Documenting Provider Competency: Tips and Tools

Session Code: WE10
Time: 10:30 a.m. – 12:00 p.m.
Total CE Credits: 1.5
Presented by: Kathy Matzka, CPMSM, CPCS
Documenting Provider Competency: Tools and Techniques

Presented by Kathy Matzka, CPMSM, CPCS

What is competence?

• Ability to do a particular activity to a prescribed standard or a desirable outcome
• Based on knowledge, traits, skills, and abilities

ACGME and ABMS Core Competencies

Interpersonal and Communication Skills
Practice-based Learning and Improvement
Core Competencies
Medical Knowledge
Patient Care and Procedural Skills
Professionalism
Systems-Based Practice
Verification of Competency

- Training program
- Affiliations
- Peers

See sample letters pps 1-8

Provisional Appointment

- Clinical work is subject to review and evaluation for a period of time
- May include proctorship, chart review
- Need adequate volume

Performance Improvement (PI)

“The continuous study and adaptation of a health care organization’s functions and processes to increase the probability of achieving desired outcomes and to better meet the needs of individuals and other users of services” - Joint Commission
**Intent of PI**

- Monitor patient care - appropriateness and timeliness
- Provide a mechanism for responding to and reporting issues
- Identify and address impediments to improving patient care
- Enhance patient outcomes

**Joint Commission FPPE**

- All initially requested privileges (new app or current member)
- When issues affecting the provision of safe, high quality patient care are identified
- Consistently implemented

**TJC – FPPE required components:**

- Criteria for conducting performance evaluations
- Method for establishing the monitoring plan specific to the requested privilege
- Method to determine the duration of performance monitoring
- Circumstances under which monitoring by an external source is required
Components of FPPE

- The issue
- Start date
- Means of identifying and documenting the issue
- Periodic reporting as the review progresses
- Interventions taken during the review to correct problematic issues
- Completion date or endpoints of the review
- Final analysis
- Mechanism for reporting results

See FPPE Plan – Pg 9

Joint Commission OPPE

- Used in decision to maintain/revise/revoke privileges:
- Clearly defined process that facilitates evaluation of each practitioner’s professional practice
- Type of data to be collected is determined by individual departments and approved by the MS
- Information is used to determine whether to continue, limit, or revoke any existing privilege

Potential Aspects of OPPE/FPPE:

- Periodic chart review
- Direct observation/Proctorship
- Monitoring of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of each patient

See proctorship forms pps 10 - 11
Sample Indicators – Current Appointees

- Small number of admissions or procedures
- Longer LOS than other practitioners
- Unplanned returns to surgery
- Frequent or repeat readmission
- Patterns of unnecessary diagnostic testing/treatments
- Failure to follow approved clinical practice guidelines

Indicators for APRNs and PAs

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<th>ED Physician Assistant</th>
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<td>ED MD monitor/proc-</td>
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<td>Death in ED</td>
<td>ICU admission due to</td>
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<td>Unplanned returns</td>
<td>anesthesia management</td>
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<td>Patients admitted to</td>
<td>Discussions with OR</td>
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<td>Anesthesiologist present in OR room</td>
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Documenting Recommendations

Use standardized forms
- FPPE/OPPE
- Appointment/Privileges
Document in minutes

See sample form and language pps 13-16
Low or No Volume Practitioners

- Get data from another organization
- Peer recommendations
- Ask them why they want to be on staff
- Consider using temporary privileges rather than staff appointment
- If referring to hospitalist, consider “admit and follow privileges” or “refer and follow” category

See samples pgs. 17-19

Medical Peer Review

“...process by which a professional review body considers whether a practitioner’s clinical privileges or membership in a professional society will be adversely affected by a physician’s competence or professional conduct. The foremost objective of the medical peer review process is the promotion of the highest quality of medical care as well as patient safety.”

- Source AMA

Peer Reviewer Selection

- Peer = Individual with subject matter expertise who is practicing in the same professional discipline (i.e. MD, DO, DPM, DDS)
- No conflict of interest
- If no physician on the staff is qualified to conduct the review, the MEC or the Board of Trustees may request external peer review

See sample form pg 20
Practitioner’s Right to Access

Questions to Consider

• Is the requested information relevant?
• Is the requested information privileged or confidential under any law or regulation?
• Was the supplier of the information promised confidentiality?

