CERTIFIED PROVIDER
CREDENTIALING SPECIALIST
\textit{(CPCS)} PREPARATION COURSE
Module 1

Introduction
Course Overview

• Assumptions
• Purpose
• Course structure
Course Topics

• Credentialing & Privileging
  – Application Process
  – Initial Application
  – Clinical Privileging
  – Reappointment & Recredentialing
• Ongoing Monitoring
  – Primary Source Verification
• Supporting Departmental Operations
• Your Study Strategy
• Knowledge Assessment Exercise
Key Course Resources

- Consolidated standards – AAAHC, HFAP, NCQA, TJC, URAC
- Comparison of accreditation requirements for verification of credentials
- Key healthcare regulatory requirements
- Medicare CoPs
- Overview of health plan delegation
- Meeting management chapter
- Parliamentary Motions Guide
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.
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
CPCS Exam

150 multiple choice questions

– Credentialing and Privileging 55-63%
– Ongoing Monitoring 19-27%
– Supporting Departmental Operations 13-24%

NOTE: Exam is assembled in April of each year and administered in the fall, spring and summer.
Exam Success

- On average, 404 people sit for the exam every year.
- From 2009 to 2017, the average passing rate for the exam was 56%.

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Medical Environments

- Hospital
- Ambulatory Care/Surgery Center
- CVO
- Provider Organizations
- Health Plan
Hospital Credentialing Driven by:

Federal/State laws and regulations
- Medicare CoPs
- Healthcare Quality Improvement Act

Accreditation standards
- The Joint Commission (TJC)
- Healthcare Facilities Accreditation Program (HFAP)
- Det Norske Veritas - National Integrated Accreditation for Healthcare Organizations (DNV GL)
- Center for Improvement in Healthcare Quality (CIHQ)
Hospital Credentialing Driven by:

**Governing Documents:**
- Hospital and Medical Staff Bylaws
- Medical Staff Rules and Regulations
- Hospital and Medical Staff Policies and Procedures

**Standard of Care:**
- Legal aspect
Sample Organizational Chart: Health Plans/Provider Organization

- Committee
  - Director/Manager
    - Contracts Management
    - Financial Management
    - Client Services
    - Network Administration
Health Plan Credentialing Driven by:

- Federal/State laws and regulations
- Accreditation standards
  – NCQA and URAC
- Policies and procedures
- Standard of care (legal aspect)
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers (CAHPS)
- CMS
Organizational Chart: CVO
Varies Depending on Size

- Director
  - Contracts/Sales
  - Credentialing Staff
  - Human Resources
  - Bus. Intel/IT/Data Analyst
CVO Credentialing Driven by:

- Contract
- Policies and Procedures
- Accreditation Standards
  - NCQA
  - URAC
  - The Joint Commission
  - DNV GL
  - HFAP
  - CIHQ
Independent CVO vs. Organizational CVO

- Contracts with many outside organizations
- Typically for-profit company
- Must satisfy the accreditation requirements/needs of customers
Independent CVO vs. Organizational CVO

- Handles organization specific credentialing
- Bigger the system, the more “customers”
- May be structured as a part of the not-for-profit organization
- May be for-profit and have customers outside the organization
Ambulatory Care/Surgery Center Credentialing Driven By:

- Accreditation standards
  - AAAHC, TJC, NCQA, URAC, HFAP
- CMS regulations
- State and Federal law
- Policies and procedures
- Contractual agreements

- Ambulatory Care Governance Documents
  - Policies and Procedures
  - Bylaws
Review and Questions
Module 2

Credentialing and Privileging
Exam Content Outline Summary

- Analyze initial application and supporting documents
- Analyze reappointment/recredentialing application and supporting documents
- Process initial and reappointment/recredentialing applications using primary and secondary/equivalent sources
- Compile, analyze, validate, and present practitioner specific data
- Process practitioner requests for privileges
Credentialing and Privileging

Application Process
Process Overview

• Timeframe to process application defined in the bylaws for policy and procedures
• Should not begin until:
  • Application is complete
  • Primary source verification is complete
  • Current competency for privileges requested is obtained
• Complete vs Completed
• Hospital vs Health Plan
Activity 2.1:
Application Processing Steps (Mixed up)

