Morrisey Consulting Services
How to Define and Manage Criteria-Based Privileges

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A New Look at “Competency”
The Centers for Medicare and Medicaid Services (CMS) as well as the accreditation organizations for hospitals (The Joint Commission, Det Norske Veritas or DNV, and Healthcare Facilities Accreditation Program, or HFAP) are charged with the responsibility for evaluation of privilege delineation systems in hospitals. The mission of CMS is fairly obvious: it wants to make sure that the care and services paid for by CMS and provided to Medicare and Medicaid patients are provided by practitioners who are currently competent to provide that care. Because CMS is the 500-pound gorilla (so to speak)—paying for more than 50 percent of the care provided in most hospitals—it has leverage to ensure that the accreditation bodies that have received “deemed status” from CMS are using methods during surveys of hospitals to assess whether organizations are employing effective methods to assure that patients are cared for by competent practitioners.

In fact, it appears that many healthcare-related organizations are on a mission to ensure competency. Several years ago, the Accreditation Council for Graduate Medical Education (ACGME) incorporated six general competencies into programs that train residents and fellows:

- Patient care
- Medical knowledge
- Practice-based learning and improvement
- Systems-based practice
- Professionalism
- Interpersonal skills and communication

The American Board of Medical Specialties (ABMS) followed by incorporating these same competencies into board certification (called “maintenance of certification”). Finally, The Joint Commission incorporated these same six competencies into The Joint Commission standards for hospitals (found in the Comprehensive Accreditation Manual for Hospitals). Basically, the definition of a competent practitioner has been expanded from technical skill and knowledge to issues such as how well a practitioner works with colleagues (including nursing and ancillary staff), his or her professionalism, behavior, and how well practitioners work within the healthcare system to improve patient safety. Healthcare organizations today realize that the ability to demonstrate that those practitioners granted clinical privileges meet this expanded definition of competency is more important than ever. No healthcare organization wants to grant clinical privileges to those practitioners who are
How to Define and Manage Criteria-Based Privileges

consistently ranked as below average. Today’s healthcare consumer is checking whatever sources are available (most often via the Internet) and has the ability to “comparison shop” for his or her healthcare needs. Documented competency is not only an accreditation requirement, but also a differentiator healthcare organizations can use as a competitive edge for marketing purposes in their service area.

These expanded accreditation requirements come at a time when healthcare organizations have diminishing resources, due to the current economic situation. Healthcare organizations need to use tested and proven methods of evaluating practitioner competency. And unfortunately, because systems to define and evaluate competency are still in their infancy, there isn’t a lot of reliable data available that clearly substantiates the most effective methods and measures to evaluate competency.

Assessing and Monitoring Competency

Current clinical competency is the heart and soul of credentialing. In the past, organizations were more concerned with medical staff membership requirements: who could vote, hold office, serve on committees, and so forth. These are still important considerations, but the centerpiece of credentialing and privileging now is having data to show that a practitioner is competent to provide those services for which he/she has been privileged to provide.

A new requirement introduced into standards by The Joint Commission in 2008 is called Focused Professional Practice Evaluation (FPPE). This standard requires that when a new appointee to the medical staff is granted privileges (or a current appointee is granted increased or new privileges), the organization must validate his or her competency to exercise those privileges at the organization. This requirement has caused much consternation among medical staff organizations.

Basically, before this Joint Commission requirement went into effect, healthcare organizations, through the “initial appointment process,” obtained information from a variety of sources about an applicant, granted membership and clinical privileges, and waited to see if anything bad occurred during a “provisional” period of time. It was clearly the “no news is good news” era of credentialing. That has been replaced by FPPE, which requires that once a practitioner is granted privileges, the organization must validate his or her competency to exercise those privileges at the organization. This requirement has caused much consternation among medical staff organizations.

Additionally, a requirement for Ongoing Professional Practice Evaluation (OPPE) also took effect on January 1, 2008. While OPPE is not entirely new (The Joint Commission standards have, for many years, required that data support decisions to reappoint), the standards do include some new aspects. New aspects relate to how often data must be generated and used to evaluate competency. In the past, competency was commonly evaluated at two-year intervals (at the time of reappointment). Standards related to OPPE now require an “ongoing” process that must take place more often than annually. The standards require that the healthcare organization take action at the time action is determined to be necessary rather than
wait for the next reappointment period. Again, this has put an increased burden on hospitals and medical staff organizations to comply with this requirement. Unfortunately, many healthcare organizations do not have the data systems in place to generate meaningful data on a frequent basis that helps to determine competency.

