Tips for keeping your credentials committee on track

The credentials committee plays a vital part in medical staff governance. The membership of the credentials committee consists primarily of physicians, and has input into key processes for credentialing, privileging, peer review, and quality. This committee is also charged with making recommendations for or against applicants’ appointment and reappointment to the medical staff.

However, in the Credentials Committee Essentials Handbook, authors Richard A. Sheff, MD, and Robert J. Marder, MD, pointed out “there is often a disconnect between what the medical staff bylaws say credentials committee members should do and what they actually do.”

Whether or not there’s a disconnect in your organization’s credentials committee functions, it’s important to keep committee members up to speed on new developments in privileging criteria, the status of practitioners, and other key information. If a disconnect does exist, MSPs and medical staff leadership have some options for reconnecting committee activities with expectations.

Take time to teach

Education is on the agenda at American University Beirut Medical Center (AUBMC), a Joint Commission International-accredited hospital in Beirut, Lebanon.
“We have incorporated educational sessions into our credentialing committee meetings, where a particular topic is decided upon and a short, five- to 10-minute presentation is done by the medical staff office to touch on the most important issues on this subject,” says Diana El Banna, medical staff officer at AUBMC.

Previously, El Banna says the medical staff office tried to send weekly articles to the credentials committee members for educational purposes, but found that nobody was reading them. “We decided on an alternative approach, and [committee members have been] more receptive,” she says.

Recent topics have included considerations that go into a leave of absence policy (see p. 4), and the components of physician disclosure of information. The AUBMC credentials committee meets once a month, and the presentations are usually done at the end of the committee meeting, after the committee’s agenda has been completed, she says.

Providing credential committee members with the opportunity to attend credentialing and privileging courses or seminars is another way to help members understand how state and federal regulations and accreditation standards mesh with their own bylaws, according to Kathleen Tafel, manager of credentials verification service at Allegheny Health Network, in Pittsburgh, Pennsylvania; and former manager of the office of medical affairs at St. Clair Hospital, in Pittsburgh.

The St. Clair Hospital physician leadership is invited to attend one of the large credentialing education events held by companies like Greeley, she says. An overview of Robert’s Rules of Order or similar procedural resources can be helpful to keeping meetings on track, she says.

In addition, the chair may find it helpful to have multiple check-ins with the specialists who are performing the investigations and/or preparing for the meeting to ensure a well-rounded knowledge of what to expect on the agenda, according to Tafel.

Clear expectations

When bylaws and expectations are clear, possible disconnects between credentials committee duties and actual activity are minimal, according to Christina Giles, MS, CPMSM, a medical staff services consultant in Nashua, New Hampshire.

“Typically, the bylaws state that the job of the credentials committee is to review and assess all requests for initial appointment and reappointment and all requests for privileges, whether they are an initial request or additional requests or temporary,” Giles says.
The committee is also charged with establishing recommendations for privilege criteria and reviewing and revising, as necessary, all forms, policies, and procedures used in the credentialing process.

“My experience has been that [credentials committees] knowledgeable about the forms, policies, and procedures, but they have become more sophisticated in the last five to 10 years in assessing applications and making recommendations that would then be forwarded to the medical executive committee,” she adds.

A lack of education provided by the MSP and/or other medical staff leaders can contribute to issues on a credentials committee or any other. “I still find that many medical staffs do not provide any formal education to the members of key committees such as the credentials committee,” says Giles.

She recommends that actions to help keep credentials committee members on track are planned, scheduled, and ongoing. Outside speakers can be brought in, or members can be sent out to programs. In addition, insights gained from actual case studies can be a very useful learning method for members.

“There also needs to be more education on the privileging process and what the credentials committee can bring to it,” says Giles. Too often, the committee relies on department chairs to provide the majority of the information for revisions to privilege forms. Practices are changing and many disciplines are now doing similar procedures, so the credentials committee has to objectively view changes to privilege forms, “looking to the future and the reality of what specialties are involved,” she adds.

Don't overlook meeting minutes
Meeting minutes and follow-up from other committees have a role in building and maintaining an effective credentials committee. “I believe minutes are always helpful for new members and chairs—if for no other reason but to review the recent activities and to get a feel for how the process works (or doesn’t). Of course, the helpfulness of minutes is totally dependent upon the minute taker and how good he/she is,” says Giles.