Right to Access – Things to Keep in Mind

• At some point in the peer review process, the affected practitioner
  – Will have access to everything the decision making body reviewed OR,
  – May have access to everything relating to the discussion from his or her file.
• Be deliberate and precise in all documentation: minutes, reports, etc.

Protecting Confidentiality

• Never discuss credentialing or peer review activities outside the actual process
• Ask legal counsel to review responses regarding practitioners who have had disciplinary actions or use NPDB report language
• Store in secure area
• Obtain signed release
ACPE 2006 Survey Patient Trust and Safety

Is there a doctor in your community that you would avoid because you think he or she makes medical mistakes?

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<thead>
<tr>
<th>Patient Responses</th>
<th>Physician Responses</th>
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<tbody>
<tr>
<td>20% Yes</td>
<td>77% Yes</td>
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<tr>
<td>78% No</td>
<td>23% No</td>
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<tr>
<td>2% Don't know</td>
<td></td>
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Mongan Institute for Health Policy at Mass. General Hospital 7/2010 Study

- 64 percent agreed that physicians should always report impaired or incompetent colleagues
- 17% had direct personal knowledge of impaired colleague, but only 67% reported

Reasons for not Reporting

- Someone else is taking care of problem
- Nothing will happen
- Fear of retribution

"Our findings cast serious doubt on the ability of medicine to self-regulate with regard to impaired or incompetent physicians"
Questions/Comments/Discussion
Provider Competency Evaluation and Documentation

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BIOGRAPHICAL SKETCH, KATHY MATZKA, CPMSM, CPCS

Kathy Matzka, CPMSM, CPCS is a speaker, consultant, and writer with over 25 years of experience in credentialing, privileging, and medical staff services. She holds certification by the National Association Medical Staff Services (NAMSS) in both Medical Staff Management and Provider Credentialing. Ms. Matzka worked for 13 years as a hospital medical staff coordinator before venturing out on her own as a consultant, writer, and speaker.

Ms. Matzka has authored a number of books related to medical staff services including *Medical Staff Standards Crosswalk: A Quick Reference Guide to The Joint Commission, CMS, HFAP, and DVN Standards*, *Chapter Leader’s Guide to Medical Staff: Practical Insight on Joint Commission Standards*, *Compliance Guide to Joint Commission Medical Staff Standards*, and *The Medical Staff Meeting Companion Tools and Techniques for Effective Presentations*. For the past eight years, she has been the contributing editor for *The Credentials Verification Desk Reference* and its companion website The Credentialing and Privileging Desktop Reference.

She has performed extensive work with NAMSS’ Education Committee developing and editing educational materials related to the field including CPCS and CPMSM Certification Exam Preparatory Courses, CPMSM and CPCS Professional Development Workshops, and NAMSS *Core Curriculum*. These programs are essential educational tools for both new and seasoned medical services professionals. She also serves as instructor for NAMSS.

Ms. Matzka shares her expertise by serving on the editorial advisory boards for two publications - *Briefings on Credentialing*, and *Credentialing & Peer Review Legal Insider*.

Ms. Matzka is a highly-regarded industry speaker, and in this role has developed and presented numerous programs for professional associations, hospitals, and hospital associations on a wide range of topics including provider credentialing and privileging, medical staff meeting management, peer review, negligent credentialing, provider competency, and accreditation standards.

In her spare time, Ms. Matzka takes pleasure in spending time with her family, listening to music, traveling, hiking, fishing, and other outdoor activities.
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SAMPLE LETTER FOR VERIFICATION OF TRAINING

[Date]

Re: [Applicant’s full name, Title]
Training: [Residency/fellowship]
Specialty: [Specialty]
Dates: [From/to]

Dear [Program Director name):

We have received an application from the above-named provider for medical staff appointment and/or privileges. A copy of the privileges requested is attached. The applicant noted that the above-specified training took place at your institution. In order to process the application we require verification of completion of training and documentation of experience, ability, and current competence on the six areas of “General Competencies” adopted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative.

