Pelletier, CPMSM, CPCS

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## How to Use the Files on the CD

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To adapt any of the files to your own facility, simply follow the instructions below to open the CD. If you have trouble reading the forms, click on “View,” and then “Normal.” To adapt the forms, save them first to your own hard drive or disk (by clicking “File,” then “Save as,” and changing the system to your own). Then change the information to fit your facility, and add or delete any items that you wish to change.

## Figure List

The following file names on the CD correspond with tools listed in the book:

<u>File name</u>	<u>Document</u>
Fig1.1.rtf	Drafting an FPPE Policy
Fig1.2.rtf	Physician Appraisal Report
Fig2.1.rtf	Sample Intended Practice Plan Questions
Fig3.1.rtf	Sample Initial Application Questions
Fig3.2.rtf	Sample Policy and Procedure: Clinical References
Fig3.3.rtf	Professional Reference Questionnaire
Fig3.4.rtf	Sample Policy: Placing the Burden on the Applicant
Fig3.5.rtf	Notification of Incomplete Application
Fig3.6.rtf	Notification Letter: Ineligibility for Renewal of Privileges
Fig4.1.rtf	Sample Bylaws Language: Membership Qualifications
Fig4.2.rtf	Sample Bylaws Language: Medical Staff Categories
Fig4.3.rtf	Locum Tenens FAQ
Fig4.4.rtf	Sample Preceptorship Policy

The CD also includes the following bonus tool not found in the book:

<u>File name</u>	<u>Document</u>
PrivForm.rtf	Sample Internal Medicine Privilege Form

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# Introduction

At a recent national credentialing seminar, the crowd of physician leaders, medical staff services professionals, credentialing specialists, quality specialists, high-level managers, and others almost unanimously agreed that determining the competency of low-volume and no-volume practitioners was their top credentialing dilemma. This was as true for the small, rural, critical access hospital as it was for the large, urban, tertiary care hospital.

Why is this problem so universal, and why is its solution so difficult to achieve? The purpose of this book is to explore and answer these very questions. Chapter 1 analyzes the forces that have contributed to this trend and discusses how this dilemma affects medical staff leaders, medical staff services professionals, and the hospital as a whole. In this chapter, we also seek to explain how the new Joint Commission standards have affected and even exacerbated the problems medical staff offices face when credentialing low-volume/no-volume practitioners.

A two-part strategic approach to managing the low-volume/no-volume conundrum is introduced in Chapter 2. This approach will help you build a framework to align the hospital's and medical staff's overall goals and answer tough questions, such as:

- What will our medical staff look like in five years?
- Will the nature of the physician-hospital relationship change?
- How will our medical staff function best?

Also, we discuss how the medical staff, management, and the board can work collaboratively to achieve answers to the preceding questions.

Chapter 3 zeroes in on how to determine the competency of low-volume and no-volume practitioners. This will involve examining the competency equation and solving the competency triangle. We discuss what types of performance data should be measured and methods to obtain these data in light of these practitioners' limited time in the hospital. This chapter ends with a discussion of how focused professional practice evaluation and ongoing professional practice evaluation processes must be integrated into the overall credentialing process. Several useful tools and forms that you can adapt to fit your facility's needs are included.

Chapter 4 explores how best to implement the strategic approach discussed in Chapter 2. We examine the membership and privileging options medical staffs can offer licensed independent practitioners and how to incorporate these various options into your credentialing process. Finally, we discuss specific problem areas, including:

- Physicians who have been away from clinical practice and want to reenter
- The effect that contracts (including HMO contracts) have on the credentialing process
- Physicians who participate in limited clinical duties, such as specialty or emergency department coverage

In Chapter 5, we bring our experiences in the field to life through case studies that represent many of the principles outlined in Chapters 3 and 4. We will include potential solutions for some very tough and realistic situations.

We hope the tools and strategies provided in this book will help you better understand the low-volume/no-volume trend and better manage your credentialing and privileging practices.



