NAMSS™

EDUCATION. ADVOCACY. PATIENT SAFETY.

Medical Services Management (CPMSM)

Certification Preparation Course

Participant Workbook

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Contents

Find Someone Who:

1. Has less than six months experience as an MSP

_____

2. Works in an ambulatory care setting (i.e., surgery center)

_____

3. Worked in a managed care organization

_____

4. Now works in a CVO

_____

5. Is a member of NAMSS or a state association

_____

6. Is a part-time student

_____

7. Drinks more than four cups of coffee a day

_____

8. Traveled more than 250 miles to attend this class

_____

9. Has the same first name as you

_____

10. Exercised this morning

_____

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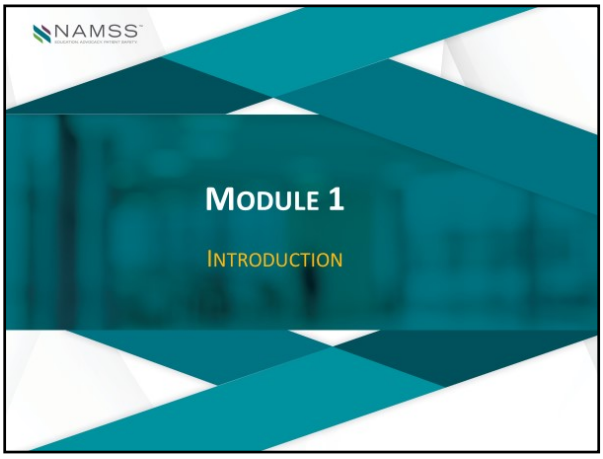
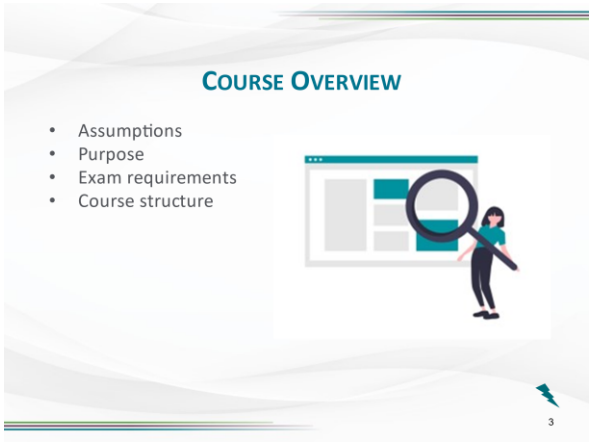
NAMSS
CERTIFIED PROFESSIONAL
MEDICAL SERVICES MANAGEMENT
(CPMSM) PREPARATION COURSE


NAMSS
MODULE 1
INTRODUCTION


COURSE OVERVIEW
Assumptions
Purpose
Exam requirements
Course structure
3

Course Topics

- Introduction
- Credentialing and Privileging (38%)
- Ongoing Monitoring and Compliance (27%)
- Department Operations Management (20%)
- System Management (15%)
- Your Study Strategy
- Assess Your Knowledge

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Course Resources

- Candidate Handbook
- Consolidated Standards
- Medicare CoP Summary
- Healthcare Regulatory Requirements
- Meeting Management Core Curriculum
- Comparison of Accreditation Standards
- Responding to Requests for Information
- Policy and Procedure Development
- AMA Physician's Recognition Award and CME Credit System
- NAMSS Certification FAQs
- Key Legal Terms
- Legal Case Summary
- And more

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Certification Commission of NAMSS (CCN)

- Certification Program accredited by National Commission For Certifying Agencies
- Independent authority for establishing standards for certifications and operating policies
- Autonomous arm of NAMSS
  - Protect against undue influence

The CCN does not develop, administer, sponsor, endorse, or financially benefit from any type of exam review, preparatory course or published materials related to the content of the certification examinations. The purchase and/or use of any exam preparation material does not guarantee a passing score on the exam.

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Education Committee

- Determines educational needs
  - Identifies or develops resources to address those needs
- Assesses current educational offerings and partnerships
- Monitors ongoing effectiveness of all educational activities
- Oversees education activities

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CPMSM Exam

175 Multiple Choice Questions

35%	*Credentialing and Privileging*
26%	*Ongoing Monitoring and Compliance*
20%	*Department Operations Management*
19%	*System Management*

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Exam Success

- Since 1985, over 6,500 people have taken the exam
- Averages 185 persons/year
- Passing rates from last 10 years vary from 32% to 71%
- Average passing rate is 54%
- For the last testing session in 2020, the passing rate was 50%

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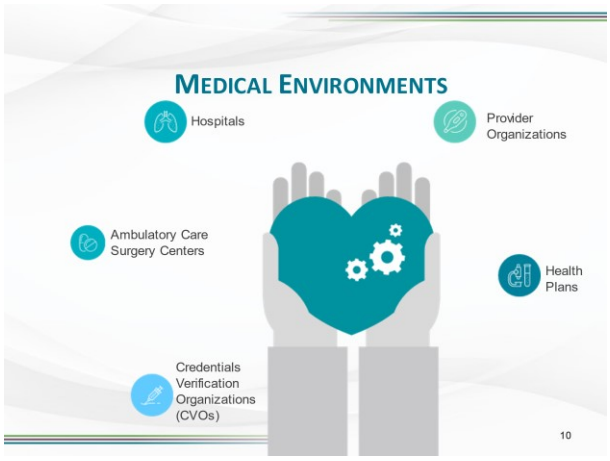
MEDICAL ENVIRONMENTS
Hospitals
Provider Organizations
Ambulatory Care Surgery Centers
Health Plans
Credentials Verification Organizations (CVOs)
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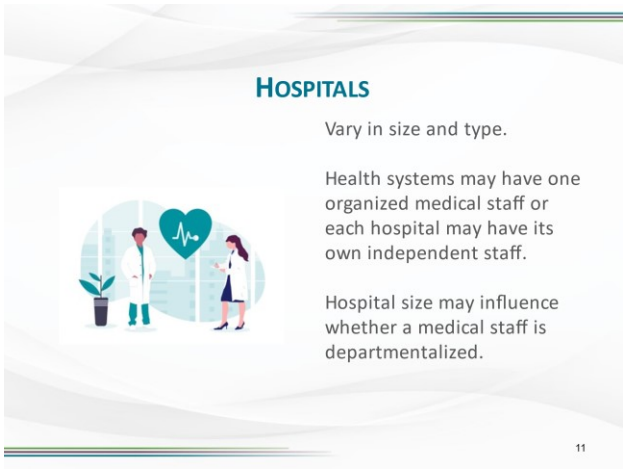
HOSPITALS
Vary in size and type.
Health systems may have one organized medical staff or each hospital may have its own independent staff.
Hospital size may influence whether a medical staff is departmentalized.
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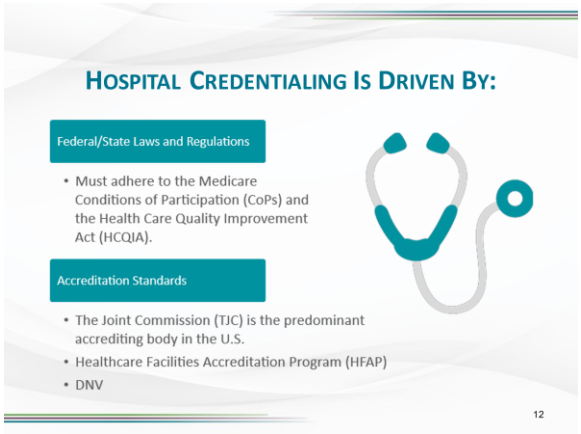
HOSPITAL CREDENTIALING IS DRIVEN BY:
Federal/State Laws and Regulations
• Must adhere to the Medicare Conditions of Participation (CoPs) and the Health Care Quality Improvement Act (HCQIA).
Accreditation Standards
• The Joint Commission (TJC) is the predominant accrediting body in the U.S.
• Healthcare Facilities Accreditation Program (HFAP)
• DNV
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Hospital Credentialing Is Driven By:

Governing Documents

- Hospital and Medical Staff Bylaws
- Hospital and Medical Staff Policies and Procedures
- Medical Staff Rules and Regulations

The CPMSM exam will only cover actual requirements.

Standard of Care

- The degree of care and skill of the average health care practitioner who practices in the same specialty

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Ambulatory Care & Surgery Centers

- Organizational structure varies depending on size
- Credentialing influenced by:
- Accreditation Standards
  - Accreditation Association for Ambulatory Health Care (AAAHC)
  - The Joint Commission (TJC)
    - Healthcare Facilities Accreditation Program (HFAP)
  - National Committee for Quality Assurance (NCQA)
  - URAC
- Centers for Medicare and Medicaid Services (CMS) Regulations
- State and Federal Law
- Policies and Procedures / Bylaws (if applicable)
- Contractual Agreements

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Credentials Verification Organizations

Independent CVO

- Typically for-profit company
- Contracts with many outside organizations
- Must satisfy all different accreditation requirements and needs of its customers

Organization-specific CVO

- Handles organization specific credentialing
- May also be for-profit and have customers outside the organization

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CVO Credentialing is Driven By:

- Regulatory and accreditation requirements based on contract
- Could encompass:
  - NCQA
  - URAC
  - TJC
  - DNV
  - HFAP
  - CMS
  - AAAHC
- Policies and Procedures (governance documents)

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Provider Organizations

- Medical Groups
- Independent Practice Associations (IPAs)
- Physician/Hospital Organizations (PHOs)
- Accountable Care Organizations
- Clinically Integrated Networks

- Organizational structures vary depending on size and function.
- Federal and state laws and regulations apply.
- Typical accreditation standards are NCQA and URAC but may include others.
- Policies and procedures will detail credentialing process and medical standard of care.

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Health Plans

- CMS has specific regulations for Medicare Advantage networks or managed Medicaid networks
- HCQIA applies
- State Departments of Insurance also regulates activities

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Health Plans

Accreditation Standards

NCQA

- Accredited health plans must also submit annual Healthcare Effectiveness Data and Information Set (HEDIS) data.
- Accredited health plans must participate in Consumer Assessment of Healthcare Providers and Systems(CAHPS)

URAC

- URAC accredited health plans must participate in CAHPS

Policies and Procedures

- Perform credentialing based on policies and procedures.
- May have bylaws, but they do not apply to credentialing.
- Policies and Procedures are unique to each health plan and may exceed regulatory requirements.

- **CPMSM exam will only cover actual requirements.**

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Management Overview

Management is the achievement of the organization's objectives through and with people and other resources.

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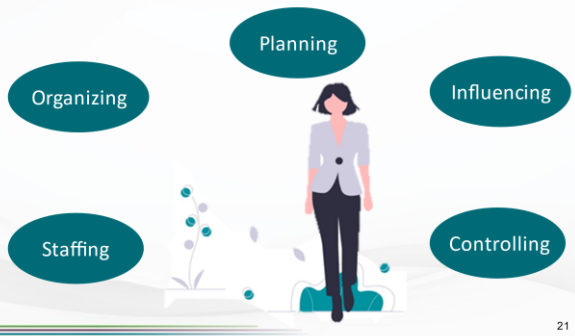
Management Functions



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Management Functions: Planning

Determines in advance what should be done.

A medical services manager would:

- Determine department objectives
- Set goals
- Formulate policies and procedures, programs, rules and regulations
- Develop budgets and annual meeting calendars
- Schedule review and updates of governance documents

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Management Functions: Organizing

Determines how work in a department will be accomplished.

A medical services manager would:

- Identify roles and responsibilities for staff
- Assign duties to staff
- Assign levels of supervision
- Coordinate activities and teams to achieve departmental goals

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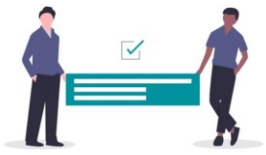
Management Functions: Influencing

Includes motivation, coaching, and problem solving.

A medical services manager would:

- Know and understand staff
- Influence through supervision, guidance, and motivation



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Management Functions: Staffing

Determines numbers, training, and experience levels of employees

A medical services manager would:

- Assess, appoint, evaluate and develop employees
- Work with Human Resources (HR) for hiring of staff and performance appraisals

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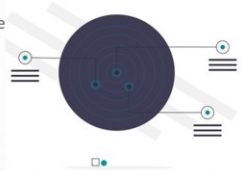
Management Functions: Controlling

Ensures that events proceed as planned and objectives are achieved

A medical services manager would:

- Monitor goals and take action to ensure objectives are met
- Control budgets and inventory
- Perform file audits
- Ensure compliance with accreditation standards and regulatory requirements



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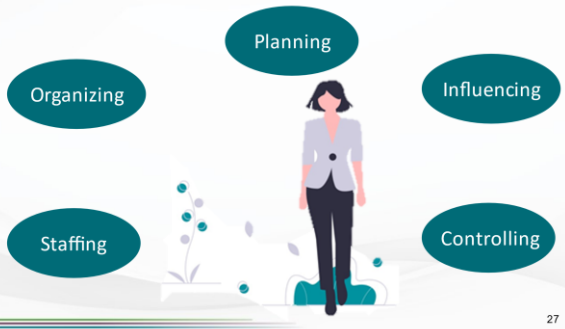
Management Functions



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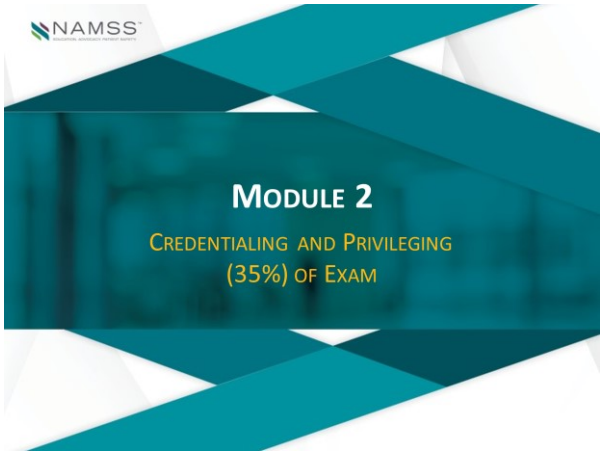

EXAM CONTENT OUTLINE

- Direct the credentialing, privileging, and enrollment processes of practitioners/providers in accordance with regulatory requirements, accreditation standards, and organizational policies and procedures to mitigate organizational risk and promote the delivery of safe, quality care.
- Oversee the evaluation of credentialing/privileging requests and evidence of education, training, competence, ability to perform, and experience against established criteria for practitioners/providers to determine eligibility for requested privileges, membership, and/or plan participation.
- Oversee the submission of complete and accurate applications and/or practitioner data/roster to ensure timely approval and maintenance of network participation.

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Module 2: Credentialing and Privileging Pre-Test

1. Which of the following bodies approves clinical privileges?

   a. Credentials Committee
   b. Peer Review Committee
   c. Governing Body or Board

2. Which of the following credentials must be tracked on an ongoing basis?

   a. Medical school completion
   b. Closed medical malpractice claims
   c. Licensure

3. Which of the following terms describes a step-by-step sequence for proper completion of a task?

   a. Policy
   b. Procedure
   c. Bylaws

4. The Joint Commission hospital standards require that clinical privileges are hospital specific and:

   a. Based on the individual's demonstrated current competence and the procedures the hospital can support
   b. Based on board certification
   c. Based on the privileges the individual is currently approved to perform at other hospitals

5. In a Joint Commission accredited hospital, applications for initial appointment to the medical staff must be acted on:

   a. within 90 days after the medical staff office receives the application
   b. as specified in the medical staff bylaws
   c. within 30 days of receipt of a completed application

6. Peer references should be obtained from:

   a. Practitioners who have referred patients to the provider
   b. Former hospital administrators
   c. Practitioners in the same professional discipline as the applicant

7. When developing clinical privileging criteria, which of the following is important to evaluate?

   a. The number of providers in that specialty.
   b. Established standards of practice such as, specialty board recommendations.
   c. Whether or not the quality department can support the FPPE process.

8. When credentialing and privileging practitioners it is appropriate to:

   a. Handle each applicant on a case-by-case basis
   b. Follow a routine process for each applicant
   c. Give preferential treatment to those providers whose specialty is primary care

9. The governing body delegates the task of credentialing, recredentialing, and privileging to

   a. The hospital administrator
   b. The medical staff office
   c. The medical staff

10. What is the only hospital medical staff committee required by The Joint Commission hospital standards?

   a. Credentials committee
   b. Medical executive committee
   c. Pharmacy and therapeutics committee

What is Credentialing?

The process of assessing and validating the qualifications of a practitioner to provide care in a healthcare environment.

- Extensive process of gathering information that serves as the foundation upon which to base our decisions
- Required by CMS and accrediting bodies
- Ensures that all patients receive quality care by competent and qualified practitioners

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Credentialing Recommendation and Decision Timeframe

- Timeframe to process application defined in the bylaws (hospital) or policy and procedures (health plans and CVOs)
- Medical Staff review and recommendation process should not begin until:
  - Application is complete
  - Primary source verification is complete
  - Current competency for privileges requested is obtained

Some of the differences between hospital and health plans include:

- Whether or not a credentials committee is utilized
- Hospital medical staff acting as "committee of whole"
- Whether health plan allows medical director "sign off"
- Bylaws, policies, and procedures of specific organization

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Advanced Practice Professionals (APPs)

Whether or not a healthcare practitioner is an LIP or non-LIP is defined by each individual organization and is based on the applicable state regulations and accreditation standards, as well as its bylaws.

Advanced Practice Clinicians– also known as Allied Health Professionals (AHPs) or Advanced Practice Professionals (APPs) typically include:

- Advanced Practice Registered Nurses (APRNs)
  - Certified Registered Nurse Anesthetists
  - Clinical Nurse Specialists
  - Nurse Practitioners
  - Certified Nurse Midwives
- Physician Assistants (PAs)
- Psychologists

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Accreditation Requirements For APPs

TJC requires that all LIPs, APRNs and PAs be privileged.

DNV allows non-physicians to be included in the medical staff, subject to state regulations. These non physician practitioners may include CRNA, APRN, CNM, psychologists or others.

HFAP standards, which mirror CMS CoPs, recognize non-physician practitioners that provide a medical level of care or perform surgical procedures under supervision.

NCQA requires that practitioners be credentialed if they have an independent relationship with the organization and provide care under the plan's medical benefits. An independent relationship exists primarily when the practitioner has a participation agreement with the health plan and is listed in the health plan's directory.

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Membership/Appt. vs. Privileges

Membership/Appt.

The appointment to the medical staff that grants a practitioner specific rights, responsibilities and prerogatives including voting, holding office, committee appointments, and dues.

Is a ***privilege*** extended only to professionally competent individuals and is contingent upon compliance with organizational requirements.

Clinical Privileges

A description of the clinical and patient care activities of the practitioner; each privilege or core of privileges has its own criteria based on education, training, experience, and competence.

AKA: Delineation of Privileges (DoPs)

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Membership/Appt. vs. Privileges

Depending on the healthcare environment:

- Membership categories are described in medical staff bylaws
  - examples include: active, associate, consulting, courtesy
- Membership criteria can be different than criteria for privileges
- You can have membership without having privileges
- You can have privileges without membership
- Some criteria are the same for both membership and privileges (example: licensure)

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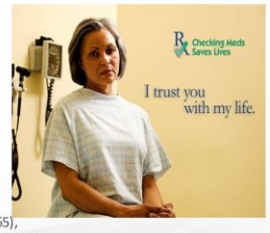
Why is Credentialing Important?