Our policies require completion of the enclosed form. Failure to receive this form will delay consideration of the applicant’s request for privileges. Also, our policies require the physician to document competency in performing specific procedures by allowing our organization to obtain a copy of his/her procedure list from your program and the outcomes for those procedures (if outcomes are available). The applicant has authorized you to provide this information to our organization via signature on the attached Authorization and Release Form.

Enclosed is a copy of a release and immunity statement signed by the applicant consenting to this inquiry and your response. The immunity statement releases from liability any individual who provides the requested information.

Thank you for your assistance. We look forward to hearing from you.

Sincerely,

Director

Enclosures
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<th>NO</th>
<th>Unable to Evaluate</th>
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<tbody>
<tr>
<td>1 Were you the director of the program at the time of this applicant's training?</td>
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<td>2 Was the applicant at your institution in the above program for the stated period of time?</td>
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<td>3 Was the program fully accredited throughout the applicant’s participation in it?</td>
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<td>4 Did the applicant successfully complete the program?</td>
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<td>5 Did the applicant receive satisfactory ratings for all aspects of his/her training in the program?</td>
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<td>6 Was the applicant ever subject to or considered for disciplinary action?</td>
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<td>7 Did the applicant ever attempt procedures beyond his/her assigned training protocols?</td>
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<td>8 Was the applicant’s status and/or authority to provide services ever revoked, suspended, reduced, restricted, not renewed, or was he/she placed on probationary status or reprimanded at any time or were proceedings ever initiated that could have led to any of the actions?</td>
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<td>9 Did the applicant ever voluntarily terminate his/her status in the program or restrict his/her activities in the program in lieu of formal action or to avoid an investigation?</td>
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<td>10 In reviewing the attached request for privileges, do you feel that the applicant’s training and experience included these procedures?</td>
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<td>11 In reviewing the attached request for privileges, do you feel that the applicant is currently competent to carry out these procedures?</td>
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<td>12 Are you aware of any physical or mental condition that could affect this practitioner’s ability to exercise clinical privileges in his/her specialty area, or would require an accommodation to exercise those privileges safely and competently?</td>
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**Comments:**

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<th>Question</th>
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Training Program Director’s Evaluation and Recommendation

Re: [Applicant’s full name]
Training: [Residency/fellowship]
Specialty: [Specialty]
Dates: [From/to]

Please rate the applicant in each of the following areas:

<table>
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<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Unable to evaluate</th>
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<tr>
<td>Patient care/Procedural Skills</td>
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<td>Medical knowledge</td>
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<td>Practice-based learning and improvement</td>
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<td>Interpersonal and communication skills</td>
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<td>Systems-based practice</td>
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This evaluation is based upon:

☐ Personal knowledge of the applicant.
☐ Review of file.
☐ Other ____________________________________________

Overall Recommendation (check ONE):

☐ I recommend privileges as requested without reservation.
☐ I recommend privileges as requested with the following reservation(s) (use back of form, if necessary
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

☐ I do not recommend this applicant for the following reason(s)
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

Signature ___________________________________________________ Date ___________________________

Name, Position/Title (Please Print) __________________________ Phone Number ___________________

Please return this form within 2 weeks. Failure to receive the form will delay consideration of the applicant’s request for privileges.
SAMPLE LETTER: FACILITY PRIVILEGES AND COMPETENCY VALIDATION

Date

Facility Name
Facility Address

Regarding applicant: John Doe, M.D.
Specialty: General Surgery

Dear Medical Services Professional:

We have received an application from the above-named provider for medical staff appointment and privileges. A copy of the privileges requested is attached. The applicant noted that s/he currently, or has in the past, held privileges at your facility. In order to process the application we require documentation experience, ability, and current competence on the six areas of “General Competencies” adopted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative. These competencies include assessment of patient care, interpersonal and communication skills, professionalism, medical knowledge, practice-based learning and improvement, and systems-based practice.

