Credentialing Resource Center Journal

Innovation and privileging challenges for MSPs

Editor's note: The following is a CRC members only article that Credentialing Resource Center has made available to the public.

In healthcare, change is constant, and credentialing and privileging are no exception. Rapidly expanding technology and increased variation in how practitioners are providing care (e.g., telemedicine, locum tenens, outpatient vs. inpatient) means that MSPs need to be proactive and monitor how these changes will alter the clinical privileges granted to their practitioners.

This can be challenging because most MSPs do not possess a clinical background; therefore, working closely with medical staff leaders and management is crucial to be able to monitor when new technology/innovative techniques are being introduced for consideration within an organization. Another challenge is that frequently, the organization is already talking about new technology/service line implementation with privileging as an afterthought—or worse, they are near implementation date and no discussion of privileging has taken place. This can create privileging nightmares for MSPs.

Facilitating the privileging process is one of an MSP's key functions. MSPs are usually the ones to stay up to date and be aware of the various and new components involved with privileging, which have become more complex as technology advances and organizations become more innovative in their approach to patient care. It's not enough to be familiar with bylaws, rules and regulations, and policies and procedures related to privileging; an MSP must be proactive in the facilitation of the initial privileging of applicants, the re-privileging of practitioners, and ongoing requests in between appointment dates. In addition, an MSP must be familiar with all of the nuances related to a new innovation being discussed so that the legwork can be accomplished before the eleventh hour.

MSPs need to have knowledge of the potential for development of new privileges/criteria in order to complete the steps involved so that by the time a practitioner needs to apply for the privileges, a process has been implemented/updated. An implementation or update may be a fairly simple adjustment to already defined privileges/criteria, or it may require the addition of new privileges/criteria with the associated steps to define staffing, resources, equipment, space, performance metrics, etc. It's also important to have the privileging process completed and practitioners approved before patients are scheduled for innovative procedures and, preferably, before the organization begins any marketing campaign for new treatment offerings. Good communication between the MSP and the marketing department can prevent costly implementation delays.

With or without new technology/treatment modalities on the horizon, MSPs must encourage and facilitate periodic review and revision of the current clinical privileges and associated criteria of the hospital. It keeps medical staff leaders in the habit of continually assessing the privileges that are offered and what changes may need to be made based on industry standards.

Establishing performance metrics

Part of the MSP's function in the process for defining new privileges resulting from new technologies or other innovative treatment is to ensure performance metrics are defined so that the medical staff and management can evaluate the innovations' outcome from both a peer review perspective as well as other industry benchmarks or anticipated outcomes. The definition and measurement methodologies may be performed by another department, but the information needs to be reported back to the medical staff and practitioner. This process is built into the standards of the Centers for Medicare & Medicaid Services (CMS) and other major accreditors, such as The Joint Commission, DNV GL, and the Healthcare Facilities Accreditation Program (HFAP), as a means to evaluate and improve patient care. The Joint Commission and HFAP have specific standards for evaluation of those new privileges approved (either for new applicants or new privileges), referred to as focused professional practice evaluation (FPPE); the ongoing evaluation process of these new privileges is referred to as ongoing professional practice evaluation (OPPE).

The FPPE process for practitioners new to the organization or requesting a privilege for the first time must be evaluated on those privileges granted. The evaluation must be done for the privileges exercised at that organization. (If the practitioner also utilizes these privileges elsewhere, evaluations from those organizations can be used to supplement the evaluation only by the organization granting these new privileges.) Some examples of methods that can be used to evaluate the practitioner include:

- Chart review
- External peer review
- Discussion with others involved in the care
- Simulation
- Monitoring of clinical practice patterns
- Proctoring

Educating medical staff leaders

Educating medical staff leaders about their role in clinical privilege review, revision, and implementation is a key component of new leadership orientation as well as ongoing discussions with leadership to keep abreast of new innovations that frequently lead to a change in clinical privilege offerings. Even though many organizations have some type of technology committee, they all function differently, and the privileging process may not necessarily be a key component of the committee's role. The committee needs to understand its responsibility for defining privileges and related criteria when appropriate.

Another function of the MSP is to guide the medical staff leadership to what policies and processes are in place; this is because the MSP is more than likely the one "constant" for knowledge of these policies, especially for those organizations whose leadership changes on a regular basis (i.e., every one to two years). The function of reviewing and recommending new privilege requirements frequently comes from the appropriate medical staff department, and if no departments exist, the review must come from the medical executive committee (MEC). Service lines that may have replaced the traditional medical staff departments could have this authority (to recommend). Departments or service lines may also delegate the review process to a task force. Regardless of the process, the MSP needs to participate in the proceedings so that the recommendations follow the proper channels, ultimately ending up with the governing body for action.