The primary purpose of credentialing is to protect our patients.



Darling v. Charleston Memorial Hospital (1965),
Johnson v. Misericordia Community Hospital (1981),
and
Frigo vs. Silver Cross Hospital (2007).

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Negligence

The four elements of negligence are as follows:

1) **Duty to Exercise Due Care** can be established by statute or common law. For example, the duty a physician owes to a patient is very high. The standard of care is the generally accepted level of professional care provided in the community.
2) **Breach of Duty**. If the duty to exercise due care is not met, then a breach occurs.
3) **Injury**. If there is no injury incurred by the patient, then there is no liability.
4) **Proximate Cause**. It must be established that the injury was directly caused by the breach of duty.

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Duty Defined By:

A hospital's duty to exercise due care is defined by several factors, including:

- State and federal hospital licensing regulations
- Applicable accreditation standards
- Medical staff and hospital bylaws, rules and regulations, policies
- Hospital policies
- Case law

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Examples of Breach of Duty

- Failure to follow bylaws, policies and procedures, accreditation requirements, state regulations
- Failure to address concerns identified in the credentialing/recredentialing process
- Adopting a credentialing policy/procedure that does not reflect what a reasonable hospital would do to protect another individual from a foreseeable risk of harm

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Negligent Credentialing

If the organization knew or should have known that a practitioner is not qualified and the practitioner injures a patient through an act of negligence, the organization can be found separately liable for the negligent credentialing of this practitioner.

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Liability Theories

- Authority of Hospital Corporations
- Corporate Duties and Risk Management
- Antitrust
- Doctrine of Respondeat Superior
- Borrowed Servant Doctrine

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Mitigating Other Risks

- Discrimination
  - American Disabilities Act
  - Civil Rights Act
- Delivery of Safe Quality Care
  - Patient Safety and Quality Improvement Act
  - Patient Protection and Affordable Care Act
  - Healthcare Quality Improvement Act (HQIA)

See "Key Healthcare Regulatory Requirements" in the supplemental materials for more information.

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Health Care Quality Improvement Act

- HCQIA was passed to extend immunity to good faith peer review and the creation of the NPDB.
- HCQIA only protects the review of physicians and dentists not allied health professionals.

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National Practitioner Data Bank

- The NPDB is a workforce tool that prevents practitioners from moving state to state without disclosure or discovery.
- Reports are confidential.
- Click on the Resources link to learn more about the NPDB.

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Activity 2.1: Application Processing Steps

- Review the steps shown on the cards
- Working with your table, place them in the correct order as required by:
  - TJC (Departmentalized Hospital)
  - NCQA (w/Medical Director approval of a clean file)
  - NCQA (Credentialing Committee review)
- Be ready to discuss any differences as the process is applied in your facility.

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Expedited Credentialing – Hospital (TJC and DNV)

- Streamlines the governing body approval process for initial appointment and reappointment process and granting of privileges
- Governing body grants authority to a subcommittee to make credentialing and privileging decisions on its behalf
  - Must be comprised of at least 2 voting members of the governing body
- Medical staff develops criteria; applications ineligible if
  - Applicant submits an incomplete application
  - MEC final recommendation is adverse or has limitations

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Delegate Authority

TJC: Governing body can use an expedited process for initial appointments and reappointments to the medical staff and when granting privileges by delegating the decisions to a subcommittee of at least two voting governing body members.

DNV: Governing body may elect to delegate the authority to render initial appointment, reappointment, and renewal or modification of clinical privileges decisions to a committee of the governing body.

NCQA: Organization may have a process for the medical director or qualified physician to review and approve clean files.

URAC: Credentialing Committee may delegate the authority to approve clean applications to the senior clinical staff person.

AAAHC: The governing body may delegate the review of applications to an internal reviewer or reviewers, e.g., the Medical Director or a Committee that provides recommendations for appointment and reappointment to the governing body. The governing body remains responsible for making appointment and reappointment decisions.

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What is Enrollment?

The process of applying to health insurance plans or payers to gain approval for participation in provider networks and to receive reimbursement for healthcare services provided.

- Medicare / Medicaid
- Commercial Payers, e.g., Aetna, Blue Cross Blue Shield, United Healthcare
- Tricare / TriWest
- Workers' Compensation

Enrollment is NOT credentialing

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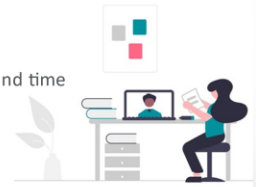
Integrating Credentialing and Enrollment

Many MSPs are gaining responsibility for enrollment due to similarities in activities.

Organizational benefits include

- Reduced duplication
- Increased efficiency
- Decreased onboarding turnaround time
- Improved overall satisfaction



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Enrollment Responsibilities: Medicare and State Medicaid Enrollment

Medicare	State Medicaid
• Submit application via PECOS or paper, along with supporting documents and forms • Receive confirmation of enrollment approval from Medicare Administrative Contractor (MAC)	• Submit application via website portal, paper, or a combination (varies by state) • Receive confirmation of enrollment approval from state Medicaid agency

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Enrollment Responsibilities: Reporting Adds, Changes and Terminations

Submit all updates to commercial payers, Medicare and Medicaid via requested method

- New practitioners (if delegated)
- Practitioner name/address changes
- Practitioner terminations
- Office location (new, updates, termination)
- Facilities (new, updates to ownership / tax identification number (TIN), termination)

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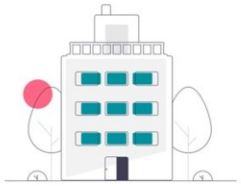
Enrollment Responsibilities: Facility Enrollment

New Facility

- Submit application and supporting documents / forms
- Payer credentials facility
- Receive confirmation from payer of approval; notify internal key stakeholders

Changes

- New ownership, new TIN
- Adds and terminations



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Enrollment Responsibilities: Re-enrollment and Revalidation

- Re-enrollment with commercial payers every 3 years
- Similar to initial enrollment process
  - Non-delegated via submitting application data through CAQH or payer portal / paper
  - Delegated via organization recredentialing process and reporting activity to payer
- Practitioner revalidation with Medicare and Medicaid every 3-5 years; may vary by state
- Office / Group location revalidation with Medicare and Medicaid; frequency varies by state

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Ongoing Enrollment Activities

- Maintain provider data in internal database
- Maintain provider data in CAQH ProView system
- Regular reporting to delegated payers of credentialing activities
  - At least semi-annually
  - More often based on activity
- Accuracy of provider data is critical to ensuring directories and rosters contain correct and current information

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Privileging

Granting approval for an individual to perform a specific procedure or specific set of clinical and patient care activities based on documented competence in the specialty in which privileges are requested.

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Privileges Should Be:

- A documented, objective, and evidence -based process.
- Based on defined criteria including training, experience and demonstrated current competence.
- Based on services provided at the facility or location.
- Consistently and uniformly applied for all applicants.

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Legal Issues That Could Arise If You Do Not Use a Standard DoP and Review Process:

A negligent credentialing allegation

- If the organization knew or should have known that a practitioner is not qualified and the practitioner injures a patient through an act of negligence, the organization can be found separately liable for the negligent credentialing of this practitioner
- Three well-known cases worth reviewing related to negligent credentialing are:
  - Darling v. Charleston Community Memorial Hospital, 1965.
  - Johnson v. Misericordia Community Hospital, 1991.
  - Kadlec Medical Center v. Lakeview Anesthesia Associates, 2008

A practitioner claim of discrimination

- The criteria for the privilege should be applied to everyone equally– whether they are male/female; American/foreign trained or any other reason.

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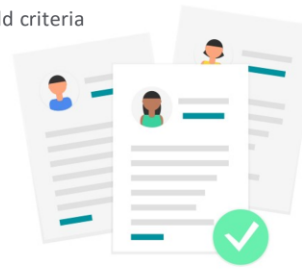
Privileging System Considerations

- Laundry vs. Core vs. Category
- Developing minimum threshold criteria
- Special procedures
- Approval of forms
- Privilege form maintenance



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Sample Laundry List

Privileges in a Department of Medicine: Special Procedures

To be eligible to apply for core privileges in internal medicine, the applicant must meet the following criteria:

- Current certification or active participation in the examination process leading to certification in internal medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine
- Applicants must be able to demonstrate provision of inpatient services to at least 50 patients in the last 12 months

To be eligible to renew core privileges in general internal medicine, the applicant must demonstrate competence and an adequate volume of experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

Check the procedures for which privileges are requested.

SPECIAL STUDIES, INVASIVE		
☐ Arterial Puncture & Cannulation	☐ Cardiac Catheterization	☐ Pericardiocentesis
☐ Angiography, Cerebral	☐ Cardiac pacemaker (Transvenous)	☐ Peritoneal Dialysis
☐ Arteriography	☐ Cholangiography, Percutaneous	☐ Phlebography
☐ Arthrocentesis	☐ Cisternal Tap	☐ Pneumoencephalography
☐ Bronchial Brushing	☐ Hemodialysis	☐ Spinal Tap
☐ Bronchial Lavage	☐ Lymphangiography	☐ Subclavian Puncture
☐ Bronchograms	☐ Myelography	☐ Swan-Ganz Catheterization
☐ Bone Marrow Aspiration	☐ Paracentesis, Abdominal	☐ Thoracentesis

BIOPSY AND EXCISION			
Needle Biopsy Of:			
☐ Bone Marrow		☐ Skin Biopsy	
☐ Kidney		☐ Small Intestinal Biopsy with Crosby Capsule and Shiner Tube	
☐ Liver			
☐ Thyroid		☐ _____ (specify)	
☐ Pericardial Biopsy (Closed)			
☐ Peritoneal Biopsy (Closed)		☐ _____ (specify)	
☐ Pleural Biopsy (Closed)			
Endoscopy	With Biopsy	**Endoscopy**	With Biopsy
☐ Bronchoscopy	☐	☐ ERCP	☐
☐ Colonoscopy	☐	☐ Peritoneoscopy	☐
☐ Duodenoscopy	☐	☐ Sigmoidoscopy	☐
☐ Esophagoscopy	☐	☐	☐
☐ Mediastinoscopy	☐	☐	☐
SPECIAL STUDIES, NON-INVASIVE AND OTHER PROCEDURES			
☐ Echocardiography		☐ Esophageal Dilatation	
☐ ECG Interpretation		☐ Hypnosis	
☐ Electroconvulsant Therapy		☐ Peripheral Vascular Studies (non-invasive)	
INTERNAL MEDICINE CLINICAL PRIVILEGES		☐ Phonocardiography	
☐ Electromyography		☐ Pulmonary Function Interpretation	
Intubation:		☐ Vectorcardiography Interpretation	
☐ Endotracheal			

Sample Core Privileges

Internal Medicine Core Privileges

To be eligible to apply for core privileges in internal medicine, the applicant must meet the following criteria:

- Current certification or active participation in the examination process leading to certification in internal medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine
- Applicants must be able to demonstrate provision of inpatient services to at least 50 patients in the last 12 months

To be eligible to renew core privileges in general internal medicine, the applicant must demonstrate competence and an adequate volume of experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

Core privileges include:
Admit, evaluate, diagnose, treat, and provide consultation to patients 15 years of age and older with common and complex illnesses, afflictions, diseases, and functional disorders of the circulatory, respiratory, digestive, endocrine, metabolic, musculoskeletal, hematopoietic, and eliminative systems of the human body. The core privileges in this specialty include the procedures on the list below and such other procedures that are extensions of the same techniques and skills.

- Arthrocentesis
- I & D abscess
- I & D hemorrhoids
- Biopsy of superficial lymph nodes
- Breast cyst aspiration
- Burns, superficial and partial thickness
- Excision of skin and subcutaneous lesions
- Excision of cutaneous and subcutaneous tumors and nodules
- Local anesthetic techniques
- Nasogastric tube placement
- Placement of anterior and posterior nasal hemostatic packing
- Perform simple skin biopsy or excision,
- Preliminary interpretation of electrocardiograms, own patient
- Remove non-penetrating corneal foreign body, nasal foreign body
- Suprapubic bladder aspiration
- Venous cut down

Non-core Privileges: Exercise Testing—Treadmill

Initial privileges: Successful completion of an ACGME accredited residency in internal medicine that included a minimum of four weeks or the equivalent of training in the supervision and interpretation of exercise testing and evidence that the training included participation in at least 50 exercise procedures.

AND

Required current experience: Demonstrated current competence and evidence of the performance of at least 25 exercise tests in the past 12 months or completion of training in the past 12 months.

Renewal of privileges: Demonstrated current competence and evidence of the performance of at least 75 exercise tests in the past 36 months based on results of ongoing professional practice evaluation and outcomes.

Source: American College of Cardiology, American Heart Association, American College of Physicians—American Society Internal Medicine task force on clinical competence, May 2000.

Category Privileges for Family Practice:

Category I
This category includes privileges for uncomplicated, basic procedures and cognitive skills. Physicians applying for privileges in this category will be graduates of approved medical/osteopathic schools who are properly licensed, and who have demonstrated skills in family medicine.

Category II
Privileges in this category include privileges in Category I as well as privileges for those procedures and cognitive skills involving more serious medical problems, which normally are acquired during successful completion of a family practice residency program. This category may include procedures and cognitive skills also acquired by physicians trained in other specialty residency programs.

Physicians requesting privileges in this category will have completed training in a family practice residency program, be qualified to take the family practice board exam and/or be board certified in family practice by the American Board of Family Practice (ABFP), or the American Osteopathic Board of Family Practice (AOBFP); or will have documented experience, demonstrated abilities and current competence in family medicine.

Category III
Privileges in this category require special skills and knowledge and, therefore, require documentation of such training and experience that may have been acquired in a family practice residency, in a post-residency fellowship program, in a special course, or by practice experience.

Source: American Academy of Family Physicians

These categories would include listings of procedures that can be performed in each category.

Developing Privileging Criteria for New Procedures

Examples of when it is necessary include:

- New technology or procedure
- New service added to hospital
- New specialist

Process for developing criteria is:

- Determine what the specialty organization or manufacturer recommends for education/training or experience.
- Decide what specialties qualify and if any monitoring or proctoring is required.

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Activity 2.3 New Privilege Requests

- Discuss what you did when faced with a request for privileges for a procedure not already performed at your facility.
- List at least 3 issues that had to be considered.

Activity 2.4: New Privileges

- Using the information in the case study, with your groups complete the worksheet for consideration of new privileges.

Activity 2.4: New Privileges Case Study:

Your hospital wishes to begin offering balloon kyphoplasty. Products from the company, Kyphon, will be utilized for this procedure. Kyphon maintains a list of physicians who have been trained to use and are both active and proficient users of Kyphon's products. They are also willing to accept patient referrals. These physicians are listed in a searchable database on the Medtronic – Kyphon Web site. In order to appear in this database, physicians must have attended a didactic and hands on course by Kyphon in the use of Kyphx Inflatable Bone Tamp.

Subsequent to this training, the surgeon must complete proctoring by a company representative at the physician's facility. Orthopedic surgeons, neurosurgeons, neuroradiologists, and interventional radiologists, are eligible for this course of training. Proctorship for at least 10 cases is recommended.

An Internet search was unable to reveal any guidelines from specialty societies regarding this procedure. Using this information, complete the worksheet for Consideration of New Privileges.

Activity 2.4 Worksheet for Consideration of New Privilege

Name of procedure/privilege Balloon Kyphoplasty

Education required to request privilege (check all that apply)

☐ MD - Medical Doctor
☐ DO - Osteopathic Physician)
☐ DDS - Oral and Maxillofacial
☐ Surgeon DMD - Dentist
☐ DPM - Podiatrist
☐ APN – Advance Practice Nurse (specify specialty)____ PA – Other
☐ (specify) _____
☐
☐

Training Required:

Experience Required

Additional Requirements:

☐ CME ☐ Board Certification
☐ Manufacturer's Training Course/Certificate ☐ Peer Recommendations

Is monitoring or proctoring required?

☐ **No** ☐ **Yes**.

If yes, specify the following:

☐ Number of procedures ☐ Length of time _____
☐

In order to complete proctorship/monitoring requirements, the applicant must perform

_____(number) procedures within_____(time frame).

What type of review or follow up will be conducted?

Source for Form: Kathy Matzka, CPMSM, CPCS

Additional Types of Privileges

Telemedicine

Temporary Privileges

Locum Tenens

Emergency & Disaster Privileges

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Telemedicine Privileges

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status.

Examples:

- Teleneurology is a subcategory of neurology.
- Teleradiology is a subcategory of radiology.

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Telemedicine Privileges

- Originating site
  - The site where the patient is located at the time the service is provided.
- Distant site
  - The site where the practitioner providing the professional service is located.

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Why Use Telemedicine?

- Access to providers
  - Provide healthcare and services that would not be available otherwise
  - Specialty care consultations for isolated specialists, practitioners
- Eliminate expensive travel
- Reduce need to move patient
- Provide CME for isolated healthcare providers

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Temporary Privileges: TJC

When do TJC standards allow the granting of temporary privileges?

1) To fulfill an important patient care, treatment and service need.
2) When an applicant for *new privileges* with a complete application that raises no concerns is awaiting review and approval by the medical staff executive committee and the governing body.

Please note that *applicant for new privileges* includes:

- An individual applying for clinical privileges at the hospital for the first time;
- An individual currently holding clinical privileges who is requesting one or more additional privileges; and
- An individual who is in the reappointment/reprivileging process and is requesting one or more additional privileges.
- The file must be complete with no red flags

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Temporary Privileges: HFAP

Under what circumstances can Temporary Privileges be granted?

1) For care of specific patient(s)
2) During review and consideration of complete application waiting to go to MEC and the Board for final approval
3) For locum tenens
4) For times of emergency/disaster

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TEMPORARY PRIVILEGES: DNV

Under what circumstances can Temporary Privileges be granted?

- urgent patient care need; or
- application is complete without any negative or adverse information before action by the medical staff or governing body.

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ACTIVITY 2.5: TEMPORARY PRIVILEGE EXERCISE

- Review sample bylaws and scenario
- Discuss whether or not it is appropriate to grant temporary privileges
- Discuss what information needs to be verified to meet TJC standards and bylaws

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Activity 2.5 Temporary Privilege Exercise

Sample Bylaws Language for Temporary Privileges
Temporary privileges may be granted by the hospital CEO or designee on recommendation of the medical staff president or designee in the following circumstances:

Patient Care Need– In the case of a circumstance in which privileges are required to fulfill a patient care need, temporary privileges may be granted upon written request of the practitioner. Such privileges are limited to 180 days. Prior to granting of such privileges, documentation of the patient care need, verification of current licensure, current competency, and National Practitioner Data Bank will be obtained.