One other fairly new Joint Commission requirement that relates to clinical privileges is the standard that requires that organizations assure that they can support privileges that are granted. For example, if a hospital decided to open a bariatric program, the first issue would not be what surgeons would be granted bariatric privileges. The first issue should be careful consideration of whether the hospital has the infrastructure in place (equipment, trained staff, and so forth) to support such a program.

The following is a succinct summary of Joint Commission requirements related to defining and granting clinical privileges:

| Privileging is the process by which a healthcare organization, after reviewing an individual provider’s credentials and performance, authorizes the practitioner to perform a specific scope of patient care services within the organization. Privileging involves the following four distinct activities: |
|---|---|
| 1. Determining which clinical procedures or treatments the organization will offer and support. |
| 2. Determining what training, skills, behaviors, and experience are required for authorization to perform each clinical procedure or treatment. |
| 3. Determining whether applicants for privileges meet these requirements and officially granting or denying the requested privileges. |
| 4. Monitoring the individuals who are granted privileges to ensure their continued competence and practice within the scope of privileges granted. |


Note that number 4 above relates specifically to FPPE and OPPE.

The centerpieces of FPPE and OPPE are the systems for defining and granting clinical privileges (i.e., those “lists” of cognitive activities and procedures that a given practitioner has been authorized to provide by the board via the credentialing and privileging system designed and administered by the medical staff organization). All too often, the privileging systems are antiquated and in need of revision. Why? Because revision of clinical privileges can be extremely time-consuming and complex (due to “turf” issues—there is much overlap between the care provided under various specialties). Privileging projects are usually supported by individuals who work in medical staff offices, and these departments may not be staffed with individuals who have sufficient time and/or expertise to support and guide privileging projects.
Additionally, privileging is still evolving from the old (and tired) laundry list systems to methods of definition that make more sense in today’s healthcare environment.

**Methodologies**

Let’s take a look at the various methodologies currently in use:

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**Laundry Lists**

Laundry lists have been the most common approach to delineation of clinical privileges since privileging was initiated in healthcare organizations. However, laundry lists do not lend themselves to thoughtful evaluation of current clinical competency, and organizations still using laundry lists are usually eager to replace them with a more contemporary approach.

It is not possible to clearly determine and provide documentation of competency using a laundry list approach because it would be overwhelming to establish criteria for each and every privilege/procedure on a laundry list.

In addition, laundry lists are problematic because they are rarely complete (i.e., some privileges are missed), often include privileges that are not exercised at a specific hospital (because laundry lists are often borrowed from other hospitals), and they are difficult to maintain.

Also, laundry lists are usually procedurally focused and often neglect to list the cognitive privileges that procedurally-based practitioners exercise.

Finally, routine clinical procedures are usually listed side-by-side with complex procedures, with no distinction in the qualifications that a practitioner would need to demonstrate in order to be determined competent to exercise a complex privilege vs. a more simple privilege. Imagine attempting to establish criteria for each and every listed procedure (and condition, if delineated) on a laundry list privilege form!

The following laundry list privilege delineation form is a partial form a hospital used for obstetrics and gynecology until 2006, when its privilege forms were completely overhauled into a core privileging format. Note that procedures are mixed with cognitive-type privileges, and that there is no logical grouping of similar procedures or treatments (other than the fact that the privileges are alphabetized).

