Design and Implementation of Effective Criteria-Based Privileges

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Presented by

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Why Do We Privilege?

- Healthcare organizations determine a scope of services that can be provided within the organization – and then determine the practitioners who are qualified and currently competent to direct, manage, coordinate and provide the scope of services.

Values: At the Heart of a Criteria-Based Privileging Program

- How do physician leaders in your organization describe their role in credentialing and privileging?

- Do they expect to impact the quality of care provided at your organization by participating in the credentialing/privileging program?
Why Do We Privilege?

• **Reasons for development of delineated clinical privileges:**
  – Legal requirements established corporate liability
    • Darling v. Charleston Community Hospital (hospital’s duty to supervise physicians)
    • Purcell v. Zimbleman (improper review of clinical competence)
    • Johnson v. Misericordia (failure of initial credentialing process)

Why Do We Privilege?

– **Regulatory requirements**
  • Centers for Medicare and Medicaid Services (CMS)
  • The Joint Commission, HFAP, DNV
Current Focus of Clinical Privileging Systems: Current Competence

• What does “current competence” mean?
• The two dimensions of current competence are:
  – Recent activity
  – Quality performance information

National Emphasis on Competency

• American Council of Graduate Medical Education
  – Introduction of six general competencies (1999)
    • Patient Care
    • Medical/Clinical Knowledge
    • Practice-Based Learning and Improvement
    • Interpersonal and Communication Skills
    • Professionalism
    • Systems-Based Practice
National Emphasis on Competency

- **American Board of Medical Specialties**
  - Development of Maintenance of Certification program – centered around ACGME’s six general competencies

- **Other certification boards are also in the process of developing ongoing competency processes**
  - American Osteopathic Association Boards
  - Physician Assistant and Advanced Practice Nursing Boards

National Emphasis on Competency

- **Centers for Medicare and Medicaid Services (CMS)**
  - Focus on clinical privileges and criteria to perform privileges
    - Interpretive Guidelines revised on 10/17/08
CMS Requirements Related to Privileges

- **November 12, 2004 – memo to State Survey Agency Directors from the Director of the Survey and Certification Group of CMS**
  - The hospital’s Governing Body must ensure that all practitioners who provide a medical level of care and/or conduct surgical procedures in the hospital are individually evaluated by its Medical Staff and that those practitioners possess current qualifications and demonstrated competencies for the privileges granted.
  - State Survey Agency (SA) surveyors are to determine whether the hospital’s privileging process and its implementation of that process comply with the hospital Conditions of Participation (CoPs).

CMS Requirements Related to Privileges

- **Excerpts from the memo**
  - The process (for privileging) must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners.
  - Specific privileges (for each category of practitioner) must clearly and completely list the specific privileges or limitations for that category of practitioner. It cannot be assumed that a practitioner can perform every task/activity/privilege listed/specified for the applicable category of practitioner. The individual practitioner’s ability to perform each task/activity/privilege must be assessed and not assumed.
  - If the practitioner is not competent to perform one or more tasks/activities/privileges, the list of privileges is modified for that practitioner. Hospitals must assure that practitioners are competent to perform all granted privileges.
CMS Requirements Related to Privileges

- The Medical Staff must actually examine each individual practitioner's qualifications and demonstrated competencies to perform each privilege he/she has requested from the applicable scope of privileges for their category of practitioners. Components of practitioner qualifications and demonstrated competencies would include at least: current work practice, special training, quality of specific work, patient outcomes, education, maintenance of continuing education, adherence to medical staff rules, certifications, appropriate licensure, and currency of compliance with licensure requirements.

- Any privilege requested by and recommended for a practitioner beyond the specified list of privileges for their particular category of practitioner would require evidence of additional qualifications and competencies, and be an activity/task/procedure that the hospital can support and is conducted within the hospital.

CMS Requirements Related to Privileges

- The purpose of the Medical Staff’s evaluation of each individual practitioner is to determine that a new applicant possesses the qualifications and competencies to have specific privileges granted, or in the case of current members of the medical staff, to evaluate the individual practitioner’s qualifications and demonstrated competencies in order to determine if that practitioner’s clinical privileges should be continued, discontinued, or revised.