Medical staff leaders must be ready to handle a new technology or innovation request long before it lands on the CEO's or chief medical officer's desk. To begin, it is vital to reiterate to all parties involved the shared mission of medical staff physicians and the institution: delivering high-quality, high-value, efficient patient care.

The first step is making sure your medical staff has a policy in place regarding the introduction of new technology. In the absence of such a policy or body to create and guide an organization in privileging for innovations, adhere to The Greeley Company's "5 P's."

"In our hospital, it is our policy to follow our policy. In the absence of a policy, it is our policy to create a policy."

Although the 5 P's policy may seem oversimplified or even a bit trite, it is good advice for any hospital that has not yet created a standardized mechanism to weigh the credentialing/privileging, business, regulatory, and organizational issues posed by an innovation. Simply put, myriad issues involving new technologies are coming down the pike, and failure to institute a policy allowing you to address these issues in a straightforward, rational, and organized way will almost guarantee that your facility will fail to make decisions that are in the best interests of the community, patients, institution, and physicians involved.

Be wary of privileging "quick fixes"

In the absence of a standard process to assess new technologies or procedures, hospitals often will simply "stretch" a physician's existing privileges to cover a new innovation or technique. But that can lead to problems. In the 1994 case *Candler General Hospital v. Persaud*, for example, a hospital allowed a surgeon to perform a laparoscopic abdominal procedure for which no generally recognized credentialing standards existed at the time. The surgeon already had privileges to perform general abdominal surgery, and his peers considered him to be experienced and competent. The hospital granted him temporary privileges to perform the laparoscopic procedure on the same day he applied for them.

After the patient bled to death as a result of complications from the procedure, her estate sued, alleging that the hospital was negligent in allowing the surgeon to perform the procedure without having instituted any standards, training requirements, protocols, or other methods for judging the surgeon's qualifications to perform the procedure. The court allowed the suit to go forward, in part because a question of fact existed as to whether the hospital should have done more to ensure that the surgeon had the requisite training and experience to perform the procedure.

In the absence of a standard process to assess new technologies or procedures, hospitals may be tempted to not only stretch a practitioner's privileges but also to hastily grant the privileges without sufficient review. This may occur in part because regulators "force" a detailed analysis of a physician's competence. And when any kind of a policy to assess an innovation is lacking, hospitals may reason that leaning on the privileging process to cover for the global assessment of a new technology is, at least, a quick fix. However, this is a dangerous way to operate.

Researching clinical privilege criteria can be time-consuming, and it may be initially delegated to the MSP. This request may be based on new procedures to be provided by the organization or new technology that enhances current privileges. The request most likely comes from medical staff leaders, the technology committee, or an individual practitioner who is applying for privileges/procedures that are new to the organization. If coming from the individual practitioner, it might be more time-efficient to gather some general information for a committee, task force, or department to initially review along with the request. Any additional time spent researching the data should be at the direction of the same groups mentioned previously once a decision is made to proceed with the new service, procedure, etc., or the groups decide they need additional information. Without this organizational action or request, too much time can be spent on research that is never used.

MSPs might feel overwhelmed at adding another task to their workload, but keep in mind that there are various resources for researching privilege criteria. They include:

- A board specialty or society.
- The device manufacturing company or healthcare organization (e.g., academic program) where a particular new technology or innovation has been developed and utilized.
- An internet search for specific criteria. This may produce numerous sites where the criteria are used. When considering another organization's criteria, be sure they are applicable to your organization. For example, an academic institution may have more stringent criteria because of expertise on-site (someone there developed the procedure/technology and/or the training takes place at that site).
- Other MSPs. Take advantage of any networking opportunities with your colleagues. No one wants to reinvent the wheel, so other MSPs are usually happy to share examples of what they have implemented.

New credentialing and privileging challenges

Some credentialing and privileging challenges that MSPs have encountered in recent years include:

- Variation in practice environments where clinical privileges have surfaced (beyond hospitals)
- Practice patterns of those practitioners who still provide acute care services within hospitals
- Over-duplication of primary source collection and data gathering performed on the same practitioner

The latter doesn't affect the privileging aspect as much because privileging remains a site-specific decision. However, anyone involved in the centralization of primary source verification or data gathering, or whose responsibilities extend beyond one medical staff or group's practice, may have had their work double or triple in collecting this information for the same practitioner at multiple locations. It's possible that newer technology or procedures may not be available at all sites that an MSP is managing, so privileges/criteria may exist at some sites and not others, or be different.