New Applicants – Upon receipt of a complete application (as described in section II.A) for medical staff appointment, including a request for specific temporary privileges, an applicant may be granted temporary privileges for a period not to exceed 120 days while awaiting approval of the application. In order to be eligible for temporary privileges, there must be no evidence of current or previously successful challenge to licensure or registration, involuntary termination of medical staff membership at another organization, involuntary limitation, reduction, denial, or loss of clinical privileges. Prior to granting temporary privileges, verification of the following must be obtained:

- Current licensure
- Relevant training or experience
- Current competence
- Ability to perform the privileges requested
- Query and evaluation of the NPDB information

Temporary Privileges Exercise

Scenario
You receive a phone call that an ophthalmologist on staff is in the military reserves and is being deployed. You have two other ophthalmologists on staff, but one is currently on maternity leave and will be returning in one month. There is an ophthalmologist in a neighboring town that has applied to your hospital, but the application is not complete. This doctor is willing to cover until the doctor on maternity leave returns.

Are temporary privileges allowed in a situation like this?

Locum Tenens

A medical practitioner who temporarily takes the place of another.

TJC does not recognize this term. Locum tenens would be considered Temporary Privileges.

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Hospital Leave of Absence

- Practitioner's current appointment cannot extend beyond the accrediting body standards – which may be 2 years or 3 years.
- Medical Staff Bylaws should outline the process for requesting a leave of absence
  - If the practitioner has been out for health reasons, then clearance from their physician may be needed.
  - If the practitioner has not been practicing medicine for a significant period, then several options can be considered before allowing the practitioner to return:
    - Appropriate CME
    - A mini-residency
    - Proctoring
- Consider the following when a practitioner is on a leave of absence when their reappointment is due:
  - Allow the reappointment to lapse and conduct full credentialing of the practitioner upon return to practice; or
  - Process the practitioner's reappointment during the leave of absence.

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Emergency & Disaster Privileges

Emergency Privileges allow physicians to perform tasks outside of their existing privileges to save a patient's life, limb, or organ.

Disaster Privileges can only be granted to volunteer licensed independent practitioners when the organization's Emergency Operations Plan has been activated.

When granting disaster privileges:

- Include documentation regarding the approval process in the facility's Emergency Operations Plan which should have an identified mechanism for oversight of volunteers.
- Requirements for credentialing should be defined in the bylaws and/or the entity Disaster Policy.
- Volunteers should only function within the scope of their license/certification.
- Ensure privileges are time limited.

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File Audits

- Help verify compliance with the requirements of bylaws, accrediting agencies, and state and federal regulations.
- Tools should include necessary documentation and completion within the required timeframe.
- Audit tools vary depending on the processes being audited.
- Must be in compliance with current accreditation standards.
- Audit for required timeframes, if applicable.

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Credentials File Audit Form for New Applicant

Name					
Item	**Present**	**Completed in Required Timeframe?**		**Not Present**	**Comments**
		Y	**N**		
Completed application					
Signed and dated attestation statement 365 days					
Verification of identity					
Malpractice insurance coversheet or date and amount of coverage on application					
Verification of medical/dental school					
Medicare/Medicaid sanction check 180 days					
Verification of board certification(s) 180 days					
Verification of residency(ies)					
Verification of fellowship(s)					
Verification of state license(s) 180 days					
Verification of state licensure sanctions 180 days					
CDS copy/NTIS/Documented visual inspection of the original certificate					
DEA copy/NTIS/Documented visual inspection of the original certificate					
ECFMG verification (if applicable)					
NPDB					
Completed clinical privilege request form(s)					
Peer recommendations					
Professional liability claims history 180 days					
5 year's work history on application or CV – 365 days. Signature or initials of staff who reviewed work history and the date of review present. Gaps exceeding six months must clarified. CV or application includes the beginning and ending month and year for each position in the practitioner's employment experience.					

Credentials File Audit Form for Reapplicant

Name					
Item	**Present**	**Completed in Required Timeframe?**		**Not Present**	**Comments**
		Y	**N**		
Completed application					
Signed and dated attestation statement 365 days					
Malpractice insurance coversheet or date and amount of coverage on application					
Medicare/Medicaid sanction check 180 days					
Verification of board certification(s) 180 days					
Verification of state license(s) 180 days					
Verification of state licensure sanctions 180 days					
CDS copy/NTIS/Documented visual inspection of the original certificate					
DEA copy/NTIS/Documented visual inspection of the original certificate					
NPDB					
Completed clinical privilege request form(s)					
Peer recommendations if there are insufficient practitioner-specific data available					
Professional liability claims history 180 days					
5 year's work history on application or CV – 365 days. Signature or initials of staff who reviewed work history and the date of review present. Gaps exceeding six months must clarified. CV or application includes the beginning and ending month and year for each position in the practitioner's employment experience.					
Documentation of CME					
Appointment does not exceed 2 years					

Database Audits

Best practices include:

- Run reports from credentialing database containing information. For example – you can run reports to be sure all licenses have expiration dates in there or that reappointment dates are not missing.
- Compare data from credentialing database with information from credentials file.
- Look for missing data.
- Correct discrepancies.
- Rerun report to verify accuracy.
- Run audits of who is accessing database to assure no breach in confidentiality.
- Utilize software capabilities to track errors and educate staff to increase accuracy.
- Develop a policy that includes how often you should perform these audits and who is responsible.

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NCQA Audit of Delegated Entity

- The organization remains accountable for credentialing and recredentialing its practitioners, even if it delegates all or part of these activities
- Delegated Agreement:
  - Is mutually agreed upon
  - Describes the responsibilities of the organization and delegated entity
  - Describes the delegated activities

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NCQA Audit of Delegated Entity

Delegated Agreement:

- Is mutually agreed upon
- Describes the delegated activities and responsibilities of the organization and delegated entity
- Requires at least semiannual reporting to the organization
- Describes the process by which the organization evaluates the delegated entity's performance
- Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement
- Organization retains the right to make the final decision

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ACTIVITY 2.6: RECREDENTIALING/REAPPOINTMENT

- Review the scenario
- Discuss and list options
- Pick one person from your table to report

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Activity 2.6: Recredentialing/Reappointment Scenarios

Scenario 1

Your hospital is accredited by The Joint Commission. There are two physicians, members of a large physician group, who have not submitted their reappointment application on time. As a result, the application will not be submitted for approval by the board of directors prior to their reappointment date. Both doctors are heavy admitters to the hospital. Discuss options.

Scenario 2

When completing the reappointment profile for your hospital, you found that there was one physician who had only five patient encounters during the last two years. Discuss options for evaluating competency for low volume practitioners.

Scenario 3

Your managed care organization is accredited by NCQA. When evaluating reapplication forms, you see that a provider included information regarding a recent licensure disciplinary action. This action did not occur in the state in which the applicant provides services to your members. Discuss appropriate follow-up.

Scenario 4

When you sent out the reappointment forms, you included a new privilege form. When comparing the new form to the current privileges, you see that the provider has requested additional privileges. What do you do?

Scenario 5

You are working at an NCQA-accredited MCO. During the recredentialing process, you receive documentation from the provider that she forgot to renew her DEA certificate on time, resulting in her not having a current DEA. What should you do?

Hospital Reappointment Process

Timeframe: not to exceed 2 years for TJC and HFAP
Submit an application that meet requirements

Applications must include:

- Primary Source Verification
- CME
- Competency evaluation (related to privileges):
  - For LIPs: OPPE/quality monitoring
  - Non-LIPs brought to the hospital by LIPs– performance evaluation at same interval as employees in same discipline (TJC)
  - Peer recommendations
- Approval process: same as initial application

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Hospital Reappointment Process

Timeframe: 3 years for DNV unless defined by State law
Submit an application that meets requirements

Applications must include:

- Primary Source Verification
- Review of involvement in any professional liability action
- Receipt of database profiles from NPDB, and Medicare/Medicaid Exclusions
- CME, at least in part related to their clinical privileges
- Review of individual performance data for variation from benchmark.
  - Variation shall go to Peer Review for determination of validity, written explanation of findings and, if appropriate, an action plan to include improvement strategies
- Approval process: same as initial application

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Ambulatory Health Care Recredentialing Process

Timeframe: not to exceed 3 years for AAAHC

- Submit an updated application and signed attestation that meets requirements
- Primary or secondary source verifications
- NPDB query required
- Competency evaluation (related to privileges):
- Peer recommendations
- Review and decision-making process same as initial application

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Managed Care Recredentialing Process

- Timeframe: at least every 3 years for NCQA and URAC
- Submit an updated application and signed attestation that meets requirements
- Primary or approved (NCQA) source verification
- Review and decision-making process same as initial credentialing

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Continuing Medical Education (CME)

Educational activities to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession.

CME is not educational activities which respond to a physician's non-professional educational need or interest, such as personal financial planning or appreciation of literature or music.

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CME Examples

Examples of AMA PRA Category I

- Live Activities
- Enduring Materials
- Journal-Based CME
- Test Item Writing
- Manuscript Review
- Performance Improvement (PI-CME)
- Internet Point of Care (POC) Learning
- Other (Introduced in 2017)

Examples of AMA PRA Category II

- Teaching physicians, residents, medical students or other health professionals
- Unstructured online searching and learning (i.e., not Internet PoC)
- Reading authoritative medical literature
- Consultation with peers and medical experts small group discussions
- Self assessment activities
- Medical writing
- Preceptorship participation
- Research
- Peer review and quality assurance participation

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CME Requirements

TJC and HFAP
- Specialty specific
- Required at reappointment / reprivileging

DNV
- Required participation in CME that is at least, in part, related to their clinical privileges
- Action is withheld until the information is available and verified

The Joint Commission allows documentation of attendance in several different ways, including but not limited to:
- Obtaining copies of program certificates
- Obtaining a copy of the information submitted with a license renewal application when CMEs are required by the state
- Obtaining an attestation statement from the LIP that attests to his/her attendance at CME programs related to their area of practice, with the stipulation that proof of attendance and program content upon request

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Provider Directories

Managed Care

Ensure that listings are consistent with credentialing data including education, training, certification, and specialty

Hospital

Patients and staff need to have current information
Need current listings for contracted insurance plans

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Module 2: Credentialing and Privileging Post-Test

1. Which of the following bodies approves clinical privileges?

   a. Credentials Committee
   b. Peer Review Committee
   c. Governing Body or Board

2. Which of the following credentials must be tracked on an ongoing basis?

   a. Medical school completion
   b. Closed medical malpractice claims
   c. Licensure

3. Which of the following term describes a step-by-step sequence for proper completion of a task?

   a. Policy.
   b. Procedure.
   c. Bylaws.

4. The Joint Commission hospital standards require that clinical privileges are hospital specific and

   a. Based on the individual's demonstrated current competence and the procedures the hospital can support.
   b. Based on board certification.
   c. Based on the privileges the individual is currently approved to perform at other hospitals.

5. In a Joint Commission accredited hospital, applications for initial appointment to the medical staff must be acted on:

   a. within 90 days after the medical staff office receives the application
   b. as specified in the medical staff by laws
   c. within 30 days of receipt of a completed application

6. Peer references should be obtained from:

   a. Practitioners who have referred patients to the provider
   b. Former hospital administrators
   c. Practitioners in the same professional discipline as the applicant

7. When developing clinical privileging criteria, which of the following is important to evaluate?

   a. The number of providers in that specialty.
   b. Established standards of practice such as, specialty board recommendations.
   c. Whether or not the quality department can support the FPPE process.

8. When credentialing and privileging practitioners it is appropriate to:

   a. Handle each applicant on a case-by-case basis.
   b. Follow a routine process for each applicant.
   c. Give preferential treatment to those providers whose specialty is primary care.

9. The governing body delegates the task of credentialing, recredentialing, and privileging to

   a. The hospital administrator
   b. The medical staff office
   c. The medical staff

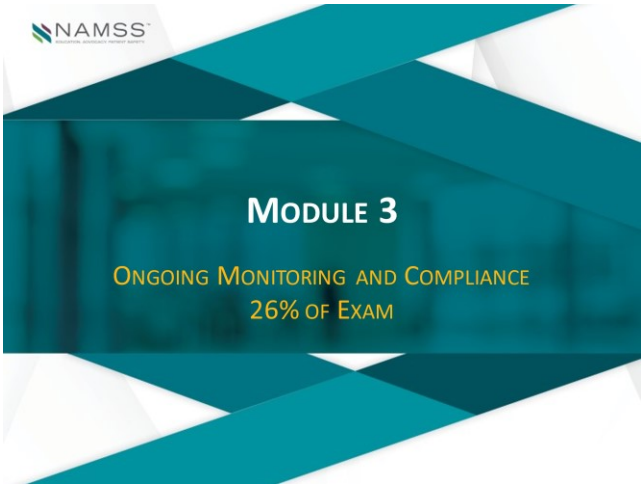
10. What is the only hospital medical staff committee required by The Joint Commission hospital standards?

   a. Credentials committee
   b. Medical executive committee
   c. Pharmacy and therapeutics committee

Additional Study Worksheet

Test Area: Credentialing and Privileging

Topics for Further Study:


NAMSS
MODULE 3
ONGOING MONITORING AND COMPLIANCE
26% OF EXAM

Module 3: Ongoing Monitoring and Compliance Pre-Test

1. If a medical staff member has privileges and/or medical staff appointment revoked, he/she must be:

    a. Granted temporary privileges.
    b. Provided due process.
    c. Reported immediately to the national practitioner databank.

2. According to NCQA standards, an organization that discovers sanction information, complaints, or adverse events regarding a practitioner must take what action?

    a. Determine if there is evidence of poor quality that could affect the health and safety of its members.
    b. Immediately take action to remove the provider from its panel.
    c. Initiate Ongoing Professional Practice Evaluation.

3. Why it is important to check that the practitioner is not currently excluded, suspended, debarred, or ineligible to participate in Federal health care programs?

    a. A facility could lose its accreditation if it does not do so.
    b. It is required by Medicare Conditions of Participation.
    c. The facility won't get paid for treating patients unless service is provided by authorized provider.

4. To whom does the AAAHC give the responsibility for approving and ensuring compliance with policies and procedures related to credentialing, quality improvement, and risk management?

    a. Medical staff
    b. Credentials committee
    c. Governing Body

5. Which body has the obligation to the community to assure that only appropriately educated, trained and currently competent practitioners are granted medical staff membership and clinical privileges?

    a. Medical Staff
    b. Governing Body
    c. The Joint Commission on Accreditation of Healthcare Organizations

6. Changes in medical staff bylaws are not final until formally approved by the:

    a. Medical staff
    b. Medical staff president
    c. Governing Body

7. The Healthcare Quality Improvement Act:

    a. Provides immunity for health care entities that do not report information to the National Practitioner Data Bank.
    b. Keeps hospitals and physicians who perform peer review from being sued.
    c. Provides qualified immunity from antitrust liability arising out of peer review activities that are conducted in good faith.

8. Which term describes the mechanism by which an aggrieved practitioner, one who has been the recipient of disciplinary action, is entitled to be heard and to appeal an adverse decision?

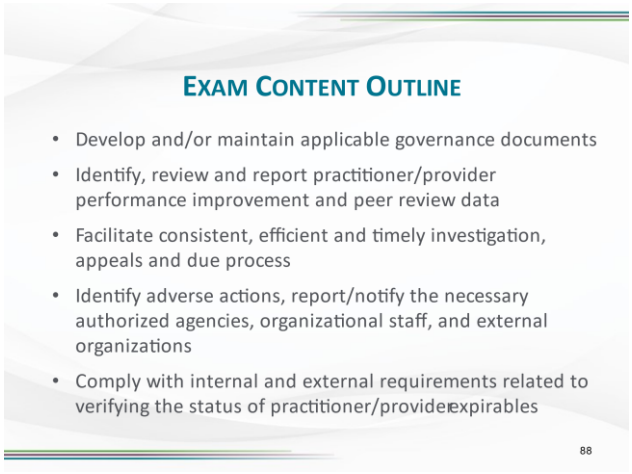
    a. medical staff executive committee
    b. procedural rights or fair hearing
    c. corrective action

9. Hospital credentialing is driven by accreditation standards, regulatory requirements, medical staff bylaws, rules & regulations as well as

    a. the religious affiliation of the hospital.
    b. the standard of care.
    c. the composition of the medical staff.

10. In a credentials verification organization, the documents that describe the credentialing function are:

    a. Bylaws
    b. Rules and Regulation
    c. Policies and Procedures



Module 3 Exam Content Outline

- Develop and/or maintain applicable governance documents that support and direct organizational practices and that comply with regulatory requirements, accreditation standards, managed care requirements, and organizational policies and procedures.
- Identify, review and report practitioner performance data, complaints, sanctions, adverse actions, and quality of care issues in order to facilitate analysis by the appropriate organizational leadership to enable evaluation of current/ongoing practitioner competency or network participation.
- Facilitate consistent, efficient and timely investigation, appeals, and due process to comply with an organization's corrective action, fair hearing, and appeals policies as well as applicable legal and regulatory requirements.
- Identify adverse actions taken against a practitioner/provider and appropriately report/notify the necessary authorized agencies, organizational staff, and external organizations in accordance with applicable law and contractual requirements.
- Comply with internal and external requirements related to verifying and reporting the status of practitioner/provider expirables by querying approved sources and recommending action(s) to medical staff and/or organizational leadership based upon bylaws and policies/procedures.

CHECKING FOR SANCTIONS: WHY IS THIS IMPORTANT?

- Required for corporate compliance
- Maintains eligibility for Medicare, Medicaid and other federally funded programs
- Protects your patients, staff and organization's reputation
- Avoids Civil Monetary Penalties (CMPs)
- You should be checking with the state licensing boards, available state Medicaid exclusion lists, NPDB, the DEA, OIG and SAM.

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VERIFYING EXPIRABLES – WHY IS THIS IMPORTANT?