- CMS does not have a preference as to the “term” used to name the hospital’s privileging process. A hospital’s privileging process must comply with the CMS hospital CoPs. A privileging process that results in a practitioner being granted privileges based on other than the medical staff’s assessment of that individual practitioner’s qualifications and demonstrated competencies would not comply with CMS requirements.
Conditions of Participation: Medical Staff

§482.22(a)(1) (Excerpts)
The medical staff appraisal procedures must evaluate each individual practitioner’s qualifications and demonstrated competencies to perform each task or activity within the applicable scope of practice or privileges for that type of practitioner for which he/she has been granted privileges. Components of practitioner qualifications and demonstrated competencies would include at least: current work practice, special training, qualify of specific work, patient outcomes, education, maintenance of continuing education, adherence to medical staff rules, certifications, appropriate licensure, and currency of compliance with licensure requirements.

In addition to the periodic appraisal of members, any procedure/task/activity/privilege requested by a practitioner that goes beyond the specified list of privileges for that particular category of practitioner requires an appraisal by the medical staff and approval by the governing body. The appraisal must consider evidence of qualifications and competencies specific to the nature of the request. It must also consider whether the activity/task/procedure is one that the hospital can support when it is conducted within the hospital. Privileges cannot be granted to tasks/procedures/activities that are not conducted within the hospital, regardless of the individual practitioner’s ability to perform them.

The Joint Commission

- Recent Joint Commission standards revisions have raised the bar higher
  - Expanded definition of a competent practitioner
    - More than technically competent
    - Incorporation of the six general competencies into the Medical Staff standards (2008)
  - New practitioners that are required to be privileged
    - Physician Assistants and Advanced Practice Registered Nurses (2004)
  - New requirements for evaluation of competency
    - Focused Professional Practice Evaluation (2008)
Privileging is the process by which a health care organization, after reviewing an individual provider’s credentials and performance, authorizes the practitioner to perform a specific scope of patient care services within the organization. Privileging involves the following four distinct activities:

- Determining which clinical procedures or treatments the organization will offer and support
- Determining what training, skills, behaviors, and experience are required for authorization to perform each clinical procedure or treatment.
- Determining whether applicants for privileges meet these requirements and officially granting or denying the requested privileges.
- Monitoring the individuals who are granted privileges to ensure their continued competence and practice within the scope of privileges granted.

The Privileging Process

Establishing Privileging Criteria

Applying Privileging Criteria and Making Privileging Decisions
The Privileging Process

Monitoring Competency

Components of Privileging Criteria
Education and Training

- Completion of Professional School (MD/DO Degree, RN Degree, DPM Degree, etc.)
- Completion of accredited post graduate education (internship, residency, fellowship)
- Completion of formal training endorsed by recognized specialty society(ies)
  - Example: American College of Emergency Physicians endorsed training for emergency bedside ultrasound

Education and Training

- Preceptorships
  - A period of practical experience and training for a student, especially of medicine or nursing, that is supervised by an expert or specialist in a particular field (outside of an accredited program)
- Board Certification
- CME/CEUs
Education and Training

- Other recognized and reputable certifications
  - Examples
    - ACLS, ATLS, PALS, NALS
    - National Board of Echocardiography certification in TEE

Clinical Activity

- Number and types of patients admitted/discharged or treated
  - By diagnosis or DRG
- Number and types of consultations provided
  - By diagnosis or DRG
- Numbers and types of procedures performed
  - Reports on procedures performed that match terminology on privilege delineation forms are necessary (need cross-walk)
Clinical Activity

• **Specialty-specific clinical activity**
  – Anesthesiologists – types of anesthesia provided (perhaps by anesthesia classification)
  – Patients treated in the ED (by diagnosis) or number of hours worked in the ED. Procedures performed.
  – Radiologists – Invasive procedures performed. Number of interpretations (mammograms, CT, MRI, etc.)