**Our policies require completion of the enclosed form. Failure to receive this form will delay consideration of the applicant’s request for privileges. Also, our policies require the physician to document competency in performing specific procedures by allowing our organization to obtain a copy of his/her privilege form from your hospital as well as a list of the actual procedures performed in the past 12 months and the outcomes for those procedures. The applicant has authorized you to provide this information to our organization via signature on the attached Authorization and Release Form.**

Sincerely,

Medical Staff Coordinator
CONFIDENTIAL EVALUATION OF PRIVILEGES AND COMPETENCY VALIDATION

Name of Facility Providing Information:___________________________________________________________

Name of Practitioner for which Information is Provided:_____________________________________

Dates on Staff: From ________________________________  To ____________________________________

Has the practitioner been subject to any disciplinary action, restrictions, modifications, or loss of privileges or medical staff appointment either voluntary or involuntary at your facility?  □ Yes  □ No

Are you aware of any restrictions, modifications, or loss of privileges or medical staff appointment, either voluntary or involuntary, at another facility? □ Yes □ No

Are you aware of any physical or mental condition that could affect this practitioner’s ability to exercise clinical privileges as requested, or would require accommodation to perform privileges safely and competently? □ Yes □ No

If the answer to any of the above questions is “YES”, please explain:
________________________________________________________________________
________________________________________________________________________

Evaluation: Please rate the practitioner in the following areas.

- **Patient Care** is compassionate, appropriate, and effective for the treatment of health problems and promotion of health. Procedural skills are adequate and reflect those of a graduate of an accredited training program.

- **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

- **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.

- **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals.

- **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

- **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

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<th>Excellent</th>
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<td>Systems-based practice</td>
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_______________________________________  ______________________________
Signature                          Date

Name, Position/Title (Please Print)       Phone Number

Please return this form within 2 weeks along with a copy of the applicant’s privilege list for your hospital and a list of the actual procedures performed in the past 12 months and the outcomes for those procedures.
SAMPLE PEER RECOMMENDATION LETTER

Date

Facility Name
Facility Address

Regarding applicant: John Doe, M.D.
Specialty: General Surgery

Dear ______________:

We have received an application from the above-named provider for medical staff appointment and privileges. A copy of the privileges requested is attached. The applicant has listed you as a peer who will be willing to provide a recommendation. In order to process the application we require your evaluation of the applicant’s experience, ability, and current competence in the areas of medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

Our policies require completion of the enclosed form. Failure to receive this form will delay consideration of the applicant’s request for privileges. You may supplement the form with additional information, if you so desire. The applicant has authorized you to provide this information to our organization via signature on the attached Authorization and Release Form.

Sincerely,

Medical Staff Coordinator
SAMPLE PEER RECOMMENDATION FORM

CONFIDENTIAL Professional Peer Reference & Competency Validation
Page 1 of 2

Name of Applicant:________________________________________________________________________________

Name of Evaluator:____________________________________ Relationship to Applicant:____________________________________

How well do you know the applicant? □ not well □ casual personal acquaintance □ professional acquaintance □ very well

Do you refer your patients to the applicant? □ yes □ no. If no, list reason(s) why not ____________________________________________

PLEASE RATE THE PRACTITIONER IN THE FOLLOWING AREAS

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<th>Area</th>
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Medical knowledge - Practitioner should have a good knowledge of established and evolving biomedical, clinical, and cognate sciences, and how to apply this knowledge to patient care. This is evidenced by completion of educational and training requirements as well as on-the-job experience, inservice training, and continuing education.

Technical and clinical skills - Skill involves the capacity to perform specific privileges/procedures. It is based on both knowledge and the ability to apply the knowledge.

Clinical judgment - Clinical judgment refers to the observations, perceptions, impressions, recollections, intuitions, beliefs, feelings, inferences of providers. These clinical judgments are used to reach decisions, individually and/or collectively with other providers, about a patient’s diagnosis and treatment.

Communication skills - The provider should create and sustain a therapeutic and ethically sound relationship with other care givers, patients, and their families. He/she should be able to communicate effectively and demonstrates caring, compassionate, and respectful behavior. This also includes effective listening skills, effective nonverbal communication, eliciting/providing information, and good writing skills.