Furthermore, minutes should contain sufficient information for a historical look at any particular topic and provide the basis for why decisions were made. In some organizations, however, meeting minutes contain so little information that it’s almost impossible to figure out the problem, much less the solution reached, she adds.

The credentials committee members should also be allowed to review the medical executive committee (MEC) minutes to see how that body takes actions on their reports. Typically the chair of the credentials committee sits on the MEC, if not as a member, then at least as an ad hoc member.

“It is important for that person to report back to the committee any and all questions raised by the MEC and discussions that took place concerning a particular topic,” she says.

Both the medical staff office and the committee should be ready for new issues as well. “The credentials committee can also be charged with additional duties, research or resolution by the MEC and/or the medical staff leaders, so they should be ready for new assignments and not become too inflexible in their view of their responsibilities,” Giles says.

Educating the credentials committee
When a new member or chair joins an organization’s credentials committee, there are things the medical staff office can do to orient the newcomers to their tasks, says

Christina Giles, MS, CPMSM, a medical staff services consultant in Nashua, New Hampshire.

At a minimum, the MSP should develop an orientation program for new credentials committee members and chairs that provides:

- The background for the committee’s responsibilities
- Documents that outline the responsibilities, the relevant accrediting body, and CMS standards
- Ongoing mini-sessions that can be presented at the meetings or provided online to support the knowledge of the committee members
- Case study–based educational sessions, when there is time for discussion

“Books like Blind Eye [about the case of Michael Swan-go] and others that reveal credentialing horror stories are always useful as well,” she says.
Figure 1: Leave of Absence Policy for Medical Staff

Following is a recent educational presentation about the leave of absence (LOA) policy which the AUB Medical Center’s medical staff office created for the credentials committee.

My goals for this presentation is to:
• Explain what a Leave of Absence (LOA) for physicians is.
• Inform the audience about how to credential and privilege a physician who is coming back from an LOA.

Example: Let us look at a scenario
A pediatric neurosurgeon takes a leave of absence for one year and he returns to active duty after this period of time. He wants to resume his clinical activities, which include performing pediatric neurosurgeries.

During his LOA he has conducted very important research in his field in another institution outside the country, but during that time he has performed only one type of procedure that was related to the research. What course of action will be taken to reinstate him?

Will you grant him the same privileges as he had before?
Will you require him to be observed for a particular number of surgeries by a proctor who has the same privileges?

Introduction
Definition of leave of absence: Leave of absence is a temporary leave taken from active duty by members of the medical staff for a variety of reasons, such as drug or alcohol issues, family issues, health issues, career changes, or further education. LOAs range from a few months to several years.

The main concern with a physician coming back from LOA is competency.
The question is, how do we evaluate this competence?
Two things need to be evaluated:
1. Length of time he/she took as LOA
We need to decide the cutoff time after which we need to investigate competence; e.g., six months or one year.
2. Activity done during LOA
Was the physician clinically active in his or her area of expertise—e.g., doing only one type of privilege? These are all questions that should be asked when evaluating competence of this physician.

Was the LOA taken for health issues? If LOA was taken for illness, we need to make sure that he or she is physically and mentally able to perform clinical duties and will not endanger patients’ lives.

The most important step that will guide us when credentialing and privileging these physicians is to create a policy to deal with physicians returning from LOA. Some issues that must be addressed in the policy are:
a. Which groups of physicians will be reinstated automatically and which need to be evaluated (low or no activity)
b. Process used to evaluate the competency of physicians and who will evaluate them
c. What kind of focused review will they be subject to

Questions we should ask ourselves while preparing the policy
i. Do we reinstate physicians automatically?
ii. Will they be evaluated by the chairperson for current competency?
iii. Should they pass through the credentialing and privileging committee to evaluate their activities during their LOA?
iv. Should we request from them a detailed logbook with a summary of their clinical activity?
v. In case he was not active or has been practicing in a specific area that does not cover all his privileges, what kind of reentry program will we implement?
vi. Will he be given independent privileges without any supervision or with supervision?
vii. Will a focused review be required for a provisional period (i.e., detailed report of his outcomes during this time period after review by the quality department or a colleague who does not have conflict of interest)?
viii. If her reappointment occurs during the LOA, what are the requirements that we need (reappointment forms, CME, fire safety, infection control, radiation safety, resuscitative training)?