Hospitals have moved more services to an outpatient basis or ambulatory sites, in some cases to perform these services with more cost-efficiency. That has caused some hospitals to lose profit but remain competitive within the community. In today's environment of cost competition for services, the precedence of moving existing services from "on license," that is, under a hospital's license, which places credentialing under the purview of the hospital's medical staff, to "off license," which leaves the credentialing and privileging to another body, is challenging.

Medical staffs must discuss how privileging might be affected and what, if any, adjustments need to be made to privileging criteria. For example, if a new innovation has been approved for use in the hospital environment and off-site, are the same resources available at both sites? How could privileges be affected if the innovation is not available at both places? Will reappointment criteria include any hospital "campus" when defining minimum activity for ongoing competency evaluation? Where is the nonhospital care going to be evaluated?

Establishment of a peer review process/policy that covers multiple environments may be needed, or at least a process whereby a general competency evaluation can be shared among the sites (if separate medical staffs/physician groups could prevent a more open peer review process from taking place). The MSP needs to work with each location where privileges are now defined to be sure an adequate review process is taking place, documentation is kept, and any legal assistance is requested to ensure no breach of confidentiality will occur as processes are put into place. Privileges should always be site-specific so that individuals are only requesting privileges to provide services that are offered at a particular site.

Changes in treatment technology may present privileging challenges. For example, physicians providing telemedicine services to a hospital would need to be privileged and credentialed just like someone physically located at the hospital. CMS allows credentialing by proxy, meaning the hospital receiving the telemedicine services can use credentialing information from the site where the practitioner is privileged. What services the hospital offers would determine which privileges physicians could request. Obviously, just any procedural privileges would not apply.

Another challenge that MSPs face today is the traditional process in which medical staff departments function in a

silo approach to credentialing, privileging, and peer review. With so much crossover in privileging, comorbidity treatment, and multidisciplinary approaches to provide patient care, it might appear more practical from a process perspective to collapse specialty departments and move to a service line approach. Frequently, these service line committees already exist for administrative reasons, with medical staffs clinging to their specialty-specific domains, which may duplicate efforts and resources for both to function side by side. For example, a heart and vascular service line might be composed of cardiology, cardiovascular and thoracic surgery, and vascular surgery. Another service line might be women's health, composed of GYN oncology, maternal and fetal medicine, obstetrics, gynecology, pediatrics, reproductive endocrinology, and urogynecology.

None of the major accrediting bodies, nor CMS, requires medical staff departments. (But if you have them, define them and each chairperson's responsibilities.) This allows medical staffs the flexibility to organize and function in an environment to complement how care is provided. Certainly, specialists can be called in when a technical question arises regarding specific treatment evaluated during peer review or to review clinical privilege requests of a more specialized nature, but experience has shown that most credentialing and privileging is not complicated, barring the small percentage that requires specific review for concerns or issues identified. Even though a service line committee could function as a medical staff committee to be afforded the confidentiality that state statutes and the Health Care Quality Improvement Act provide, an "executive session" can be utilized for the peer-only review segment of the committee meeting with appropriate personnel remaining in the meeting (in those cases where a specific practitioner's care may be questioned or corrective action may be discussed). This venue becomes very advantageous during ongoing peer review when more than one specialty is involved as well as when a service line is considered a hospital function. The "peer review" portion can still be considered a medical staff function and thus afforded the protections provided by laws and regulations.

Algorithm for deciding whether to develop scope-of-practice criteria

Even when your facility has a policy for assessing and adding innovations, there is still a temptation to react to each individual practitioner's application, rather than to consult the policy. Every request, it seems, comes with its own "special circumstances." However, such a haphazard approach can spawn problems that could be avoided by following your policy. Figures 1 and 2 can prevent you from making rash decisions. These algorithms can help you walk through the decision-making process regarding whether to develop scope-of-practice criteria for a given procedure or treatment, as well as processing privileging requests.

If you have a practitioner who is requesting a new procedure or technology for consideration, pause, take a deep breath, and be ready to provide your medical staff leaders and hospital leaders with the information they need to make the proper decision.

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