Outcomes/Quality

• **Directly linked to privileges granted**
  – Data for pathology and radiology will be quite different from that for surgeons

• **In order to be of the most value, should be able to be compared to other practitioners in the specialty and/or to recognized benchmarks or organization-specific targets**
Outcomes/Quality

• **Mortality rates**
  – Can be calculated by diagnosis or DRG (for example, mortality rate for COPD)

• **Unexpected mortality rates**
  – Can be used for diagnoses where mortality is not anticipated

• **Complication rates**
  – Can be calculated by procedures (for example complication rate for TAH)

Outcomes/Quality

• **Length of Stay**
  – By diagnosis/DRG

• **Other utilization factors**
  – Blood Usage
  – Use of antibiotics

• **Malpractice**
Outcomes/Quality

- Passing a test (for use of moderate sedation, for example)
- Compliance with policies and procedures related to completion of patient records
  - H&Ps completed within 24 hours
  - Operative reports dictated immediately after surgery

Outcomes/Quality

- Incidents
  - Behavior
  - Lack of compliance with policies/procedures (for example, related to taking ER call)
- Patient Satisfaction
- Cost
  - Of hospitalization, or specific costs associated with a specific episode of care (for example, costs associated with drug therapy)
Outcomes/Quality

- New Methods
  - Simulation

Best Practices: Developing Effective Privileging Systems
Best Practices

• Privilege forms that accurately reflect the scope of services of the organization
• Privileges that are grouped or clustered in some way.
  – Setting clinical activity and outcome criteria against each individual diagnosis and/or procedure is not realistic (nor achievable by most organizations)

Historical Evolution of Privileging

1. Privileges were not delineated
2. Laundry lists or categories/levels of privileges
3. Bundled privileges and core privileges
Current Privileging Methodologies

Laundry list approach

• Characteristics
  – Usually procedure-focused
    • Cognitive privileges are often not defined
  – May be grouped in some logical fashion
  – May be simply listed alphabetically
  – All procedures/privileges given “equal weight”

Laundry list, cont.

– No or minimal criteria – often poorly defined
  • “Must provide evidence of training and experience” is often used on laundry list forms
    (some procedures have an asterisk that refers to this phrase)
– Often includes an invitation to add items to the laundry list (blank lines to write in additional procedures)
**Urology**

<table>
<thead>
<tr>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operations on vas deferens or epididymis</td>
</tr>
<tr>
<td>Orchidopexy</td>
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<tr>
<td>Orthidectomy</td>
</tr>
<tr>
<td>Other plastic penile operations</td>
</tr>
<tr>
<td>Percutaneous nephrolithotomy (with radiologist)</td>
</tr>
<tr>
<td>Percutaneous nephrolithotomy (without radiologist)</td>
</tr>
<tr>
<td>Plastic surgery for correction of scar</td>
</tr>
<tr>
<td>Prostate brachytherapy</td>
</tr>
<tr>
<td>Renal surgery (all approaches, including thoraco-abdominal)</td>
</tr>
<tr>
<td>Renal vascular surgery</td>
</tr>
<tr>
<td>Retro-peritoneal node dissection relative to genito-urinary pathology</td>
</tr>
<tr>
<td>Retropubic cysto-urethropexy</td>
</tr>
<tr>
<td>Urethroscopy</td>
</tr>
<tr>
<td>Vesico-vaginal fistula repair</td>
</tr>
</tbody>
</table>

**Orthopedic Surgery**

<table>
<thead>
<tr>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>JOINT PROCEDURES</td>
</tr>
<tr>
<td>Arthrodesis</td>
</tr>
<tr>
<td>Arthroscopy - diagnosis and treatment</td>
</tr>
<tr>
<td>Arthroplasty</td>
</tr>
<tr>
<td>Aspiration/injection</td>
</tr>
<tr>
<td>Arthroscopy</td>
</tr>
<tr>
<td>Replant arthroplasty</td>
</tr>
<tr>
<td>Soft tissue reconstruction</td>
</tr>
<tr>
<td>Synovectomy</td>
</tr>
<tr>
<td>Total joint replacement</td>
</tr>
<tr>
<td>LUMBAR DISCECTOMY</td>
</tr>
<tr>
<td>Anterior cervical discectomy</td>
</tr>
<tr>
<td>Discectomy</td>
</tr>
<tr>
<td>Discectomy, lumbar</td>
</tr>
<tr>
<td>PERIPHERAL NERVE</td>
</tr>
<tr>
<td>Endoscopic carpal tunnel release</td>
</tr>
<tr>
<td>Neurolysis/ Decompression</td>
</tr>
<tr>
<td>Repair</td>
</tr>
<tr>
<td>Transposition</td>
</tr>
<tr>
<td>SKIN GRAFTS/FLAPS</td>
</tr>
<tr>
<td>Advanced skin grafts</td>
</tr>
<tr>
<td>Cross flaps</td>
</tr>
<tr>
<td>Rotator flaps</td>
</tr>
<tr>
<td>Full thickness</td>
</tr>
<tr>
<td>Split thickness</td>
</tr>
<tr>
<td>Tubo or pedicle</td>
</tr>
<tr>
<td>Capless</td>
</tr>
<tr>
<td>SPINAL FUSION</td>
</tr>
<tr>
<td>Anterior/post-spondylitic fusion</td>
</tr>
<tr>
<td>Posterior/medial</td>
</tr>
</tbody>
</table>
Current Privileging Methodologies