- Credentials Committee reviews/recommends to MEC
- Verify completeness and that all requested materials are included
- Executive Committee reviews and recommends to board
- Notify applicant of final decision
- Medical director reviews and make final decision
- Process application: conduct PSV and verify current competency for privileges requested
- Board approval
- Chief of Service/Department Chair reviews and recommends
- Application is received
- Medical Director reviews and refers to credentials committee
- Process application, conduct PSV
- Credentials Committee reviews/approves
Expedited Credentialing

• Medical staff develops criteria
• Governing body subcommittee, at least 2
• Applicant for privileges is ineligible if:
  – Applicant submits an incomplete application
  – MEC final recommendation is adverse or has limitations
Expedited Credentialing (continued)

- Case-by-case basis evaluations, usually resulting in ineligibility:
  - 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
  - Pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant
Discussion

Steps in the application review process

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Review and Questions
NCQA Provisional Credentialing

- Current application and signed attestation
- PSV of current, valid license
- PSV of past 5 years of malpractice claims or settlements from the malpractice carrier, or NPDB
- No more than 60 calendar days
- Medical Director can approve “clean” files; other files go to Credentials Committee
Membership/Appointment vs. Privileges

What's the Difference?
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.

**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.
Membership/Appt. vs. Privileges

- Membership categories are described in medical staff bylaws
- 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)
Hospital Credentialing Communication

Communication of information regarding approval of privileges:

– Orient practitioner to facility (mandated topics)
– Notify facility representatives
– Access by key personnel of approved privileges (scope of practice)
– No required timeframes
NCQA Credentialing Communication

• When information obtained during the credentialing process varies substantially between the source and the practitioner
• Committee decisions must be communicated within 60 calendar days
  • All initial credentialing decisions
  • Recredentialing adverse decisions
• Notification of the following rights:
  • Right to correct erroneous information
  • Receive status of application upon request
  • Right to review information submitted
Credentialing decisions must be communicated, in writing, within 10 business days.
Review and Questions
Credentialing and Privileging

Initial Application
Activity 3.1: Application Challenges

• Work with your table to identify worst case situations occurring during the initial application phase
• Elect one person to describe the issue in one minute or less
RED FLAGS
Activity 3.2: Red Flag

- Review your scenario
- Discuss if the scenario represents a red flag
- If it is a red flag, why is it red?
- What is the appropriate follow up process?
- Report your decision to group
NCQA Application Timeframes: Completion of Application Process

- Organization defines timeframe
- NCQA does not require a timeframe for completion, but does set time limits on specific credentialing items
  - 180 days on licensure, malpractice history, Medicare/Medicaid, board certification, and licensure sanctions
  - 365 days for work history
  - Attestation signature
  - 60 days less for CVO
Advanced Practice Clinicians

LIP vs. Non-LIP – Defined by individual organization based on state regulations, accreditation standards, bylaws

NCQA – Organization defines, requires credentialing for non-physician practitioners who have an independent relationship with the organization, and who provide care

The Joint Commission – LIPs, APRNs, and PAs must be privileged

HFAP – addresses practitioners functioning under supervision who provide a medical level of care or perform surgical procedures
Consent and Release Form

Key element #1:
Applicant consents to disclosure and releases from liability the organization, its employees/representatives, and affiliates, when gathering, obtaining, and exchanging documents, records, and other information pertaining to his or her application.
Consent and Release Form

Key element #2:
Applicant authorizes any third parties to release information concerning his or her:

- Qualifications
- Credentials
- Clinical competence
- Quality assurance data
- Information pertaining to character
- Physical or mental health condition
- Behavior, ethics
- Claims history
- Disciplinary action
- Any other matter reasonably having a bearing on his or her qualifications
NCQA Attestation Form

• Must include an attestation, by the practitioner ONLY, to the correctness and completeness of the application.