1. Validate current credential and disciplinary action
2. Ensure ongoing eligibility with the organization – meet bylaws requirements
3. Meet accreditation and regulatory requirements

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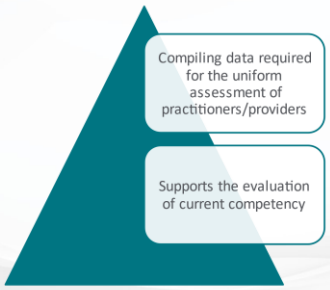
PERFORMANCE MONITORING



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Professional Practice Evaluation Credentialing Report

Provider: **Sample**
Facility: **Sample Medical Center**
Comparison Group: **IM-Cardiovascular-Cardiovascular Surgery**
Report Period: **Last 24 months (07/01/2014 - 06/30/2016)**
Report Date: **09/08/2016**

Volumes

Volume (Group Volume)	Admit	Attending	Consult	Emergency	Surgeon
Inpatient	193 (1,131)	273 (1,509)	91 (439)	1 (4)	325 (1,617)
Outpatient - Ambulatory Surgeries/Procedures	4 (226)	4 (227)	20 (56)		
Outpatient - Observation	2 (22)	2 (22)			
Emergency - Charge Code	18 (112)	50 (265)	35 (210)	1 (4)	49 (284)

CaseMix/Utilization

	Provider Measure	Provider Cases	Comparison Measure	Comparison Cases
Case Mix Index - Total Inpatient	5.0	273	4.0	1,509
Case Mix Index - Outpatient	0.3	4	0.6	191
% of Discharges with Severity of Illness - Minor	9.2%	273	16.4%	1,508
% of Discharges with Severity of Illness - Moderate	36.3%	273	38.9%	1,508
% of Discharges with Severity of Illness - Major	28.6%	273	24.3%	1,508
% of Discharges with Severity of Illness - Extreme	26.0%	273	20.4%	1,508
Average Inpatient Length of Stay by Severity of Illness - Minor	4.2	25	4.2	248
Average Inpatient Length of Stay by Severity of Illness - Moderate	6.4	99	6.1	587
Average Inpatient Length of Stay by Severity of Illness - Major	8.4	78	8.1	366
Average Inpatient Length of Stay by Severity of Illness - Extreme	15.4	71	18.1	307
Number of Cryoprecipitate units transfused		110		695
The ratio of total number of RBC/WB units crosmatched to the total number of RBC/WB units transfused	2.4	102	3.5	708
Number of fresh frozen plasma units transfused		116		715
Number of platelet units transfused		45		337
Number of red blood cell units transfused		102		708
Number of red blood cells and whole blood units crossmatched		240		2,511
Number of red blood cells and whole blood units transfused		102		708
Number of total blood units transfused		373		2,455
Number of whole blood units transfused		0		0

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Mortality

	Provider Measure	Provider Cases	Comparison Measure	Comparison Cases
Acute Inpatient Mortality ↓	3.7%	273	3.6%	1,509
Total Inpatient Mortality ↓	3.7%	273	3.6%	1,509
Mortality Rate by Risk of Mortality - Minor ↓	0.0%	50	0.0%	524
Mortality Rate by Risk of Mortality - Moderate ↓	0.0%	89	0.5%	414
Mortality Rate by Risk of Mortality - Major ↓	1.5%	66	2.9%	280
Mortality Rate by Risk of Mortality - Extreme ↓	13.2%	68	15.5%	290
% of Discharges with Risk of Mortality - Minor	18.3%	273	34.7%	1,508
% of Discharges with Risk of Mortality - Moderate	32.6%	273	27.5%	1,508
% of Discharges with Risk of Mortality - Major	24.2%	273	18.6%	1,508
% of Discharges with Risk of Mortality - Extreme	24.9%	273	19.2%	1,508

Clinical Quality

	Provider Measure	Provider Cases	Comparison Measure	Comparison Cases
Core Measures Composite	%	295	%	937
All-Cause Inpatient Readmission attributed to the attending of record, within 30 days of discharge date. ↓	11.5% +2	209	9.5%	1,181
All-Cause Inpatient Planned Readmission attributed to the attending of record, within 30 days of discharge date. ↓	100.0%	4	100.0%	7
All-Cause Inpatient Unplanned Readmission attributed to the attending of record, within 30 days of discharge date. ↓	10.2%	206	9.1%	1,177
All-Cause Inpatient Readmission attributed to the primary surgeon of record as defined by case-mix. ↓	10.5%	229	10.2%	1,172
All-Cause Inpatient Planned Readmission attributed to the primary surgeon of record as defined by case-mix. ↓	100.0%	3	100.0%	5
All-Cause Inpatient Unplanned Readmission attributed to the primary surgeon of record as defined by case-mix. ↓	9.7%	227	9.8%	1,169

Acute Myocardial Infarction Core Measures

	Provider Measure	Provider Cases	Comparison Measure	Comparison Cases
AMI-1:Aspirin Given at Arrival ↑	100.0%	1	100.0%	4
AMI-2: Aspirin Prescribed at Discharge ↑	100.0%	10	100.0%	39
AMI-3: ACE Inhibitors for LVSD ↑	100.0%	1	0.0%	0
AMI-5: Beta Blocker Prescribed at Discharge ↑	100.0%	9	100.0%	36
AMI-10: Statin Prescribed at Discharge ↑	100.0%	10	100.0%	38

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Heart Failure Core Measures

	Provider Measure	Provider Cases	Comparison Measure	Comparison Cases
CHF-1: Discharge Instructions ↑	100.0%	1	100.0%	6
CHF-2: LVF Assessment ↑	100.0%	2	100.0%	8
CHF-3: ACE Inhibitors for LVSD ↑	100.0%	1	100.0%	1

Surgical Care Improvement Core Measures

	Provider Measure	Provider Cases	Comparison Measure	Comparison Cases
SCIP-1a: Prophylactic antibiotic received within one hour prior to surgical incision - overall rate ↑	98.2%	55	94.7%	152
SCIP-2a: Prophylactic antibiotic selection for surgical patients - overall rate ↑	100.0%	55	98.0%	152
SCIP-3a: Prophylactic antibiotics discontinued within 24 hours after surgery end time - overall rate ↑	100.0% +2	52	97.3%	147
SCIP-4: Cardiac Surgery Patients With Controlled 6 A.M. Postoperative Serum Glucose ↑	78.6%	14	86.2%	29
SCIP-6: Surgery Patients with Appropriate Hair Removal ↑	100.0%	65	100.0%	203
SCIP-9: Surgical patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day ↑	100.0%	11	100.0%	53

Satisfaction

	Provider Measure	Provider Cases	Comparison Measure	Comparison Cases
How often did the doctor explain things in a way you could understand? (% Always - HCAHPS) ↑	83.3%	54	80.1%	276
How often did the doctor treat you with courtesy and respect (% Always - HCAHPS) ↑	100.0% +4	54	90.6%	276
How often did the doctor listen carefully to you? (% Always - HCAHPS) ↑	94.4% +3	54	87.7%	276

Peer Review

	Provider Measure	Provider Cases	Comparison Measure	Comparison Cases
Peer Review - Total		13		87
Peer Review - Appropriate ↑	100.0%	13	96.6%	87
Peer Review - Inappropriate ↓	0.0%	13	2.3%	87
Peer Review - Controversial ↓	0.0%	13	1.1%	87
Peer Review - Questionable ↓	0.0%	13	0.0%	87

Note: Arrows appear next to names of measures where provider's performance is statistically compared with their group's performance. "Up" arrows indicate that higher numbers are better, "Down" arrows indicate that lower numbers are better. Flags may appear on those measures to indicate how many Group standard deviations the Provider Measure is from the Group Measure. For example a '+3' flag indicates that the Provider Measure is over three Group standard deviations from the Group Measure (but is within four standard deviations).

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Medical Records Compliance

	Provider Measure	Provider Cases	Comparison Measure	Comparison Cases
History and Physical Delinquency		0		0
Post Procedure Dictation		0		0

Facility Specific Measures

	Provider Measure	Provider Cases	Comparison Measure	Comparison Cases
All Cause 30 Day Readmissions	12.9%	263	9.4%	1,416
Blood: CRYO Units Transfused		110		695
Postoperative PE or DVT (Modified AHRQ Outcome Measure)	2.9%	243	0.7%	1,326
Unplanned Readmission Within 30 Days ↓	11.4% +3	263	8.9%	1,416
Unplanned Return to OR within 30 Days ↓	2.3% +3	307	1.3%	1,668

Note: Arrows appear next to names of measures where provider's performance is statistically compared with their group's performance. "Up" arrows indicate that higher numbers are better, "Down" arrows indicate that lower numbers are better. Flags may appear on those measures to indicate how many Group standard deviations the Provider Measure is from the Group Measure. For example a '+3' flag indicates that the Provider Measure is over three Group standard deviations from the Group Measure (but is within four standard deviations).

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Volumes by APRDRG

APRDRG Code	APRDRG Description	Total	Inpatient	Outpatient
163	Cardiac valve procedures w/o cardiac catheterization	81	81	
165	Coronary bypass w cardiac cath or percutaneous cardiac procedure	49	49	
166	Coronary bypass w/o cardiac cath or percutaneous cardiac procedure	42	42	
162	Cardiac valve procedures w cardiac catheterization	34	34	
167	Other cardiothoracic procedures	15	15	
24	Extracranial vascular procedures	13	13	
710	Infectious & parasitic diseases including hiv w o.r. procedure	6	6	
175	Percutaneous cardiovascular procedures w/o ami	5	5	
143	Other respiratory diagnoses except signs, symptoms & minor diagnoses	4	3	1
169	Major thoracic & abdominal vascular procedures	4	4	
4	Tracheostomy w mv 96+ hours w extensive procedure or ecmo	3	3	
197	Peripheral & other vascular disorders	3	2	1
791	O.r. procedure for other complications of treatment	2	2	
813	Other complications of treatment	2	2	
2	Heart &/or lung transplant	1	1	
120	Major respiratory & chest procedures	1	1	
173	Other vascular procedures	1	1	
180	Other circulatory system procedures	1	1	
191	Cardiac catheterization w circ disord exc ischemic heart disease	1		1
198	Angina pectoris & coronary atherosclerosis	1	1	
200	Cardiac structural & valvular disorders	1	1	
201	Cardiac arrhythmia & conduction disorders	1	1	
206	Malfunction, reaction, complication of cardiac/vasc device or procedure	1		1
346	Connective tissue disorders	1	1	
420	Diabetes	1	1	
711	Post-op, post-trauma, other device infections w o.r. procedure	1	1	
721	Post-operative, post-traumatic, other device infections	1	1	
951	Moderately extensive procedure unrelated to principal diagnosis	1	1	

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Procedure Code	Procedure Description	Total	Inpatient	Outpatient	Emergency
	approach				
4A023N8	Measurement of cardiac sampling and pressure, bilateral, percutaneous approach	6	6		
025S0ZZ	Destruction of right pulmonary vein, open approach	5	5		
35.33	Annuloplasty	5	5		
5A1955Z	Respiratory ventilation, greater than 96 consecutive hours	5	5		
96.71	Continuous mechanical ventilation for less than 96 consecutive hours	5	5		
B2111ZZ	Fluoroscopy of multiple coronary arteries using low osmolar contrast	5	5		
B24BZZ4	Ultrasonography of heart with aorta, transesophageal	5	5		
021009W	Bypass coronary artery, one site from aorta with autologous venous tissue, open approach	4	4		
02100A9	Bypass coronary artery, one site from left internal mammary with autologous arterial tissue, open approach	4	4		
02BG0ZZ	Excision of mitral valve, open approach	4	4		
02RF3JZ	Replacement of aortic valve with synthetic substitute, percutaneous approach	4	4		
02RG38Z	Replacement of mitral valve with zooplastic tissue, percutaneous approach	4	4		
02RJ08Z	Replacement of tricuspid valve with zooplastic tissue, open approach	4	4		
35.06	Trnspd rep aortic valve	4	4		
35.12	Open heart valvuloplasty of mitral valve without replacement	4	4		
35.24	Opn/nec rep mitral valve	4	4		
39.31	Suture of artery	4	4		
5A1945Z	Respiratory ventilation, 24-96 consecutive hours	4	4		
99.62	Other electric countershock of heart	4	4		
00.96	Nfsn 4fctr prthmb cmplx	3	3		
0212093	Bypass coronary artery, three sites from coronary artery with autologous venous tissue, open approach	3	3		
025T0ZZ	Destruction of left pulmonary vein, open approach	3	3		
02RW0JZ	Replacement of thoracic aorta with synthetic substitute, open approach	3	3		
0JPT0PZ	Removal of cardiac rhythm related device from trunk subcutaneous tissue and fascia, open approach	3	3		
34.01	Incision of chest wall	3	3		
34.1	Incision of mediastinum	3	3		
36.99	Other operations on vessels of heart	3	3		
37.11	Cardiotomy	3	3		
88.72	Diagnostic ultrasound of heart	3	3		
96.72	Continuous mechanical ventilation fro 96 consecutive hours or more	3	3		
02580ZZ	Destruction of conduction mechanism, open approach	2	2		
027034Z	Dilation of coronary artery, one site with drug-eluting intraluminal device, percutaneous approach	2	2		
02BM0ZZ	Excision of ventricular septum, open approach	2	2		
02C00ZZ	Extirpation of matter from coronary artery, one site, open approach	2	2		
02RF0JZ	Replacement of aortic valve with synthetic substitute, open approach	2	2		
02RF38H	Replacement of aortic valve with zooplastic tissue, transapical, percutaneous approach	2	2		
02UJ0JZ	Supplement tricuspid valve with synthetic substitute, open approach	2	2		
02YA0Z0	Transplantation of heart, allogeneic, open approach	2	2		
03CJ0ZZ	Extirpation of matter from left common carotid artery, open approach	2	2		
03CK0ZZ	Extirpation of matter from right internal carotid artery, open approach	2	2		

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34.1	Incision of mediastinum	3	3		
36.99	Other operations on vessels of heart	3	3		
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02C00ZZ	Extirpation of matter from coronary artery, one site, open approach	2	2		
02RF0JZ	Replacement of aortic valve with synthetic substitute, open approach	2	2		
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02UJ0JZ	Supplement tricuspid valve with synthetic substitute, open approach	2	2		
02YA0Z0	Transplantation of heart, allogeneic, open approach	2	2		
03CJ0ZZ	Extirpation of matter from left common carotid artery, open approach	2	2		
03CK0ZZ	Extirpation of matter from right internal carotid artery, open approach	2	2		

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Procedure Code	Procedure Description	Total	Inpatient	Outpatient	Emergency
03HB33Z	Insertion of infusion device into right radial artery, percutaneous approach	2	2		
05HM33Z	Insertion of infusion device into right internal jugular vein, percutaneous approach	2	2		
06BQ3ZZ	Excision of left greater saphenous vein, percutaneous approach	2	2		
0HD5XZZ	Extraction of chest skin, external approach	2	2		
0J960ZZ	Drainage of chest subcutaneous tissue and fascia, open approach	2	2		
0P800ZZ	Division of sternum, open approach	2	2		
0W3C0ZZ	Control bleeding in mediastinum, open approach	2	2		
34.09	Other incision of pleura	2	2		
35.72	Other and unspecified repair of ventricular septal defect	2	2		
37.12	Pericardiotomy	2	2		
37.31	Pericardiectomy	2	2		
37.34	Endovsc exc/des tis hrt	2	2		
37.61	Implant of pulsation balloon	2	2		
39.57	Repair of blood vessel with synthetic patch graft	2	2		
39.65	Extracorporeal membrane oxygenation (ecmo)	2	2		
4A023N7	Measurement of cardiac sampling and pressure, left heart, percutaneous approach	2	2		
5A1223Z	Performance of cardiac pacing, continuous	2	2		
86.04	Other incision with drainage of skin and subcutaneous tissue	2	2		
88.56	Coronary arteriography using two catheters	2	2		
89.68	Monitoring cardiac output by other technique	2	2		
96.04	Insertion of endotracheal tube	2	2		
B246ZZ4	Ultrasonography of right and left heart, transesophageal	2	2		
00.41	Proc on 2 vessels	1	1		
00.46	Insrt 2 vasc stents	1	1		
00.66	Prq trnsl cor angioplsty	1	1		
0210099	Bypass coronary artery, one site from left internal mammary with autologous venous tissue, open approach	1	1		
0210Z8	Bypass coronary artery, one site from right internal mammary, open approach	1	1		
0210Z9	Bypass coronary artery, one site from left internal mammary, percutaneous endoscopic approach	1	1		
0211093	Bypass coronary artery, two sites from coronary artery with autologous venous tissue, open approach	1	1		
0211Z9	Bypass coronary artery, two sites from left internal mammary, open approach	1	1		
021149W	Bypass coronary artery, two sites from aorta with autologous venous tissue, percutaneous endoscopic approach	1	1		
0213093	Bypass coronary artery, four or more sites from coronary artery with autologous venous tissue, open approach	1	1		
0213Z9	Bypass coronary artery, four or more sites from left internal mammary, open approach	1	1		
02560ZZ	Destruction of right atrium, open approach	1	1		
02570ZZ	Destruction of left atrium, open approach	1	1		
02584ZZ	Destruction of conduction mechanism, percutaneous endoscopic approach	1	1		
02CQ0ZZ	Extirpation of matter from right pulmonary artery, open approach	1	1		
02CR0ZZ	Extirpation of matter from left pulmonary artery, open approach	1	1		
02HK3JZ	Insertion of pacemaker lead into right ventricle, percutaneous approach	1	1		
02JA0ZZ	Inspection of heart, open approach	1	1		

Assessing Current Competency

- Proficiency requires practice
- High-risk procedures
- Use both internal and external sources to assess competency
- Assess low-volume practitioners
- Consider impact of age on competency

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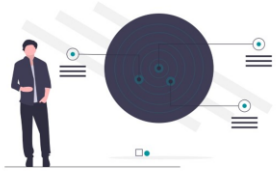
Low/No Volume Practitioner Data

- Peer recommendations
- Data from other facilities
- Procedure logs



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Age-Related Competency

- Applicants should be asked to document their ability to exercise the privileges requested safely with or without reasonable accommodation.
- The Americans with Disabilities Act (ADA) is a federal civil rights law that prohibits discrimination based on disability and bars discrimination against a qualified individual due to the disability.
- When discussing the issue of the aging provider, it is essential to maintain compliance with state and federal law related to age discrimination.
- The Joint Commission standards require that the hospital evaluate the health status of physicians who exercise or seek to exercise clinical privileges or other health care services.

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Compiling Data - Hospital

- Performance appraisals or annual evaluation by supervisor
- 360-degree feedback tool
- Information regarding any rewards, recognition or compliment letters received
- KPIs
  - Department specific indicators
  - Hospital-wide indicators

95

Compiling Data - Hospital

Comparative Reports

- Physician profiles to evaluate data, compare to benchmark data and compare to others (contents, timeframes, action)

Specific Practitioner Feedback

- Provide performance data on a routine basis to each physician

TJC, HFAP & CMS Ongoing Professional Practice Evaluation (OPPE)

96

Performance Monitoring

FPPE – Focused Professional Practice Evaluation

- HFAP and TJC requires focused reviews for all initial requests for privileges (all new applicants or current applicants requesting new privileges).
- Focused reviews for potential problematic areas for a current provider.

OPPE - Ongoing Professional Practice Evaluation

- HFAP and TJC requires ongoing monitoring of professional practice to assure competency.
- The results of the ongoing monitoring are reviewed at reappointment along with the other information gathered in the Medical Staff office.

QR or PI – Quality Review or Performance Improvement Programs

- Involved in both FPPE and OPPE.
- Typically set up monitoring criteria– such as unanticipated return to the operating rooms or infection rates and these will be applied to all practitioners. This will be reviewed in further detail later in the module.

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FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

Evaluates the privilege -specific competence of a practitioner who does not have documented evidence at your organization, including:

1) Newly appointed practitioners;
2) New privilege(s) granted; or
3) When questions concerning competence are raised.

Data may be collected through any of the following methods: concurrent or retrospective chart reviews, monitoring clinical practice patterns, simulation, proctoring, external peer review, or discussions with peers.

FPPE is time -limited.

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ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

Allows the organization to identify professional practice trends that impact quality of care and patient safety.

Ongoing is generally defined as more than once per year, most organizations perform evaluations every 68 months.

Criteria should include:

- Operative and other clinical procedures performed and outcomes
- Length of stay patterns
- Morbidity and mortality data
- Pattern of blood and pharmaceutical usage
- Requests for tests and procedures
- Practitioner's use of consultants
- Other relevant criteria as determined by medical staff

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ACTIVITY 3.1: COMPILING DATA FOR HOSPITALS

- Refer to the Professional Practice Evaluation Credentialing Report.
- Discuss the questions in Activity 3.1.
- Materials are in your Participant Guide.