# The Growing Low-Volume/ No-Volume Trend in Hospital Medical Practice

## How Did We Get Here?

---

To understand how the low-volume/no-volume practitioner trend has come about, you need to start by looking at the evolution of medical practice in the hospital setting. Prior to and for part of the 20th century, hospitals had two primary functions: They served as places where people came to die or as isolation areas for those with communicable diseases, such as tuberculosis or leprosy. Medical care did not have a lot to offer back then: quarantine and tender loving care summed it up. Some diagnostic work and procedural care took place, but those methods appear meager by today's standards.

Over time, advances in anesthesia allowed surgeons to carry out more procedures successfully. As devastating as World War II was, it allowed for several medical advancements. For example, medics treating traumatic conditions in the field fostered developments in emergency care. Certain diseases that had historically produced high mortality rates, such as acute appendicitis, became more controllable, and the discovery of penicillin and other antibiotics reduced mortality due to various infections.

## Chapter 1

After World War II, the government began funding building projects, which led to the expansion of hospitals throughout the country. At the same time, specialty medicine was evolving out of the general medical training that had been the norm prior to the war. During the 1950s, surgery divided into the many specialties that we are familiar with today, such as orthopedic surgery, neurosurgery, and pediatric surgery. Internal medicine evolved similarly, specializing into cardiology, gastroenterology, infectious disease, and so forth.

Because most doctors centered their practices in the hospital setting, this was also the age during which the organized medical staff was created. The relationship between practitioners and the hospital was symbiotic: Practitioners needed to admit patients who required more intensive care than could be rendered in the office or at home, and hospitals needed practitioners to supply a steady stream of patients.

Competency requirements at this time were fairly simple. If a practitioner had a medical license and appropriate training (loosely defined), he or she was declared competent. In addition, privileges were not set in stone. A practitioner was allowed to do anything that fell into his or her general purview. The medical staff provided little performance monitoring, and when it did, it was usually through peer committees conducting individual case reviews.

Reappointments in this laissez-faire atmosphere were straightforward. Unless there was information indicating clear incompetence, the medical staff re-granted practitioners all their privileges almost automatically. Since most practitioners provided care in a hospital setting, low-volume and no-volume practitioners were those who were on staff at more than one hospital but practiced exclusively at one. Even so, this did not present many problems to

## The Growing Low-Volume/No-Volume Trend in Hospital Medical Practice

the credentialing bodies and medical executive committees (MEC) of the day due to limited privileging criteria.

During the 1960s and 1970s, hospital medicine further improved with the development of supportive care techniques, the expansion of blood banks and product usage guidelines, the rise of chemotherapy, and improved nutrition support. In 1965, the federal government established the Centers for Medicare & Medicaid Services (CMS), which increased the number of hospital services available to patients.

By the late 1970s and into the 1980s, a new trend emerged: Care was being pushed into the outpatient setting. Thanks to advances in surgical technologies, many surgeries that were traditionally performed in the hospital were now being done on an outpatient basis. For example, orthopedic surgeons developed arthroscopy, a minimally invasive approach to joint surgery that could be performed in an outpatient setting. Ophthalmologists simplified cataract repairs, transforming a three-hour procedure that required general anesthesia into a 30-minute procedure done under local anesthesia with or without sedation. Many skin and subcutaneous procedures, as well as ear-nose-throat operations, also lent themselves to the outpatient setting.

This push toward outpatient care allowed for the creation of ambulatory surgery centers. Although many of these centers were developed by hospitals to unload their inpatient operating rooms, many others were developed as freestanding entities by independent companies or by entrepreneurial practitioners.

## Chapter 1

The move toward minimally invasive medicine was in full swing by the 1980s. Angioplasty and subsequent coronary artery stents replaced open cardiac surgery as the primary method of treating ischemic heart disease. The use of upper and lower endoscopy allowed gastroenterologists to conduct diagnostic and therapeutic procedures that previously required inpatient hospitalization. The rise of laparoscopy for intra-abdominal surgery started with the gallbladder, but quickly extended to almost all intra-abdominal organs.