Also note that at the end of the listing, there is a place for an applicant to request additional privileges that were not delineated by the healthcare organization. This is always a mistake because it leads to requests for privileges that may not be supported by the organization (and there would obviously be no criteria for privileges that had never been delineated).
Sample partial laundry list: Department of OB/GYN—Obstetrical Privileges

<table>
<thead>
<tr>
<th>Name</th>
<th>Privileges</th>
<th>Requested</th>
<th>Granted</th>
<th>Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adnexitomy, ovarian cystectomy or other adnexal surgery during Cesarean section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amniocentesis, 1st trimester</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amniocentesis, 2nd or 3rd trimester</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amniotomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anesthesia, via local infiltration of the perineum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Augmentation of labor, initiation (distinguished from induction of labor)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breech delivery, all types</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breech extraction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cerclage of cervix, McDonald type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cerclage of cervix, Shirodkar type</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Cervical lacerations, repair (extensive or involving the vaginal sulcus)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cervical lacerations, repair (not involving the vaginal sulcus)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cesarean hysterectomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cesarean section, classical type</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Cesarean section, low transverse type</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Cesarean section, low vertical type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dilatation and curettage, for incomplete abortion (&lt;12 weeks)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dilatation and curettage, for 2nd trimester fetal demise</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Episiotomy, performance and repair</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Evacuation and suturing of vaginal or vulvar hematoma</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>External cephalic version, non-vertex presentation</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Fetal scalp blood sampling</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Fourth degree severe lacerations, repair</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Herpes simplex Type II affecting pregnancy or labor</td>
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<tr>
<td></td>
<td>Hypogastric artery ligation, for intractable postpartum hemorrhage (any cause)</td>
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<tr>
<td></td>
<td>Induction of labor, greater than or equal to 37 weeks - via cervical ripening, amniotomy or dilute intravenous pitocin by infusion</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Initiation of electronic fetal monitoring, including internal scalp electrode and internal pressure catheter monitoring</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Other:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Categories or Levels**

Categories or levels of privileges followed laundry lists and were often recommended for use by professional societies—particularly for the more cognitive-focused specialties such as internal medicine, pediatrics, and so forth. Here is an excerpt from a pediatric privilege form using a category/level approach:

*Level 1: Privileges to admit and treat patients with complex or severe illness or potentially life-threatening problems usually requiring skills acquired after pediatric training sufficient for board certification/eligibility.*
Level II: Illness or problem requiring expertise acquired only during subspecialty training or similar experience. Patients requiring this level of care generally will be referred to a tertiary care setting.

Note that while there is some semblance of establishing criteria for what type of training would make a pediatrician qualified to request these privileges, there is virtually no definition of the procedures that could be performed, diagnoses treated, and so forth.

Self-Definition by Practitioners
The method of having a practitioner write down what he or she wishes to do has not been widely used by many healthcare organizations because it just isn't a practical method. The practitioner may use different terminology that may be misunderstood by those who need to interpret the scope of his or her activities. More importantly, the practitioner may request privileges that are not supported by the organization and for which no criteria have been developed. Organizations that have used this approach often used it for specialties that they knew little about and, therefore, asked the applicant to define the scope of the specialty.

Initial Approaches to Core or Bundled Privileging
Core and bundled privileging was introduced in the early 1990s. The methodology behind core privileges was to include within a core those privileges that represent a scope of practice within a clinical specialty in which practitioners in that specialty would likely have gained an understanding and proficiency during residency and/or fellowship training. Thereafter, the actively practicing practitioner would generally maintain competency in that clinical specialty through continued clinical practice. For example, core privileges for urologists would be those procedures that a physician who has completed an ACGME- (Accreditation Council for Graduate Medical Education) or AOA- (American Osteopathic Association) accredited residency in urology would have acquired during training and should be capable of performing.

Criteria that outline the education, training, and experience that an applicant seeking the core privileges must demonstrate are paired with the “core” description. “Special” privileges encompass areas that practitioners in the specialty may be trained in and might want to do, but they are not included the “core” description because they typically require demonstration/documentation of additional qualifications above and beyond the core privileges in the specialty. Special privileges are therefore separated from the core and have specific criteria related to education, training, and experience.

Some organizations who were “early adopters” of core privileges made a radical departure from defining in great detail what a practitioner could do (as was normally the case when using a laundry list system), to sometimes a simple two-sentence description of an entire specialty.

For example, here is an example of core privileges in orthopedic surgery from a 1997 hospital privilege delineation form:
Operative and non-operative procedures and treatment: spine, upper extremities, lower extremities, and pelvis, which includes the following, within each anatomic area: fractures, dislocations, arthritis, internal derangement, infections, tumors, metabolic diseases of bones, problems involving trauma and non-traumatic conditions related to joints (large and small), fascia, bursa, muscles, nerves, and soft tissue.