Category (or Levels) Approach

- Characteristics
  - Often poorly defined
    - What cognitive and procedural privileges are included and may be granted/exercised
    - Leads to confusion and potential misinterpretations related to what privileges have been actually granted
  - Lack of definitive criteria
    - Broad criteria
    - Often not specifically defined
    - Again – may lead to confusion and misinterpretation

INTERNAL MEDICINE

LEVEL 1  Successful completion of ACGME-approved sub-specialty fellowship training in a recognized ABIM subspecialty (or AOA equivalent) or equivalent training. Physicians in this category can treat inpatients and outpatients within the ____ Health System, and will be competent in the diagnosis and management of the most complex Internal Medicine-related problems as well as in the supervision and teaching of residents and students. [It is preferred and recommended that applicants to the Medical Staff be certified by the appropriate Specialty Board, or be in the process of board certification. Following an evaluation and review of an application by the Credentials Committee comparable clinical competence may be recognized in lieu of the American Board certification process.]

LEVEL 2  Completion of an ACGME-approved residency (or AOA equivalent) in Internal Medicine or equivalent training. Physicians in this category can treat inpatients and outpatients within the ____ Health System and will be competent in the diagnosis and management of the more difficult Internal Medicine problems as well as in the supervision and teaching of residents and students.

LEVEL 3  Competency to render medical consultation in circumstances requiring the services of a licensed physician with training in Internal Medicine, Geriatrics, Long-Term Care or Family Practice but not necessarily completion of an Internal Medicine residency. Physicians in this category may not ordinarily supervise residents and students.
Current Privileging Methodologies

Core Approach

• Characteristics
  – Core relates to training (residency or subspecialty)
  – Non-core privileges have specific criteria
  – Poor to excellent – usually depends upon when an organization transitioned to core privileges (early core privileges were often not clearly defined as to what privileges were included in the core)
    • That issue has been corrected by the addition of “procedure lists” associated with the core that can be made applicant-specific

<table>
<thead>
<tr>
<th>University of ____ Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLINICAL AREA: FAMILY MEDICINE</td>
</tr>
<tr>
<td>Applicant: Place a check mark in the (R) column for each privilege requested. Initial applicants must provide documentation of the number and types of hospital cases during the past 24 months.</td>
</tr>
<tr>
<td>(R)=Requested (A)=Recommended as Requested (C)=Recommended with Conditions (N)=Not Recommended</td>
</tr>
<tr>
<td>Note: If Recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason for same must be stated on the last page of this form.</td>
</tr>
<tr>
<td>(R) (A) (C) (N) ADULT CORE PRIVILEGES</td>
</tr>
<tr>
<td>Privileges include but are not limited to admission and management of non-surgical or surgical patients over the age of 17, suture uncomplicated lacerations, I &amp; D abscess, simple skin biopsy or excision, removal of non-penetrating corneal foreign body, uncomplicated minor closed fractures, and uncomplicated dislocations.</td>
</tr>
<tr>
<td>(R) (A) (C) (N) PEDIATRIC CORE PRIVILEGES</td>
</tr>
<tr>
<td>Privileges include admission and management of the general pediatric patient under the age of 18 including but not limited to circumcision and lumbar puncture.</td>
</tr>
<tr>
<td>(R) (A) (C) (N) OBSTETRICAL CORE PRIVILEGES</td>
</tr>
<tr>
<td>Privileges include admission and management of pregnancy, labor, and delivery. This includes illnesses and disorders of the urinary tract and reproductive system. Neonatal Resuscitation Program Provider (NRP) Certification is required for all physicians who participate in deliveries.</td>
</tr>
</tbody>
</table>
Qualifications for Privileges in Family Medicine

To be eligible to apply for core privileges in family medicine, the applicant must meet University of [_____] Medical Center membership requirements and the following privileging criteria:

Initial Applicants:
Successful completion of a residency training program in family medicine accredited by the Accreditation Council for Graduate Medical Education (ACGME) or its equivalent.