• Verification time limit is 365 days.
Activity 3.3: Application Review Exercise

- Review each hospital profile
- Review the application form
- Discuss and respond to questions
  - Does applicant meet criteria for membership?
  - What issues need to be resolved?
  - What should communication to applicant include?
  - Appropriate consent and release form
  - Is an electronic signature acceptable on consent and release form?
CME

• Specialty specific
• Accrediting bodies require documentation and it is considered in reappointment/reprivileging decisions
• Appropriate documentation of CME
Due Process

• Hospital – fair hearing (MS process), appeal (board process)
  – May differ for medical staff members vs non-members
• Health Plans & Provider Organizations – practitioner appeal rights under NCQA
• HCQIA defines due process requirements for healthcare entities
• State regulations contain rules for both hospital and health plans & provider organizations
• Bylaws and policies must meet the most strict requirement – State or Federal
Initial Application Recap
Review and Questions
Credentialing and Privileging

Clinical Privileging
Clinical 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.
**Privileges Should Be:**

- Documented, objective, evidence-based process
- Based on defined criteria (training, experience, demonstrated current competence)
- Based on services provided (or soon to be provided) at the facility/location
- Consistently applied
- Continuously monitored (FPPE/OPPE)
- Approval process usually mirrors application approval process
Privileging System Considerations

- Core vs. Laundry vs. Category
- Developing minimum threshold criteria
- Special procedures
- Approval of forms
- Privilege form maintenance
When to Develop New Criteria

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

• First determine:
  – Board approval for the service/procedure
  – Required equipment
  – Necessary support staff
New Privileges: Issues

• Does the hospital support the new procedure?
• What training/experience is required?
• Are there any other requirements?
  – CME, board certification, training course, peer recommendations
• Will proctoring be required?
New Privileges: Issues

• What is the evaluation process for new criteria/forms?
• How will this be implemented?
• How will we follow up/review quality?
• Who will be able to do it? (turf issues)
Telemedicine Privileges
Telemedicine Overview

• The use of medical information exchanged from one site to another via electronic communications.
  – It is not a separate medical specialty – just another way of providing services.
• 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.
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
Temporary Privileges

• Who can grant?
• Under what circumstances can TP be granted?
• For how long can TP be granted?
Locum Tenens

A medical practitioner who temporarily takes the place of another
Emergency Privileges

Allows physicians to perform tasks outside of their existing privileges to save a patient’s life, limb, or organ
Disaster Privileges

- Include in Emergency Operations Plan
- Should have mechanism for oversight of volunteers
- Define requirements for credentialing
- Volunteers should only function within the scope of their license/certification
Activity 4.1: Temporary Privilege Exercise

• Review sample bylaws and scenario
• Discuss whether or not it is appropriate to grant TP
• Discuss what information needs to be verified to meet TJC standards and bylaws
Activity 4.2: Privileging/Terminology Exercise

Review Column A and match terms with meaning in Column B.
Privileges Recap
Review and Questions
Credentialing and Privileging

Reappointment/Recredentialing Process
Hospital Process

• Submit application that meets requirements
• Timeframe: 2 years for CMS, TJC, and HFAP
• Primary source verification
• CME
• Competency evaluation (related to privileges):
  – For LIPs: OPPE/quality monitoring
  – Non-LIPs brought to the hospital by LIPs – performance evaluations at same interval as employees in same discipline (TJC)
  – Peer recommendations
• Approval process: same as initial application
Health Plan/Provider Organization Process

- Must submit application that meets specific requirements
- Timeframe: 3 years for AAAHC, URAC, NCQA
- Scope of practitioners recredentialed are defined in policies and procedures
- Approval process is same as initial application
Activity 5.1: Recredentialing/Reappointment

- Review scenario
- Discuss and list options
- Pick one person from your table to report
Hospital Leave of Absence

• The practitioner’s current appointment cannot extend beyond 2 years.
• Medical Staff Bylaws should outline the process for requesting a leave of absence.
• Considerations when a practitioner takes a leave of absence:
  – Allow the reappointment to lapse and conduct full credentialing of the practitioner upon their return;
  – Process the practitioner’s reappointment during their leave of absence.
If the organization cannot recredential a practitioner within the 36-month time frame because the practitioner is on active military assignment, maternity leave or sabbatical, the organization documents this and recredentials the practitioner within 60 calendar days of the practitioner’s return to practice.
Reappointment/Recredentialing Process Recap
Review and Questions
Module 3
Verification and Ongoing Monitoring
Exam Content Outline Summary

- Monitor and evaluate practitioner sanctions, complaints, and adverse data
- Verify and document expirables
Ongoing Monitoring

