

Criteria-based core privileging: A better way to privilege

Although credentialing and privileging are related and many people use the term *credentialing* to include privileging activities, the two processes are distinct. As stated in rule #4 in the “Rules of Credentialing” (see Chapter 1), a hospital can grant a practitioner medical staff membership, but not grant him or her clinical privileges.

Privileging, in particular, presents one of the biggest challenges for medical staff leaders. With today’s constantly evolving medical technology, the proliferation of new subspecialty areas in medicine, and increased crossover among specialties in performing certain procedures, the task of delineating clinical privileges can be complex and demanding.

Approaches to privileging

Over the years, healthcare organizations have taken various approaches to privileging, the most common being:

- “Laundry lists”
- Categorization
- The descriptive approach
- Combinations of the above three approaches
- Delineation by codes

Because there are many problems associated with each of these approaches, this book recommends using the criteria-based core privileging approach, described later in this chapter. But first, we’ll discuss the other options.

Laundry lists

Laundry lists, sometimes referred to as *privilege lists* or *privilege cards*, are detailed checklists that itemize the procedures/conditions that applicants can specifically request to perform/treat. Hospitals often use such lists for surgical specialties. See Figure 3.1 for a sample laundry list.

Figure 3.1

Sample delineation by 'laundry list' approach: An excerpt from a department of radiology request form

Please check appropriate areas:

- Admitting privileges
- General diagnostic radiology
- Computerized tomography
- Ultrasonography
- Magnetic resonance imaging
- Nuclear medicine
- Special procedures
 - Arteriography
 - Angioplasty, balloon
 - Angioplasty, laser
 - Intravascular embolization
 - Venography
 - Lymphangiography
 - Lumbar puncture and myelography (lumbar or C1-2 puncture)
 - Percutaneous transhepatic cholangiography and biliary drainage
 - Percutaneous cholecystostomy/bile duct stone removal
 - Percutaneous nephrostomy/stone extraction
 - Percutaneous drainage of fluid collections
 - Percutaneous biopsies
 - Vena cava filter insertion
 - Percutaneous gastrostomy

For years, hospitals throughout the United States have delineated clinical privileges using laundry lists or modified laundry lists. The American College of Surgeons recommended the laundry list system in the 1950s because many physicians throughout the country had not completed approved residency programs in specific specialty areas. Many were general practitioners or physicians trained on the job after they completed medical school. The laundry list system has remained in use to the present time. Only within the past decade have medical staffs begun to reassess the usefulness of these long, unwieldy lists of procedures or conditions.

Today, nearly all physicians who apply for appointment and clinical privileges have completed an approved medical training program in one of the 24 American Board of Medical Specialties–approved specialties or more than 60 subspecialty areas.

Therefore, the original rationale for using laundry lists no longer applies. The Joint Commission has indicated that the delineation of clinical privileges need not be so exhaustive, but laundry lists remain a common approach to the delineation of privileges in hospitals. Despite their popularity, laundry lists have numerous shortcomings:

- **Laundry lists are usually not associated with predefined criteria.** When practitioners apply for privileges, they simply check off the procedures they would like to perform or the conditions they would like to treat. Typically, the hospital and its medical staff have not defined the criteria that must be met for *each* requested privilege (there may be criteria for some but not all privileges) even though both The Joint Commission and the Centers for Medicare & Medicaid Services require criteria-based privileging. (See Chapter 2 for more information about requirements related to criteria-based privileging.) When using laundry lists, applicants are not routinely required to provide specific documentation of training and experience to show that they are qualified for all requested privileges. Practitioners have been known to apply for “all privileges listed” because they did not want to take the time to request each procedure or condition. In addition, this approach requires highly trained practitioners to place check marks next to the most mundane clinical conditions or procedures for which they have been thoroughly trained and for which their qualifications are unquestioned.
- **Laundry lists are most often procedurally focused.** A laundry list commonly includes those procedures that a practitioner might want to perform, but often the cognitive areas of practice are not addressed.
- **Laundry lists are often not inclusive.** Because of this drawback, many organizations are tempted to write “other” at the bottom of the request form, which enables practitioners to request to perform procedures or treat conditions for which the hospital has no predefined privileging criteria or that are

outside the scope of services of the hospital. As stated in rule #2 in the “Rules of Credentialing” (see Chapter 1), a practitioner who is denied a privilege might be entitled to a fair hearing—a traumatic, time-consuming process—and, in most cases, the hospital must report the denial to the National Practitioner Data Bank (NPDB).

