Standardization of Privilege Forms Across a Health System. You Can Do It!

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Speaker

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So Why Did You Pick This Session?

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How Evolved Is Your Health System?

• Past experience is important
• Have you already implemented shared services in Medical Records? IT? Others?
**Impetus for Change**

- Physicians may have multiple affiliations – duplication of effort
- Chaotic processing between hospitals and managed care - example
- Inconsistent privileging criteria applied to determine clinical competence

**Is It Possible To Get Everyone On The Same Page?**

YES! It can be done but you have to use a thoughtful approach......
Build Your Case

- Take a hard look at what is working and what is not working
- Identify opportunities for improvement
- Evaluate whether standardized privileges would improve the performance of the organization

You Will Likely Identify Deficiencies

- You may discover that your current program does not meet prevailing standards
- You may discover that you have physicians providing services that they do not have privileges to provide or have not adequately addressed some areas.
- This is what you are fixing by initiating this project
- You are doing the right thing!
- Don’t “flip out”!
What’s Next?

• Build the Problem Statement
  » If stakeholders don’t comprehend the end state they won’t want to get on board
  » Make the case regarding why this is in the best interest of the organization as well as the individual stakeholders

Introduction of the Concept to the Organization(s)
The Role of the Concept Document

- High level outline of the vision
- Describe the end state
- Overview the anticipated project structure and experience
- Obtain authorization to proceed

Make Sure Technology Set Up Supports Your Privilege Form Design AND Process

Privilege Request

- Hospital A
- Hospital B
- Hospital C
Start From Scratch or Obtain Pre-Fab Content?

- Tweak what you have?
- Migrate to a different model?
- Where can you get Pre-Fab content?

Consider the Following in Designing Your New/Revised Approach

What privileging format will you use?
Privileging Design Considerations

Options:
- Laundry lists
- Categories
- Groupings (core, bundles, primary/clusters)
- Combinations

Review of Selected Specialty

Obstetrics and Gynecology
First Consider How Formal Training Programs Are Organized

- **RESIDENCY PROGRAM**
  - OBSTETRICS AND GYNECOLOGY

- **FELLOWSHIP PROGRAMS**
  - UROGYNECOLOGY
  - GYN-ONCOLOGY
  - MATERNAL FETAL MEDICINE
  - REPRODUCTIVE ENDOCRINOLOGY AND FERTILITY

**Special Procedures Clusters**

- Identify where there are privileges that require special training or certification that not all individuals in the basic specialty may possess.
- Set those items apart as special procedure privileges.
- Group or cluster them whenever possible.
Now You Have A Basis For Forming The Basic Clustered Privileges For the Privilege Form

Let’s Look at an Example

A Great Example of How Clustered Privilege Delineation Works in a Health System Environment!
Project Structure

The project will be much easier to manage if it is expeditiously completed.

Resources allocated to the project will influence the time frame required to complete the project.

A dedicated project manager versus a “part time” project management approach.

Set expectations.
Specific Tips for Management of the Project

- List what you have now
- Assess whether there are “holes” in coverage with regard to specialties and locations
- Confirm with operations management that you have privileges that cover all services provided by the organization

Inventory What Specialties Practice at Your Organization

- List what you have now
- Assess whether there are “holes” in coverage with regard to specialties and locations
- Confirm with operations management that you have privileges that cover all services provided by the organization
Sample Inventory

<table>
<thead>
<tr>
<th>Item</th>
<th>Specialties (include all specialties within a delineation)</th>
<th>Specialty Representative(s)</th>
<th>Additional Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Allergy and Immunology</td>
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<td></td>
</tr>
<tr>
<td>2</td>
<td>Anesthesiology</td>
<td></td>
<td>Pain Medicine is also included on the PM&amp;R delineation (see #__)</td>
</tr>
<tr>
<td></td>
<td>• Pain Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Cardiovascular Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Clinical Cardiac Electrophysiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Interventional Cardiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Colon and Rectal Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Critical Care Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Dermatology</td>
<td></td>
<td>Dermatopathology is also on the Pathology delineation (see #__)</td>
</tr>
<tr>
<td></td>
<td>• Dermatopathology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Emergency Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Endocrinology, Diabetes and Metabolism</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7/31/2014

Use Project Management Tools

- Inventory List
- Form Status Grid
- Conversion Map
- Sample Transition Letter
Privileging Design Considerations

Setting-specific privileges

- Special care units (critical care medicine form)
- Inpatient/outpatient care
- SNFs
- Sub-Acute

Privileging Design Considerations

- Are these separate forms? Do they rise to the level of privileging in your organization?
  - Geriatrics
  - Sports Medicine
  - Hospice and palliative care
  - Hospitalists
  - Admitting privileges vs. management privileges
Delineation Tips

Delineation of Training Requirements: Types of Training Experiences

- Accredited residency or fellowship
- Non-accredited fellowships
- Didactic coursework with human subjects experience
- Didactic coursework including lab experience
- Didactic coursework without lab experience
- On the Job Training (OJT)
Nuances of Residency or Fellowship Training

- Level 1, 2 or 3 training
  - Level 1: Observation or “Familiarity”
  - Level 2: Performance on human subjects; competence to perform independently
  - Level 3: Performance of a high number of cases; typically required to be a lab or program director; characterized as an “expert”

- Check the ACGME requirement for a given specialty
- Sometimes articulated in “White Papers”

Delineating Criteria for Non-Accredited Residency/Fellowship Training

- Is “equivalence” with accredited training required?
- Case logs and program director references?
- If Board Certification is eventually required the easiest route may be for the applicant to obtain a letter from the board stating that they qualify to sit for the exam
**Evaluation of Didactic Training**

- If there was no lab or human subjects experience then a preceptorship will be required unless the application of the acquired knowledge has no associated technical skill.
- Simulation or lab experience may suffice in specific circumstances.
- Human subjects experience is required when there are specific technical skills that must be mastered or when the patient’s response to treatment may require modification of technique or approach.

**Manufacturer Designated Training**

- If a device is involved you may find guidance from the manufacturer and/or a specialty organization or the evolving community standard

- If there is no guidance available you will need to meet internally and develop criteria based upon peer consensus
Criteria for Verification of Training

- Verification of training that occurred more than 5 years ago may not be helpful
- If applicant completed training prior to the existence of specific fellowships then evaluation of “ongoing clinical practice may be more relevant

Strategies for Delineating Clinical Activity Requirements

- Specific numeric criteria is not required
- National/community standards
- Delineating criteria when program accreditation/certification is expected
- Evidenced based criteria vs. peer consensus
- “Evidence of ongoing clinical practice reflective of the scope and complexity of privileges requested”
Periodic Update of Privilege Forms Will Be Required

Example: A Natural Progression in Surgical Approach

- **Open**
  - 20cm incision
  - 1980s thru ‘90s
  - Paradigm shift driven by innovative procedures
- **Laparoscopic**
  - 0.5-1cm incisions
  - 2000 thru now
  - The impetus: Gall Bladder Surgery
- **NOS**
  - No incision

Coming Attractions

- Constant innovation in the industry will challenge us to periodically revisit our privilege forms to make sure that they remain current.

- Use a structured approach to future form modification.
What Are Your Thoughts?