Source: American University of Beirut Medical Center. Used with permission.
Creating a committee for AHPs

If you are struggling with questions related to peer review, privileging, and other medical staff functions, an allied health committee may be the answer.

“NPs and PAs are here to stay. We need to bring them to the table; they have a pivotal role in providing healthcare here at the hospital,” says Cindy Radcliffe, CPMSM, director of medical staff services at St. Jude Medical Center in Fullerton, California.

It was with this mentality that St. Jude Medical Center created an allied health committee earlier this year. The committee is for nurse practitioners (NP) and physician assistants (PA) who are credentialed and privileged through the medical staff services department (MSSD), but are not allowed to be appointed to the medical staff (per California state law). Meetings are held once a quarter, and NPs and PAs are required to attend 50% of meetings during their appointment cycle. The meetings are similar to medical staff department meetings, but also incorporate peer review and privileging. According to a news brief in the hospital’s medical staff newsletter, the committee was created to “help ensure the quality and consistency of medical staff services provided by PAs and NPs as well as provide a vehicle for education, feedback, and peer review.”

According to Radcliffe, the committee was created with a few goals in mind. The first was to provide a similar forum to the one that physicians have for coming together as a group to discuss general information about the hospital. “They are at the bedside, they are in the trenches, and we had no way for them to get information on things they should know in general, like policy changes. We have a lot going on with EMR—we had a huge upgrade a year ago—and they are accessing it. They need to know these things, need to know about order sets. They also need to know how we are doing as an organization with our infection prevention data; they are part of that.”

“They are at the bedside, they are in the trenches, and we had no way for them to get information on things they should know in general, like policy changes.”
—Cindy Radcliffe, CPMSM

Another goal of the committee is to conduct peer review that is specific and relevant to the 60 NPs and PAs at St. Jude’s.

“The problem is, we credential them, and then they are just kind of out there on their own,” says Radcliffe. “We hope that their supervising physician is taking them under their arms and helping them do things appropriately, but we have no assurance that is happening. It is also extremely difficult to monitory them. We have proctoring if they are new on
staff, but we really haven’t had a robust peer review process for them. The medical staff felt we needed to develop something close to the medical staff peer review process.”

**Peer review**

To develop the committee’s role in peer review, the key players—key medical staff leaders, medical staff services, and the clinical excellence department—had several pre-meetings. They decided to create a core group—one AHP from each specialty represented at the hospital by NPs and PAs. This includes:

- A PA from emergency medicine
- A PA from cardiovascular medicine
- An NP from orthopedics (representing surgery)
- An NP from medicine

This core group is responsible for conducting peer review through chart review. They will review a combination of random charts and ones that come through via the incident reporting system. Like the peer review process for medical staff members, the charts are pre-screened by the peer review manager, who is a registered nurse, and who does a write-up and passes it along to the core group of the allied health committee. The core group will review it and decide whether the standard of care was met. The core group can then decide whether it wants to discuss the case as a larger group at the allied health committee meeting.

“[They would] discuss the cases from an educational perspective; we definitely don’t want to do it punitively,” explains Radcliffe. “[Similar to] when you work with doctors and peer review, it is a challenge, it is a balancing act with the goal to educate versus being on the hot seat feeling like they did something wrong.

The goal is to get the group to talk about opportunities for improvement or what could have been done differently. If the case is subjective (i.e., not something black and white like a rule violation), the core group extends a special invitation to the NP or PA involved to make sure he or she is at the meeting to explain the case.

“We want them to be engaged, at the table, involved, and informed,” says Radcliffe. “And we want to find a way that we can do ongoing monitoring of the care they provide.”

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—Cindy Radcliffe, CPMSM

The four core members receive a stipend for their peer review work. The medical staff members who helped construct the committee felt it was important to acknowledge the additional work and time away from patients.

Radcliffe says the goal is to review two to three charts per AHP at each meeting. The core group then reports its findings/recommendations to its respective medical staff department, and the information is included in the AHP’s ongoing professional practice evaluation report. The core group is the liaison between AHPs and physicians, and it can provide a level of review that physicians might not be able to match.