- **The legal issues associated with laundry lists are complex.** Can an organization demonstrate that it critically reviewed a practitioner’s request when the request was one of 60 or 80 check marks on a form? If a practitioner fails to check a particular procedure on the list and performs that procedure anyway, is the organization liable for a charge of corporate negligence? Did the organization review the applicant’s prior education, training, and experience for each privilege requested? These are all legal issues that are open for interpretation when using a laundry list privileging method.
- **Maintaining laundry lists is an extreme administrative and clinical nightmare.** New procedures or new conditions are identified, thus requiring that organizations update and maintain these laundry lists on an almost continuous basis.

Categorization

Categorization, sometimes referred to as *categories or levels of privileges*, identifies major treatment areas or procedures that are classified based on the degree of complexity of the procedure or illness to be treated. Typically, categories are based on the level of a practitioner’s training and experience. Categorization is widely used to delineate privileges in internal or family medicine because this approach seems to be more applicable to medical (i.e., cognitive) areas than to surgical (i.e., procedural) areas. See Figure 3.2 for an example of categorization.

Figure 3.2

**Sample delineation by category approach:
An excerpt from an obstetrics and gynecology request form**

<i>Procedures</i>	<i>Requested Privileges</i>		<i>Recommended by Department Chair</i>	
	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
<i>Class I Privileges</i>				
<p>Qualifications: Satisfactory training, current experience, and demonstrated competence in the specific privileges being requested.</p> <p>1. Diagnostic D&C 2. I&D of Bartholin cyst or perineal abscess 3. Cervical biopsy (not with colposcope) 4. Vulvar biopsy (small punch-Keyes) 5. Marsupialization of Bartholin cyst 6. Pap smear 7. Endometrial biopsy 8. Excision of Bartholin cyst</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<i>Class II Privileges</i>				
<p><i>Note: The following list is an excerpt of the complete list of Class II privileges.</i></p> <p>Qualifications: Board certification by or current active participation in the examination process leading to certification by the American Board of Obstetrics and Gynecology, or in all instances there must be current demonstrated competence and experience in the requested privileges.</p> <p>Operations for treatment of benign pelvic disease</p>	<p>_____</p>	<p>_____</p>	<p>_____</p>	<p>_____</p>

Figure 3.2

**Sample delineation by category approach:
An excerpt from an obstetrics and gynecology request form (cont.)**

<i>Procedures</i>	<i>Requested Privileges</i>		<i>Recommended by Department Chair</i>	
	Yes	No	Yes	No
1. D&C with or without cervical biopsy	_____	_____	_____	_____
2. D&C with or without conization of cervix	_____	_____	_____	_____
3. Laparotomy	_____	_____	_____	_____
4. Operation for removal of uterus, cervix, oviducts, ovaries, and appendix	_____	_____	_____	_____
a. Abdominal	_____	_____	_____	_____
b. Vaginal	_____	_____	_____	_____
<i>Class III Privileges</i>				
<p><i>Note: The following list is an excerpt of the complete list of Class III privileges.</i></p> <p>Qualifications: Evidence of acceptable performance in a supervised clinical training program of sufficient breadth and length and, when appropriate, use of the procedure, technique, or treatment in practice when indicated and with acceptable results.</p>				
1. Uterovaginal fistula	_____	_____	_____	_____
2. Radical hysterectomy for treatment of invasive carcinoma of cervix	_____	_____	_____	_____
3. Treatment of invasive carcinoma of vulva by radical vulvectomy	_____	_____	_____	_____
4. Microsurgical tubal operations	_____	_____	_____	_____
a. Salpingolysis/salpingoplasty/salpingostomy	_____	_____	_____	_____
b. Tubal anastomosis	_____	_____	_____	_____
c. Tubal reimplantation	_____	_____	_____	_____

When a hospital uses categorization to delineate clinical privileges, The Joint Commission requires that the categories be well defined. The hospital must state clearly the standards that the applicant must meet for each category. However, many hospitals that use this approach create vague categories that do not specify the required education, training, and experience. Further, many fail to specify the privileges that may be requested/granted.

Descriptive approach

The descriptive approach enables the applicant to describe, in a narrative format, the privileges that he or she is requesting. The practitioner is not required to complete a checklist or use categories, but instead is asked to describe in his or her own words those areas in which he or she possesses clinical competence. For example, a practitioner might write that his or her clinical privileges “shall be defined as those standard and customary activities appropriate to the diagnosis and treatment of any and all diseases encompassed by the specialty of internal medicine.”

Few hospitals nationwide use the descriptive approach to grant clinical privileges; it is more commonly used to delineate privileges for nonphysician healthcare workers, such as licensed clinical social workers or alcoholism counselors—primarily because the hospital is sometimes uncertain about exactly the services these nonphysicians provide.