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Activity 3.1 Compiling Data for Hospitals

1. What is a benchmark?

2. Can someone identify a benchmark on the example?

3. In looking at the data for % of Discharges with Severity of Illness – Extreme on Page 53, how does the physician compare?

4. In looking at the data for Average Inpatient Length of Stay by Severity of Illness – Extreme on Page 53, how does the physician compare?

5. In looking at data for Total Inpatient Mortality on page 54, how does the physician compare?

6. What do all three of these indicators point to?

7. In looking at Surgical Care Improvement Core Measures where is the provider below the benchmark?

Roles in Documenting Competency (Hospital)

Practitioner	Maintain and document competency
MSP	Assure documentation is evident to verify the defined criteria are met
Medical Staff	Define the criteria used to determine competency
MEC	Review information, make informed decision regarding the privileges requested, make recommendation to the board
Governing Body	Review medical staff recommendations and make final decision

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Roles in Documenting Competency (Managed Care)

Practitioner	Maintain and document competency
MSP	Assure documentation is evident to verify health plan's criteria are met
Medical Director	Reviews and approves clean files if granted authority by Credentialing Committee
Credentialing Committee	Reviews files that do not meet established criteria and make final decision

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Compiling Data (MCOs)

- NCQA requires a process for monitoring practitioner sanctions, complaints and adverse events.
- Mechanisms for investigating individual complaints (including complaint history) upon receipt and review history of complaints for all practitioners at least every 6 months.
- Collecting and reviewing information from identified adverse events at least every 6 months.
- Implementing appropriate interventions when instances of poor quality are identified.

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Due Process

Course of formal proceedings carried out regularly, fairly, and in accordance with established rules and principles.

Purpose: to facilitate efficient and timely due process that complies with an organization's corrective action, fair hearing, and appeals policies as well as applicable legal and regulatory requirements.

Healthcare Quality Improvement Act of 1986 (HCQIA): provides immunities for peer review participants that deal with "professional review actions" and follow stringent rules and principles.

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Two Elements of Due Process

Substantive	Proof that an adverse recommendation concerning a medical staff appointee is reasonable and not arbitrary, capricious, or discriminatory
Procedural	Adherence to procedural guidelines

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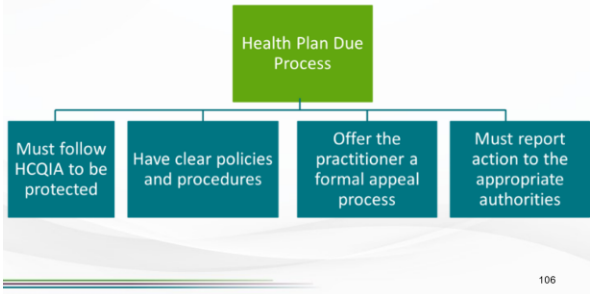
Health Plan & Provider Organization Due Process



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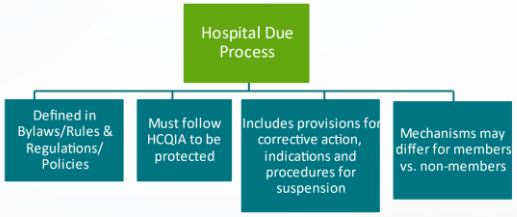
Hospital Due Process



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Fair Hearing

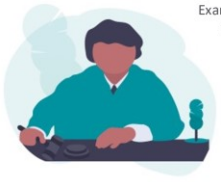
Governing documents must include:

- Process for scheduling hearings and appeals
- Process for conducting hearings and appeals
- Composition of the fair hearing panel

A fair hearing is a formal proceeding at which evidence and arguments are presented on the matter to a person or body having decision-making authority.

Fair Hearing

Requested by provider after an adverse recommendation is made.



Examples of adverse recommendations based on quality:

- deny or terminate an applicant's request for initial appointment, reappointment or clinical privileges
- restrict and/or suspend all, or some, of a practitioner's clinical privileges for more than 30 days, and/or
- require a practitioner to obtain a consultation from a consultant whose approval is required in order for the practitioner to proceed with clinical care for more than 30 days.

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HCQIA Due Process Policies and Procedures

1) Written notification when a professional review action has been brought against a practitioner and the reasons for the action.
2) A summary of the hearing rights and process; ability to request a hearing and the specific time period for submitting the request.
3) Allowing for at least 30 calendar days after the notification for practitioners to request a hearing; allowing representation by an attorney or another person.
4) Statement providing consequences if failing to request a hearing.

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HCQIA Due Process Policies and Procedures

5) The organization shall promptly schedule and arrange for a hearing
6) Proper notification to the practitioner of at least 30 days prior to hearing
7) Include a summary of the Practitioner's hearing rights, list of witnesses and documents
8) Appointment of a hearing officer or a panel of individuals to review the evidence
9) Written notification of the decision that contains specific reasons for the decision

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Appeal

Formal request to the Board by a practitioner for reconsideration of an adverse action

Hearing and appeals process must comply with Healthcare Quality Improvement Act (HCQIA)

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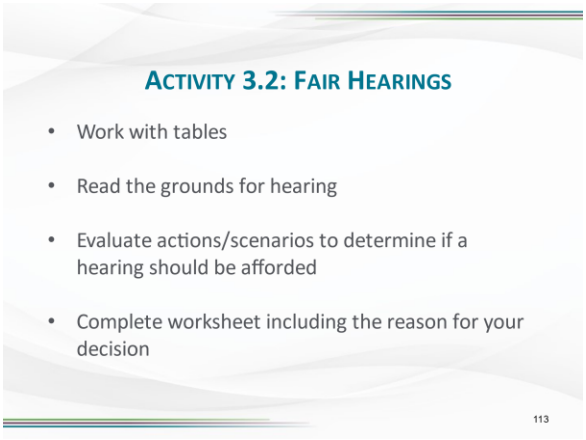

Activity 3.2 Determining if Grounds for Hearing Exist

Sample Language from Fair Hearing Plan

Grounds for Hearing
An individual is entitled to request a hearing whenever the MEC makes one of the following recommendations:

- denial of initial appointment to the Medical Staff (exception: It is determined that the applicant does not meet appointment criteria);
- denial of reappointment to the Medical Staff;
- revocation of appointment to the Medical Staff;
- denial of requested clinical privileges (exception: It is determined that the applicant does not meet privileging criteria;
- revocation of clinical privileges;
- suspension of clinical privileges for more than 30 days; or
- mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance).

Scenarios

1. A new medical staff applicant is recommended for approval by the Credentials Committee. After the Credentials Committee meets, but prior to the MEC meeting, it is discovered that the board that certified the applicant is not an ABMS or AOA member board as is required by the bylaws. The MEC does not recommend appointment.

   Should a hearing be afforded? Why, or why not?

2. Privileges are automatically suspended due to the applicant having a lapse in medical malpractice insurance.

   Should a hearing be afforded? Why, or why not?

3. A current medical staff appointee requests additional privileges. The MEC recommends denial of the request citing that there are already enough practitioners providing this service. The service has not been officially closed by action of the Board.

   Should a hearing be afforded? Why, or why not?

4. The MEC recommends denial of reappointment for a current applicant because she has not admitted any patients to the hospital in the past two years.

   Should a hearing be afforded? Why, or why not?

Federal and State Regulations

- Health care requirements are also spelled out in:
  - Federal Licensing Requirements (Medicare CoPs)
  - State Licensing Requirements
- Many other federal and state regulations that affect healthcare

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Activity 3.3: Healthcare Regulation

- Work with your table to match the legislation to the correct description.
- When you reach agreement, raise your hands.
- Designate someone from the table to report your results.

115

Activity 3.3: Federal Healthcare Regulatory Quiz

Match each regulation with the correct requirement.

Regulation	Requirement
1. Emergency Transfer and Active Labor Act (EMTALA)	
2. Healthcare Quality Improvement Act of 1986	
3. Americans with Disabilities Act (ADA)	
4. Sherman Anti-Trust Act	
5. Stark Law	
6. The Patient Safety and Quality Improvement Act of 2005	
7. The Civil Rights Act of 1964	
8. Patient Self-Determination Act	

Requirements:

A. Prohibits a physician who has a financial relationship with an entity from referring Medicare or Medicaid patients to that entity for the provision of a designated health service.

B. This act requires that patients be allowed to participate in treatment decisions including the use of advance directives.

C. Establishes a voluntary reporting system designed to enhance the data available to assess and resolve patient safety and health care quality issues.

D. This law was enacted in part to “enforce the constitutional right to vote, to prevent discrimination in federally assisted programs”. It applies to discrimination in the medical staff application process.

E. Purpose is to encourage good faith professional review activities.

F. Federal “anti-dumping” law to fight hospitals transferring, discharging, or refusing to treat indigent patients coming to the emergency department because of cost factors.

G. Federal law that prohibits discrimination based on disability and bars discrimination against a qualified individual due to the disability.

H. Provides that: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.”

Reporting Adverse Actions

- Types of reports
- Who makes report?
- What is included?
- Implications of making a report
- Implications of **not** making a report
- Reporting actions to internal personnel

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Exercise 3.4: Reporting Adverse Actions

1. Review the sample regulations and policy.
2. Review the six scenarios.
3. Determine if the hospital must submit a report.
4. If not, be prepared to explain why.

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Activity 3.4: Reporting Adverse Actions

Healthcare Quality Improvement Act of 1986

SEC. 423. [42 U.S.C. 11133**] REPORTING OF CERTAIN PROFESSIONAL REVIEW ACTIONS TAKEN BY HEALTH CARE ENTITIES.**

a) REPORTING BY HEALTH CARE ENTITIES. —
    1) ON PHYSICIANS. —Each health care entity which—
        a) takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30days;
        b) accepts the surrender of clinical privileges of a physician—
            i. while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct, or
            ii. in return for not conducting such an investigation or proceeding; or
        c) in the case of such an entity which is a professional society, takes a professional review action which adversely affects the membership of a physician in the society, shall report to the Board of Medical Examiners, in accordance with section 424(a), the information described in paragraph (3).

PART C—DEFINITIONS AND REPORTS SEC. 431. [42 U.S.C. 11151**] DEFINITIONS.**

In this title:

(1) The term "adversely affecting" includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.

(9) The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. In this title, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on—

a) the physician's association, or lack of association, with a professional society or association,
b) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business,
c) the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,
d) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or
e) any other matter than does not relate to the competence or professional conduct of a physician.

CODE OF VIRGINIA REPORTING REQUIREMENTS:
§ 54.1-2400.6. Hospitals, other health care institutions, assisted living facilities required to report disciplinary actions against and certain disorders of health professionals; immunity from liability; failure to report.

A. The chief executive officer and the chief of staff of every hospital or other health care institution in the Commonwealth and the administrator of every licensed assisted living facility in the Commonwealth shall report within 30 days, except as provided in subsection B, to the Director of the Department of Health Professions the following information regarding any person (i) licensed, certified, or registered by a health regulatory board or (ii) holding a multistate licensure privilege to practice nursing or an applicant for licensure, certification or registration unless exempted under subsection E:

1. Any information of which he may become aware in his official capacity indicating that such a health professional is in need of treatment or has been committed or admitted as a patient, either at his institution or any other health care institution, for treatment of substance abuse or a psychiatric illness that may render the health professional a danger to himself, the public or his patients.

2. Any information of which he may become aware in his official capacity indicating, after reasonable investigation and consultation as needed with the appropriate internal boards or committees authorized to impose disciplinary action on a health professional, that there is a reasonable probability that such health professional may have engaged in unethical, fraudulent or unprofessional conduct as defined by the pertinent licensing statutes and regulations. The report required under this section shall be submitted within 30 days of the date that the chief executive officer or chief of staff determines that a reasonable probability exists.

3. Any disciplinary proceeding begun by the institution or facility as a result of conduct involving (i) intentional or negligent conduct that causes or is likely to cause injury to a patient or patients,
(ii) professional ethics, (iii) professional incompetence, (iv) moral turpitude, or (v) substance abuse. The report required under this section shall be submitted within 30 days of the date of written communication to the health professional notifying him of the initiation of a disciplinary proceeding.

4. Any disciplinary action taken during or at the conclusion of disciplinary proceedings or while under investigation, including but not limited to denial or termination of employment, denial or termination of privileges or restriction of privileges that results from conduct involving (i) intentional or negligent conduct that causes or is likely to cause injury to a patient or patients,
(ii) professional ethics, (iii) professional incompetence, (iv) moral turpitude, or (v) substance abuse. The report required under this section shall be submitted within 30 days of the date of written communication to the health professional notifying him of any disciplinary action.

5. The voluntary resignation from the staff of the health care institution or assisted living facility, or voluntary restriction or expiration of privileges at the institution or facility of any health professional while such health professional is under investigation or is the subject of disciplinary proceedings taken or begun by the institution or facility or a committee thereof for any reason related to possible intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, medical incompetence, unprofessional conduct, moral turpitude, mental or physical impairment, or substance abuse.

HOSPITAL POLICY FOR REPORTING OF HEALTH CARE PROFESSIONALS TO STATE LICENSURE BOARD

The following are substandard actions which would provide a reasonable basis for a concern for the safety of patients, and as such, would be reported:

1) Significant deficiencies in clinical practice, for example: lack of diagnostic or treatment capability; multiple errors in transcribing, administering, or documenting medications; inability to perform clinical procedures considered basic to the performance of one's occupation; or performing procedures not included in one's clinical privileges in other than emergency situations.

2) Patient neglect or abandonment.

3) Mental health impairment sufficient to cause the individual to: make judgment errors affecting patient safety, behave inappropriately in the patient care environment, or provide unsafe patient care.

4) Physical health impairment sufficient to cause the individual to provide unsafe patient care.

5) Substance abuse when it affects the individual's ability to perform appropriately as a health care provider or in the patient care environment.

6) Falsification of credentials.

7) Falsification of medical records or prescriptions.

8) Theft of drugs.

9) Inappropriate dispensing of drugs.

10) Unethical behavior or moral turpitude (such as sexual misconduct toward any patient).

11) Patient abuse, including mental, physical, sexual, and verbal abuse, and including:
    a) Any action or behavior that conflicts with a patient's rights identified in Title 38, Code of
    b) Federal Regulations (CFR);
    c) Intentional omission of care;
    d) Willful violations of a patient's privacy; and/or
    e) Willful physical injury, or intimidation, harassment, or ridicule of a patient, employee, or medical staff member, visitor, or any other person providing care in the hospital.

Activity 3.4 Reporting Adverse Actions (Continued)

Review the following scenarios and determine if the hospital must submit a report under the NPDB, State Licensing Board, hospital Policy (or any combination of such). If not reportable, state why.

1. Dr. Jones privileges were automatically suspended because she failed to complete her medical records in the timeframe specified in the bylaws. No adverse patient care was identified.

2. A surgeon is suffering from schizophrenia. The Medical Executive Committee has evaluated evidence and concluded that this health impairment is sufficient to cause the surgeon to make judgment errors affecting patient safety, behave inappropriately in the patient care environment, and provide unsafe patient care. The issue has been discussed with the physician who requests and is granted a medical leave of absence.

3. A dentist is denied a medical staff appointment and clinical privileges because the bylaws do not include a provision for dentists to request appointment.

4. A physician is notified that he is under investigation due to allegations of improper professional conduct. The physician resigns and surrenders clinical privileges during the investigation.

5. The hospital is notified that a physician did not renew her board certification making her no longer eligible for medical staff appointment and clinical privileges. Medical staff appointment and clinical privileges are terminated by the governing body.

6. Based on assessment of professional competence during the ongoing professional practice evaluation process, a proctor is assigned to a physician for a period of 60 days. The practitioner does not have to get approval of the proctor before providing medical care. The proctor will perform a retrospective review of medical records.


QUESTIONS?

Module 3: Ongoing Monitoring and Compliance Post-Test

1. If a medical staff member has privileges and/or medical staff appointment revoked, he/she must be:

    a. Granted temporary privileges.
    b. Provided due process.
    c. Reported immediately to the national practitioner databank.

2. According to NCQA standards, an organization that discovers sanction information, complaints, or adverse events regarding a practitioner must take what action?

    a. Determine if there is evidence of poor quality that could affect the health and safety of its members.
    b. Immediately take action to remove the provider from its panel.
    c. Initiate Ongoing Professional Practice Evaluation.

3. Why it is important to check that the practitioner is not currently excluded, suspended, debarred, or ineligible to participate in Federal health care programs?

    a. A facility could lose its accreditation if it does not do so.
    b. It is required by Medicare Conditions of Participation.
    c. The facility won't get paid for treating patients unless service is provided by authorized provider.

4. To whom does the AAAHC give the responsibility for approving and ensuring compliance with policies and procedures related to credentialing, quality improvement, and risk management?

    a. Medical staff
    b. Credentials committee
    c. Governing Body

5. Which body has the obligation to the community to assure that only appropriately educated, trained and currently competent practitioners are granted medical staff membership and clinical privileges?

    a. Medical Staff
    b. Governing Body
    c. The Joint Commission on Accreditation of Healthcare Organizations

6. Changes in medical staff bylaws are not final until formally approved by the:

    a. Medical staff
    b. Medical staff president
    c. Governing Body

7. The Healthcare Quality Improvement Act:

    a. Provides immunity for health care entities that do not report information to the National Practitioner Data Bank.
    b. Keeps hospitals and physicians who perform peer review from being sued.
    c. Provides qualified immunity from antitrust liability arising out of peer review activities that are conducted in good faith.

8. Which term describes the mechanism by which an aggrieved practitioner, one who has been the recipient of disciplinary action, is entitled to be heard and to appeal an adverse decision?

    a. medical staff executive committee
    b. procedural rights or fair hearing
    c. corrective action

9. Hospital credentialing is driven by accreditation standards, regulatory requirements, medical staff bylaws, rules & regulations as well as

    a. the religious affiliation of the hospital.
    b. the standard of care.
    c. the composition of the medical staff.

10. In a credentials verification organization, the documents that describe the credentialing function are:

    a. Bylaws
    b. Rules and Regulation
    c. Policies and Procedures

Additional Study Worksheet

Test Area: Ongoing Monitoring and Compliance

Topics for Further Study:

DAY 2: WELCOME BACK!

- Questions from yesterday?
- Warm-up exercise

Day 2 Warm Up Exercise

1. According to NCQA standards, if the MCO verifies this credential, it does not have to verify education and residency.

2. The Joint Commission standards require that all LIPs must participate in continuing education. When must this continuing education be evaluated?

3. According to NCQA, must the MCO verify boards that are granted for “life”?

4. The Medicare Conditions of Participation require that criteria for selection of medical staff members be based on five areas. What are they?

5. What is an acceptable source which would meet the NCQA standard to verify education for a “closed” residency program when a physician is not board certified?