This privilege delineation form did not include any “special procedures” except for the “Midas Rex high-speed bone cutter” which was listed separately.

This early practice to greatly simplify definitions of privileges eventually caused much controversy associated with the core privileging methodology. In November, 2004 CMS issued a memorandum to state survey agency directors related to Medicare Conditions of Participation for hospitals and requirements for clinical privileges. The following is an excerpt from that memorandum:

“The hospital’s medical staff bylaws must state the duties and scope of privileges each category of practitioner may be granted. Specific privileges for each category must clearly and completely list the specific privileges or limitations for that category of practitioner. The specific privileges must reflect activities that the majority of practitioners in that category can do and that the hospital can support. It cannot be assumed that a practitioner can perform every task/activity/privilege listed/specified for the applicable category of practitioner. The individual practitioner’s ability to perform each task/activity/privilege must be assessed and not assumed.

If the practitioner is not competent to perform one or more tasks/activities/privileges, the list of privileges is modified for that practitioner. Hospitals must assure that practitioners are competent to perform all granted privileges.”

Core or Bundled Privileging Today
In 2008, The Joint Commission posted an FAQ (frequently asked question) on its Web site related to core and bundled privileges that basically reiterated the position of CMS.

<table>
<thead>
<tr>
<th>CORE/BUNDLED PRIVILEGES</th>
<th>Updated November 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q: Does The Joint Commission endorse or recommend the use of the core/bundle privileging format?</td>
<td></td>
</tr>
<tr>
<td>A: The Joint Commission's credentialing and privileging standards in all accreditation manuals do not reference the concept of core privileges nor do they suggest or promote a particular format for granting privileges.</td>
<td></td>
</tr>
<tr>
<td>Q: Are there any specific issues with using the core/bundle privileging format?</td>
<td></td>
</tr>
<tr>
<td>A: The definition of the activities that are being covered by the core/bundle terminology</td>
<td></td>
</tr>
</tbody>
</table>
The implementation of an evaluation to determine that the applicant can be granted each of the activities listed the core privileges

Definition:

- The core/bundled privilege must be clearly and accurately defined to reflect specific activities/procedures/privileges to be included in the core terminology, and those activities/procedures/privileges that are outside the core.
- The core/bundled privilege must be clearly and accurately defined to reflect only activities/procedures/privileges actually performed at the organization.
- The core/bundled privilege must be clearly defined to reflect activities that the organization believes a majority of applicants should be able to perform.

Implementation:

- Before the core/bundle is granted, the organization must evaluate each applicant's education, training, and current competence to perform each activity listed in the core/bundle, and any that are assigned outside the core/bundle.

It cannot be assumed that every applicant can do every activity listed.

- There needs to be a clearly defined method for the applicant to request deletion of specific activities if they don't wish for them to be granted.
- If the organization's evaluation determines that the applicant is not competent to perform certain activities, then the organization must modify the core/bundle that is granted to the applicant.
- In accordance with the medical staff standards, the applicant and all appropriate internal and/or external persons or entities (as defined by the organization and applicable law) are notified as to the granting decision; i.e., whether the full core/bundle or a modified bundle has been granted. If the core/bundle was modified, the notification must detail the specific modifications.

Note: The expectation for the evaluation of each applicant's education, training, and current competence to perform each specific activity would be the same if the organization were to use a "laundry list" format for the applicant to select activities.

Q: Is The Joint Commission aware of any issue that CMS might have with the use of core/bundle privileging?

A: In November 2004 CMS issued their [sic] position on privileging which addresses the concept of core/bundle privileging. It is in line with The Joint Commission expectation outlined above.

