Clinical Privilege

We are constantly updating and expanding our library of Clinical Privilege White Papers. Here are a few of the latest updates and additions:

- Intravascular brachytherapy for coronary arteries—Procedure 12
- Vagus nerve stimulation for epilepsy—Procedure 31
- Pediatric pulmonology—Practice area 460
- Stereotactic radiosurgery—Procedure 250
- Harmonic scalpel tonsillectomy—Procedure 58

Download the latest papers from www.credentialingresourcecenter.com.

In house or by proxy: The telemedicine credentialing predicament persists

The latest addition to St. Jude Medical Center’s psychiatry department isn’t your run-of-the-mill medical staff recruit. Standing four feet tall atop a pair of razor-thin wheels, VGo is a remote-controlled telemedicine robot that has played the middleman between patients in the Fullerton, California facility and a community-based psychiatrist since the spring. Mounted to the head of VGo’s Q-tip–shaped frame are a six-inch monitor and full-range camera that enable two-way audio and video. By downloading the associated computer app, practitioners can maneuver the robot from afar to gain all-angles views of a patient and his or her environment.

Despite VGo’s futuristic appearance and functionality, St. Jude enlisted the robot to fill gaps in a fundamental service area.

“It’s a nationwide crisis, having mental health resources, and it’s really been a problem even here at St. Jude,” says Cindy Radcliffe, CPMSM, director of the hospital’s medical staff services department, recalling the trials that the medical staff went through in trying to replace the facility’s foremost psychiatrist after his departure eight months ago. Currently, one private psychiatrist participates in the program, providing remote diagnostic and prescription services to psychiatric patients in the emergency department when his hectic schedule prevents an in-person visit—the physician currently

Q&A: APRNs: VA pushes for full-practice authority

The VA’s pending proposal may have a limited impact on day-to-day vetting and governance, but it speaks to nationwide shifts in medical staff structuring.

Gain medical staff buy-in on professional practice evaluation

The key is a strong, strategic, and consistent message that appeals to practitioners on a professional level. Peruse sample messages to determine which would resonate most with your medical staff.

The MSP’s Voice: Can a single meeting improve engagement?

Rosemary Dragon, CPMSM, CPCS, shares her story about participating in a multidisciplinary initiative to open communication lines between CRNAs and hospital leadership.

In house or by proxy: The telemedicine credentialing predicament persists

The latest addition to St. Jude Medical Center’s psychiatry department isn’t your run-of-the-mill medical staff recruit. Standing four feet tall atop a pair of razor-thin wheels, VGo is a remote-controlled telemedicine robot that has played the middleman between patients in the Fullerton, California facility and a community-based psychiatrist since the spring. Mounted to the head of VGo’s Q-tip–shaped frame are a six-inch monitor and full-range camera that enable two-way audio and video. By downloading the associated computer app, practitioners can maneuver the robot from afar to gain all-angles views of a patient and his or her environment.

Despite VGo’s futuristic appearance and functionality, St. Jude enlisted the robot to fill gaps in a fundamental service area.

“It’s a nationwide crisis, having mental health resources, and it’s really been a problem even here at St. Jude,” says Cindy Radcliffe, CPMSM, director of the hospital’s medical staff services department, recalling the trials that the medical staff went through in trying to replace the facility’s foremost psychiatrist after his departure eight months ago. Currently, one private psychiatrist participates in the program, providing remote diagnostic and prescription services to psychiatric patients in the emergency department when his hectic schedule prevents an in-person visit—the physician currently

Q&A: APRNs: VA pushes for full-practice authority

The VA’s pending proposal may have a limited impact on day-to-day vetting and governance, but it speaks to nationwide shifts in medical staff structuring.

Gain medical staff buy-in on professional practice evaluation

The key is a strong, strategic, and consistent message that appeals to practitioners on a professional level. Peruse sample messages to determine which would resonate most with your medical staff.

The MSP’s Voice: Can a single meeting improve engagement?

Rosemary Dragon, CPMSM, CPCS, shares her story about participating in a multidisciplinary initiative to open communication lines between CRNAs and hospital leadership.

In house or by proxy: The telemedicine credentialing predicament persists

The latest addition to St. Jude Medical Center’s psychiatry department isn’t your run-of-the-mill medical staff recruit. Standing four feet tall atop a pair of razor-thin wheels, VGo is a remote-controlled telemedicine robot that has played the middleman between patients in the Fullerton, California facility and a community-based psychiatrist since the spring. Mounted to the head of VGo’s Q-tip–shaped frame are a six-inch monitor and full-range camera that enable two-way audio and video. By downloading the associated computer app, practitioners can maneuver the robot from afar to gain all-angles views of a patient and his or her environment.

Despite VGo’s futuristic appearance and functionality, St. Jude enlisted the robot to fill gaps in a fundamental service area.

“It’s a nationwide crisis, having mental health resources, and it’s really been a problem even here at St. Jude,” says Cindy Radcliffe, CPMSM, director of the hospital’s medical staff services department, recalling the trials that the medical staff went through in trying to replace the facility’s foremost psychiatrist after his departure eight months ago. Currently, one private psychiatrist participates in the program, providing remote diagnostic and prescription services to psychiatric patients in the emergency department when his hectic schedule prevents an in-person visit—the physician currently

Q&A: APRNs: VA pushes for full-practice authority

The VA’s pending proposal may have a limited impact on day-to-day vetting and governance, but it speaks to nationwide shifts in medical staff structuring.