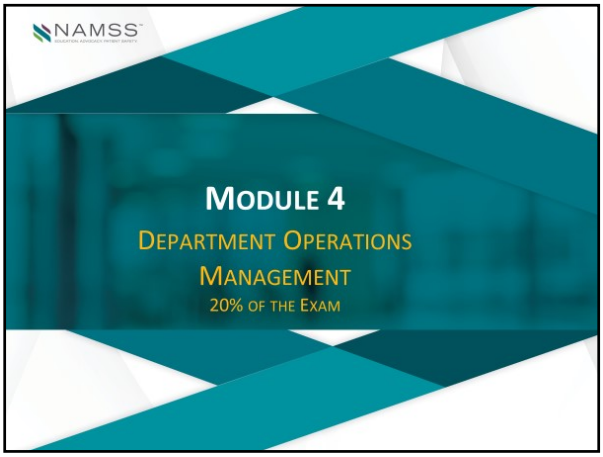
6. True or False: AAAHC standards require NPDB query on initial application.

7. URAC standards assign the responsibility for oversight of the clinical aspects of the credentialing program to whom?

8. What is the NCQA- required time limit for verification of licensure for a health plan? What is the time limit for a CVO?

9. True or False: According to The Joint Commission standards, all advanced practice nurses and physician assistants who make independent patient diagnosis, care, and treatment decisions must be credentialed, privileged and reprivileged through the medical staff process.

10. True or False: NCQA standards allow the medical director to “sign off” or approve complete, clean files.


NAMSS
MODULE 4
DEPARTMENT OPERATIONS
MANAGEMENT
20% OF THE EXAM

Module 4: Department Operations Management Pre-Test

1. Robert's Rules of Order is an example of:
    a. Executive privilege.
    b. Parliamentary procedure.
    c. A code of conduct.

2. Which NCQA-required committee makes credentialing decisions?

    a. Medical Executive Committee
    b. Quality Care Committee
    c. Credentialing Committee

3. HFAP standards require three medical staff committees to be delineated in the medical staff structure. Two of them are the Medical Executive Committee and the Utilization of Osteopathic Methods & Concepts Committee (required for hospitals with ten or more DOs who admit patients and provide direct patient care). What is the other required medical staff committee?

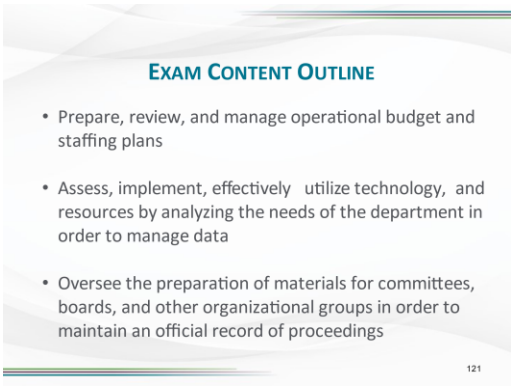
    a. Credentials Committee
    b. Investigational Review Board
    c. Utilization Review Committee

4. In addition to conclusions, recommendations made, and actions taken, which of the following should always be documented in meeting minutes:

    a. Names and professional titles of all in attendance
    b. Date and location of next scheduled meeting
    c. Any required follow-up to occur.

5. Which term below describes the achievement of the organization's objectives through and with people and other resources?

    a. Planning
    b. Staffing
    c. Management



Module 4 Exam Content Outline

- Prepare, review, and manage operational budget and staffing plans, and perform human resources-related functions by evaluating financial and other internal and external resources to support departmental operations.
- Assess, implement, effectively utilize, and maintain products and information systems (e.g., files, reports, minutes, databases) by analyzing the needs and resources of the department in order to manage data with efficiency and integrity in a manner that complies with regulatory requirements, accreditation standards, and organizational policies and procedures.
- Oversee the preparation of materials for committees, boards, and other organizational groups in order to maintain an official record of proceedings and decisions and to identify and ensure follow-up on action items (e.g., scheduling, agendas, meeting materials, action plans).

Budgeting

- A budget is a planning and control tool reflecting revenues, operating expenses, and cash receipts and outlays.
- You may be involved in budget preparation, and will monitor your budget on a monthly basis.
- Budgets cover a specific 12 -month period.
- A budget should result in a plan of operation for the coming year.

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Preparing a Budget

Consider the following factors when preparing a budget:

- Levels of spending- current level for ongoing projects, anticipated level for new projects
- Expected changes in costs (estimated in percentages) for salaries, etc.
- Projected changes in project activities- new services added, etc.
- Other relevant factors that may change, for example the population you plan to serve, etc.
- Contingencies - funds set aside for unexpected additional expenses

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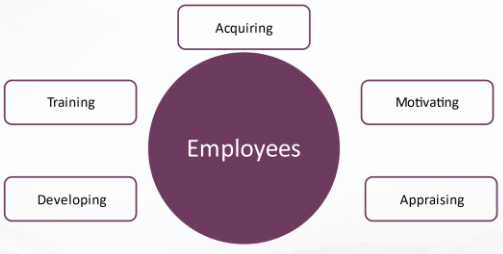
Staffing Plans



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Job Analysis, Descriptions, and Specifications

Job analysis	Nature and requirements for successful performance
Job description	Work to be performed, responsibilities, skills
Job specification	Qualifications

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Acquiring Employees

Selection	• Screen applicants for best candidate
Testing	• Eliminate unsuitable candidates
Background Check	• Education • Personal references • Previous employment
Physical Exam	• Determine if applicant is physically able to perform • Protect employer from future disability claims • Often includes drug testing

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Employee Orientation

Key Policies
- Vacation
- Sick Leave
- Absenteeism
- Breaks
- Safety Policies

Could also include social media, dress code, and corporate compliance policies.

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Employee Training

Training typically includes:

- credentialing database
- credentialing data and database security
- operational policies and procedures
- industry-specific education

Training could be performed:

- On-the-job
- In a classroom environment
- Online
- Through mentoring

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Developing

Beneficial to employee and organization

Methods may include:

- Assign new responsibilities
- Provide ongoing training
- Identify new opportunities
- Develop managerial skills

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Motivating

As a medical services manager, you have direct influence on motivating staff by the environment established within your department. These include:

- Provide feedback to both individual staff and the team as a whole
- Recognize individual and team contributions –both within the department but to leadership as well
- Empower staff to take actions and make decisions within their areas of responsibility
- Listen to your employees and be open to their ideas and suggestions
- Offer training courses to enhance their skills and knowledge
- And when possible, offer opportunities to advance within the department

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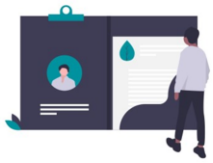
Performance Evaluation

- Evaluates actual performance compared to desired performance.
- Used for determining:
  - Compensation
  - Promotion
  - Termination
  - Need for additional training
- Performance evaluations can be used to motivate an employee.
- Performance evaluations are the responsibility of the manager.



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Discipline

Disciplinary actions occur as a result of employee behavior which violates a rule, endangers patients, or jeopardizes the employee's position by poor performance.

To be meaningful, discipline must be corrective, not punitive.

The managers should practice the following basic disciplinary rules:

- Act immediately in response to the undesired behavior
- Follow the progressive steps in disciplinary action
- Apply discipline consistently to all employees in the department

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Why Use Committees?

- Efficiency
- Implement and document required functions
- Evaluate and make recommendations

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Required Medical Staff Committees

The Joint Commission
- Medical Executive Committee (MEC)

DNV
- Medical Executive Committee (MEC)

HFAP – Medical Staff Committees
- MEC Function (Can assume the duties of the Credentials Committee)
- Utilization Review Committee

CMS Conditions of Participation for Hospitals
- MEC Function

No accreditors or federal regulations require hospitals to have service line departments .
There are no requirements for hospitals to have a Credentials Committee.

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Required Committees – Health Plans & Ambulatory Care

- For health plans, NCQA and URAC both require a Credentialing Committee.
- AAAHC does not.

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Meeting Management Functions

- Planning
- Notification
- Room arrangements
- A/V equipment
- Food
- Agenda
- Follow up
- Documenting attendance
- MSP and Chairperson's role
- Meeting minutes

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Parliamentary Procedure (aka Robert's Rules of Order)

- Robert's Rules of Order is the standard for facilitating discussions and group decision -making.
- Four procedures are used in smaller committee or board meetings:
  - To introduce (motion)
  - To change a motion (amend)
  - To adopt (accept a report without discussion)
  - To adjourn (end the meeting)

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What is a Motion?

- To introduce a new piece of business or propose a decision or action, a motion must be made by a group member ("I move that.....")
- A second motion must then also be made (raise your hand and say, "I second it.")
- After limited discussion the group then votes on the motion.
- A majority vote is required for the motion to pass (or quorum as specified in your bylaws.)

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Amend a Motion

- The member raises his/her hand and makes the following motion: "I move to amend the motion on the floor."
- This also requires a second.
- After the motion to amend is seconded, a majority vote is needed to decide whether the amendment is accepted.
- Then a vote is taken on the amended motion.

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Call the Question

- Needs a second
- Vote held immediately
- 2/3 majority required
- If passed, motion on the floor is voted on

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Table a Motion

- Lay aside the business at hand in a manner to consider later in the meeting or at another time
- A second is needed and a majority vote required to table the item being discussed
- Always indicate how long it will be tabled, the reason and who is following up on the motion.

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Adopt

- To accept an action without discussion
- Requires a second
- Majority vote required

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Adjourn

- A motion is made to end the meeting.
- The motion must be seconded.
- A majority vote is then required for the meeting to be adjourned (ended).

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Activity 4: Steps to a Motion Exercise

Instructions: Put the following steps in order by labeling each 1 through 6

Steps to a Motion	
Step	**Step Sequence**
Motion seconded	
The presiding officer restates the motion to the assembly	
The presiding officer announces the result of the voting	
Presiding officer asks for the affirmative votes & then the negative votes	
Motion made	
The members debate the motion	

Parliamentary Procedure Definitions

	Term	Definition
1	Precedence	This concept is based on the principle that a meeting can deal with only one question at a time. Once a motion is before a meeting, it must be adopted or rejected by a vote, or the meeting must dispose of the question in some other way. Each motion is given a particular rank. The main motion—which does not take precedence over anything—ranks lowest.
2	Yielding to	What motions may be made and considered while a motion is pending.
3	Accepting	Adopting
4	Chair	The presiding officer, whether temporary or permanent
5	Meeting	An assembling of the members of a deliberative body for any length of time during which they do not separate for longer than a few minutes.
6	Pending and Immediatel y Pending	These terms describe when a question has been stated by the chair and has not yet been disposed of either permanently or temporarily
7	Motion	Used to bring before the assembly any particular subject.
8	Subsidiary motion	Used to modify, delay, or otherwise dispose of a motion.
9	Privileged motions	While having no relation to the pending question, these motions are of such urgency or importance as to require them to take precedence over all other motions.
10	Incidental motion	A motion that arises out of another question which is pending or has just been pending, and must be decided before the pending question, or before other business is taken up.
11	Previous Question	The name given to the motion to close debate and at once to take the vote on the immediately pending question and such other questions as are specified in the motion.
12	Substitute	An amendment where an entire resolution, or section, or one or more paragraphs, is struck out and another resolution, or section, or one or more paragraphs, is inserted in its place.
13	Majority	When, in an election a candidate has more than half the votes cast, ignoring blanks.
14	Plurality	When, in an election a candidate has a larger vote than any other candidate.

Choosing an Information System

- Integration with current systems
- Training
- Hardware requirements
- Flexibility

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Choosing an Information System

- Customized Reporting
- User Support
- References
- Additional Software Requirements

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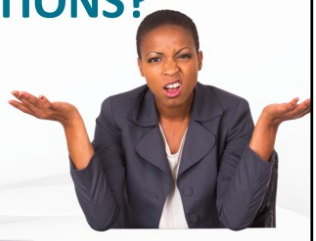
QUESTIONS?



Module 4: Department Operations Post-Test

Read each question and circle the correct answer.

1. Robert's Rules of Order is an example of
    a. executive privilege.
    b. Parliamentary procedure.
    c. a code of conduct.

2. Which NCQA-required committee makes credentialing decisions?
    a. Medical Executive Committee
    b. Quality Care Committee
    c. Credentialing Committee

3. HFAP standards require three medical staff committees to be delineated in the medical staff structure. Two of them are the Medical Executive Committee and the Utilization of Osteopathic Methods & Concepts Committee (required for hospitals with ten or more DOs who admit patients and provide direct patient care). What is the other required medical staff committee?
    a. Credentials Committee
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    c. Utilization Review Committee

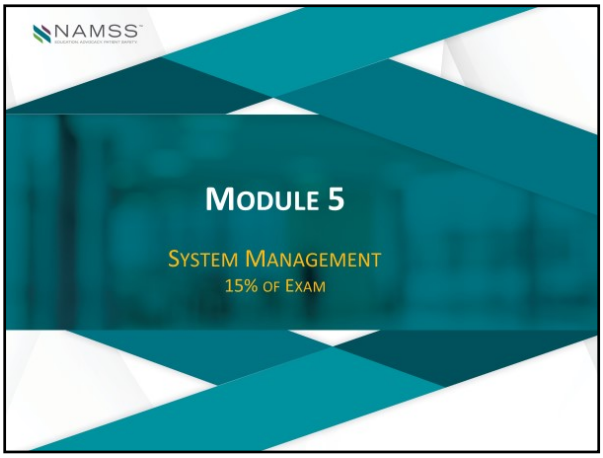
4. In addition to conclusions, recommendations made, and actions taken, which of the following should always be documented in meeting minutes:
    a. Names and professional titles of all in attendance
    b. Date and location of next scheduled meeting
    c. Any required follow-up to occur

5. Which term below describes the achievement of the organization's objectives through and with people and other resources?
    a. Planning
    b. Staffing
    c. Management

Additional Study Worksheet

Test Area: Department Operations Management

Topics for Further Study:


NAMSS
MODULE 5
SYSTEM MANAGEMENT
15% OF EXAM

Module 5: System Management Pre-test

Read each question and circle the correct answer.

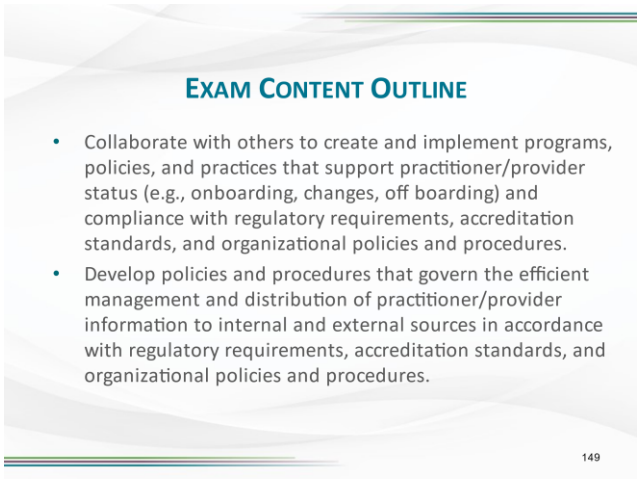
1. Access to credentials files should be:
    a. Available to all members of the organization's staff
    b. Described fully in an access policy
    c. Available to any physician on the staff

2. The release of liability statement signed by the applicant for medical staff appointment should include:
    a. The name of the department chairman for all past hospital appointments
    b. A statement providing immunity to those who respond in good faith to requests for information
    c. A statement of the correctness of the information provided

3. Who should have access to medical staff meeting minutes?
    a. Medical Staff President
    b. Personnel as documented in a records access policy and procedure
    c. Hospital President

4. Prior to releasing peer review information to a third party regarding a practitioner, the organization should acquire
    a. A picture ID of the provider
    b. A signed consent and release form
    c. Informed consent

5. Which of the following topics would be considered continuing medical education?
    a. personal finance review course
    b. understanding dermatology for the non-dermatologist
    c. appreciation of literature



Module 5 Exam Content Outline:

- Collaborate with others to create and implement programs, policies, and practices that support practitioner/provider status (e.g., onboarding, changes, off boarding) and compliance with regulatory requirements, accreditation standards, and organizational policies and procedures.
- Develop policies and procedures that govern the efficient management and distribution of practitioner/provider information to internal and external sources in accordance with regulatory requirements, accreditation standards, and organizational policies and procedures.

Onboarding Practitioners

Onboarding is a multi -phased process to integrate new practitioners into an organization.

Activities vary based on practitioner employment status.

Non-Employed
- Recruitment
- Credentialing
- Privileging
- Orientation

Employed
- Recruitment
- Credentialing
- Privileging
- Orientation
- Contracting
- Human Resources
- Underwriting
- Enrollment

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Provider/Practitioner Orientation

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Medical Staff Leader Orientation

New medical staff leader training might include information on:
- bylaws
- applicable polices and procedures
- fair hearing plan
- organizational charts
- contact lists for administrators and key medical staff personnel

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Practitioner Changes & Offboarding

Changes in practitioner data must be updated and communicated timely to internal stakeholders, including:

- Office information
  - Address, phone, email, etc.
- Privileging information
  - New and renewed/revised privileges
- Medical Staff status
  - Resignation or termination– all system access must be disabled
  - Reporting to the NPDB may be required if criteria are met

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Important Policies

- Professional Code of Conduct/Behavior
- Late Career Practitioner
- Low/No Volume Providers
- Who Has Access to Your Files
- Peer Review
- FPPE/OPPE
- Confidentiality

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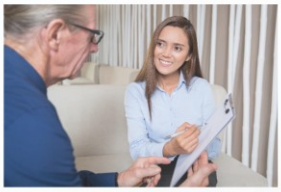
Responding to Requests for Information

Must Have a Policy Addressing:

- What can be provided
- What type of consent is necessary
- Who has access to records
- Any information that can be provided without a consent form



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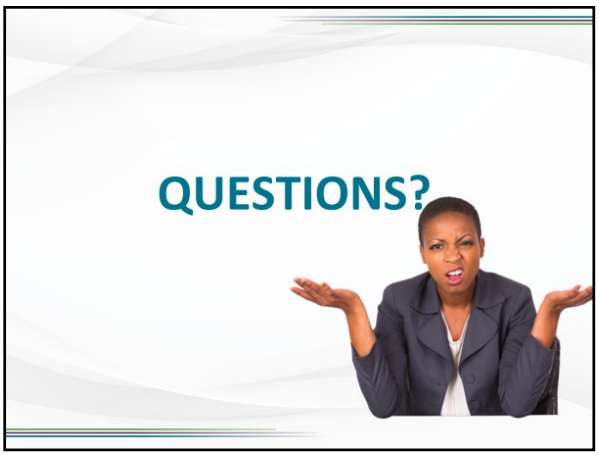
QUESTIONS?

Module 5: System Management Post-Test

Read each question and circle the correct answer.

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Additional Study Worksheet

Test Area: System Management

Topics for Further Study:

NAMSS

Module 6

Your Study Strategy

The Key to Success

Be Prepared!

Prepare to Succeed

- Know the exam
- Know how to answer multiple choice questions
- Understand test-taking strategies
- Explore your learning style
- Create a study plan
- **Implement the plan!**

What Do You Think?

- Every exam is a reading test.
- Knowing a little can be dangerous; knowing a lot can be disastrous.
- Manage information to prepare, manage time to pass.
- Be a test-maker, not just a test-taker.