Therefore, organizations that choose to use a core or bundling methodology, must be prepared to modify a core based on a specific applicant’s education, training, and current competence. The following is a recent example of an organization’s use of core privileging.
Sample Recent Core Privileging Approach in Urology

<table>
<thead>
<tr>
<th>REQUESTED</th>
<th>PRIVILEGE DESCRIPTION</th>
<th>CRITERIA FOR PRIVILEGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology description of privileges: Privileges to admit, evaluate, diagnose, consult, and provide non-surgical and surgical care to patients of all ages (except as specifically excluded from practice) presenting with malignant medical and surgical disorders of the genitourinary system and the adrenal gland and including endoscopic, percutaneous, and open surgery of congenital and acquired conditions of the urinary and reproductive systems and their contiguous structures. Privileges also include the following representative procedures: • Bowel surgery as related to the urogenital system • Cystectomy/anterior exereration • Cystoscopy • Extracorporeal shock wave lithotripsy • Female incontinence, all categories • Hernia repair • Incidental splenectomy • Lymphadenectomy, pelvic and retroperitoneal • Other incidental procedures • Percutaneous renal surgery • Prostatectomy, radical, all categories • Renal surgery, partial or total nephrectomy • Surgery of male internal/external genitalia • Transrectal ultrasound/prostate biopsy • Transurethral prostate surgery • Transurethral resection, bladder tumor • Ureteroscopy and urethroplasty (The above listing is not intended to be an all-encompassing list, but rather to reflect the categories/types of patient problems included in the description of privileges. See attached procedures list for additional detail.) Privileges include provision of care to patients in the ICCU and to assume complete responsibility for those aspects of the patient’s illness/condition covered by his/her expertise. Initial privileges: Retrospective chart review of 10 varied cases during first three months of practice.</td>
<td>Successful completion of an ACGME or AOA accredited residency training program in Urology. Current board certification in urology by the American Board of Urology or the American Osteopathic Board of Surgery (Urological Surgery) OR Obtain board certification (as noted above) within five years of completion of training AND Board certification must be continuously maintained. Initial appointment: Completion of residency or fellowship in the past two years OR Demonstration of sufficient participation in active practice to enable evaluation of competency. Applicant must have performed at least 50 urology procedures of varied complexity within the past 12 months that reflects the scope of privileges requested. Reappointment: Sufficient participation in active practice to evaluate competency. Must be able to provide documentation of the performance of at least 100 urology procedures that covers the range of privileges requested during the past 24 months with acceptable results based on quality improvement activities and outcomes.</td>
<td></td>
</tr>
<tr>
<td>Special Privileges: Urology</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Note: Practitioner must request privileges in specialty in order to request special privileges.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Requirements</th>
<th>Initial privileges</th>
</tr>
</thead>
</table>
| Laparoscopic nephrectomy         | Successful completion of a fellowship program in minimally invasive surgery or minimally invasive urology.  
                                          | OR Successful completion of AUA-sponsored course.  
                                          | AND Applicant must have the ability to perform open nephrectomies. |
|                                  | **Clinical activity requirement**  
                                          | **Initial appointment:** Applicant must be able to demonstrate that he/she has performed at least three laparoscopic nephrectomy procedures in the past 24 months. |
|                                  | **Clinical activity requirement**  
                                          | **Reappointment:** Applicant must be able to demonstrate that he/she has maintained competence by the performance of at least three laparoscopy nephrectomy procedures during the previous 24 months. |
| Urologic micro surgery           | Letter from previous training program director (if training was completed in the past 5 years) that applicant was successfully trained in this procedure  
                                          | OR Letter from hospital where procedure has been performed confirming successful outcomes  
                                          | OR Successful completion of AUA-sponsored CME program in urologic micro surgery |
|                                  | **Clinical activity requirement**  
                                          | **Initial appointment and reappointment:** Applicant must be able to demonstrate that he/she has performed at least 10 urologic micro surgery cases during the past 12 months. |

Note that the privilege form above does contain fairly comprehensive criteria related to qualifications to request privileges in urology. The organization would have to be prepared, however, to allow practitioners to eliminate items from the
core. The following is an example of how some organizations communicate to applicants that a core can be modified.