As these medical advances were being accomplished, the economics of medicine were also changing. During the 1960s, CMS initiated the greatest expansion in the delivery of healthcare in the United States by approving a fee-for-service payment system. Practitioners saw this as an opportunity to increase their incomes by providing services to the greatest extent that they could.

The government, seeing that fee-for-service was becoming costly, sought to curb medical spending during the 1980s. This led to the creation of diagnosis-related groups (DRG). Essentially, government payers limited their economic risk by placing a cap on hospital reimbursement according to diagnosis. Government payers reimbursed hospitals the same amount of money for an uncomplicated heart attack regardless of the methods practitioners used to treat the patient.

Because practitioners controlled how much care they delivered and therefore indirectly controlled the cost of that care, DRGs put hospitals and their practitioners at odds. If hospitals could convince practitioners to be more efficient by eliminating unnecessary tests and procedures and limiting expensive inpatient hospital days, they could profit well under a fixed fee-for-diagnosis program. To the contrary, DRGs had limited success curbing spending, so by 1990, the government started to look for another payment method.

## The Growing Low-Volume/No-Volume Trend in Hospital Medical Practice

During the 1990s, the government threw its weight behind managed care. Managed care requires practitioners to experience economic risk by rewarding “gatekeeper” primary care practitioners with a greater piece of the economic pie and limiting specialists via capitation. This allowed the government to reimburse providers with consistent payments for all care rendered to a given patient population regardless of how much care was delivered. Managed care was intended to encourage providers to limit the amount of care delivered, and therefore curb medical spending. In effect, many practitioners started to limit the amount of care they provided in the hospital.

Managed care was not popular with patients, as it limited the care they received. As a result, patients demanded more care, and costs started to spiral upward again. To combat cost increases, payers reduced reimbursement across the board, and practitioners and hospitals alike experienced declining revenues.

Today, as the price of providing health insurance continues to rise, many employers have cut back on the amount of health insurance they provide to their employees, causing the number of uninsured to increase to more than 45 million in 2008, according to the U.S. Census Bureau. Because the uninsured do not have normal access to healthcare, they tend to seek their care through the emergency department (ED), placing greater burden on hospitals. The industry responded by creating urgent care centers that provide care for patients seeking emergent care but whose conditions do not require the resources available in a hospital’s ED.

Insurance companies and the government are now seeking new ways to limit their economic exposure and encourage improved quality of care. One option is pay-for-performance plans that supposedly tie increased reimbursements to

## Chapter 1

the provision of better care. If a provider or healthcare entity does not provide adequate quality care, reimbursement decreases. The success or failure of this approach is not yet measurable.

### Past Meets Present

---

So why have we gone through the history of healthcare? It serves to explain the conditions under which practitioners and providers are presently working and why the industry is faced with so many low- and no-volume practitioners. Here are some of the primary drivers of the low-volume/no-volume practitioner trend:

- Primary care practitioners have withdrawn from inpatient care because they make more money in outpatient practice.
- The hospitalist movement got under way during the 1990s as a result of the decreased availability of primary care practitioners in the hospital. Hospitalists practice only in the hospital setting and provide inpatient care services, as well as coverage in the ED. Hospitalists have been the fastest growing segment of the practitioner population during the past 10 years. Although most hospitalists practice general medicine, many are specializing into areas such as pediatrics, obstetrics, and general surgery. The presence of hospitalists encourages independent primary care practitioners who remain in the hospital to withdraw from inpatient care, as they know their patients will be cared for by practitioners who specialize in hospital medicine.

## The Growing Low-Volume/No-Volume Trend in Hospital Medical Practice

- Many specialists have narrowed their practices and are now providing outpatient care via office practice or ambulatory care centers. As a result, many hospitals try to attract numerous specialists to their staffs merely to be available for coverage. This increases the overall number of practitioners on the medical staff who provide limited or no care in the hospital.
- Medical advances continue to push procedures historically performed in the hospital into the outpatient setting.