Interpersonal skills - Areas of evaluation include how the provider works effectively with other professional associates, including those from other disciplines, to provide patient-focused care as a member of a healthcare team.

Professionalism - Professionalism is demonstrated by respect, compassion, and integrity. It means being responsive and accountable to the needs of the patient, society, and the profession. It means being committed to providing high-quality patient care and continuous professional development as well as being ethical in issues related to clinical care, patient confidentiality, informed consent, and business practices.
Name of Applicant: ____________________________________________________________

Name of Evaluator: __________________________________________________________

Relevant training and experience – In reviewing the attached request for privileges, do you feel that the applicant’s training and experience are adequate to carry out these procedures?

☐ No - If no, please provide an explanation ______________________________________
☐ Yes
☐ Unable to evaluate

Current competence – In reviewing the attached request for privileges, do you feel that the applicant is currently competent to carry out these procedures?

☐ No - If no, please provide an explanation ______________________________________
☐ Yes
☐ Unable to evaluate

Health Status - Are you aware of any physical or mental condition that could affect this practitioner’s ability to exercise clinical privileges in his/her specialty area, or would require an accommodation to exercise those privileges safely and competently?

☐ No
☐ Yes - If yes, please provide an explanation ______________________________________
☐ Unable to evaluate

Overall Recommendation (check ONE):

☐ I recommend privileges as requested without reservation.

☐ I recommend privileges as requested with the following reservation(s) (use back of form, if necessary

________________________________________________________________________________

________________________________________________________________________________

☐ I do not recommend this applicant for the following reason(s) ___________________________________________

________________________________________________________________________________

________________________________________________________________________________

Signature ___________________________ Date ___________________________

Name, Position/Title (Please Print) ___________________________ Phone Number ___________________________

Please return this form within 2 weeks. Failure to receive the form will delay consideration of the applicant’s request for privileges.
FOCUSED PROFESSIONAL PRACTICE EVALUATION PLAN

Practitioner Name: _______________________________________________
Medical Staff Department: _________________________________________
Practitioner Specialty: ____________________________________________

Reason(s) for Review

- Initially requested privilege(s) for current medical/professional staff (list privilege(s)) ____________________
- Newly-credentialed practitioner new to staff
- Referred to peer review due to incident
- Low volume of clinical activity
- Trigger (list) ______________________________________________________
- Other: ___________________________________________________________

Duration (Complete for recommended timeframe and/or volume)

- Time Specific: Start Date: ___________________ End Date:____________
- Volume Specific: Designated # of Cases: __________
- Other (specify): _________________________________________________

Method for Monitoring (Check all that apply)

- Chart review
  - Retrospective (name of reviewer) ____________________________________________
  - Concurrent (name of reviewer) _____________________________________________
- Direct observation by (name of observer) _______________________________________
- Monitoring of diagnostic and treatment techniques and clinical practice patterns via QAPI program
- Proctoring by (name of proctor) _____________________________________________
- External Review (list criteria met)
- Discussions with other individuals, involved in the care of the patient, including consulting physicians, assistants at surgery, nursing and administrative personnel
- Other (list) ___________________________________________________________________

Additional Individual(s) Assigned for Review/Observation/Monitoring/Proctoring

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Additional Details/Specifics of Plan

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

SIGNATURE:_________________________________________ Date: ______________________

Departmental Chair                                                                                   

Printed Name of Department Chair
SAMPLE PROCTORSHIP FORM

Verification of Proctored Procedure/Treatment

If a surgery or an invasive procedure is performed, the Proctor should evaluate the indication for the procedure, the technique for the procedure, how it is performed, and the preoperative, operative, and postoperative care of the patient. The Proctor may utilize the patient’s record, discussion with the physician, and actual observation as the basis for the review.