Primary Source Verification
Overview

• Primary source verification (PSV) is required by all accrediting bodies
• Requirements vary by organization
  – The Joint Commission (TJC)
  – NCQA
  – URAC
  – AAAHC
  – HFAP

NOTE: Check our NAMSS online resources and standards comparison grid
Verification Sources

- Primary
- Secondary
- TJC Designated Equivalent
- NCQA Approved
What are some appropriate ways to document PSV?
PSV Challenge Game
PSV Challenge Game Rules

• Points are given for each correct answer and increase along with the difficulty of the question.
• The time limit is 30 seconds.
• When team comes up with the answer, indicate that they are ready.
• Contestant teams can ask their audience team for help one time (this is done at the end of the time limit).
• A contestant can resign, but not until the current question has been answered.
• Per NCQA, is the ABMS Certification Matters, accessible through the ABMS Web site, an acceptable source for verifying board certification for an MD?
Correct Answer

No.

This site is intended for consumer reference only and is not considered PSV.
10 Points

• TJC requires licensure to be verified with the primary source at what four times?
Correct Answer

1. Initial granting
2. Renewal of privileges
3. Revision of privileges
4. At the time of license expiration
• According to TJC, the hospital must query the National Practitioner Data Bank at what three times?
Correct Answer

When:
1. Clinical privileges are initially granted
2. Renewal of privileges
   • Renewal of privileges is pertinent to returning from a leave of absence
3. A new privilege(s) is requested
10 Bonus Points

• Can the hospital accept an NPDB self-query performed by a physician to satisfy TJC’s requirement for NPDB query?
Correct Answer

No.
The hospital or its designated agent must perform the query.
According to NCQA standards, on initial credentialing, an organization must verify sanctions or limitations on licensure in each state where the practitioner holds or has ever held licensure.

25 Points - True or False: True
Correct Answer

False.

The organization must verify sanctions or limitations on licensure in each state where the practitioner provides care to members.
According to NCQA standards, on initial credentialing, an organization must verify that the practitioner’s Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner has ever practiced.

True or False
Correct Answer

False.

The organization must verify sanctions or limitations on licensure in each state where the practitioner provides care to members.
According to HFAP Standards, in addition to querying the specialty board directly, what other sources can be used to verify board certification?
Correct Answer

• If certified by a member board of ABMS, verify with ABMS.
• If certified by a specialty board of AOA, verify with AOA Official Osteopathic Physician Profile.
According to AAAHC standards, is it appropriate to use information from another healthcare organization, i.e. hospital or group practice that has conducted PSV for credentialing?
Correct Answer

Yes.

Provided the other healthcare organization supplies the PSV directly, without transmission or involvement by the applicant or other third party.
According to TJC standards, peer recommendation must include written info on six elements. Five of these are:

- ✔ Patient Care
- ✔ Current Medical Clinical Knowledge
- ✔ Practice-based Learning & Improvement
- ✔ Interpersonal & Communication Skills
- ✔ System-based Practice

What is the sixth element that must be included in a peer recommendation?
Correct Answer

Professionalism
• Name three of the four appropriate sources for peer recommendations according to TJC standards.
Correct Answer

1. Performance improvement committee, majority members are the applicant’s peers

2. A reference letter(s), written documentation, or documented telephone conversation(s) about the applicant from a peer(s) who is knowledgeable about the applicant’s professional performance and competence

3. A department or major clinical service chairperson who is a peer

4. The medical staff executive committee
Per NCQA, is it acceptable to use confirmation from the state licensing agency in lieu of verification of education, residency training, and board certification?
Correct Answer

Yes.

If the state agency performs primary-source verification of these elements and, at least annually, the organization obtains written confirmation from the state licensing agency that it performs primary-source verification.
25 Bonus Points

• Name the accrediting body that requires criminal background checks.
Correct Answer

HFAP
According to AAAHC, ______________ must be monitored on an ongoing basis.
Correct Answer

1. Expirables
2. Aspects of patient care
Name the six Joint Commission designated equivalent sources and the elements that can be verified by using them.