Test Taking Strategies

- Read the directions.
- Read all the questions.
- Answer the ones you know first.
- Come back to the hard ones.
- Read all the answers.
- Look for the *best* answer, not just a correct answer.
- Your first answer is *usually* the correct one.

Answering Tough Questions

- Read the question
  - Look for key words
- Read all the answers
  - Replace the obviously wrong ones
  - Give each answer the "true-false" test
  - Question options that:
    - Are totally unfamiliar to you
    - Contain negative or absolute words

Sample Question

Which hospital department would supply a weekly delinquency report for patient records?

a. Administration

b. Medical Records

c. Inpatient Services

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Sample Question

Which BEST describes the process of delegated credentialing?

a. One accredited organization allows another accredited organization to perform primary source verification on its behalf.

b. An HMO allows a CVO to assume final responsibility for credentialing/recredentialing decision-making.

c. An organization grants, by mutual agreement, responsibility to another organization to perform a specified scope of credentialing/recredentialing activities.

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Sample Question

According to TJC, how is a practitioner's quality of care assessed during the reappointment process?

a. Analysis of financial costs associated with performed procedures.

b. Analysis of medically complex cases managed and treated by the practitioner

c. Review of aggregate data, information, and clinical performance evaluations

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Guessing

- Test score is based on the number of right answers.
- There is NO penalty for guessing.
- Eliminate the answers that are clearly wrong.
- Take your best guess from what's left.

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Three Keys to Success

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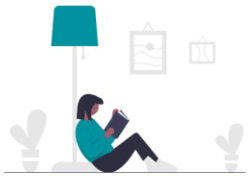
Study Skills



- Studying can be habit forming.
- Create a supportive studying environment.
- Learn high level concepts first then drill down to the detail.
- Use mnemonics.
- Take breaks.
- Keep a reminder pad handy.
- Have fun!

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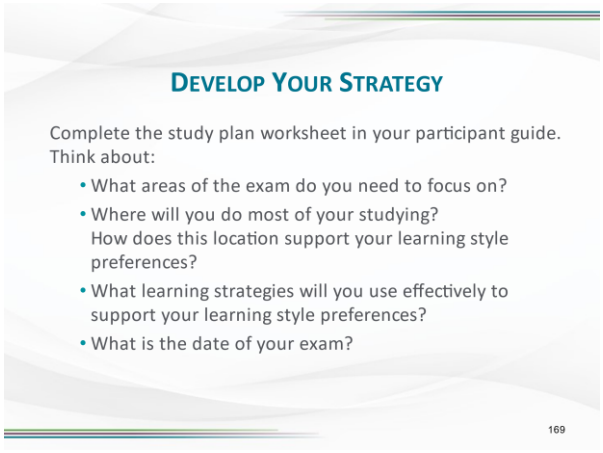
DEVELOP YOUR STRATEGY
Complete the study plan worksheet in your participant guide. Think about:
• What areas of the exam do you need to focus on?
• Where will you do most of your studying? How does this location support your learning style preferences?
• What learning strategies will you use effectively to support your learning style preferences?
• What is the date of your exam?
169

Study Plan Worksheet

What areas of the exam do you need to focus on?

Where will you do most of your studying? How does this location support your learning style preferences?

What learning strategies will you use effectively to support your learning style preferences?

What is the date of your exam?

For each week, between now and your exam, which topics and strategies will you use to prepare? (You may need to finish this section after class.)

Week	Topic	Strategy

Form a Study Group

- Keep on schedule
- Share learning strategies
- Share expertise – teach others!
- In person, online, or over the phone

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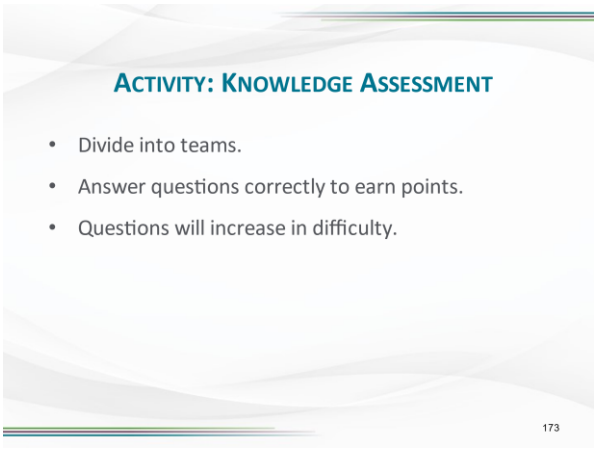
NAMSS

Module 7

Assess Your Knowledge


ACTIVITY: KNOWLEDGE ASSESSMENT
• Divide into teams.
• Answer questions correctly to earn points.
• Questions will increase in difficulty.
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NAMSS
THANK YOU!

Sample Test Questions

Test Question Answer Sheet

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Sample Test Questions

1. Why it is important to check that the practitioner is not currently excluded, suspended, debarred, or ineligible to participate in Federal health care programs?

    a. A facility could lose its accreditation if it does not do so.
    b. It is required by Medicare Conditions of Participation.
    c. The facility won't get paid for treating patients unless service is provided by authorized provider.

2. Which of the following credentials must be tracked on an ongoing basis?

    a. Medical school completion
    b. Closed medical malpractice claims
    c. Licensure

3. According to NCQA standards, an organization that discovers sanction information, complaints, or adverse events regarding a practitioner must take what action?

    a. Determine if there is evidence of poor quality that could affect the health and safety of its members.
    b. Immediately take action to remove the provider from its panel.
    c. Initiate Ongoing Professional Practice Evaluation.

4. What is the name of the entity that was established through the Health Care Quality Improvement Act of 1986 to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from state to state without disclosure or discovery of previous medical malpractice payment and adverse action history?

    a. Emergency Medical Treatment and Active Labor Act
    b. The National Practitioner Data Bank
    c. The Patient Safety and Quality Improvement Act

5. When developing clinical privileging criteria, which of the following is important to evaluate?

    a. How many providers are in that specialty.
    b. Established standards of practice such as, specialty board recommendations.
    c. Whether or not the quality department can support the FPPE process.

6. What is the main reason for periodically assessing appropriateness of clinical privileges for each specialty?

    a. It's required by accreditation standards.
    b. It is required by the Medicare Conditions of Participation.
    c. To protect patient safety by ensuring current competency, relevance to the facility, and accepted standards of care.

7. Which of the following specialists is most likely to perform a PTCA?

    a. General surgeon
    b. OB/GYN
    c. Interventional Cardiologist

8. The Joint Commission hospital standards require that clinical privileges are hospital specific and

    a. Based on the individual's demonstrated current competence and the procedures the hospital can support.
    b. Based on board certification.
    c. Based on the privileges the individual is currently approved to perform at other hospitals.

9. Which of the following would be routinely performed by a cardiologist?

    a. Hysterectomy
    b. Transesophageal Echocardiography
    c. Urethral dilation

10. Which NCQA-required committee makes recommendations regarding credentialing decisions?

    a. Medical Executive Committee
    b. Quality Care Committee
    c. Credentialing Committee

11. HFAP standards require three medical staff committees to be delineated in the medical staff structure. Two of them are the Medical Executive Committee and the Utilization of Osteopathic Methods & Concepts Committee (required for hospitals with ten or more DOs who admit patients and provide direct patient care). What is the other required medical staff committee?

    a. Credentials Committee
    b. Investigational Review Board
    c. Utilization Review Committee

12. If you needed to find out about what the Federal Government requires in regards to anti-trust issues, what law would you consult?

    a. Healthcare Quality Improvement Act
    b. Patient Safety and Quality Improvement Act
    c. Sherman Anti-trust Act

13. Peer references should be obtained from:

    a. Practitioners who have referred patients to the provider
    b. Family, friends and neighbors
    c. Practitioners in the same professional discipline as the applicant

14. Patrick v. Burgett is an important case because it:

    a. Showed that a hospital can assert that peer review is performed at the state's request.
    b. Illustrates that the governing body is the ultimate authority.
    c. Illustrates the potential for antitrust liability arising out of peer review activities.

15. If a medical staff member has privileges and/or medical staff appointment revoked, he/she must be:

    a. Granted temporary privileges.
    b. Provided due process.
    c. Reported immediately to the national practitioner data bank.

16. Access to credentials files should be:

    a. Available to all members of the organization's staff.
    b. Described fully in an access policy.
    c. Available to the organization's patients and potential patients.

17. Which of the following bodies approves clinical privileges?

    a. Credentials Committee
    b. Peer Review Committee
    c. Governing Body or Board

18. What primary source verification is required by NCQA prior to provisional credentialing?

    a. Current competence
    b. Licensure and 5 year malpractice history or NPDB
    c. Education and Training

19. According to The Joint Commission standards, initial appointments to the medical staff are made for a period of:

    a. Two years
    b. Three years
    c. Not to exceed two years

20. According to The Joint Commission standards, temporary privileges may be granted by:

    a. The department chair
    b. The CEO
    c. The CEO on the recommendation of the medical staff president or authorized designee

21. According to The Joint Commission Standards, which of the following items must be verified with a primary source?

    a. Medicare/Medicaid Sanctions
    b. Proof of professional liability insurance
    c. Licensure, training, experience, and competence

22. According to NCQA standards, a copy of which of the following is acceptable verification of the document?

    a. DEA certificate
    b. Licensure
    c. Board certification

23. According to NCQA standards, which is an acceptable source for primary source verification of Medicare and Medicaid sanction activity against physicians?

    a. Federation of State Medical Boards
    b. American Board of Medical Specialties
    c. Education Commission on Foreign Medical Graduates Profile

24. According to The Joint Commission standards, which of following is considered a designated equivalent source for verification of board certification?

    a. The American Board of Medical Specialties
    b. Education Commission on Foreign Medical Graduates Profile
    c. Federation of State Medical Boards

25. Which of the following organizations have been recognized by The Joint Commission and NCQA to provide primary source verification of medical school graduation and residency training for U.S. graduates?

    a. American Medical Association Masterfile
    b. National Practitioner Data Bank
    c. Federation of State Medical Boards

26. According to NCQA standards, the application attestation statement must affirm that the application

    a. Is correct and complete.
    b. Was actually completed by the provider.
    c. Was signed in the presence of a notary public.

27. According to The Joint Commission standards, medical staff bylaws should define

    a. The structure of the medical staff.
    b. Mechanism for appointment/reappointment of physician employed non-independent practitioners.
    c. A requirement that departments meet on at least a quarterly basis.

28. According to The Joint Commission hospital standards, professional criteria for the granting of clinical privileges must include at least

    a. Relevant training or experience, ability to perform privileges requested, current licensure, and competence.
    b. Verification of all current and prior malpractice suits filed and settlements made.
    c. Letters of reference from the Chief Executive Officer of all current and prior hospital affiliations.

29. The Joint Commission hospital standards require medical staff bylaws to include

    a. A mechanism for selection and removal of officers.
    b. A requirement that all quality of care information be reviewed by the medical staff president.
    c. A mechanism for removal of the hospital's chief executive officer.

30. According to NCQA standards, which of the following is an approved source for verification of board certification?

    a. National Practitioner Data Bank
    b. State licensing agency if state agency conducts primary verification of board status
    c. Viewing of the original board certificate

31. According to The Joint Commission hospital standards, which of the following is a required component of the reappointment process?

    a. Documentation of the applicant's health status
    b. Verification of residency training
    c. Medicare/Medicaid sanctions query

32. According to URAC's health network standards, each applicant within the scope of the credentialing program submits an application that includes at least which of the following:

    a. State licensure information, including current license(s) and history of licensure in all jurisdictions
    b. A listing of all current and past hospital affiliations
    c. A NPDB self-query

33. According to AAAHC, which must be monitored on an ongoing basis?

    a. Current licensure
    b. Medical malpractice liability coverage
    c. Health status

34. According to The Joint Commission, a nurse practitioner functioning independently and providing a medical level of care must:

    a. Have a job description.
    b. Be granted delineated clinical privileges.
    c. Be directly supervised by an active physician staff member.

35. According to The Joint Commission, which of the following is an acceptable source for verification for medical education of an international graduate?

    a. Board certification
    b. Federation of State Medical Boards
    c. Education Commission for Foreign Medical Graduates

36. When evaluating compliance with the required time-frame for recredentialing, NCQA counts the recredentialing period to the:

    a. Day
    b. Week
    c. Month

37. NCQA standards require the organization to verify board certification at recredentialing:

    a. If a practitioner has received Medicare/Medicaid sanctions.
    b. If a practitioner is requesting a change in status.
    c. In all cases.

38. To whom does the AAAHC give the responsibility for approving and ensuring compliance with policies and procedures related to credentialing, quality improvement, and risk management?

    a. Medical staff
    b. Credentials committee
    c. Governing body

39. In order for a healthcare facility to participate in the Medicare and Medicaid programs it must comply with the

    a. Medicare Conditions of Participation
    b. The Joint Commission of Accreditation of Healthcare Organizations standards
    c. National Committee for Quality Assurance (NCQA) standards

40. According to The Joint Commission hospital standards, which of the following is an element of a self-governing medical staff?

    a. The medical staff determines the mechanism for establishing and enforcing criteria for assigning oversight responsibilities to practitioners with independent privileges.
    b. There can be any number of organized medical staffs as long as they are approved by the governing body.
    c. The hospital's board of directors determines the criteria for granting medical staff privileges.

41. Robert's Rules of Order is an example of
    a. executive privilege.
    b. Parliamentary procedure.
    c. a code of conduct.

42. The medical staff application should provide a chronological history of

    a. The applicant's education, training, and work history.
    b. CME activities and completion of residency.
    c. Marriages since medical school.

43. In order to participate in a managed care plan, a provider must be accepted to the plan's

    a. Provider panel
    b. Medical staff
    c. Medical team

44. In order for a physician to practice medicine in any state in the United States, he/she must possess

    a. Malpractice insurance with limits of at least $1 million per occurrence and $3 million annual aggregate.
    b. Membership on the provider panel of the majority of the state's major managed care plans.
    c. Current state licensure.

45. Which of the following is considered post-graduate education?

    a. Medical school
    b. College
    c. Residency training

46. Which of the following elements may not be used to evaluate credentials of applicants?

    a. Gender
    b. Licensure
    c. Post-graduate training

47. The release of liability statement signed by the applicant for medical staff appointment should include:

    a. The name of the department chairman for all past hospital appointments.
    b. A statement providing immunity to those who respond in good faith to requests for information.
    c. A statement of the correctness of the information provided.

48. Primary source verification is:

    a. Receiving information directly from the issuing source.
    b. Required by the health care quality improvement act.
    c. Considered economic credentialing.

49. Unexplained delays between graduation and medical school, incomplete training, and unexplained lapses in professional practice are examples of:

    a. Red flags.
    b. Medicare sanctions.
    c. Events reportable to the National Practitioner Data Bank.

50. When documenting a telephone conversation regarding primary source verification what should be documented?

    a. The date and time of the call only.
    b. Who answered the call.
    c. Name of person and organization contacted, date of call, what was discussed and who conducted the interview.

51. According to HFAP standards, when confirming malpractice coverage the organization must:

    a. Query the NPDB
    b. Obtain the claim history with each carrier over the last five years
    c. Have evidence of professional liability insurance, which includes certificate showing amounts of coverage

52. Which of the following providers is considered a primary care physician (PCP)?

    a. General surgeon
    b. Gastroenterologist
    c. Family medicine practitioner

53. Which body has the obligation to the community to assure that only appropriately educated, trained and currently competent practitioners are granted medical staff membership and clinical privileges?

    a. Medical Staff
    b. Governing Body
    c. The Joint Commission

54. When credentialing and privileging practitioners it is appropriate to:

    a. Handle each applicant on a case-by-case basis.
    b. Follow a routine process for each applicant.
    c. Give preferential treatment to those providers whose specialty is primary care.

55. Medical liability insurance should be held in what limits?

    a. $500,000 per occurrence and $1,000,000 annual aggregate
    b. $1,000,000 per occurrence and $3,000,000 annual aggregate
    c. As specified by the medical staff and board of directors

56. Which of the following would be an appropriate question to ask an applicant for medical staff?

    a. How many children to you have?
    b. Are you married?
    c. Do you have any medical conditions, treated or untreated, that would negatively affect your ability to provide the services or perform the privileges you are requesting?

57. The governing body delegates the task of credentialing, recredentialing, and privileging to

    a. The hospital administrator
    b. The medical staff office
    c. The medical staff

58. Who should have access to medical staff meeting minutes?

    a. Medical Staff President
    b. Governing Body members
    c. Personnel as documented in a records access policy and procedure

59. In addition to conclusions, recommendations made, and actions taken, which of the following should always be documented in meeting minutes:

    a. Names and professional titles of all in attendance
    b. Date and location of next scheduled meeting
    c. Any required follow-up to occur.

60. Active, Associate, Courtesy, Honorary, Consulting are all examples of:

    a. Committees
    b. Medical staff officers
    c. Membership categories

61. Changes in medical staff bylaws are not final until formally approved by the:

    a. Medical staff
    b. Medical staff president
    c. Governing body

62. What is the only hospital medical staff committee required by The Joint Commission hospital standards?

    a. Credentials committee
    b. Medical executive committee
    c. Pharmacy and therapeutics committee

63. The Healthcare Quality Improvement Act:

    a. Provides immunity for health care entities that do not report information to the National Practitioner Data Bank.
    b. Keeps hospitals and physicians who perform peer review from being sued.
    c. Provides qualified immunity from antitrust liability arising out of peer review activities that are conducted in good faith.