Gain medical staff buy-in on professional practice evaluation

The key is a strong, strategic, and consistent message that appeals to practitioners on a professional level. Peruse sample messages to determine which would resonate most with your medical staff.

The MSP’s Voice: Can a single meeting improve engagement?

Rosemary Dragon, CPMSM, CPCS, shares her story about participating in a multidisciplinary initiative to open communication lines between CRNAs and hospital leadership.

In house or by proxy: The telemedicine credentialing predicament persists

The latest addition to St. Jude Medical Center’s psychiatry department isn’t your run-of-the-mill medical staff recruit. Standing four feet tall atop a pair of razor-thin wheels, VGo is a remote-controlled telemedicine robot that has played the middleman between patients in the Fullerton, California facility and a community-based psychiatrist since the spring. Mounted to the head of VGo’s Q-tip–shaped frame are a six-inch monitor and full-range camera that enable two-way audio and video. By downloading the associated computer app, practitioners can maneuver the robot from afar to gain all-angles views of a patient and his or her environment.

Despite VGo’s futuristic appearance and functionality, St. Jude enlisted the robot to fill gaps in a fundamental service area.

“It’s a nationwide crisis, having mental health resources, and it’s really been a problem even here at St. Jude,” says Cindy Radcliffe, CPMSM, director of the hospital’s medical staff services department, recalling the trials that the medical staff went through in trying to replace the facility’s foremost psychiatrist after his departure eight months ago. Currently, one private psychiatrist participates in the program, providing remote diagnostic and prescription services to psychiatric patients in the emergency department when his hectic schedule prevents an in-person visit—the physician currently

Q&A: APRNs: VA pushes for full-practice authority

The VA’s pending proposal may have a limited impact on day-to-day vetting and governance, but it speaks to nationwide shifts in medical staff structuring.

Gain medical staff buy-in on professional practice evaluation

The key is a strong, strategic, and consistent message that appeals to practitioners on a professional level. Peruse sample messages to determine which would resonate most with your medical staff.

The MSP’s Voice: Can a single meeting improve engagement?

Rosemary Dragon, CPMSM, CPCS, shares her story about participating in a multidisciplinary initiative to open communication lines between CRNAs and hospital leadership.

In house or by proxy: The telemedicine credentialing predicament persists

The latest addition to St. Jude Medical Center’s psychiatry department isn’t your run-of-the-mill medical staff recruit. Standing four feet tall atop a pair of razor-thin wheels, VGo is a remote-controlled telemedicine robot that has played the middleman between patients in the Fullerton, California facility and a community-based psychiatrist since the spring. Mounted to the head of VGo’s Q-tip–shaped frame are a six-inch monitor and full-range camera that enable two-way audio and video. By downloading the associated computer app, practitioners can maneuver the robot from afar to gain all-angles views of a patient and his or her environment.

Despite VGo’s futuristic appearance and functionality, St. Jude enlisted the robot to fill gaps in a fundamental service area.

“It’s a nationwide crisis, having mental health resources, and it’s really been a problem even here at St. Jude,” says Cindy Radcliffe, CPMSM, director of the hospital’s medical staff services department, recalling the trials that the medical staff went through in trying to replace the facility’s foremost psychiatrist after his departure eight months ago. Currently, one private psychiatrist participates in the program, providing remote diagnostic and prescription services to psychiatric patients in the emergency department when his hectic schedule prevents an in-person visit—the physician currently

Q&A: APRNs: VA pushes for full-practice authority

The VA’s pending proposal may have a limited impact on day-to-day vetting and governance, but it speaks to nationwide shifts in medical staff structuring.

Gain medical staff buy-in on professional practice evaluation

The key is a strong, strategic, and consistent message that appeals to practitioners on a professional level. Peruse sample messages to determine which would resonate most with your medical staff.

The MSP’s Voice: Can a single meeting improve engagement?

Rosemary Dragon, CPMSM, CPCS, shares her story about participating in a multidisciplinary initiative to open communication lines between CRNAs and hospital leadership.
serves on half a dozen medical staffs in Orange County alone, according to Radcliffe.

As physician shortages pick up speed and rural patients’ complex care needs overstep physical boundaries, more and more medical staffs will fortify their ranks with telemedicine tools, experts predict.

“If you’re not currently using telemedicine services, eventually you’re going to be,” says Kathy Matzka, CPMSM, CPCS, FMSS, a medical staff consultant in Lebanon, Illinois.

**Broaching the telemedicine conversation**

One of the top considerations in kicking off a telemedicine program—or retooling an existing one—is whether to operationalize CMS’ 2011 final rule allowing a hospital or critical access hospital (CAH) seeking telemedicine services for its patients (the originating site) to use the credentialing and privileging decisions of the facility dispatching the remote practitioner (the distant site).