Most of the reviews are random chart reviews because often the NP or PA is not attributed to specific charts. This makes it hard to create a list of triggers to look for in charts. “Triggers that a peer review manager looks for—complications, readmissions—we don’t have that for allied health because they are not tied to any coded data. So we have to do random chart review,” says Radcliffe. “We hate to do it, but we have to do it.”

**Practice privileges**

Another task for the allied health committee is to review and revise practice privilege forms, when necessary.

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**Save the date!**

If you missed the 2015 CRC Symposium in Las Vegas, mark your calendar now for the 2016 event, to be held April 7-8, 2016, in Orlando, Florida. Check the Credentialing Resource Center website (www.credentialingresourcecenter.com) for more information.
In California, PAs must have a delegation of service agreement, which is the legal document with the supervising physician that lists all the things the AHP is allowed to do within his or her scope. However, to comply with The Joint Commission and CMS, the MSSD has to credential NPs and PAs because they are providing a medical level of care. The AHPs’ privileges are called practice privileges to differentiate them from physician clinical privileges. Radcliffe says it is beneficial to have AHPs review their practice privilege forms because they are the ones who know what they are doing and not doing.

Support from the medical staff

One compromise that had to be made was who would chair the committee. A physician leader initially wanted it to be an AHP; the chief of staff wanted it to be a physician. To get the support of the medical staff, it was agreed that a physician would be chairperson, as long as that physician was currently using a NP or PA in practice. The chief of staff has been attending the AHP meetings regularly to ensure a smooth transition.

The MSSD included an article in its medical staff newsletter letting everyone know about the new committee and encouraging supervising physicians to let AHPs attend.

“It is really about enhancing the quality of care they are providing,” says Radcliffe. “We really thought all of these things were so important to have a forum to meet collectively, and that is how we finally got the green light from the medical staff to institute an allied health committee.”

To report or not to report: What to do about the recent NPDB Guidebook update

by Rick Sheff, MD, principal and chief medical officer, The Greeley Company; Sally Pelletier, CPMSM, CPCS, chief credentialing officer, The Greeley Company; and Carol Cairns, CPMSM, CPCS, advisory consultant, The Greeley Company

In April 2015, the National Practitioner Data Bank (NPDB) published its first new guidebook in 13 years. The new guidebook includes a significant expansion of the NPDB’s definition of an investigation with direct impact on reporting requirements for physicians or dentists who resign while under investigation.

The impetus behind the expanded language is reportedly based on troubling statistics of underreporting...
by healthcare entities and insurers, with only 47% of all hospitals ever filing a report to the Data Bank. The NPDB’s concerns about underreporting are valid. Hospitals and medical staffs do cut deals that allow problem physicians to surrender existing privileges in order to avoid further investigation or review or to execute a “geographic cure” for their performance problems without meaningfully changing the quality of their care or conduct. Too many times hospitals and physician organizations provide neutral or frankly falsely positive references for physicians with problematic performance. These practices should be modified to better serve quality patient care.

In an effort to force change in such practices, the NPDB added the following language to the new guidebook:

A routine, formal peer review process under which a health care entity evaluates, against clearly defined measures, the privilege-specific competence of all practitioners is not considered an investigation for the purposes of reporting to the NPDB. However, if a formal, targeted process is used when issues related to a specific practitioner’s professional competence or conduct is identified, this is considered an investigation for the purposes of reporting to the NPDB. [Emphasis added.]

Of note, the NPDB published a draft version of the new guidebook language, followed by a period of public comment. Several organizations provided feedback on the draft, including but not limited to such entities as the American Hospital Association (AHA), American Health Lawyers Association (AHLA), the American Medical Association (AMA), The Joint Commission, and National Association Medical Staff Services (NAMSS). Notable concerns raised in this feedback included:

1. The draft expanded language referring to a focused professional performance evaluation (FPPE) as being an “investigation”
2. The physician does not need to be notified or aware that they are under investigation for the resignation to be reportable
3. The NPDB maintained it had the ultimate authority to determine whether a practitioner was under investigation regardless of the healthcare entity’s definition espoused in its medical staff bylaws, policies, or procedures

In the final version, the reference to FPPE was removed, but the other concerns remained. It is unclear whether the reference to FPPE was removed because the Medicare Conditions of Participation and some accrediting agencies do not use this term, or whether the NPDB recognized a distinction between an investigation and FPPE for new privileges or for cause. Regardless, the current guidebook language still represents a significant expansion of the NPDB’s definition of an investigation.