### The Challenge This Trend Poses for Your MSPs, Medical Staff Leaders, and Board

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Given the forces driving the low- and no-volume practitioner trend, it's clear that it is not going away soon. Medical staff services professionals (MSP), medical staff leaders, and hospital boards need to understand not only why this trend is occurring, but also how it directly affects their jobs on a day-to-day basis. Let's explore how the low-volume trend affects MSPs, medical staff leaders, and hospital boards.

#### ***Medical staff services professionals***

MSPs play a key role in the credentialing and privileging process. They gather data, including references, license and insurance verifications, and so forth, on all new applicants, as well as performance data on existing medical staff members at reappointment. By definition, low- and no-volume providers lack performance data because they do not practice at the hospital regularly, if at all. Even references are hard to come by because no one sees them in action. The challenge for MSPs is gathering adequate information to support a successful credentialing and privileging process and confirm competency.

## Chapter 1

### ***Medical staff leaders***

Medical staff leaders, including department chairs, credentials committee members, and MEC members, make recommendations regarding a practitioner's membership and privileges based on the information MSPs collect. In Chapters 3 and 4, we will discuss the differences between the process of collecting data and the process of determining competency. Suffice it to say that the absence of data makes this recommendation process almost impossible.

Leadership defines the data required to make a credentialing decision and determines how these data will be collected to ensure that proper decisions are made. Because most medical staff leaders are still actively practicing medicine and tend to their medical staff duties for little or no compensation, they often make these decisions during off-hours and at the expense of something else, including time with family and patients.

### ***Hospital board***

With regard to credentialing and privileging, the hospital organization has two primary functions. The first is to provide the resources that enable the credentialing process. Usually, credentialing is not perceived as a revenue-generating activity, and in times of economic constraints, it may be hard to justify.

The second function is to grant or deny membership and privileges to practitioners. Although boards have ultimate authority to grant or deny privileges, they usually delegate this work to the organized medical staff and agree with most of the medical staff's recommendations.

If the medical staff lacks data regarding a practitioner's performance, granting him or her privileges is a game of chance. The board's challenge is to ensure a proper credentialing process in the face of the low- and no-volume trend.

High-performing boards will encourage criteria-based privileging that will equitably and objectively define required clinical competency volume.

### CMS and Joint Commission Regulations Pose Credentialing Challenges

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CMS' 2008 medical staff *Conditions of Participation* state: "The medical staff must periodically conduct appraisals of its members" (see §482.22[a][1]). In addition, CMS' survey guidelines require surveyors to determine ". . . how the medical staff conducts the periodic appraisals of any current member of the medical staff who has not provided patient care at the hospital or who has not provided care for which he or she is privileged to patients at the hospital during the appropriate evaluation time frames."

In addition to CMS requirements, The Joint Commission's latest initiatives directly affect the ability of hospitals with low- and no-volume providers on their medical staffs to comply with its requirements. The Joint Commission states that recommendations to grant, renew, or deny privileges must be made using "an objective, evidence-based process." By definition, competency must be determined based on data regarding a practitioner's performance and his or her ability to meet predetermined criteria.

During the past three years, The Joint Commission has given great attention to the following areas:

- **General competencies.** In 2007, The Joint Commission adopted the six core competencies that were originally developed by the Accreditation Council for Graduate Medical Education and The American Board of Medical Specialties. These competencies provide medical staffs with a comprehensive framework to measure practitioner performance.