### Description of Privileges

**NEUROSURGERY CORE PRIVILEGES**

- **Requested** Admit, evaluate, diagnose, consult and provide non-operative and pre-, intra-, and post-operative care to patients of all ages, including critically ill patients in the intensive care unit in conformance with unit policy, presenting with injuries or disorders of the central, peripheral, and autonomic nervous system, including their supporting structures and vascular supply; the evaluation and treatment of pathological processes that modify function or activity of the nervous system, including the hypophysis; and the operative and non-operative management of pain. These privileges include but are not limited to care of patients with disorders of the nervous system: the brain, meninges, skull, and their blood supply, including the extracranial carotid and vertebral arteries; disorders of the pituitary gland; disorders of the spinal cord, meninges, and vertebral column, including treatment by spinal fusion or instrumentation; and disorders of the cranial and spinal nerves throughout their distribution. These privileges also include the ordering of diagnostic studies and procedures related to the problem or disorder.

Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the [attached procedure list](#) and such other procedures that are extensions of the same techniques and skills.

### Core Procedure List

*This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.*

**To the applicant:** If you wish to exclude any procedures, please strike through those procedures you do not wish to request, initial, and date.

**Neurological Surgery Core Procedure List**

1. All types of craniotomies, craniectomies, and reconstructive procedures (including microscopic) on the skull, including surgery on the brain, meninges, pituitary gland, cranial nerves and including surgery for cranial trauma and intracranial vascular lesions including congenital lesions
2. Angiography
3. Cordotomy, rhizotomy, dorsal column, and other open and percutaneous procedures on the spine for pain or dysfunction including placement of associated hardware
4. Epidural steroid injections for pain
5. Insertion of subarachnoid or epidural catheter with reservoir or pump for drug infusion or CSF withdrawal
6. Laminectomies, laminotomies, and other approaches to the spinal canal with fixation and reconstructive procedures of the spine and its contents including instrumentation
7. Lumbar puncture, cisternal puncture, ventricular tap, subdural tap
8. Lumbar subarachnoid-peritoneal shunt
9. Management of congenital anomalies, such as encephalocele, meningocele, myelomeningocele
10. Muscle biopsy
11. Myelography
12. Nerve biopsy
13. Nerve blocks and placement of nerve stimulators including placement of associated hardware
14. Peripheral nerve procedures, including decompressive procedures and reconstructive procedures on the peripheral nerves
15. Posterior fossa-microvascular decompression procedures
16. Radiofrequency or balloon compression ablation of nervesablation
17. Selective blocks for pain medicine, stellate ganglion blocks
18. Shunts: ventriculoperitoneal, ventriculotrial, ventriculopleural, subdural peritoneal, lumbar subarachnoid/peritoneal (or other cavity)
19. Spinal cord surgery for decompression of spinal cord or spinal canal, for intramedullary lesion, intradural extramedullary lesion, rhizotomy, cordotomy, dorsal root entry zone lesion, tethered spinal cord or other congenital anomalies (diastematomyelia)
20. Stereotactic guidance for operations on the head and spine including stereotactic placement of both intracranial and spinal electrodes
21. Surgery for congenital lesions of the brain
22. Surgery for intervertebral disc disease
23. Surgery on the sympathetic nervous system
24. Transsphenoidal procedures for lesions of the sellar or parasellar region, fluid leak or fracture
25. Ultrasonic surgery procedures
26. Use of lasers
27. Ventricular shunt operation for hydrocephalus, revision of shunt operation, ventriculocisternostomy
28. Ventriculography

The practice of modifying a core, however, can cause problems in communication of granted privileges throughout the organization. Many credentialing software programs accommodate laundry lists or core privileges, but not both. Making sure that the granted privileges are appropriately “attached” to a specific practitioner is critical to the ability to be able to monitor exercising of privileges.

It should be noted that currently there are two credentialing-related findings that have immediate (and significant) impact during a Joint Commission survey: a practitioner who does not have a license, registration, etc., or a practitioner who exercises privileges that were not granted. Therefore, it is important for organizations to communicate accurately the specific privileges that have been granted to each practitioner and to have effective monitoring processes in place.

Many organizations are taking a look at their core privileges (or are carefully considering the type of core privileges they want to use prior to any revision of their current method of delineating privileges) to assure that the selected method can evolve over time without requiring a major revision (which is time-consuming and costly), and will provide the healthcare organization with an effective tool for managing practitioner competence.