Combination approach

A combination approach combines various features of the laundry list, categorization, and descriptive approaches. Many hospitals list specific privileges within categories; others may use categories for basic procedures and create lists for those privileges that do not fit into the categories. Still others use a descriptive approach and list privileges that need further consideration.

Delineation by codes

Some hospitals delineate privileges by certain ICD-9-CM, CPT, or DRG codes. These codes—International Classification of Diseases codes, Current Procedural Terminology codes, and diagnosis-related group codes, respectively—define the procedures for the medical staff leadership, the credentials committee, and the medical executive committee. These individuals/committees forward their recommendations to the board for approval. Assuming that an individual meets the predefined criteria for a particular clinical area, he or she would be granted privileges based on the ICD-9-CM, CPT, or DRG codes for those procedures. Unfortunately, delineating by codes often results in rather extensive privilege lists that can consist of 18–20 pages for one surgical specialty (e.g., general surgery). See Figure 3.3 for an example of delineation by codes.

Figure 3.3

Sample delineation by ICD-9 code: An excerpt from a plastic surgery request form

Procedures	ICD-9-CM codes	Requested	Granted	Not granted*	Granted with condition(s)**
Radical orbit surgery	1651–1659				
Arterial ligation for epistaxis	2104–2106				
Extensive tongue resections	2520–2540				
Sialoadenectomy	2630–2632				
Lip and mouth procedures	2750–2759				
Palate procedures	2760–2769				
Pharyngeal procedures	2900–2990				
Closure of thoracotomy	3472–3473				
Excision of deep lymph nodes	4021–4023				
Penile reconstruction	5845–5846, 6443–6445				
Vaginal reconstruction	7062				
Facial bone (reconstruction)	7631, 7639, 7640–7646				
Temporomandibular, arthroplasty, osteoplasty, and reduction	7650–7666, 7694–7696				
Ostectomies (chest wall, radius, ulna, metacarpals, carpals, tibia/fibula)	7781, 7783–7784, 7787–7788				

Criteria-based core privileging

Criteria-based core privileging is an effective alternative to the approaches described earlier. It incorporates predefined criteria in conjunction with clinically realistic, well-defined core privileges. The term *core privileges* refers to those clinical activities within a specialty or subspecialty that any appropriately trained, actively practicing practitioner with good references would be competent to perform. In the criteria-based core privileging approach, practitioners who meet predefined criteria are eligible to apply for core privileges, and those who can document additional training and experience may request special (or noncore) privileges. Special noncore privileges nearly always correspond to one or more of the following:

- New advances in technology
- High-risk/problem-prone, volume-sensitive diagnoses or procedures that would not be automatically incorporated within the core
- Issues that occasionally cross specialty lines

If a practitioner meets criteria to request core privileges and the practitioner's requests are supported by references attesting to his or her current clinical competence, privileges may be granted. See Chapter 7 and Part III for sample privilege request forms.

Procedures requiring specialized training or experience beyond the predefined criteria would be applied for and granted separately. The same is true for the privilege of performing a procedure in an unusual fashion—what would otherwise be a basic procedure, such as performing surgery, but using a robot instead of a scalpel, for example.

Individuals who do not meet the predefined criteria in a particular clinical area may still qualify for certain limited privileges by providing evidence that they possess the training/experience to perform the procedures requested. For example, a family practitioner could apply for certain procedures on the basic obstetric list, such as performing cesarean sections. But to be granted those privileges, the family practitioner would have to demonstrate to the hospital board's satisfaction that he or she possesses training and experience that is equivalent to the training and experience of an OB/GYN specialist to warrant the granting of the privilege to perform cesarean sections.

Why criteria-based core privileging?

Criteria-based core privileging reflects the thought process a department chair uses when recommending privileges for a practitioner. When looking at a laundry list of privileges for a particular specialty, a department chair recognizes that almost all the listed procedures are appropriate to the specialty area. He or she checks several procedures with little hesitation—an appropriately trained practitioner in that specialty should be competent in performing those procedures. However, a few procedures likely would cause him or her to hesitate and question whether to recommend those privileges for the practitioner. This is the same categorization system that the core privileging system uses.

In addition to reflecting the thought process that department chairs use to decide whether to recommend privileges for a practitioner, the core privileging approach has several other advantages that help make it effective:

- Consistency
- Flexibility
- Objective prescreening

Consistency

One of the key advantages to the criteria-based core privileging system is its consistency. All practitioners in a clinical area are asked to meet the same minimum threshold criteria covering education, training, experience, and demonstrated current competence. The same holds true for practitioners from different clinical areas who request privileges to perform the same procedures or treat the same conditions.