Although CMS debuted the regulations half a decade ago, effective implementation is a moving target, propelled by rapid-fire advances in technology, evolving patient populations, and shifting stances of individual medical staffs. And, like virtually all healthcare regulations, the rule has its fair share of pros and cons.

Adopting a credentialing-by-proxy approach can significantly reduce the burden on MSPs to vet telemedicine practitioners, who are often enlisted en masse and come bearing numerous affiliations.

Under such arrangements, the distant site provides the originating site with a comprehensive list of its approved telemedicine practitioners and their associated privileges. All that’s left for MSPs to do is shepherd the list through the requisite medical staff and governing board sign-offs.

“You can’t get much more streamlined than that,” says Matzka.

Despite the significant efficiency boon, some stakeholders worry that departing from tried-and-true credentialing approaches could compromise the medical staff’s confidence in its inherited privileging decisions, the organization’s oversight of affiliates, and the safety of patients.

Beyond these immediate concerns, some experts wonder about the practice’s big-picture implications.

“It hasn’t really been transformative in terms of expanding access to telehealth as we had hoped,” says Mario Gutierrez, executive director of the Center for Connected Health Policy, though he qualifies that this relationship could change over time. “More and more, I think people are starting to recognize telehealth as part of mainstream medicine, and I think that will accelerate
the process for using this streamlining tool of credentialing by proxy.”

Still, given the inherent challenges in outfitting traditional services with telemedicine options and varying positions on viable credentialing paths, medical staffs should think long and hard about whether and how to apply CMS’ 2011 rulemaking.

“It’s such a case by case to determine the right approach,” says Radcliffe.

Despite the culture-specific nature of the decision, experts point to a number of opportunities, obstacles, and considerations to mull over in each approach.

In house

When deciding whether to go the proxy route, comfort level should take priority, according to Matzka and Radcliffe.

Hospital leadership may have the last word in telemedicine implementation and governance strategy, but medical staff leaders, who are responsible for making recommendations regarding appointment of involved practitioners, should have a major say in the credentialing approach, says Matzka. MSPs, as the resident credentialing pros, should also have a voice in the conversation, adds Radcliffe.

These stakeholders’ stance on telemedicine credentialing options can run the gamut. “Some medical staffs are completely comfortable with using the credentialing and privileging decision of another entity,” says Matzka. A small, rural facility, for example, might put great stock in a major, regional telemedicine partner’s credentialing chops, given the larger hospital’s expansive resources and strong reputation.

St. Jude is on the other end of the spectrum. Radcliffe’s five-person team credentials St. Jude’s telemedicine practitioners as they would any applicant for clinical privileges—an approach that Radcliffe spearheaded several years ago during the rollout of St. Jude’s teleradiology program, the facility’s first foray into telemedicine. Since then, the hospital has launched a teleneurology program and, of course, the new telepsychiatry venture. Between the three programs, Radcliffe’s team credentials 25 telemedicine practitioners.

For Radcliffe, firsthand credentialing ensures consistent vetting standards for all privileged practitioners and alleviates doubts about potential conflicts of interest stemming from the distant site’s business interest in clearing practitioners for telemedicine practice.

Plus, given the increasing automation of credentialing activities and St. Jude’s modest roster of privileged telemedicine practitioners, doing the vetting work from scratch is a manageable undertaking, says Radcliffe.

Still, accommodating the additional applications and special considerations in telemedicine privileges took some creative thinking. The biggest challenge was developing a practical approach to confirming telemedicine practitioners’ affiliations, which can number in the 100s and which, on their own, reveal very little about a practitioner’s current competency, says Radcliffe.

To cut down on the needless busyness of processing scores of cookie-cutter affiliation letters, Radcliffe worked with St. Jude’s medical director of radiology and legal counsel to develop a policy that caps the number of...
of affiliations that the medical staff services department must query to 10 (Figure 1). Radcliffe recommends instating such a policy regardless of an organization’s experience with telemedicine (or lack thereof).

“We use it across the board for all physicians,” she says.

By proxy

For organizations that opt for credentialing by proxy, one of the most needling and long-standing pain points is allying intention and execution. Before enlisting telemedicine practitioners, hospitals should ensure that they have the necessary provisions in their governance documents to operationalize their chosen credentialing approach. When a proxy relationship is in play, the medical staff must update bylaws to reflect the hospital’s intent to accept the credentialing and privileging decisions of their distant-site telemedicine partners and their commitment to verifying that those determinations are predicated on compliant procedures (Figure 2).

But all too often, splintered communication forces a reversed order of events, says Matzka. For example, a hospital CEO who is eager to boost her facility’s service portfolio may identify a promising telemedicine partner, negotiate an arrangement involving scads of remote practitioners, and close the deal—all without seeking input from other stakeholders. Such unilateral decisions deprive medical staff leaders and MSPs of the opportunity to discuss whether to credential in house or by proxy and to revise their bylaws accordingly. Without these preliminary measures, medical staff leaders and MSPs are backed into credentialing and privileging all enlisted telemedicine practitioners using their standard method, which, depending on the facility and involved specialty, can mean sifting through 30 or more new applications once.

To avoid such headaches, Matzka recommends providing proactive and thorough education to medical staff and hospital leaders.