Across the country, medical staff leaders, medical services professionals, and healthcare attorneys have expressed strong concerns that the new guidebook language, if allowed to stand over time, likely will undermine medical staffs’ ability to conduct effective peer review. While physician leaders have tolerated poor quality and unprofessional conduct, and often still do, many have stepped up to drive improvements in physician performance. Their success has been achieved through the effective use of measurement, feedback, and active interventions to manage poor performance, escalating physician performance concerns in a collegial manner and driving meaningful change without fear of these activities being reportable. If the new guidebook language stands, a physician resigning during such collegial performance-improvement processes will be reportable. This may cause physician leaders to shy away from undertaking these important activities.

While it is hoped that collaboration by the NPDB with key stakeholders such as the AMA, AHA, AHLA, The Joint Commission, and NAMSS will lead to more moderate guidebook language in the near future, the current guidebook language represents today’s NPDB policy. So here are some practical suggestions for navigating the decision of whether to report:

- MSPs, CMOs, and hospital attorneys should ensure that hospital, medical staff, and governing board leaders are educated on the new NPDB guideline language and its implications for conducting the work of the medical staff and board.
- One option is not to change any policies, procedures, or bylaws at this time. This approach assumes that the key national stakeholders in this
issue will work out a compromise and that the current guidebook language will be updated in the near future. Under this situation, should a medical staff need to address an individual physician’s performance, it should work closely with legal counsel in drafting communication and documentation, including notifying a practitioner undergoing a measurement or improvement process of the Data Bank reporting guidelines. Should a practitioner resign during such a process, again, legal counsel should be consulted regarding whether or not to report.

- A hospital might consider not reporting a physician who resigns during a performance-improvement process that has not progressed to an investigation as defined in the medical staff’s bylaws because of principled disagreement with the current NPDB guideline language. This is a risky decision and not one that The Greeley Company recommends. The downside risk to a hospital that does not report when it should, according to the current NPDB Guidebook standards, occurs only if the NPDB finds out about this, which is unlikely to occur. But if it does, the NPDB can determine that the hospital will not be covered by HCQIA’s immunity for a period of three years commencing 30 days from the date of publication of the healthcare entity’s name in the Federal Register for failure to report. Thus, the likelihood of the NPDB ever finding out is very small, but the risk to the organization if the NPDB does is significant.

- Another option is to position initial peer review activities as measurement and feedback, not as an investigation. This involves clarifying in your policies that FPPE for new privileges and ongoing professional practice evaluation (OPPE) (or the equivalent screening activities for quality issues, if your organization is not accredited by The Joint Commission or HFAP) serve as a radar screen for all practitioners, and that when a blip on the radar is identified through FPPE for new privileges or OPPE, physician leaders don’t yet know what the blip means. The policy would identify that the next step is a drill down to determine what the individual practitioner’s performance really is and whether it is truly problematic (the first steps in an FPPE for cause if accredited by The Joint Commission or HFAP). If a problem is confirmed through the drill-down measurement, the physician should receive this feedback and have an opportunity to self-correct prior to this being identified as an investigation. (Of course, if the performance issue rises to the level of an urgent need to protect patient care, immediate action should be taken.) If the practitioner does not self-correct, the policy would identify the next step as moving into managing poor performance using a series of escalating interventions. With the intention of preserving the spirit of continuous performance improvement, the policy could identify that resigning during the drill-down measurement or initial improvement activities is not reportable, but resigning during the managing poor performance activities is. To be clear, this could be interpreted as being noncompliant with the letter of the current NPDB Guidebook language, and hence carries risks. However, if combined with the “evergreen letter” as described below, it could represent an approach to fulfilling the spirit of the new NPDB language, namely to prevent a “geographic cure” while preserving the medical staff’s ability to perform effective peer review. A hospital should consult legal counsel before adopting this approach because it does not strictly comply with the current guidebook language.

- Use an “evergreen letter” whenever a privileged practitioner leaves an organization with competence or conduct concerns. This involves constructing a reference letter in concert with legal counsel at the time the practitioner leaves. This letter will be used to respond to all future inquiries summarizing the practitioner’s performance and conduct in the organization, including any documented performance issues and actions taken. This will help prevent practitioners from exercising the “geographic cure” to avoid accountability for clinical care or conduct performance issues.