Consistency is not only a Joint Commission requirement—it also helps to reduce or eliminate medical staff conflict when practitioners from different clinical areas wish to perform the same procedures or treat the same conditions (see Chapter 8 for specific advice on how to deal with crossover privileges). Consistency is also a significant part of risk management, because consistent criteria help minimize the risk of corporate liability by ensuring that only practitioners with the proper education, training, experience, and demonstrated current competence perform certain procedures and treat specific conditions.

Flexibility

Another key advantage of the criteria-based core privileging system is its flexibility. When a hospital sets out to develop core criteria for a new clinical area, procedure, or treatment, the format for those criteria is already in place, ready to be followed. The easy-to-use format also increases productivity because nonclinicians can complete much of the initial research. For further details regarding the process for developing core privileging criteria, refer to the documents at the end of this chapter.

Objective prescreening

The criteria-based core privileging system's best advantage, however, is that it clearly defines minimum threshold criteria, providing an objective way to prescreen applicants for clinical privileges. Those practitioners who do not meet the predefined criteria for core privileges or special requests are not eligible to apply for those privileges. If they cannot apply, there will be no denials, no fair hearings, and no reports to the state or the NPDB.

The criteria-based core privileging approach is an efficient and effective approach to privileging. It meets regulatory requirements of The Joint Commission and other accreditors and helps protect the hospital corporation from malpractice suits and charges of antitrust violations. For further discussion of how to adopt the core privileging system and how to deal with the challenges involved in converting to this system, see Part II.

Sample policies and forms

The following pages (Figures 3.4–3.14) provide sample documents that your organization may wish to consider as you adopt a core privileging approach to your privileging practices.

Figure 3.4

Delineating clinical privileges: Dispute resolution and new technology criteria

The objectives of this hospital's privilege delineation process are to do the following:

- Ensure maximum objectivity in the granting of clinical privileges. This is accomplished by medical staff adherence to previously developed criteria granting specific privileges.
- Avoid, where possible, the use of long "laundry lists" of diagnoses that require constant updating and redrafting. These lists are, in many disciplines, difficult to monitor and not generally considered realistic.
- Grant privileges commensurate with education, residency training, prior experiences, and demonstrated current competence.
- Ensure, to the extent possible, that patients are cared for by individuals possessing the highest degree of competence.

The recommended system of core privileges operates as follows:

- For each specialty or clinical practice area, the medical staff (or an appropriate subcommittee) determines the core set of clinical activities that would be encompassed easily within the sphere of competence of any appropriately trained physician with good references who is seeking privileges.
- Added to this "core set" of privileges would be a series of special requests that would require individual application by the physician. Such special requests nearly always correspond to new advances in technology, volume-sensitivity issues that would not be automatically incorporated within the core, and issues that occasionally cross specialty lines.

This hospital follows this approach for the following reasons:

1. The process of clinical privilege delineation must be fairly straightforward. Predefined core privileges, coupled with threshold criteria, almost ensure simplicity. Just as a job description predefines the job to be done (in industry), core privileges state the clinical activities that an individual will be permitted to engage in if they are well trained and experienced.
2. Consistency is maintained because all physicians in a clinical area are asked to meet the same minimum threshold criteria covering education, training, experience, and current clinical competence.

Figure 3.4

Delineating clinical privileges: Dispute resolution and new technology criteria (cont.)

3. The system's best advantage is that it clearly defines minimum threshold criteria. Those physicians who do not meet the predefined criteria for core privileges or special requests are not eligible to apply. If unqualified physicians cannot apply, there will be no need for denials, fair hearings, and reports to the state or National Practitioner Data Bank.

Requests for clinical privileges will be processed only when the potential applicant meets the governing board's current minimum threshold criteria. Potential applicants who do not meet these criteria will not have their applications submitted to the department chair(s) or the credentials committee for evaluation and consideration. In the event that there is a request for which criteria does not currently exist, the board must determine whether it will allow the privilege or procedure. If the board allows the privilege, it will use the following procedure to develop criteria. Requests for which the board has no specific approved criteria within a specified time frame (e.g., 90 days) will be processed using the general criteria of adequate education, training, clinical experience, and references demonstrating current clinical competence.