“Make sure that people know what the rules are before they start signing these contracts,” she says. “They need to know what the regulations are, and they need to know that they have the ability to use that telemedicine entity’s credentialing.” This approach is particularly important in smaller facilities, which may not have the same built-in support and ready resources as their larger counterparts.

Once all stakeholders have agreed to a proxy approach, the next step is ensuring that the prospective telemedicine partner’s credentialing and privileging processes jibe with relevant requirements, including CMS regulations, accreditation standards, state laws, and the originating site’s established protocol. This task, which often falls to the medical staff services department, can take a variety of forms, such as requesting a copy of the distant site’s bylaws or conducting a small-scale audit of its credentials files for contracted telemedicine practitioners. This latter approach is ideal when partnering with a telemedicine entity that has gone digital.

“Ask them if you can have remote access to their credentialing software to be able to go in and look at those specific credentials files,” says Matzka.

After the medical staff settles on a methodology for confirming that a telemedicine partner’s vetting practices are up to snuff, make sure that everyone is aware of the decision, says Matzka. Two months after issuing the 2011 final rule on telemedicine, CMS released a memo directing surveyors to quiz hospitals and CAHs in credentialing-by-proxy arrangements on how they determine whether their telemedicine partners’ credentialing and privileging procedures pass muster.

Once the originating site is confident in the vetting approaches of its distant partner, the contract negotiations can begin. Matzka recommends that hospital executives, medical staff leaders, and MSPs work together to
Strategies for a successful rollout

Credentialing is far from the only process hospitals must square away before debuting a new telemedicine service or device. Following is a sampling of field-tested tips for rolling out a successful (and sustainable) program.

Identify strong candidates

VGo’s outlandish appearance raised a few eyebrows when St. Jude Medical Center first broached the idea of enlisting the telemedicine robot to bolster its understaffed psychiatry program. Medical staff leaders feared that certain psychiatric patients would be especially sensitive to the robot’s unusual looks.

“Patient selection is pretty key with this because you have this robot coming at you,” says Cindy Radcliffe, CPMSM, director of medical staff services at the Fullerton, California hospital.

Given this reality, St. Jude limits use of the robot to the emergency department (ED), where patients may have an urgent need for diagnostic services and medication. Inpatients, on the other hand, typically have an assigned hospitalist or interventionalist stabilizing their medication levels and guiding their care.

Use telemedicine sparingly

St. Jude uses VGo as a backup method for meeting pressing diagnostic and medication needs, rather than as a substitute for long-term in-person care, says Radcliffe. Currently, one private physician is privileged at St. Jude to provide telepsychiatry services, and because he’s local, he makes a physical stop at the ED whenever his schedule allows. In this way, the robot helps resolve scheduling conflicts that could compromise urgent care without overstepping the technology’s limitations.

Get involved

MSPs can play a key role in translating telemedicine goals into actionable strategy.

“My question was, ‘Do we have a policy to support this new program?’” Radcliffe recalls of her involvement in early meetings about St. Jude’s telepsychiatry initiative. “I was part of a team that was instrumental in getting the right stakeholders at the table to collaborate and ensure that we had a policy in place.”

Together, these experts carved out dedicated policies and procedures on patient eligibility, the responsibilities of ED staff, and treatment protocol, among other considerations.

Such an approach added clarity not only for the medical staff leaders and MSPs doing the behind-the-scenes vetting and governance work, but also for the clinicians on the front lines, who make split-second decisions about a patient’s candidacy for telepsychiatry services.

Beyond facilitating these important discussions, Radcliffe’s team helped drive the resulting governance materials through various approval processes necessary to bring the program to full fruition. Her medical staff coordinator, for example, ensured proposed policies and algorithms were on the agenda for the facility’s department of medicine meeting and that they received the requisite approvals from the medical executive committee and board of trustees.

Bring telemedicine practitioners into the fold

Given the physical barriers telemedicine poses to conventional credentialing, privileging, and peer review approaches, it’s important to pave new paths for confirming competence and fostering collegiality among all practitioners with ties to a facility. Empower distant practitioners to not only participate in, but also guide, the launch of the new telemedicine program. If they’re within visiting range, invite them to attend medical staff events.

Because St. Jude’s new telepsychiatrist is based locally, the chief of staff invited him to the hospital’s medical executive committee meeting “to talk about how this is going to look and what it’s going to entail,” says Radcliffe. Face time with the psychiatrist improved buy-in from long-standing medical staff members, who were able to voice their concerns and questions to the person pioneering the telemedicine program. The meeting also acclimated the psychiatrist to the community that he would be frequenting from afar, strengthening his investment in and comfort with the job.

Don’t put reimbursement on the line

Medicare reimbursement for telemedicine and other telehealth services is largely restricted to services involving live video conferencing and to relationships in which the originating site meets CMS’ narrow criteria for rurality, says Mario Gutierrez, executive director of the Center for Connected Health Policy.

Beyond federal limits, some states have even more stringent laws governing payment for telemedicine. Others, however, may have payment models with more generous terms of use (e.g., managed care).

© 2016 HCPro, a division of BLR. For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, contact the Copyright Clearance Center at copyright.com or 978-750-8400.
strategies for a successful rollout (cont.)