## Chapter 1

The six general competencies are:

1. Patient care
  2. Medical knowledge
  3. Practice-based learning and improvement
  4. Interpersonal and communication skills
  5. Professionalism
  6. Systems-based practice
- **Focused professional practice evaluation (FPPE).** The goal of FPPE is to confirm the ability of a practitioner to competently exercise specific clinical privileges. The Joint Commission does not prescribe how to conduct FPPE, but lists several methods, including proctoring, retrospective or prospective peer review, and peer references. A hospital must have a focused evaluation process in place when:
    - It does not have firsthand knowledge of a practitioner’s competence
    - Questions are raised regarding a practitioner’s performance based on the ongoing professional practice evaluation (OPPE) process

Thus, medical staffs must perform FPPE for all newly credentialed practitioners, established practitioners requesting new privileges, and any practitioners who may have potential care issues based on the OPPE process.

In the case of low- and no-volume practitioners, the absence of performance data may prompt the hospital to initiate FPPE with the goal of

gaining firsthand knowledge of a practitioner's competence to justify granting him or her privileges.

Although this book is not dedicated to an in-depth overview of FPPE or OPPE, the authors have included a guide to developing an FPPE policy (Figure 1.1) at the end of this chapter to help organizations that are struggling to find solutions.

- **OPPE.** Medical staff leaders must establish a system for continuously evaluating the performance of medical staff members who hold privileges. Although The Joint Commission does not prescribe what measures need to be evaluated, it does require that medical staffs conduct OPPE more frequently than once every 12 months. The Greeley Company recommends that organizations conduct OPPE every six to nine months.

A well-designed, criteria-based privileging system (discussed in Chapter 3) will inherently influence the OPPE process. Although the six general competencies may be applicable across all specialties, departments and clinical services should be involved in defining the data that will be collected to measure practitioners practicing in certain clinical areas. (See Figure 1.2 at the end of this chapter for a sample physician appraisal report.)

The Joint Commission's adoption of the six general competencies changes the scope of performance data that medical staffs must collect. Unfortunately, low- and no-volume practitioners pose a challenge to hospitals striving to comply with this requirement as such practitioners are not present in the hospital regularly enough to generate sufficient data.

## Chapter 1

FPPE requires a period of focused evaluation for a practitioner exercising new privileges. Once the practitioner demonstrates competency exercising these privileges, he or she is then evaluated using an OPPE process. Low- and no-volume practitioners may never be able to get beyond the FPPE process due to their lack of clinical activity at the hospital.

Finally, OPPE puts a strain on the medical staff and hospital by increasing the frequency at which collected data must be available for review. Hospitals have a hard enough time making these data available at the end of every two-year reappointment period; to do this every six to nine months poses a major challenge for most hospitals.

Now that you understand the circumstances that led to the low- and no-volume practitioner trend and the forces driving it today; how it affects MSPs, medical staff leaders, and boards; and the challenges posed by Joint Commission regulations, let's move ahead and start to deal with this issue.

**FIGURE 1.1**    **Drafting an FPPE Policy**

Recommended elements of a focused professional practice evaluation (FPPE) policy:

- Purpose
- Medical staff oversight
- Ethical positions of the medical staff
- Scope of proctoring program
- Responsibilities
- Methods
- Procedure
- Reporting: results and recommendations

**I. Purpose**

The policy should state the reasons for conducting FPPE and explain its place in the organizational scheme. Although the policy may or may not specifically reference The Joint Commission standards, the reasons for conducting FPPE should extend beyond the goal of meeting regulatory compliance. The primary goal should be to use FPPE as another tool to assess and ensure competence as part of the organization's ongoing commitment to quality.

**II. Medical staff oversight**

1. Identify which individuals or group(s) in the medical staff (e.g., the credentials committee, department chairs, the medical executive committee [MEC], or other) will have primary oversight of the FPPE process.
2. Discuss how the FPPE process will be integrated with the organization's ongoing professional practice evaluation (OPPE) process and the clinical privileging system.