Bonus Round: 20 points for each correct answer.
Correct Answer (20 Pts. Each)

1. AMA Physician Masterfile for a physician’s U.S. or Puerto Rican medical school graduation and residency completion
2. American Board of Medical Specialties (ABMS) for a physician’s board certification
3. ECFMG for a physician’s graduation from a foreign medical school
4. AOA Physician Database for a physician’s predoctoral education accredited by the AOA Bureau of Professional Education, postdoctoral education approved by the AOA Council on Postdoctoral Training, and Osteopathic Specialty Board Certification
5. FSMB for all actions against a physician’s medical license
6. American Academy of Physician Assistants (AAPA) Profile for the physician assistant education and NCCPA certification, provided through the AMA Physician Profile.
NCQA Ongoing Monitoring

- Medicare and Medicaid sanctions
- Sanctions or limitations on licensure
- Collecting and reviewing complaints
- Collecting and reviewing information from identified adverse events
- Collecting and reviewing quality issues
- Implementing appropriate interventions when instances of poor quality are identified
Expirables

- Licensure
- State Controlled Substance
- DEA
- Professional Liability (certificate of insurance)
- Other (facility specific requirements)
Verification and Ongoing Monitoring Recap
Review and Questions
Module 4
Supporting Departmental Operations
Exam Content Outline Summary

- Participate in internal and external audits
- Prepare and document meetings
Managing and Archiving Files

- Paper
- Electronic
- Policy for retention
File Audits

• Help verify compliance with the requirements of bylaws, accrediting agencies, and state and federal regulations.

• Tools should include availability of necessary documentation and completion within the required timeframe.

• Corrective action plan should be developed and implemented, if necessary.
Database Audits

• Garbage In = Garbage Out
• Evaluate data accuracy:
  – Run report from credentialing database containing information
  – Compare data with information from credentials file (if you are paperless, the database is your credentials file)
  – Look for missing data
  – Correct discrepancies
  – Rerun report to verify accuracy
• Audit who is accessing database to assure no breach in confidentiality
Integrity of Database Data

**Data integrity** refers to maintaining and assuring the accuracy and consistency of data over its entire life-cycle.

**Data preservation** refers to the activities necessary to ensure continued access to digital materials for as long as necessary.
Provider Directories

• Health Plan & Provider Organizations
  – Need a process for ensuring that listings in practitioner directories and other materials for members 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
Delegated Credentialing Oversight and Audit (NCQA)

- Yearly documentation of substantive evaluation and actions plans, if needed
- Must be based on the responsibilities stated in the delegation document and the appropriate NCQA standards
- Exception to annual audit requirement: if the delegate is an NCQA-accredited or -certified organization in the areas of credentialing and recredentialing
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
  – 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
Other Documents That Require Similar Review Processes

• Bylaws
• Policies and procedures
• Rules and regulations
• Privileges
Meeting Management

- Performing and coordinating meeting logistics
- Documentation preparation
- Follow-up
Fundamentals of Meeting Management

• Regularly scheduled meetings
• Preparation for meeting may include:
  – Development of an agenda
  – Notification of Members
  – Preparation of files and other packets of information to be distributed, emailed and/or presented
  – Arrangement of meeting logistics
  – Body of meeting
  – Adjournment
  – Minutes/Follow-up
Parliamentary Procedure
(aka Robert’s Rules of Order)

• Standard for facilitating discussions and group decision-making
• Four motions are used in smaller committee or board meetings to:
  – Introduce (motion)
  – Change a motion (amend)
  – Adopt (accept a report without discussion)
  – Adjourn (end the meeting)
Activity 7.1: Parliamentary Puzzler

• Using the grid provided select the appropriate steps for conducting a meeting in accordance to Robert’s Rules of Order.
• Refer to the Parliamentary Procedures provided in the resource material.
Operations Recap
Review and Questions
Module 5
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 learning strategies
• 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
  - Cross off 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 Questions

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

a. Administration
b. Health Information Management
c. Inpatient Services
Sample Questions

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.
Sample Questions

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
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.
Learning Strategies Exercise

- Visual strategies
- Auditory strategies
- Kinesthetic strategies
- Work with group to develop a varied list of effective study strategies
Three Keys to Success

Don’t Cram!

Don’t Cram!

Don’t Cram!
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.
Develop Your Strategy

Complete study plan worksheet in your participant guide
Form a Study Group

• Keep on schedule
• Share learning strategies
• Share expertise – teach others!
• In person, online, or over the phone
Review and Questions
Module 6
Assess Your Knowledge
Thank You!