Given this variance, understanding the fine points of relevant regulations is critical regardless of location, says Gutierrez.

Enlist outside allies to conduct peer review

Given St. Jude’s limited psychiatry presence, the medical staff has run into some issues with performing professional practice evaluation for its newly minted telepsychiatrist. This issue is common for telemedicine programs, says Matzka.

“When it comes to those people who are doing things remotely, we have very little data that we can collect,” she explains, citing the diminished opportunity for peer observation. Therefore, the responsibility to provide meaningful competency data often falls to the distant site. For CAHs, CMS explicitly assigns the peer review responsibility to the telehealth partner.

“We rely on the entity that we’re contracting with to have some kind of quality assessment and performance improvement process that they’re following for their providers, and then reporting that back to us at the hospital level,” says Matzka.

But this unconventional circumstance doesn’t take originating sites completely off the hook.

To comply with CMS’ final rule, telemedicine partners must exchange information on any adverse events and complaints associated with a participating practitioner’s telemedicine care. Other sources that originating sites can tap for peer review data include documentation and responsiveness.

When internal resources are scarce, set your sights elsewhere. Radcliffe is considering sending out several of the telepsychiatrist’s cases to an external company for retrospective review.

determine a reasonable number of contracted telemedicine practitioners. (Arriving at a feasible figure is even more important for those who opt to do the credentialing and privileging themselves.)

For Joint Commission–accredited facilities, collaboration between hospital and medical staff leadership is not just a best practice, but a necessity, says Matzka. Prior to starting down the credentialing-by-proxy path, the accredditor requires medical staffs to confirm that a given service is well-suited for telemedicine delivery.

“It can’t just be the CEO of the hospital saying, ‘We’re going to contract for this service from now on,’” says Matzka. “The medical staff has to make that determination of whether or not that’s an appropriate service to be provided via telemedicine.”

Finally, organizations that opt for the proxy shouldn’t lose sight of other state and federal laws governing appointment activities.

“Even though the CMS regulations have specific requirements that allow for certain things to happen, you may have state regulations that are stricter, and there are other federal regulations that would apply as well,” says Matzka.

In particular, she points to the Healthcare Quality Improvement Act of 1986, which requires healthcare entities to query the National Practitioner Data Bank before granting privileges to a practitioner. Applying the credentialing and privileging decisions of an approved telemedicine partner doesn’t exempt organizations from this responsibility, Matzka notes.

Diminishing risk and realizing results

When it comes to vetting and deploying telemedicine practitioners, hospitals are held to the same quality standards—and bound by the same liabilities—as they are under more traditional circumstances.

“The governing body is ultimately responsible for all patient care and services that are provided by that hospital, so they definitely would be on the hook for a negligent credentialing issue,” says Matzka.

A more common risk is that a distant site offers up a telemedicine practitioner who doesn’t have appropriate privileges for the task at hand. For this reason, originating sites should determine what mechanisms distant partners use to make sure that they only assign practitioners who have been credentialed and privileged at the originating site for the services in question. The distant site must also verify that a given practitioner has officially been awarded privileges at the originating site before arranging for him or her to provide a teleservice.

This is particularly important when assigning faceless tasks, such as radiological interpretations, where it’s not always clear who’s at the helm.

“The hospital doesn’t really know who’s on the other end doing the interpretations,” Matzka explains.
“They’re relying on that contracted company to only have people on the other end at the distant site that actually have privileges at their facility.”

Finally, all the practical strategy in the world is fruitless without the right mindset to steer it. Although comfort is key in determining how to approach telemedicine vetting, it shouldn’t become a crutch. “It’s so easy to get stuck in how we used to do things, but those days are gone,” says Radcliffe. “We have to learn how to work with new technology and find creative ways to make things happen because medicine and working in a hospital is moving in this whole new direction.”

Figure 2: Sample telemedicine bylaws language

**Scope of privileges**

The Medical Staff shall make recommendations to the Board of Trustees regarding which clinical services are appropriately delivered through the medium of telemedicine, and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards.

**Telemedicine physicians**

Any physician or practitioner who prescribes, renders a diagnosis, provides radiologic interpretation, or otherwise provides clinical treatment from a distance via electronic communications, must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in this section, as applicable.

(1) When the Hospital is not a party to a written agreement with a distant-site Medicare [Joint Commission]-participating hospital or distant-site entity containing all of the requirements of the CMS Hospital Conditions of Participation [and Joint Commission standards] related to distant-site telemedicine credentialing, the telemedicine physician must be credentialed and privileged through the Medical Staff pursuant to the general credentialing and privileging procedures described in these Medical Staff Bylaws. Recognizing that telemedicine physicians may be privileged at many healthcare facilities and entities, the Hospital shall conduct the primary verification procedures for an adequate number of hospitals, healthcare organizations, and/or practice settings with whom the telemedicine physician is or has previously been affiliated in order to ensure current competency. In order to assist in this credentialing and privileging process, the Hospital may request information from the telemedicine physician’s primary practice site to assist in evaluation of current competency. The Hospital may also accept primary source verification of credentialing information from the physician’s primary practice site or the telemedicine entity to supplement its own primary source verification.