Proctored Physician: _____________________________ Date: _____________________________

Proctor: __________________________________________________________________________

Procedure/Treatment: __________________________________________________________________________

Comments: __________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Areas of in need of Improvement: __________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Procedure Completed Successfully: _____ Yes  _____ No

________________________________________

Signature, Proctoring Physician  Date

________________________________________

Signature, Proctored Physician  Date
PROCTORING SUMMARY REPORT

Proctored Physician: ________________________________  Date: ___________________

Proctor: ______________________________________________________________________

Number of Procedures/Treatment Episodes Proctored: ________________________________

Comments: ___________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Areas in need of Improvement: _________________________________________________

___________________________________________________________________________

___________________________________________________________________________

_________________________________________  _______________________

Proctoring Completed Successfully:    _____ Yes    _____ No

Signature, Proctoring Physician  Date

Department Chair Recommendation

☐ The applicant appears to meet all of the qualifications for unsupervised practice in that
department, has discharged all of the responsibilities of staff membership, and has not
exceeded or abused the prerogative of the category to which the appointment was made, and
that the member has satisfactorily demonstrated the ability to exercise the clinical privileges
initially granted in those departments. It is recommended that proctoring cease.

☐ It is recommended that proctoring continue for _____________________________

(list number of procedures and/or time frame)

Comments______________________________________________________________

___________________________________________________________________________

_________________________________________  _______________________

Signature, Department Chairperson  Date
### Sample Indicators for LIP APRNs and PAs

<table>
<thead>
<tr>
<th>Specialty</th>
<th>FPPE</th>
<th>OPPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Midwife</td>
<td>• Proctor for first 2 cases vaginal delivery</td>
<td>• 3rd and 4th degree lacerations following vaginal delivery</td>
</tr>
<tr>
<td></td>
<td>• Review of charts for first 5 cases</td>
<td>• Delivery unattended by provider</td>
</tr>
<tr>
<td></td>
<td>• Discussion with nurse manager of OB and NB nursery</td>
<td>• Significant birth trauma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medical records legibility</td>
</tr>
<tr>
<td>CRNA</td>
<td>• Anesthesiologist present in OR room to proctor first 2 major surgical procedures</td>
<td>• ICU admission due to anesthesia management</td>
</tr>
<tr>
<td></td>
<td>• Discussion with OR nurse manager/OR staff</td>
<td>• Medical records legibility</td>
</tr>
<tr>
<td>Emergency Department PA</td>
<td>• ED physician closely monitor/proctor for (X) shifts</td>
<td>• Death in ED</td>
</tr>
<tr>
<td></td>
<td>• Visual monitoring of (X) procedures performed (i.e. suture of laceration, removal of foreign body, nasogastric intubation etc.)</td>
<td>• Unplanned returns within 48 hours for same complaint</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patients admitted to Med/Surg and moved to ICU within 4 hours of admission</td>
</tr>
<tr>
<td>APRN</td>
<td>Need to customize pertaining to area of practice.</td>
<td>• Refer to/consult with other health care professionals, as appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Order appropriate diagnostic tests</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medication usage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medical records documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Any department-specific indicators relevant to all LIPs</td>
</tr>
</tbody>
</table>
FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) REPORT

(To be included in Credentials File)

Practitioner Name:______________________________________________________

Department:____________________________________________________________

Time Period for Review: From:_____________________ To:__________________

The information from Focused Professional Practice Evaluation has been reviewed and based on this review:

☐ The practitioner is performing well or within desired expectations and it is recommended that current privileges continue and FPPE cease.

☐ Issue(s) exist or trigger(s) met requiring continuation of Focused Evaluation. The specific issue(s) is (are)___________________________________________

________________________________________________________________

________________________________________________________________

☐ Practitioner has not had sufficient patient volume or has not met assigned FPPE requirements. Continue FPPE for ________ months.

☐ Other______________________________________________________________

________________________________________________________________

________________________________________________________________

__________________________________                     _________________________
Signature, Department Chair                     Date

__________________________________                     _________________________
Name Department Chair
ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) REPORT

(To be included in Credentials File)

Practitioner Name: ____________________________________________________

Department: __________________________________________________________

Time Period for Review: From: ____________________ To: __________________

The information from Ongoing Professional Practice Evaluation has been reviewed and based on this review:

☐ The practitioner is performing well or within desired expectations and no further action is warranted. It is recommended that current privileges continue.

