Trustee Insights
PERFORMANCE IMPROVEMENT

Streamlining the Credentialing and Privileging Process

A standardized approach can align expectations and give the board peace of mind

BY LAURIE LARSON

The hospital board's legal authority to oversee the medical staff and approve, limit or deny provider credentials and privileges has always been one of its most fundamental and important responsibilities. Equally longstanding, however, has been trustees' frequent deference to medical staff recommendations for physician appointment, reappointment and privileging, because the board often feels it lacks the clinical expertise to challenge those recommendations.

Although trustees should never abrogate this responsibility, today's boards can afford to do so even less. Health care restructuring, from mergers and acquisitions to merged clinical processes, as well as rising expectations to deliver value-based care and report on more quality measures, all demand the board's certainty that all of its providers are competent, qualified and prepared to partner with the executive leadership team to meet the field's many changes and challenges.

"The strong trend toward increasing physician employment is changing medical staff culture and dynamics," says Charles E. Reiter III, founding partner of Chicago-based Reiter Burns LLP, and former senior vice president, general counsel and secretary for Loyola University Health System, Maywood, Ill. "And the macro forces in health care are moving toward consolidation at every level."

As a general counsel, Reiter has a long history of navigating between health care's executive and clinical worlds. He joined the Loyola University Health System soon after it was incorporated by Loyola University Chicago and founded the system's office of the general counsel. He later did the

TRUSTEE TALKING POINTS

- The legal authority to approve, limit or deny provider credentials and privileges is a fundamental board responsibility.
- Health care restructuring demands the board's certainty that providers are competent, qualified and prepared.
- Value-based care models are changing the credentialing process by requiring more measures and data reporting.
- The process can be inefficient if organizational efforts are duplicated or data is insufficient for ensuring quality.

same at Palos Community Hospital in Palos Heights, Ill., launching its first general counsel office before it began its affiliation with Loyola University Medical Center.

"From my standpoint, I always wanted to make sure our directors had the right clear and concise materials to review in advance of the board meeting and the opportunity for a good interaction with the medical staff," Reiter says. "Whoever presents credentialing to the board should try to create a collegial safe space for questions and answers. There is a natural deference to physicians among lay board members, but it's desirable to encourage an interactive discussion and to discourage rubber stamping."

Traditionally, the approach to physician reappointment may have been more of a routine, but Reiter says the recredentialing process has changed significantly in the 20 years he has been a board officer. "It's no longer rote, but a deep dive into statistics and quality," he says, adding that The Joint Commission's most current OPPE (Ongoing Professional Practice Evaluation) and FPPE (Focused Professional Practice Evaluation) requirements should be a standardized part of both credentialing and recredentialing. (See sidebar: "Defining OPPE and FPPE.")

System Level Credentialing

With these increasingly in-depth requirements in mind, Intermountain Healthcare in Salt Lake City believes that a streamlined credentialing process makes sense and improves consistency.

"We have a single set of expectations and standard processes for how we handle credentialing that have evolved over time, and we've been working to bring our structure in alignment across specialties," explains Susan DuBois, Intermountain's assistant vice president for physician and advanced practice clinician professional affairs. The system has centralized and standardized credentials verification for all of its employed and affiliated physicians and advanced practice clinicians across its 24 hospitals through its medical staff office, although privileging is hospital specific.

"In the past 18 months at Intermountain, physicians have started reporting [for credentialing and privileging] to physicians of their same specialty," DuBois explains, adding that Intermountain has always structured its specialty-specific clinical protocols at the system level, and now the credentialing process is following suit.

"There is accountability across the health system, with each service line in its entirety reporting at the system level," she says. "The beauty of this system is that all physicians are engaged in best practices for their specialty, and all have an opportunity to contribute in developing them." In the process, the health system has implemented several dyad (physician/operations) and triad (physician/operations/nursing) leadership models. "This process addresses variations so patients experience the same

Defining OPPE and FPPE

Federal regulations provide a solid baseline from which health care organizations can develop their own hospital and/or system-specific performance criteria for practitioner credentialing and recredentialing. According to The Joint Commission, the Ongoing Professional Practice Evaluation (OPPE) is "a documented summary of ongoing data collected to assess a practitioner's clinical competencies and professional behavior." Medical staffs determine the department or division-specific OPPE criteria for their hospital, and those criteria apply to all practitioners who are granted privileges, including advanced practice nurses and physician assistants. OPPE data is factored into the renewal or revision of privileges as they come due as well. The Commission states, "OPPE allows organizations to identify professional practice trends that impact the quality and safety of patient care."

The Focused Professional Practice Evaluation (FPPE) requirements are used to evaluate privilege-specific competencies of practitioners who do not have current evidence of competency performing a requested privilege at the hospital, or in other words, a new privilege request for existing practitioners, or for practitioners who are new to the medical staff. The need for an FPPE may also come up if there is a question about a practitioner's ability to provide safe, high quality patient care in one of his or her privilege areas. The Joint Commission stipulates that "all hospitals with a CCN [Centers for Medicare & Medicaid Services Certification Number] must collect FPPE data on practitioner performance."

Source: https://www.jointcommission.org/jc_physician_blog/oppe_fppe_tools_privileging_decisions/

NAMSS Ideal Credentialing Standards

In May 2014 the National Association Medical Staff Services (now known exclusively as NAMSS) convened an "Ideal Credentialing Roundtable" to discuss best practice standards for the initial credentialing of independent practitioner applicants. The 16 health care-entity roundtable participants — including the American Hospital Association — identified and vetted 13 essential criteria for practitioner credentialing.