(2) When the Hospital is a party to a written agreement with a distant-site Medicare [Joint Commission]-participating hospital or distant-site entity containing all of the requirements of the CMS Hospital Conditions of Participation [and Joint Commission standards] related to telemedicine credentialing and privileging, the Board has the option to have the Medical Staff rely upon (i) the telemedicine physician’s credentialing and privileging information from a distant-site Medicare [Joint Commission]-participating hospital or distant-site entity and (ii) the credentialing and privileging decisions of a distant-site Medicare [Joint Commission] participating hospital or distant-site entity related to the telemedicine physician. However, the Hospital will remain responsible for complying with applicable state regulations regarding the credentialing and privileging of practitioners; and performing the primary source verification of medical licensure, professional liability insurance, Medicare/Medicaid eligibility/exclusions, and query of the National Practitioner Data Bank.

For the purposes of this Section, the term “distant-site entity” shall mean an entity that: (1) provides telemedicine services; (2) is not a Medicare [Joint Commission]-participating hospital; and (3) provides contracted services in a manner that enables the hospital to meet all applicable CMS Hospital Conditions of Participation [and Joint Commission standards] related to the credentialing and privileging of physicians and contracted services. For the purposes of this Section, the term “distant-site hospital” shall mean a Medicare [Joint Commission]-participating hospital that provides telemedicine services.

Source: Kathy Matzka, CPMSM, CPCS, FMSS. Published with permission.
On July 25, the public comment period closed on the U.S. Department of Veterans Affairs’ (VA) proposal to grant full practice authority to advanced practice registered nurses (APRN). The regulation, which would allow APRNs to independently assess, diagnose, prescribe medications, and interpret diagnostic tests, aims to improve long wait times and other patient access issues that the VA has come under fire for in recent years.

Advocates of the proposed rule argue that APRNs provide equitable services to those delivered by their physician counterparts and that expanding their practice would speed care delivery to patients in underserved and rural communities. The regulation would also dovetail with healthcarewide initiatives to empower a broader range of practitioners with the necessary clinical autonomy to meet the demands of a rapidly aging population and escalating physician shortage.

Still, the reaction isn’t all glowing praise. Detractors contend that the proposal would lower the care standard for an already vulnerable population of veterans. “We believe that providing physician-led, patient-centered, team-based patient care is the best approach to improving quality care for our country’s veterans,” The American Medical Association wrote in a statement. “We feel this proposal will significantly undermine the delivery of care within the VA.” Comments on the proposed rule show a similar divide in perspective.

From a governance standpoint, however, the regulation would likely cause minimal disruption to existing medical staff frameworks, according to the VA. Across the department’s hospitals, medical staffs have vetted and assessed APRNs through their standard processes since 2012. In addition, many VA facilities already grant APRNs independent privileges in states where such practice is permitted. However, in hospitals without these provisions in place, the regulation would require some reworking of bylaws and privileging approaches to reflect APRNs’ expanded practice authority.

The VA now faces the significant task of reviewing more than 100,000 responses to the proposed rule before issuing a final verdict. In the meantime, CRCJ reached out to two experts to share the proposal’s takeaways for MSPs based in and beyond the VA system. Jan Towers, PhD, NP-C, FAAN, FAANP, is a senior policy consultant for the American Association of Nurse Practitioners. Penny Kaye Jensen, DNP, APRN, FNP-C, FAAN, FAANP, is the national APRN health policy liaison for the VA’s Office of Nursing Services. She’s also a nurse practitioner in the Salt Lake City VA Healthcare System’s Primary Care Clinics. The following exchange has been edited for clarity and length.

**Q** What prompted the VA’s proposal to grant APRNs full practice authority?

**Jensen:** The 2010 Institute of Medicine’s (IOM) landmark report, *The Future of Nursing: Leading...*
Change, Advancing Health, recommended removal of scope-of-practice barriers to allow APRNs to practice to the full extent of their education and training. This evidence-based recommendation by the IOM, now known as the National Academy of Medicine, prompted the VA to propose full-practice authority for APRNs in an effort to improve access to necessary healthcare services for more veterans and to address the shortages facing veterans across the continuum of care in sites across the country.

Currently, each state devises its own standards in regard to APRN practice. APRNs, as with other professionals employed by the VA, may hold licensure from any state to practice at a VA medical center. The proposed rule is consistent with the IOM recommendation to remove barriers, including the variation in APRN practice that exists across the VA system as a result of disparate state regulations.

For example, consider two nurse practitioners (NP) who graduated from the same university program and who are currently working at a VA facility in Colorado. One NP is licensed in Wyoming and may see patients, order tests, and prescribe medications for veterans without mandatory supervision by any other professional, thereby streamlining care. The other NP working in the clinic is licensed in Georgia and is therefore required to work under the auspices of a collaborative agreement with a physician who is also licensed in Georgia and who practices in the same specialty as the NP. This NP cannot streamline care for veterans and must comply with the licensure requirements of Georgia.

If the collaborating physician leaves the facility, this NP can no longer see patients until a new collaborative agreement can be secured with a physician with a Georgia license practicing in the same specialty, preventing veterans from receiving care in the interim. Therefore, the proposed rule holds all licensed individuals of the same profession to a single standard and removes regulatory barriers that often limit access to care for veterans.