AND

Current certification or active participation in the examination process leading to certification in family medicine by the American Board of Family Practice or its equivalent. Certification is to be achieved within five years of completion of residency training.

Required Previous Experience: Applicants for initial appointment must be able to demonstrate provision of services to at least 25 adult inpatients, reflective of the scope of privileges requested, during the past 12 months or demonstrate successful completion of an accredited residency, fellowship or research in a clinical setting within the past 12 months.

Applicants for reappointment: Current demonstrated competence and current experience (provision of services to at least 50 adult inpatients) with acceptable results reflective of the scope of privileges requested for the past 24 months as a result of ongoing professional practice evaluation activities and outcomes.

FAMILY MEDICINE CORE PRIVILEGES

- Admit, evaluate, diagnose, treat and provide consultation to adolescent and adult patients with illnesses, diseases, and functional disorders of the circulatory, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastrointestinal, gynecologic and genitourinary systems including disorders common to the older adult. Excludes admission to and management of patients in critical care units.

General Family Medicine Core Privileges

1. Arthrocentesis and joint injection
2. Burns, superficial and partial thickness
3. EKG interpretations – own patient
4. I & D abscess
5. Local anesthetic techniques
6. Manage uncomplicated minor closed fractures and uncomplicated dislocations
7. Perform history and physical examination
8. Perform simple skin biopsy or excision
9. Peripheral nerve blocks
10. Placement of anterior and posterior nasal hemostatic packing
11. Remove non-penetrating foreign body from the eye, nose, or ear
12. Suture uncomplicated lacerations
Primary Privileges Approach to Grouping Privileges

- **Characteristics of Primary Privileges**
  - Method of grouping privileges
  - Each grouping has specific criteria
  - Primary privileges are almost always driven by specialty training (residency or fellowship or other subspecialty training)
  - Primary privileges are a mixture of cognitive and procedural conditions/privileges

Primary Privileges Approach

- **Additional “groupings” in a primary privileges approach:**
  - A “cluster” is a method of identifying groupings of privileges that are related based on technical or procedural skills and cognitive knowledge
  - Privileges outside of the primary privileges or clustered privileges within a specialty are referred to as “stand alone” or “special” privileges/procedures

- **Emphasis:** Each grouping of privileges has specific criteria
Characteristics of Primary Privileges

- Privileges that all practitioners within a specific specialty would be qualified to apply for (and may be required to apply for)
- Prerequisite to being able to apply for clusters and/or special privileges/procedures associated with the specialty
  - For example, a urologist would not be permitted to apply for photoselective vaporization of the prostate without being qualified for and being granted primary privileges in urology

Characteristics of Clusters

- Similar conditions and/or procedures are grouped together (common knowledge and/or skills needed for all conditions or procedures within the cluster)
- Addresses the contemporary issue that practitioners often don’t continue to practice the full spectrum of their specialty, but may focus on some specific areas
Cluster - Example

• The training of family physicians includes all ages of patients and ambulatory care through critical care services, but many FPs have focused in one or more particular area(s):
  – Office-Based or Ambulatory Care
  – Adult (Ambulatory and Non-Ambulatory – includes hospitalized patients, long-term care, etc.)
  – Normal newborns
  – Pediatrics
  – Uncomplicated obstetrics
  – Advanced obstetrics

Cluster - Example

• The training of general surgeons includes all ages of patients and numerous types of procedures, but many general surgeons have focused in one or more particular areas:
  – Trauma, Abdomen and Alimentary Tract: Basic
  – Abdomen and Alimentary Tract: Advanced
  – Endocrine and Head and Neck
  – Vascular
  – Thoracic
  – Breast
Characteristics of Special Privileges