- Finally, the organization—not its attorney—should make the decision whether to report or not. The decision will depend on many factors, including the organization’s degree of risk tolerance, the anticipated downstream impact on future peer review activities, and other issues related to physician-hospital alignment and collaboration. [1]
NMTCB, ARRT update requirements for nuclear medicine technologists

Editor’s note: Following is an excerpt from the recently updated Clinical Privilege White Paper for nuclear medicine technologists—Practice area 200.

Background

Nuclear medicine technologists (NMTs) work under the direction of nuclear medicine physicians (MD or DO). The primary responsibilities of an NMT include preparing and administering radiopharmaceuticals; using radiation-detecting instruments for imaging procedures; supplying physicians with imaging, data analysis, and patient information for diagnostic interpretations.

NMTs must complete an associate’s or bachelor’s degree program, or post-bachelor’s certificate. Coursework in NMT-specific education includes physical sciences, biological effects of radiation exposure, radiation protection and procedures, use of radiopharmaceuticals, adjunctive medications, imaging medication, imaging techniques, and computer applications.

Graduates of accredited NMT education programs may choose to become certified through the Nuclear Medicine Technology Certification Board (NMTCB) or the American Registry of Radiologic Technologists (ARRT). Certification exams are designed to ensure that graduates have the knowledge necessary for competent, entry-level performance in nuclear medicine technology.

At least 26 states now require NMTs to be licensed. In many of these states, NMTCB certification is acceptable in lieu of a state examination.

Positions of certifying boards

NMTCB

Candidates for NMTCB certification in nuclear medicine technology must meet eligibility requirements by showing documented evidence of one of the following:

• Completion of an NMTCB-recognized nuclear medicine technology program.
• Completion of a certificate, associate, or bachelor’s degree in a nuclear medicine technology program from a regionally accredited academic institution. Regionally accredited college and university programs must have structured clinical training sufficient to provide clinical competency in radiation safety, instrumentation, clinical procedures, and radiopharmacy. This should include approximately 1,000 hours of clinical training supervised by the program faculty.

As of 2016, the NMTCB will only accept applications for entry-level examination from graduates of programmatically accredited nuclear medicine technology educational programs. The NMTCB recognizes the following accreditation organizations for this purpose:

• The Joint Review Committee on Educational Programs in Nuclear Medicine Technology
• Armed Forces Military Training Commands
• Canadian Association of Medical Radiation Technologists
• Australian and New Zealand Society of Nuclear Medicine

Candidates, including non-U.S.–trained candidates for NMTCB certification, can meet alternate eligibility requirements through December 31, 2015, by completing the following education, clinical experience, and didactic coursework:

• Education (completion of one of the following):
  – A bachelor’s or associate degree in one of the physical or biological sciences
  – A bachelor’s or associate degree in other disciplines with successful completion of courses in college algebra, physics, chemistry, human anatomy, or physiology
  – National certification as a registered medical technologist, registered radiographer, registered nurse, registered diagnostic medical sonographer, or radiation therapist
• Clinical experience: Four years of full-time (or 8,000 hours) clinical experience in nuclear medicine technology under the supervision of a physician who is board certified in nuclear radiology or nuclear medicine or isotopic pathology, or an authorized physician user of radioactive materials with special competency in nuclear medicine
• Didactic coursework: A minimum of 15 contact hours of coursework in each of the following: radiopharmacy, nuclear medicine instrumentation, and radiation safety. Coursework must be in an accredited college or university, accredited nuclear medicine program, or approved CE credits recognized by NMTCB.

**ARRT**
Candidates for ARRT certification in nuclear medicine technology must meet the following eligibility requirements:
• Compliance with ARRT standards of ethics
• Completion of a nuclear medicine education program
• Passage of the ARRT’s Nuclear Medicine Technology examination, which covers:
  – Radiation protection
  – Radionuclides and radiopharmaceuticals
  – Instrumentation and quality control
  – Diagnostic and therapeutic procedures
  – Patient care and education

As of 2015, candidates must hold an associate’s (or more advanced) degree from an institution accredited by an agency recognized by ARRT to be certified as an NMT.

**CRC draft criteria**
The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding NMTs. The core privileges and accompanying procedure list are not meant to be all-encompassing. They define the types of activities, procedures, and privileges that the majority of NMTs perform. Additionally, it cannot be expected or required that practitioners perform every procedure listed. Instruct practitioners that they may strike through or delete any procedures they do not wish to request.