A significant number of states have approved full practice authority for NPs and certified registered nurse anesthetists, with many VA medical centers successfully utilizing these APRNs to the full extent of their education and training to the benefit of taxpayers and veterans.

Q What are the key features of the proposal?

Jensen: As full-practice providers, APRNs would be required to apply for privileges at the facility level rather than working under a scope of practice. As full-practice providers, APRNs would deliver care under a set of privileges, based upon education, training, and certification. They would continue to practice under leadership by their local service chief, depending on the administrative structure at their VA facility. The local service chief would have the same input regarding the level of practice in the privileging process of APRNs as he or she currently does for other healthcare providers, with confirmation by the local medical executive board or its equivalent.

Q What implications does the proposal have for MSPs and medical staff office processes?

Jensen: The process for credentialing, privileging, and peer review would be the same as for other healthcare providers as outlined in existing VHA policies. APRNs are already recognized as independent, privileged providers in many VA facilities that are located in states that recognize APRNs as licensed independent practitioners. If not already privileged, the APRNs would transition from a scope of practice to the privileging process. They would be credentialed and privileged in the same way as any other privileged provider. The peer review process would also be in accordance with existing VHA policy. Facility-specific medical staff bylaws would need to be updated to reflect the recognition of all APRNs as privileged and independent providers.

Calling all CRC members!

We want to know: What keeps the Credentialing Resource Center your go-to resource for actionable strategy, expert guidance, and customizable tools in all things medical staff governance and credentialing? Is it the targeted news and analysis? The best practice–driven privileging white papers and forms? The spirited and supportive community of peers? Let us know, and you could see your testimonial featured in an upcoming CRC outreach initiative. Email CRC Editor Delaney Rebernik at drebernik@hcpro.com with the details.
The VA’s proposal has received a mixed reaction from stakeholders. Defend your stance.

Jensen: The proposed rule was introduced at a time when many stakeholders have come forward to support full-practice authority and full utilization of APRNs. The VA’s proposed rule is in line with these organizations and also comes at a time when access to care for veterans, quality of care, and cost effectiveness are under intense scrutiny by Congress and others.

Healthcare provided by APRNs produces outcomes that are comparable to those produced by physicians. The body of literature supports the position that NPs provide high-quality healthcare that is safe, patient-centered, timely, efficient, equitable, and evidenced-based. Furthermore, NPs’ care is comparable in quality to that of their physician colleagues. A team-based model, particularly implemented in the care of patients with chronic disease, is increasingly viewed as vital to improved patient care and a way to reduce hospital readmissions as well as unnecessary emergency department visits.

Contrary to the belief of detractors, APRNs may serve as leaders of the team, and many NPs are already doing so in VA facilities that are located within the 22 states that already allow full-practice authority. These models hold promise for improved patient outcomes because they allow individual providers to work at the top of their education and training. Since APRNs are playing a more prominent role in providing ongoing patient care in a team, physicians should be available to perform the tasks that only they have been trained to perform.

Towers: Our membership is responding—as is the profession—in support of the regulation. It’s the direction that the entire profession is going. There is a need to modernize, and that’s what the VA is doing. It will resolve many of the problems that the VA is having currently. The research speaks for itself. The documentation of the quality of care and the safety of the care provided by nurse practitioners is extensive, and we stand on that.

In summary, we can help tremendously, but we need to get the barriers removed. This rule adjustment will remove the barriers. We applaud the VA for stepping forward to modernize their healthcare system.

What’s next? Do you anticipate that the rule will be promulgated as-is?

Towers: It certainly is able to go forward the way it is, so we don’t expect any further adjustments. The proposed rule itself went through a lot of vetting before it actually became a proposed rule, so we’re hoping that this will be a quick turnaround. This proposal has been around a long time in concept, and we really need to get it off the ground so we can begin to resolve some of the problems our veterans are encountering in the VA.

In this world of never-ending email and constant connection, determining the most effective and efficient ways to share professional performance evaluation data with practitioners can be a challenge. Formal communication plans can help cut through the clutter and engage practitioners on a professional level.

Ideally, medical staff leaders should inform the general medical staff of the ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) processes from the beginning, regardless of whether their program is long-standing, under construction, or brand new.

In addition, program champions can head off practitioner pushback that may arise from unfavorable findings by delivering a consistent message about the rationale for professional practice evaluation and by addressing the program’s benefits for individual practitioners.