- “Special” or single privileges that require additional training, clinical activity or other evidence that will assist in determination of competence to perform
- Examples:
  - Bariatric surgery for a general surgeon
  - ERCP for a gastroenterologist
  - Robotic surgery for GYN, Neurosurgeons, Urologists and General Surgeons

Primary Privileges Approach

Primary Privileges

Privilege Clusters

Special Privileges
Primary Privileges Example

Hematology

Bone Marrow Transplantation

Moderate Sedation

Primary Privileges Example

Nephrology

Interventional Nephrology and Transplant Nephrology

Renal Sonography
Primary Privileges Example

Nurse Practitioner
Adult Primary Care

Critical Care Procedures

Designing Criteria-Based Privileges

• Select a privileging methodology or classification system (i.e., laundry list, core privileges, primary privileges, clustering, etc.)
  – Selection should be based on organization preference – it is beneficial to obtain opinions on what will work best within the organization from medical staff leaders as well as those individuals who will be required to support all/some portions of the privileging process
  – Selection should also take into account access to technology and how technology will be used for deployment of the privileging methodology
More Best Practices in Privilege Development

• There are no blank lines inviting write-in requests for privileges that have not been delineated

Best Practices, cont.

• Applicants are provided with easy to understand privilege forms that are clear about what privileges may be requested and the criteria associated with specific privilege(s).
  – Criteria is easily accessed
    • Located on the privilege forms
Best Practices, cont.

• The need for frequent clarifications related to whether (or not) a privilege has been granted is minimized

Best Practices, cont.

• Uniform application of criteria
  – Means that criteria must be explicit (i.e., black and white)
  – Definitive criteria allows the Medical Staff Office know specifically what information must be obtained (either by verification or by requesting the applicant to submit) to demonstrate that the applicant is qualified to request privileges

• Criteria can be implemented
  – For example, if there is a clinical activity requirement, the data is available and can be obtained.
Example: Privileges in Interventional Nephrology

Completion of a 12-month fellowship in interventional nephrology approved by the American Society of Diagnostic and Interventional Nephrology AND Certification by the American Society of Diagnostic and Interventional Nephrology

Initial Request – 25 cases of each of the following during the previous 12 months OR completion of fellowship training in interventional nephrology during the previous 12 months:
- Angiography of peripheral hemodialysis vascular access
- Angioplasty of peripheral hemodialysis vascular access
- Thrombolysis/thrombectomy of peripheral hemodialysis vascular access
- Insertion of tunneled cuffed long-term catheters

Source: American Society of Diagnostic and Interventional Nephrology

Best Practices, cont.

- The organization is able to deny processing of requests because criteria is not met – rather than being forced to deny requests for privileges because of concerns related to competency
  - Specific criteria that would lead to a decision to not process a request is defined and implemented
Best Practices, cont.

• **Effective communication of what privileges have been granted to whom:**
  – Practitioners are not permitted to exercise privileges that have not been granted
  – Surgeons are not permitted to schedule cases to perform procedures that are not on their privilege list
  – When temporary privileges are granted, the specific privileges that have been granted are clearly communicated – as well as the time limit for TPs

Organization Challenges

• **Agreement on how privileges will be grouped**
  – What will be in the primary/core privileges vs. clusters?
• **Practitioners do not want to “give up” any privileges and would therefore prefer to keep them together in one large core**
• **Creating activity numbers in the absence of benchmarks**
• **Impact on the low volume practitioners**
• **Impact on ED coverage**
How Can Technology Assist in the New Privileging Environment?

Technology can be used to:

1. Clearly communicate privileging criteria to applicants and those who are responsible for application of privileging criteria
2. Communicate granted privileges to those who monitor to make sure that privileges are not exercised if not granted

3. Assist in managing privileging criteria
   - Provide alerts when criteria is not met
   - Provide checklists of what criteria must be met for specific privileges
   - Provide documentation of why privileging decisions were made
4. Provide reports that demonstrate compliance with criteria (i.e., clinical activity reports linked to codes)
5. Facilitate the implementation of FPPE
   - Communicate with all individuals involved in FPPE
     - Requirements
     - Status
     - Provide forms electronically to be completed by reviewers