**Minimum threshold criteria for requesting privileges as an NMT**
Basic education: Associate’s or more advanced degree
Minimal formal training: Completion of a certificate, associate degree, or bachelor’s degree in a nuclear medicine technology program, and ARRT or NMTCB certification as an NMT
AND
States licensure as an NMT (if applicable)

**Required current experience:** Approximately 1,000 hours of clinical training supervised by the program faculty (for recently trained applicants) or the ability to demonstrate they have provided nuclear medicine technology services for an appropriate number of patients in the past 12 months.

**References**
If the applicant is recently trained, a letter of reference should come from the director of the applicant’s training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.

**Core privileges for NMTs**
Core privileges for NMTs include the ability to:
• Explain test procedures to patients
• Prepare, calibrate, and administer radiopharmaceuticals under the direction of an authorized user
• Apply and manage therapeutic radiopharmaceutical treatments under the direction of an authorized user
• Monitor the patient’s physical condition during treatment
• Operate computers and special cameras to create and process images
• Obtain and test blood and other fluid samples
• Provide images, data analysis, and patient information to the physician
• Apply accepted ALARA standards of radiation safety and protection
• Record the amount and type of radiopharmaceuticals received, used, and discarded
• Perform quality control procedures

**Reappointment**
Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism.

Applicants must be able to demonstrate that they have maintained competence by showing evidence that they have provided nuclear medicine technology services to an appropriate number of patients annually over the reappointment cycle.

In addition, continuing education related to nuclear medicine technology should be required.
Meetings are part of a healthy medical staff diet

Broccoli and meetings have something in common—both elicit the response “ugh!” from me. However, like broccoli, meetings have a value: They strengthen the medical staff.

The governance structure of the medical staff relies on good nutritious building blocks that result in the medical staff’s robust committee structure and reporting in an upward direction. Succinct minutes provide the foundation of strong reporting.

The medical staff office helps to ensure the quality of the meeting “diet.” We begin with a shopping list for meetings that itemizes several of the basics:

- Obtaining a room
- Knowing who attends and why they attend
- Deciding whether a meal should be served, who pays for the meal, and any special dietary needs of the attendees
- Figuring out if there will be a presentation requiring a laptop
- Deciding the best setup for the room
- Knowing if there are handouts and if so, whether they are provided beforehand
- Figuring out if there is a sign-in sheet and if it is passed or recorded

This is not a complete list; it is an example of tasks. Generally, once you know the basics of facilitating meetings, the need for the outline will pass, but the varying grains of scheduling and preparing for the meeting should be reviewed with each event.

Let the medical staff bylaws guide you. The bylaws outline the purpose and responsibilities of each committee, and having that outline will assist you in understanding what resources you will want by your side during the meeting. Generally, I have found it valuable to have the bylaws available during the meeting. Upon occasion it has also been helpful to have Robert’s Rules of Order nearby, depending on the circumstances.

Meetings build on themselves like layers of muscle. For example, what occurs at a policy committee meeting may report up to the medical executive committee (MEC), bringing forward not only the information of the committee’s activity, but also of action items for the MEC. Having the minutes from the committees of the medical staff can help to build the agenda for the MEC.

Managing a balanced diet of meetings takes time and patience. Developing a routine to address the necessary steps is essential. One method is to draft an agenda for the next meeting of the committee directly after the minutes are completed. This method may help you collect information during the time period between the meetings.

In some circumstances, a committee meeting will occur shortly before an MEC meeting, providing too little time for upward reporting of minutes and follow-up. If this is the case, note the actionable items that may come from the preceding meeting on the MEC meeting agenda. If different people support and facilitate these meetings, it is essential that you have open and frequent communication so as not to hold up the next person in his or her meeting preparation. If there is time, the minutes from the committee meeting can be formatted prior to the MEC meeting once the agenda is set. This may help in the transcription turnaround time.

Without someone to coordinate and attend the meetings as a facilitator, the work of the medical staff may be at risk of noncompliance with the medical staff bylaws. Facilitating meetings is an essential building block of a strong medical staff. Meeting management may be about as much fun as eating broccoli, but it is an important job.

EDITOR’S NOTE
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