☐ Issue(s) exist or trigger(s) met requiring a focused evaluation. The specific issue(s) is (are) ____________________________________________ __________________________________________________________________

☐ Practitioner has had no patient contact for _____ months, notify practitioner and initiate focused review.

☐ Other ____________________________________________________________ __________________________________________________________________

____________________________________________________ ________________________
Signature, Department Chair Date

Name Department Chair
RECOMMENDATION AND APPROVAL FORM FOR MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGES

Practitioner Name:___________________________________________________

Staff Status:__________________ Department:__________________ Specialty:__________________

Departmental Recommendation
Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment of the applicant the following recommendations are made:

- Privileges be granted/renewed
- Medical staff membership be granted/renewed
- Additional privileges requested be granted
- Privileges be modified as follows: _________________________________________________________________________
  _______________________________________________________________________________________________________
- Privileges not be granted/renewed
- Medical staff membership not be granted/renewed (comment below)
- Additional privileges requested be denied (comment below)

Comments:___________________________________________________________________________________________

__________________________________________  ___________________________
  Department Chairman                             Date

Credentials Committee Recommendation
Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment of the applicant and on the evaluations and recommendations of the Department Chairman the following recommendations are made:

- Concur with recommendation(s) of the Department Chairman and forward these recommendations to the Medical Executive Committee
- Do not concur with the recommendations of the Department Chairman, and instead make the following recommendations:
  ______________________________________________________________________________
  _______________________________________________________

__________________________________________  ___________________________
  Credentials Committee Representative          Date

Medical Staff Executive Committee Recommendation
Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment of the applicant, and on the evaluations and recommendations of the Department Chairman and Credentials Committee, the following recommendations are made:

- Concur with recommendation(s) of the Department Chairman and Credentials Committee and forward these recommendations to the governing body for consideration.
- Do not agree with the recommendations of the Department Chairman, and Credentials Committee and instead make the following recommendations: _________________________________________________________________________

__________________________________________  ___________________________
  Medical Staff Executive Committee Representative  Date

Governing Body Approvals/Action Taken
Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment data and information, and on the recommendations of the Medical Staff, the following action is taken:

- Concur with and approve the recommendation(s) of the Medical Staff.
- Do not concur with the recommendations of the Medical Staff. Action taken is documented in Board minutes of _______________.

__________________________________________  ___________________________
  Board of Trustees Representative          Date
DOCUMENTING RECOMMENDATIONS

Sample language for medical staff minutes:

“Committee members reviewed the applications, the supporting documentation, the Department Chairmen’s recommendations, and information received during the credentialing and privileging processes [or insert OPPE/FPPE etc., as appropriate]. Based on this review, it is the committee’s opinion that the following applicants meet the requirements for Medical Staff appointment and have documented appropriate education, training, experience, current competency, clinical judgment, professionalism, and health status to perform the privileges requested. It was moved, seconded, and carried to recommend to the [fill in Credentials Committee or MEC as appropriate] approval of the following appointments and clinical privileges [or insert cessation of FPPE, etc]:”

Sample language for Board minutes:

“Board members reviewed the applications, the supporting documentation, the Department Chairmen’s recommendations, Medical Executive Committee’s recommendations, and information received during the credentialing and privileging processes [insert OPPE/FPPE etc., as appropriate]. Based on this review, it is the Board’s opinion that the following applicants meet the requirements for Medical Staff appointment and clinical privileges [insert cessation of FPPE etc., as appropriate] as recommended and it was moved, seconded, and carried to approve of the following appointments and clinical privileges [insert cessation of FPPE, etc]:”
**Admit and Follow Privilege Form**

Print Name: ___________________  ___________________ ____________________  
First       Last       Degree

Admit and Follow privileges include admitting a patient to the hospital and immediately referring patients to a Hospitalist or other Medical Staff member for inpatient care, following patients during the hospital stay, reviewing the medical record of referred patients and conversing with attending physician, consultants and hospital staff concerning referred patients.

Privileges do not include ordering tests, consultations, drugs or therapies for inpatients or entries in the medical record other than admitting orders.

☐ I request Admit and Follow Privileges.