**III. Ethical positions of the medical staff**

The FPPE policy should address the following ethical concerns:

- Conflicts of interest

**FIGURE 1.1**    **Drafting an FPPE Policy (Cont.)**

- Disclosure to patients
- Consent issues
- Intervention by the proctor
- Indemnification for proctors

**IV. Scope of the proctoring program**

The policy should define proctoring and delineate the activities that constitute it, including whether the organization will use the term proctoring interchangeably with FPPE. (The Greeley Company generally recommends using the terms proctoring and FPPE interchangeably.) In addition, the policy should define the methods to be employed and the individuals to whom the program applies (e.g., initial applicants and currently privileged individuals requesting additional privileges).

**V. Responsibilities**

The policy should answer the following questions:

- Who will create the practitioner-specific FPPE plan?
- Who will assign proctors?
- Who will collect the data?
- Who will analyze the data and make recommendations?

The policy should clearly delineate the duties of the person being proctored, proctors, department chairs, credentials committee, MEC, and medical staff services and quality departments.

**VI. Methods**

Typically, some or all of the following methods are used in an FPPE program:

- Prospective proctoring
- Concurrent proctoring (i.e., real-time proctoring)
- Retrospective proctoring

**FIGURE 1.1**    **Drafting an FPPE Policy (Cont.)**

- Teleproctoring
- Crossover proctoring (i.e., proctoring of clinical work is done at another institution, but a proctor from your organization is used)
- Anticipatory proctoring (i.e., proctoring is accomplished before the applicant exercises privileges on-site; with this advance proctoring, on-site FPPE may be reduced)
- Simulation

The policy should also outline the circumstances for proctoring from an external source.

**VII. Procedure**

This section of the FPPE policy provides guidelines for addressing logistical challenges:

- Data: What should be collected, how should it be collected, and how much of it should be collected?
- Scheduling: How can proctoring be scheduled efficiently?
- Are substitute proctors allowed?

**VIII. Reporting**

The FPPE policy should address how and when the data that have been gathered and analyzed will be reported, including the method for making recommendations. Most often, the end point is reached when competency is established, thus ending FPPE and triggering the start of the routine OPPE monitoring process.

Source: The Greeley Company, a division of HCPro, Inc., Marblehead, MA.

**FIGURE 1.2 Physician Appraisal Report**

<b>Provider: Doe, John    ID: XXXXX    Specialty: Family Practice</b>		
<b>Activity</b>		
Time Period	Indicator	Volume
1 Yr End 2009 Qtr 4	101 # of Inpatient Admissions	23

<b>Patient Care</b>						
Time Period	Indicator	Indicator Type	Numerator	Acceptable Value	Excellence Value	Score
1 Yr End 2009 Qtr 4	(38) Blood component use not meeting appropriateness criteria excluding autologous units	Rule	0	6	3	Green

<b>Medical Knowledge</b>						
Time Period	Indicator	Indicator Type	Numerator	Acceptable Value	Excellence Value	Score
1 Yr End 2009 Qtr 4	(32) # of case reviews deemed care inappropriate	Rule	1	2	0	Yellow

**PRACTICE BASED LEARNING AND IMPROVEMENT**

<b>Interpersonal &amp; Communication Skills</b>						
Time Period	Indicator	Indicator Type	Numerator	Acceptable Value	Excellence Value	Score
1 Yr End 2009 Qtr 4	(52) Suspensions for delinquent medical records	Rule	0	3	0	Green

<b>Professionalism</b>						
Time Period	Indicator	Indicator Type	Numerator	Acceptable Value	Excellence Value	Score
1 Yr End 2009 Qtr 4	(42) Validated incidents of inappropriate physician behavior	Rule	3	2	0	Red

<b>System Based Practice</b>						
Time Period	Indicator	Indicator Type	Numerator	Acceptable Value	Excellence Value	Score
1 Yr End 2009 Qtr 4	(48) Physician orders containing "do not use" abbreviations	Rule	1	6	3	Green

Time Period	Indicator	Indicator Type	Volume	Actual	Expected	Index	Acceptable Value	Excellence Value	Score
1 Yr End 2009 Qtr 4	(66) Severity adjusted LOS index by medical DRG	Rule	133	0.05	0.05	0.05	1.00	0.25	Yellow

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