64. If you have a question regarding whether or not information regarding a practitioner should be released to a third party, which of the following would be the best person to ask?

    a. Director of Medical Records
    b. Chief of Staff
    c. Organization's attorney

65. Prior to releasing information to a third party regarding a practitioner, the organization should acquire

    a. A picture ID of the provider
    b. A signed consent and release form
    c. Approval from the organization's attorney

66. You are working at an AAAHC accredited facility and you want to introduce the concept of utilizing a credentials verification organization. If the CVO is not accredited by a nationally recognized organization, you must:

    a. Perform an initial on-site visit of the CVO to assess their capabilities and quality of work
    b. Perform an assessment of the capability and quality of the CVO's work
    c. Perform an assessment of their turn-around times

67. What are the three major sources of authority in the traditional structure of the hospital organization?

    a. Chief executive officer, governing body, and medical staff
    b. Chief executive officer, hospital vice-president, medical director
    c. Medical staff president, vice-president, and secretary-treasurer

68. How does the governing body of a hospital set the organization policy that supports quality patient care?

    a. By assigning these responsibilities to the chief executive officer
    b. By seeking medical staff input in the hiring of key personnel
    c. By developing the mission, vision, policies, and bylaws that govern the hospital's operations

69. Governing boards may be generally classed into which two types?
    a. For-profit or not-for-profit
    b. Philanthropic or corporate
    c. General or specialty

70. Which of the following is a major responsibility of the CEO?

    a. Directly observing nursing care to assure that patients receive proper care and treatment
    b. Keeping the medical staff informed about the hospital's plans, organizational changes, board policies, and decisions affecting providers and their patients.
    c. Overseeing the patient accounts department to assure accurate billing practices

71. To whom is the medical staff organization accountable for the quality of the professional services provided by individuals with clinical privileges?

    a. The Joint Commission
    b. Hospital chief executive officer
    c. Governing body

72. Which term describes a physician employed or contracted by the hospital as a top-level management employee to act as a liaison between the medical staff and hospital administration?

    a. Medical director
    b. Chief financial officer
    c. Medical staff president

73. Which of the following are included in the functions of the medical staff?

a. Contracting for Medicare assignment
b. Training of nursing staff
c. Providing and evaluating patient care

74. Which of the following describes a committee that is assembled or appointed to perform a specific task or duty, works independently and reports back to larger committee and typically disbands after the assigned task or duty is performed or completed?

a. Standing committee
b. Ad hoc committee
c. Task force

75. When developing bylaws language for a committee, consideration should be given to which of the following?

a. The mission statement of the hospital
b. Medical staff restructuring
c. Composition, duties, and frequency of meetings

76. The credentials committee needs guidance regarding which physicians will be allowed to perform a new procedure in the hospital. It has recommended that a committee be appointed to evaluate this issue and report back to the credentials committee. What kind of committee would be appointed?

a. Standing committee
b. Ad hoc committee
c. Utilization review committee

77. Which term describes a physician who provides the general medical care of hospitalized patients only and turns over the care of the patient to the primary care physician after discharge?

a. Internist
b. Hospitalist
c. Primary care provider

78. Which term describes a category of medical staff appointment that provides a basic framework within which physicians and other health care providers carry out their duties and responsibilities?

a. Staff status
b. Privileges
c. Committee appointment

79. Which term describes interns and residents in medical education programs of a teaching hospital?

a. Affiliate staff
b. Allied health professionals
c. House staff

80. Which term describes a special classification used to reflect honor and respect for selected distinguished members of the medical community?
    a. Consulting staff
    b. Active staff
    c. Honorary or emeritus staff

81. Which term describes privileges granted for a specific period of time to a practitioner while hospital board approval is pending?

    a. Temporary privileges
    b. Provisional staff
    c. Interim appointment

82. Which document describes the organizational structure of the medical staff and defines the framework within which medical staff appointees act and interact in hospital-related activities?

    a. Fair hearing plan
    b. Joint Commission Comprehensive Accreditation Manual
    c. Medical staff bylaws

83. Bylaws changes are not effective until final approval by which body?

    a. medical staff executive committee
    b. bylaws committee
    c. governing body

84. Which term describes the mechanism by which an aggrieved practitioner, one who has been the recipient of disciplinary action, is entitled to be heard and to appeal an adverse decision?

    a. medical staff executive committee
    b. procedural rights or fair hearing
    c. corrective action

85. What the landmark case set aside the Charitable Immunity Doctrine and established the corporate negligence doctrine, also known as negligent credentialing?

    a. Patrick vs. Burgett
    b. Miller vs. Eisenhower General Hospital
    c. Darling vs. Charleston Memorial Community Hospital

86. What is the name of the act, known as the Federal “anti-dumping” law, which was enacted to stop hospitals transferring, discharging, or refusing to treat indigent patients coming to the emergency department because of cost factors?

    a. Emergency Medical Treatment and Active Labor Act (EMTALA)
    b. Transfer of Indigent Patients Act
    c. Sherman Act

87. In a hospital setting, the need for informed consent, explaining the risks and benefits of a particular course of treatment, allowing the patient to participate in decisions regarding treatment options, and confidentiality are all examples of what?

a. peer review
b. ethical issues
c. credentialing

88. Which act mandates regulations that prohibit disclosure of health information except as authorized by the patient or specifically permitted by the regulation?

a. Hospital Licensing Act (HLA)
b. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
c. Emergency Medical Treatment and Active Labor Act (EMTALA)

89. Which act defines the elements of due process that must be followed in order for an organization to have peer review protection?

a. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
b. Emergency Medical Treatment and Active Labor Act (EMTALA)
c. Healthcare Quality Improvement Act (HCQIA)

90. The Code of Ethics for which organization includes the language, “shall share knowledge, foster educational opportunities, and encourage personal and professional growth through continued self-improvement and applications of current advancements in the profession”?

a. American Medical Association
b. American Hospital Association
c. NAMSS Certification Commission

91. What term is used to describe the evaluation or review of the performance of colleagues by professionals with similar types and degrees of clinical expertise?

a. Reappointment
b. Conditional period of appointment
c. Peer review

92. Which medical staff officer is responsible for enforcing the medical staff bylaws, rules, and regulations, and procedural guidelines of the medical staff including imposing sanctions for noncompliance?

a. Credentials committee chairman
b. Medical staff president or chief of staff
c. Utilization Review Committee chairman

93. Which term defines a functional unit of the hospital, so designated because of the clinical service it performs?

a. Department
b. Credentials committee
c. Peer review committee

94. Which of the following is a responsibility of the department chairman?

a. Recommending criteria for clinical privileges in the department
b. Recommending amount of dues to be paid annually
c. Recommending to the medical executive committee the number of applicants to be allowed in the department

95. Which of the following is a Joint Commission requirement element for the process for managing LIP health?

a. Participation in AAA meetings.
b. Notification of patients regarding practitioner's participation in program
c. Education of LIP and organization staff regarding recognizing illness and impairment issues specific to LIPs

96. In the case of Frigo vs. Silver Cross Hospital, the podiatrist who performed surgery on Ms. Frigo did not meet initial criteria or revised criteria for Level II surgical privileges, but was granted privileges regardless. What was the legal concept under which the jury found Silver Cross Hospital to be negligent?

a. Breach of duty/Corporate Negligence
b. Respondeat superior
c. Antitrust

97. Which term below describes the achievement of the organization's objectives through and with people and other resources?

a. Planning
b. Staffing
c. Management

98. Which continuing medical education system has become the CME standard for licensing boards and specialty organizations nationwide and is recognized by U.S. jurisdictions?

a. The AMA's PRA Category 1 Credit™ system
b. The ACGME's CME program
c. FSMB's Profile Report

99. If you needed to find out about what the Federal Government requires in regards to anti-trust issues, what law would you consult?

a. Healthcare Quality Improvement Act
b. Patient Safety and Quality Improvement Act
c. Sherman Anti-trust Act

100. Average Length of Stay (ALOS) figures are used for which of the following purposes?

a. One measure of hospital utilization review
b. To calculate drug doses
c. Part of the calculation to determine reimbursement

101. Expenses that may vary directly with the quantity of work being performed are _____ costs.

a. Fixed
b. Semi-variable
c. Variable

102. In a Joint Commission accredited hospital, applications for initial appointment to the medical staff must be acted on:

a. within 90 days after the medical staff office receives the application
b. as specified in the medical staff bylaws
c. within 30 days of receipt of a completed application

103. Joint Commission standards require hospital-sponsored educational activities to be prioritized and that, when developing these programs, they relate to

a. the structure of the medical staff.
b. the mission statement of the hospital.
c. the type and nature of care, treatment, and services offered by the hospital

104. According to CMS's CoPs for hospitals, when utilizing telemedicine, the hospital must have evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and must send the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include

a. results of all quality assessment activities conducted by the distant site that pertain to telemedicine services.
b. the entire credentials file of the telemedicine provider.
c. all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital's patients and all complaints the hospital has received about the distant-site physician or practitioner.

105. According to Joint Commission Standards, who must inform the patient about unanticipated outcomes of care, treatment, and services related to sentinel events?

a. Medical staff executive committee
b. Risk manager
c. Responsible licensed independent practitioner or his or her designee

106. Which document contains a listing of drugs and pharmaceuticals maintained for use in the hospital?

a. pharmacy procedure manual
b. formulary
c. prescription index

107. According to Joint Commission standards, the qualifications and competence of a non-employee individual, other than a PA or APRN, who is brought into the hospital by an LIP to provide care, treatment, must be assessed by

a. the hospital.
b. the department chairperson.
c. the medical staff executive committee.

108. According to NCQA, the health plan must notify an initial applicant of the Credentialing Committee's decision within:

a. 30 days.
b. 60 days.
c. 180 days.

109. The National Technical Information Service is an NCQA-approved source to verify:

a. licensure
b. education
c. DEA

110. NCQA requires that recredentialing of practitioners and providers occur:

a. every two years
b. annually
c. at least every three years

111. Under NCQA standards, when credentialing activities are delegated by a health plan, the right to approve, terminate or suspend individual practitioners or providers is retained by:

a. NCQA.
b. the delegate.
c. the health plan.

112. You are working at a AAAHC-accredited facility. You are credentialing a new applicant, but the fellowship program has closed and you cannot find an organization that has the records. Which of the following is the best way to handle this situation?

a. Document in the credentials file that you couldn't verify.
b. Attempt to get the information from another health care organization, such as a hospital or group practice that has carried out primary source or acceptable secondary source verification of the fellowship.
c. Contact the applicant and tell him/her that he/she does not qualify for medical staff appointment since you cannot verify fellowship.

113. According to URAC's health network standards, each applicant within the scope of the credentialing program submits an application that includes at least which of the following:

    a. State licensure information, including current license(s) and history of licensure in all jurisdictions
    b. A listing of all current and past hospital affiliations
    c. A NPDB self-query

114. Before granting of initial privileges Joint Commission standards require the organization to verify current licensure, certification, or registration and training with the primary source. Which of the following is an additional Joint Commission requirement for new applicants?

    a. Verifying that the applicant has not been excluded from Medicare, Medicaid, or other Federal programs.
    b. Verification of professional liability (medical malpractice) insurance coverage.
    c. The applicant must attest that he or she has no health problems that could affect his or her ability to perform the requested privileges.

115. You are working at a Joint Commission accredited hospital. You are processing a reappointment for medical staff membership and you find that the practitioner has not performed any procedures at your facility since her last reappointment. The appointment is due to expire in one month. What should you do?

    a. As long as there is no negative information received, process the application according to the approved process.
    b. Inform the applicant that she is not eligible for appointment due to not having provided services at your facility.
    c. Ask the applicant to provide the names of other facilities where she is practicing, then write to those facilities to obtain documentation of procedures performed and outcome data, if available.

116. According to HFAP standards, in addition to direct contact with program, which of the following is/are approved designated source(s) for verification of residency training?

    a. AMA Physicians Profile for MDs and AOA Official Osteopathic Physician Profile for DOs
    b. The state licensing boards if the organization confirms that the state board does verify residency
    c. Confirmation from an association of schools of the health

117. AAAHC standards require appointments to be for no longer than

    a. One year
    b. Two years
    c. Three years

118. Substantive and procedural are two distinct elements of

    a. medical staff appointment.
    b. due process.
    c. privileging.

119. Which of the following is a requirement of the Joint Commission for the medical staff?

a. Participation in the Maryland Quality Indicator Project
b. Reporting to the National Practitioner Data bank and state licensing board those individuals who have had privileges suspended or revoked based on quality of care concerns
c. Define circumstances requiring focused review of a practitioner's performance

120. Which Federal agency has been delegated the responsibility for conducting the Medicare Program?

a. Centers for Medicare and Medicaid Services
b. Civilian Health and Medical Program
c. Federal Employee Health Benefits Program

121. What term best describes the examination and evaluation of the appropriateness of use of an organization's resources to determine medical necessity and cost effectiveness of services provided?

a. Peer review
b. Resource based value system
c. Utilization review or utilization management

122. Which is the term applied to initial appointment to the medical staff to permit observation for monitoring and evaluation of physician performance?

a. Temporary
b. Locum tenens
c. Provisional appointment

123. Which term applies to a practitioner filling in or working in place of another practitioner?

a. Temporary staff
b. Locum tenens
c. Provisional member

124. Which term is used to describe the use of criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff appointment or privileges or continued participation in a provider panel of a managed care plan?

a. Credentialing criteria
b. Case management
c. Economic credentialing

125. New amendments to the Medicare Conditions of Participation are officially published in the

a. Journal of the American Hospital Association.
b. Joint Commission of Accreditation of Healthcare Organizations Manual for Hospitals.
c. Federal Register.

126. Which type of hospital board consists of non-paid individuals who contribute their time and expertise in the interest of service to the facility or to the community?

a. Philanthropic
b. Corporate
c. Board-in-residence

127. Mind-body interventions, biologically-based treatments, manipulative and body-based methods, and energy therapies are all examples of

a. conventional medicine.
b. alternative or complimentary medicine.
c. physician privileging categories.

128. Which term describes skilled and intermediate nursing facilities, hospice programs, community mental health centers, and home health care systems are designed to provide needed services in manner that is more cost effective than in a hospital?

a. Alternative delivery systems
b. Skilled care systems
c. Managed care

129. Which term describes an organization which reviews services provided under the Medicare program to determine whether a hospital has misrepresented admission or discharge information or has taken an action that results in the unnecessary admission of an individual entitled to benefits under Medicare Part A?

a. National Committee on Quality Assurance
c. Joint Commission on Accreditation of Healthcare Organizations
c. Peer Review Organization

130. Which term describes programs providing palliative care and emotional and physical support to terminally ill patients and their families, generally during the last six months of the patient's life in the patient's home?

a. Health maintenance organization
b. Long term care facility
c. Hospice

131. Which body acts for the medical staff as a whole, and makes recommendations to the governing body with regard to medical staff issues?

a. Medical staff peer review committee
b. Governing body
c. Medical executive committee

132. You go to the file cabinet and pick out 20 files for audit. This type of sample is called

a. a cluster sample.
b. a self-selected sample.
c. a simple random sample.

133. What is the name of the data collection developed by the Centers for Medicare & Medicaid Services to improve outcomes of patient care and to ensure that they receive the best health care available.

a. Core Measures
b. Uniform Patient Discharge Data Set
c. Medicare/Medicaid Patient Discharge Data Set

134. When a proctor visits a hospital nursing station to review inpatient health records, this is called

a. retrospective review
b. concurrent review
c. discharge analysis

135. In any computerized data collection system

a. there is too much data collected to provide accurate reporting mechanisms.
b. computerized information processing requires quality control checks to be performed.
c. there is never enough data collected to provide optimal reliability in computations.

136. Which graphical presentation type always depicts percentages?

a. bar graph
b. pie chart
c. histogram

137. A person against whom an action is brought in a lawsuit is the

a. appellee
b. plaintiff
c. defendant

138. What a reasonably prudent person would have done under similar circumstances is termed the

a. duty of the provider
b. standard of care
c. patient-physician privilege

139. The party who commences a lawsuit is the

a. defendant
b. appellant
c. plaintiff

140. In order to verify HIPPA security provisions are met, an organization should have a

a. Chain-of-Trust Partner Agreement
b. Business Continuity Plan
c. Information Access Control Plan

141. According to the Medicare Conditions of Participation for Hospitals, criteria for selection to the medical staff must include individual competence, training, experience, judgment and

a. character.
b. ability to perform the procedures requested.
c. board certification.

142. Which statement is characteristic of a group practice?

a. It consists of a single specialty or multi-specialty and provides comprehensive care.
b. It has management responsibility for providing comprehensive prepaid patientcare.
c. It is an organized outpatient department physically separate from the hospital.

143. Which is an example of what would be include in a medical staff rule and regulation?

a. Description of the medical staff organization including leadership
b. Description of how members are appointed to the emergency room call schedule
c. Qualifications for medical staff membership

144. Compliance by a hospital with which of the following would be considered voluntary?

a. HFAP standards
b. Medicare Conditions of Participation
c. State hospital licensing regulations

145. According to the DNV, a History and Physical completed within 30 days prior to admission or registration shall include an entry in the medical record which documents an examination for any change in the patient's current medical condition and placed in the patient's medical record within what time frame?

a. Within 48 hours prior to the admission or registration
b. Immediately upon admission or registration, but prior to surgery or high-risk procedures
c. Within 24 hours after admission or registration, and prior to surgery requiring anesthesia services or high-risk procedure

146. A departmentalized medical staff is organized according to service. What is the title of the medical staff leader who is responsible for directing the functions of each service?

a. chairperson
b. supervisor
c. coordinator

147. Automatic Suspension of clinical privileges may be considered at a DNV accredited hospital for the following instances:

a. Providing an incomplete application; not disclosing three professional references
b. Revocation/restriction of professional license; non-compliance with completing medical records
c. Revocation/restriction of professional license; non-compliance in attending all medical staff meetings; and not utilizing all clinical privileges granted

148. In selecting a new information system, the primary consideration should be the

a. cost of the system
b. requirements of the user
c. available technology

149. According to the DNV, if the medical staff has an executive committee, who must attend the meetings?

a. Medical Staff Members and CEO
b. Medical Staff Members only
c. Medical Staff Members, CEO and CNO (or designee) on an ex-officio basis

150. Information is

a. less complex than data.
b. part of data.
c. compiled from data.

151. In addition to the Chief Executive Officer, what medical staff authority is required for granting temporary privileges.

a. Medical Executive Committee
b. Member of the Executive Committee, President of the Medical Staff, or Medical Director
c. President of the Medical Staff

152. A system that shows who has accessed what information in a computer system, such as a patient registration database, is called a (an)

a. audit trail
b. smart card
c. access point

153. Which term most accurately defines programs designed to control liability for human errors and equipment failures?

a. utilization review/management programs
b. quality management programs
c. risk management programs

154. According to Joint Commission standard, relevant findings from quality management activities must be considered as part of the

a. reappointment of clinical privileges of medical staff members.
b. selection or election of medical staff officers.
c. renewal of contracts with physicians.

1.	C
2.	C
3.	A
4.	B
5.	B
6.	C
7.	C
8.	A
9.	B
10.	C
11.	C
12.	C
13.	C
14.	C
15.	B
16.	B
17.	C
18.	B
19.	C
20.	C
21.	C
22.	A
23.	A
24.	A
25.	A
26.	A
27.	A
28.	A
29.	A
30.	B
31.	A
32.	A
33.	A
34.	B
35.	C
36.	C
37.	C
38.	C
39.	A

40.	A
41.	B
42.	A
43.	A
44.	C
45.	C
46.	A
47.	B
48.	A
49.	A
50.	C
51.	C
52.	C
53.	B
54.	B
55.	C
56.	C
57.	C
58.	C
59.	C
60.	C
61.	C
62.	B
63.	C
64.	C
65.	B
66.	B
67.	A
68.	C
69.	B
70.	B
71.	C
72.	A
73.	C
74.	B
75.	C
76.	B
77.	B
78.	A

79.	C
80.	C
81.	A
82.	C
83.	C
84.	B
85.	C
86.	A
87.	B
88.	B
89.	C
90.	C
91.	C
92.	B
93.	A
94.	A
95.	C
96.	A
97.	C
98.	A
99.	C
100.	A
101.	C
102.	B
103.	C
104.	C
105.	C
106.	B
107.	A
108.	B
109.	C
110.	C
111.	C
112.	B
113.	A
114.	C
115.	C
116.	A
117.	C

118.	B
119.	C
120.	A
121.	C
122.	C
123.	B
124.	C
125.	C
126.	A
127.	B
128.	A
129.	C
130.	C
131.	C
132.	C
133.	A
134.	B
135.	B
136.	B
137.	C
138.	B
139.	C
140.	C
141.	A
142.	A
143.	B
144.	A
145.	C
146.	A
147.	B
148.	C
149.	C
150.	A
151.	B
152.	A
153.	C
154.	A