I certify that I have requested only those privileges for which I am qualified by education, training, current experience and demonstrated competence. I understand that by making these requests that I am bound by the applicable Bylaws and policies of the Medical Staff and hospital. I also attest that my professional liability insurance covers the privileges I have requested.

---

**Refer and Follow Privilege Form**

Print Name: ___________________  ___________________ ____________________  
First       Last       Degree

Refer and Follow privileges include referring patients to a Hospitalist or other Medical Staff member for inpatient care, following patients during the hospital stay, reviewing the medical record of referred patients and conversing with attending physician, consultants and hospital staff concerning referred patients.

Privileges do not include ordering tests, consultations, drugs or therapies for inpatients or entries in the medical record.

☐ I request Refer and Follow Privileges.

I certify that I have requested only those privileges for which I am qualified by education, training, current experience and demonstrated competence. I understand that by making these requests that I am bound by the applicable Bylaws and policies of the Medical Staff and hospital. I also attest that my professional liability insurance covers the privileges I have requested.
Dear Dr. Name:

In order to meet the requirements of the Joint Commission standards and the Centers for Medicare and Medicaid’s Regulations, the Medical Staff and hospital must perform periodic evaluations of all Medical Staff members. According to the Joint Commission, it “would not be acceptable to find at the two year reappointment that someone has not performed a privilege for two years”.

In review of our records, we find that you have been appointed to the [Staff status], but you have not provided any inpatient services or consultation to patients at this hospital for a least two years.

We understand that many times, physicians may apply for staff privileges thinking they will utilize the hospital, but for a number of reasons, this doesn’t happen. In some cases, medical staff reapplication forms are completed by office staff and physicians may not put much thought into whether or not they would like to remain on the hospital staff. Additionally, physicians may initially apply for one staff status when another will more appropriately fit their needs.

In order to determine continued interest in providing inpatient care, consultation, or treatment, as well as the appropriateness of the staff category assigned to, the Medical Executive Committee and Board of [hospital name] recommended that all staff members who have not provided inpatient care or consultation in the past two years be asked to complete the attached survey.

A list of staff categories with their responsibilities and prerogatives are attached.

We ask that you complete the survey and return it by [date].

Thank you for your interest in and support of [hospital name]. If there is anything we can do to make your use of the hospital more efficient, please do not hesitate to contact us.

Sincerely,

Signature, Medical Staff President                Signature, Hospital CEO
Name: __________________________________________________________
Address: ________________________________________________________

Please provide the reason that you have applied for Medical Staff membership and appointment.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Current Staff Status: ____________________________________________

Requested Staff Status:
☒ No change
☒ Request change to (list) _______________________________________

□ I do not wish to continue Medical Staff appointment and hereby resign from the medical staff of [hospital].

Additional comments ____________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

_______________________________________  _________________
Signature                                      Date

________________________
Printed name
SAMPLE PEER REVIEW FORM

WARNING - The information contained in this report is CONFIDENTIAL. Improper disclosure of the information contained herein may result in disciplinary action, as well as civil or criminal penalties.

ASSIGNED TO DOCTOR(S):________________________________________________________

COMMITTEE/DEPARTMENT REFERRED TO:___________________________________________

EVENT DATE:______________________________________________________________

PATIENT RECORD #:___________________________________________________________

ADMISSION DATE:_____________________DISCHARGE DATE:___________________________

PHYSICIAN(S) INVOLVED IN REVIEW  ______________________________________________

REASON FOR REFERRAL: _________________________________________________________

________________________________________________________________________________

SUMMARY: ______________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

RESULTS OF PHYSICIAN REVIEW

☐ CARE APPROPRIATE - NO FURTHER ACTION NECESSARY  - Please provide documentation to reflect the bases for decision regarding the appropriateness of review of care/service. (Use back of page, if necessary.)

________________________________________________________________________________

________________________________________________________________________________

FURTHER ACTION NECESSARY AS STATED BELOW (Use back of page if necessary)

☐ Documentation Only  ☐ Counseling  ☐ Disciplinary Action  ☐ Refer to ____________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

PHYSICIAN REVIEWER SIGNATURE: _____________________________DATE______________