Optimizing the use of technology in managing privileges is also a goal of many organizations because there is so much information to be managed:

- What privileges may be granted within a specific specialty.
- The criteria associated with those privileges.
- What privileges were requested by specific practitioners.
- What privileges were ultimately granted.
- When those privileges expire.
• Conditions associated with granted privileges (e.g., consultation requirements, proctoring, and other requirements related to focused professional practice evaluation—and it should be noted that these requirements often have different expiration or tracking dates associated with them).

“Primary Privileges”

For the above reasons, many healthcare organizations are moving to an advanced version of core privileges. Morrisey’s Privilege Content and Criteria Builder (PCCB) provides a method to easily create criteria-based privilege delineations, manage the related criteria set and communicate granted privileges electronically. The PCCB privileging methodology uses the terminology “primary privileges” which is an advanced version of core privileges. But there is no doubt that because of the current situation with CMS and The Joint Commission related to problems associated with the “old core” privileges, many healthcare organizations are seeking a new name to describe a privileging methodology that incorporates many of the advantages of core privileges but that also includes some additional refinements such as “clusters.”

Clustered privileges are small groupings of similar conditions and/or procedures that address the contemporary reality that some practitioners often don’t continue to practice the full spectrum of their specialty, but rather focus on specific areas. For example, the residency training of family physicians includes all ages of patients, obstetrics, and ambulatory care through critical care, but there is no doubt that once training has been completed, few family physicians continue to practice this full spectrum. Clustered privileges in family medicine might include:

• Office-based or ambulatory care
• Acute inpatient care (hospitalized patients—which may not include privileges to manage or treat patients in critical care units)
• Refer and follow (for those FPs who are primarily office-based but wish to retain hospital "privileges")
• Normal newborns
• Pediatrics (uncomplicated)
• Uncomplicated obstetrics
• Advanced obstetrics (additional fellowship training required)

Each cluster in this specialty would have specific criteria attached that would relate to clinical activity and outcomes. And, each cluster would be able to be matched with specific requirements related to FPPE to validate competency at the time initial privileges were granted.

Another specialty that lends itself to clustering is general surgery—many general surgeons don’t continue to practice the full spectrum of what is taught in residency programs. Clusters within this specialty might include (and some of these clusters would require additional education/training):

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• Basic general surgery privileges and procedures
• Surgical hospitalist privileges
• Bariatric surgery
• Complex laparoscopic/minimally invasive procedures
• Endoscopic procedures
• Breast disease and surgical procedures
• Pediatric surgery
• Surgical critical care (trauma) privileges
• Surgical oncology
• Transplant surgery

Summary
Design and implementation of an excellent criteria-based privileging system requires time, collaboration of medical staff leaders, support staff (medical staff office and quality management), and support from administration and the board. In addition, the organization must have the appropriate technology to help manage all aspects of the privileging program as well as the ability to communicate to the organization what privileges have been granted to whom.

Whatever method is selected, healthcare organizations must assure that:

1. Privileges are criteria based:
   - Education/training
   - Clinical activity (recent)
   - Outcomes

   This means privileges need to be grouped or clustered in some way. It is inconceivable that criteria could be established for every individual privilege.

2. Privileging criteria must be uniformly and consistently applied.

3. The privileging system must provide for mechanisms to make sure that practitioners are granted only those privileges for which they can demonstrate competence.

4. The privileging system must provide a method to customize a group of privileges (whether called core, primary privileges or clusters) to an individual practitioner’s competency.

5. There must be defined, reasonable, and effective mechanisms to confirm competency for newly granted privileges (i.e., FPPE).

6. There must be defined, reasonable, and effective mechanisms to confirm competency of privileges on an ongoing basis (i.e., OPPE).

The privileging process should be designed in such a manner so as to be transparent, easy to use, and objective. To this end, physician leaders must assure
that above all else, it is a clinically realistic system that may be used to request, review, grant, and monitor use of privileges.

Healthcare organizations that are successful in development of these types of privileging systems will easily be able to answer the question, “How do you know the practitioners on your staff are competent to provide those services they have been granted privileges to provide?”

And – healthcare organizations that use Morrisey’s **PCCB** and **eDelineate** can be assured that they are able to efficiently and effectively make use of current technology to manage their criteria-based privileges.