Frame the message strategically

Regulatory and accreditation bodies require hospitals to evaluate practitioners on a consistent basis. However, because this mandate doesn’t directly impact providers, framing it as the sole or primary driver of the professional practice evaluation program may not sufficiently engage key stakeholders. Instead of only answering the question, “What are OPPE and FPPE?” also answer, “Why is understanding individual performance important to both the practitioner and the hospital?”
The following are sample messages. Consider which is likeliest to resonate with practitioners in your organization:

- Professional practice evaluation is a medical staff-led initiative to establish performance expectations and ensure that patient care meets quality standards.
- Healthcare reform has created the impetus for practitioners to understand their performance data. As the federal government continues to propose new payment structures that are tied to care quality, professional practice evaluation allows the medical staff to see how their own clinical and nonclinical practice data stack up. The better practitioners understand their performance data, the better they can manage their professional careers within the context of hospital, payer, and patient relationships.
- Healthcare transparency is a growing trend among payers, regulators, and patients. Insurance companies encourage patients to make educated decisions when choosing practitioners by displaying practitioner ratings directly on their websites. Regulators make practitioner performance data readily available through programs such as CMS’ Physician Compare website. Patients proactively research practitioners and hospitals using resources such as HealthGrades. OPPE and FPPE give practitioners similar insight into their own performance data.
- Hospital/medical staff partnerships allow administrators and practitioners to come together to understand and act on opportunities to improve the quality of patient care. Professional practice evaluation provides the vehicle for this collaboration.
- Professional development opportunities emerge when practitioners compare their performance against that of their peers. Practice evaluation gives providers access to timely data, through which they can identify opportunities for improvement in significant practice areas and ultimately advance their career.

EDITOR’S NOTE
This article was adapted from The Complete Guide to OPPE and FPPE, by Juli Maxworthy, DNP, MSN, MBA, RN, CNL, CPHQ, CPPS, CHSE, and Evalynn Buczkowski, RN, BSN, MS. For more information or to order this essential new resource for MSPs, medical staff leaders, and quality professionals, visit www.hcmarketplace.com.

The MSP’s voice by Rosemary Dragon, CPMSM, CPCS

Can a single meeting improve engagement?

About a year ago, our chief nursing officer (CNO) asked me to her office for an impromptu meeting between her, the leader of our certified registered nurse anesthetists (CRNA) group, and me. The purpose of the meeting was to brainstorm ways to improve collaboration between our CRNAs and hospital leadership. Our facility puts a high value on provider engagement; however, we recognized that we had not given our CRNAs the same opportunity for engagement as we had given some of our other credentialed provider groups.

The mission
In simple terms, we realized that we needed to improve our own engagement with CRNAs if we wanted them to be more invested in our facility. We have a phenomenal group of CRNAs, but we needed to improve communication and create additional opportunities for them to collaborate with us.

The plan
I was asked to coordinate this effort, but the vision from the start was for a multidisciplinary team to foster change. The first thing I did was to identify the key stakeholders, including the CRNA leader who initially helped to brainstorm this idea, the leaders of the clinical departments working with anesthesia, and the medical director of anesthesia.

The second step was to plan a meeting with these stakeholders. We talked about the areas we wanted to address and developed a plan of action. Through this process, we realized that most of the challenges we
had identified could initially be addressed by simply opening the door for improved communication.

As a joint effort between the anesthesia group and hospital leadership, we decided to host a dinner meeting, inviting:

- All of the credentialed CRNAs
- The hospital clinical department leaders
- The CNO
- The chief medical officer
- The medical director of anesthesia

Each of the leaders involved in the planning session had caught our vision. In the weeks leading up to the dinner meeting, we personally invited each of the CRNAs. Our anesthesia leaders also talked up the dinner during their staff meetings.

The waiting game

In the days leading up to the event, all of us involved in the planning were doubtful that we would have more than four or five CRNAs in attendance. Although we had approached all of our CRNAs with an invitation, only one had officially RSVP’ed. We knew that the meeting could conflict with surgeries and would follow a very long workday for most invitees.

Twenty-some CRNAs showed up! We quickly ran out of food and had to call the cafeteria to make more. There was a palpable energy in the room from the start. Collaborating with the anesthesia leaders and playing up the meeting with personal invitations had created the desired buy-in.

The big event

The agenda was simple. For the first half of the meeting, we recognized and thanked the CRNAs for their contributions to our facility, discussed the various recent and upcoming changes in the hospital, and shared the hospital quality measures.

The second half of the meeting was my favorite part. We asked the CRNAs what we were doing well on and where we could improve. The responses were slow and somewhat generic to start. Then one of the hospital leaders asked the guests whether there was anything that bugged them on a daily basis and that they wished was handled differently. This single prompt opened up a floodgate of responses on a wide variety of topics. We began to see the hospital through their eyes. The vast majority of the feedback was positive, but we also identified a number of improvement opportunities, some of which were addressed by the following day.

In conversations following the meeting, many of our CRNAs told me that they found it tremendously meaningful to be given the opportunity to share their perspective with the hospital’s leadership. They had been given a voice and felt more included in and valued by the organization.

The result

Did this single meeting improve our CRNA engagement? Yes, I believe it did, but it was not an all-encompassing solution to the challenges we had identified at the start of this process. The success of this meeting was in forging a more honest and direct line of communication between a specific group of providers and the people who could do something meaningful with their feedback.

I don’t believe that there are comprehensive, simple fixes for most of the challenges we face; however, the dinner proved to be a very good step in the right direction for us. Nearly a year later, the open communication that we initiated during that meeting continues—I am regularly stopped by CRNAs with questions and feedback, as are our hospital leaders.

As MSPs, we have the meeting management and communication skills to help drive collaboration and change in our organizations. Which of your hospital’s initiatives would benefit from these assets? ☐

EDITOR’S NOTE

Dragon is medical staff coordinator at OrthoColorado Hospital in Lakewood, Colorado.