Each health facility and system should establish specific qualifications for medical staff membership and clinical privileges that reflect practitioner competency for an initial applicant. They should incorporate the 13 criteria, which NAMSS has identified as essential elements in its Ideal Credentialing Standards, into their rules and regulations, credentialing policies and procedures, or other governance documents, to ensure that the credentialing process is objective, systematic, and without discrimination or bias.

Evidenced-based evaluations should verify the following 13 specific criteria from primary sources, as the data will generate the information necessary to assess an applicant's professional competence and conduct, as well as help identify practitioners who need further investigation or are not suitable to be credentialed:

1. Proof of Identity
2. Education and Training
3. Military Service
4. Professional Licensure
5. Drug Enforcement Administration (DEA) Registration, State Department of Public Safety (DPS) Certification and State Controlled Dangerous Substance (CDS) Certification
6. Board Certification
7. Affiliation and Work History
8. Criminal Background Disclosure
9. Sanctions Disclosure
10. Health Status, verifying whether the applicant has ever had any physical or mental condition that would affect his/her ability to practice.
11. National Practitioner Data Bank (NPDB) data, which provides health care-specific information on state and federal criminal convictions and civil judgments, as well as malpractice history and hospital sanctions. The Data Bank must be queried during the initial credentialing process in accordance with provisions of the Health Care Quality Improvement Act.
12. Malpractice Insurance
13. Professional and Peer References

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standard of care across the system," DuBois explains. It all ties back to improved credentialing processes, which should be standardized as much as possible, she affirms.

It's a trend she's also witnessing more frequently in her role as industry and government relations liaison for NAMSS. The organization is the professional membership association for medical services professionals, those who traditionally do the "legwork" of verifying providers' credentials as gatekeepers of patient safety, she explains. (See sidebar: "NAMSS Ideal Credentialing Standards.")

"Clinical service lines are being aligned across many health systems instead of each hospital doing their own credentialing," DuBois says. Value-based care models are also changing the credentialing process in requiring more measurement and reporting of additional value-related measures and data. In many hospitals, that task falls to the medical staff services office. But DuBois says, "It's not about getting more medical staff services professionals in the office; the solution is to more efficiently eliminate duplication of effort, and share data appropriately across the system."

She adds, "Credentialing and privileging has been a fairly stable process for a long time, and that's not going to change. But there are ongoing opportunities for streamlining and centralizing processes and sharing verification data. Ultimately, it's all about the patient, ensuring quality. It will be interesting to see what role patient experience will play in credentialing decisions. I think we'll see a lot happening there going forward."

Taking a Tandem Approach

To build stronger bridges between the C-suite and medical staff leadership, Carilion Clinic in Roanoke, Va., has forged a dyad leadership model in the roles of Tracey Criss, M.D., vice president of medical staff affairs, and Jonathan Gleason, M.D., chief quality officer.

"In order to deliver excellent and safe care, you need to be able to focus on both the systems and environments of care, as well as the performance of individual caregivers," Gleason says. The chief quality officer (CQO) has organizationwide responsibility for quality and safety systems and processes at Carilion's seven hospitals and numerous clinics and manages its Department of Clinical Advancement and Patient Safety. The vice president of medical staff affairs (VPMSA) has oversight of credentialing, clinical care and behavioral peer review (committees that report to the medical executive committee), as well as managing the medical staff office of Carilion Medical Center. Criss and Gleason also sit on the system's flagship Carilion Medical Center board.

As Gleason explains, the medical staff office and VPMSA are responsible for ensuring that the organization has the right providers, and the Department of Clinical Advancement and Patient Safety and the CQO are focused on ensuring that everything else is working. "The roles are complementary, but distinct," he says. Gleason and Criss meet weekly and also convene regularly with Carilion's general counsel.

"We tie credentialing to provider outcomes, and we pay a lot of attention to physician behavior as it affects the quality of care delivered to our patients," Criss says.

Behavioral issues are managed in part through an event-reporting tool called SafeWatch. SafeWatch is used as a patient safety and peer review tool, but it is also used in Carilion's "closed-loop recredentialing process," Criss says. "When a provider applies for reappointment, our review of SafeWatch reports contributes to our decision for reappointment, or for a 12- or 24-month reappointment. Limited information, however, is given to the committee. We also may have a credentialing meeting with a provider to listen to their story, if necessary."

Each of Carilion Clinic's hospitals has its own board — and a medical executive committee chaired by its chief of staff. Each hospital determines its privileging criteria. However, for the past three and a half years, credentialing applications have been reviewed through a systems credentialing committee.

"Our process is more streamlined and efficient now," Criss says. "We have physician representatives appointed by each medical executive committee on the systems credentialing committee. Advanced clinical practitioners are also representatives. That structure gives Carilion system board members peace of mind in approving credentialing and privileging, Criss says, as applications have been well vetted before the board reviews them.

Several Carilion board members attend medical executive committee meetings to understand medical staff governance better, Criss adds. "If trustees feel uncomfortable with their medical executive committees, they could ask to attend their meetings. It goes a long way toward building trust."

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TRUSTEE TAKEAWAYS

- The board should expect clear and concise materials for review in advance of its meetings.
- The board should also expect the opportunity for good interaction with the medical staff.
- Centralized and standardized verification can improve consistency for credentialing decisions.
- A systems credentialing committee ensures applications are well vetted before the board's review.

WEBINAR RESOURCE

"The Role of the Board in Medical Staff Credentialing," a webinar [http://trustees.aha.org/quality/the-boards-role-in-medical-staff-credentialing.shtml] from governance expert Jamie Orlikoff, explores the basics of credentialing and effective oversight to protect patients and ensure fair, thorough and consistent treatment of physicians.