Procedure for developing privilege criteria

Whenever a privileging question arises* for which there is no policy or privileging criteria, the credentials committee will follow these steps to coordinate the development of a policy and applicable criteria:

1. If the issue pertains to the use of new technology or a new treatment protocol, first put the burden on the interested practitioner to provide information about the device, technology, or protocol. The practitioner should be requested to provide a full briefing concerning the new technique or procedure. This briefing should include information concerning the development of the new technology, the names of other hospitals in which it is used, any peer-reviewed research demonstrating the risks and benefits of this technology, any product literature or educational syllabus addressing the technology, and the names of any residency training directors responsible for providing training in this area (see Figure 3.5).
2. The credentials committee will review the issue and will determine whether the technology will be permitted within the institution at all. When making this determination, the credentials committee should discuss the institution's current plan of care, whether the new

**Questions arise through various sources. A physician may request a new privilege, one may indicate that he or she desires to use a new piece of technology, the OR scheduler may notice something new on the schedule, the OR staff may be asked to set up differently than in the past, a medical service professional or department chair may bring the issue to your attention, or you may read in the local paper that your hospital will be the first in the state to introduce this new patient care technique.*

Figure 3.4

Delineating clinical privileges: Dispute resolution and new technology criteria (cont.)

technology/procedure is of proven clinical efficacy and effectiveness, and whether the new procedure/technology carries a greater risk than existing conventional therapy. (Remember, the first question that must be answered is “should this technology be permitted at all?” If the answer is no, there is no credentialing issue.) (See figures 3.6 and 3.7.)

3. If it is determined that criteria for reviewing requests for clinical privileges are necessary, the credentials committee, or an ad hoc committee appointed by the credentials committee, will develop a research paper concerning the issue. This paper will address the mechanisms the institution currently uses to handle this issue, the possible specialty/subspecialties that may be interested in the issue, the positions held by specialty societies or academies concerning the issue (if any), and the type of practitioner(s) that already perform(s)/treat(s) the issue in other similar hospitals. If necessary, it also will conduct a survey of other hospitals to determine what types of standards are in general usage for the granting of privileges.
4. The committee will submit the results of its research to, and seek the opinion of, subject matter experts. One of the following mechanisms may be used:
 - A representative of the credentials committee will facilitate a multispecialty task force with a true interest in (and knowledge of) the issue
 - The credentials committee will request each individual department/subspecialty to provide it with advice concerning the clinical issue
5. The task force or specialty shall have approximately 15 days to advise the credentials committee concerning these specific issues:
 - The type of basic education and, if necessary, continuing education required to exercise the privileges safely and effectively.
 - The number of years of formal training, and in what field(s) (and, if applicable, continuing training—either didactic or hands-on).

Note: The required number of years of basic residency training may vary by specialty, as might the need for postgraduate continuing medical education/training.

Figure 3.4

Delineating clinical privileges: Dispute resolution and new technology criteria (cont.)

- Whether fellowship training should follow completion of an American Council on Graduate Medical Education (ACGME), American Medical Association, or American Osteopathic Association–accredited residency program.
- Whether completion of accredited residency training program should be followed by at least ___ hours of accredited postgraduate training in a university or other educational setting or by a continuing medical education course.
- Whether prior experience is required and, if so, the amount of recent, direct, or indirect (but applicable) experience (evidence of prior experience may include general hospital experience in the specialty during the past 12 months) and/or specific experience in the diagnosis/procedure during the past 12 months.

Note: There should be very few exceptions to the creation of an objective requirement concerning past experience. It is not reasonable for a hospital to grant clinical privileges without evidence demonstrating that the practitioner has actually provided relevant related care during the recent past. If experience is not required, the task force should indicate the type of required continuing education. Note that all task force/specialty recommendations should be reported on the “Clinical privileges task force/specialty recommendations” form (see Figure 3.8).

6. The recommendations of the specialty(ties) task force will be reviewed by the credentials committee. If there is general agreement concerning the proposed privileging criteria, the credentials committee will determine whether the rule is acceptable. If the specialties task force has been unable to agree on the amount of education, training, or experience necessary, the credentials committee will draft a proposed rule. Such rule will be submitted to the involved specialties with a request that each group review and comment on the proposed rule.
7. The proposed rule will then be submitted to the medical executive committee for final review and recommendation to the board.
8. Once approved, the rule will be incorporated in the credentials policy and procedure manual and will, until changed, guide the institution in the processing of any requests for the privilege in question.

Figure 3.5

Worksheet requesting purchase or introduction of new technology

For the physician or group requesting the purchase or introduction of new technology:
Please complete this request/information form.

Name (MD or committee): _____

Date: _____

Specialty: _____

1. What technology/innovation are you interested in using or introducing? Device, instrument, new modality, new approach:

2. What clinical conditions might it be used for?

3. How often might it be used in this hospital over the next year?

4. How is the clinical condition affected by the technology treated at present?

5. Where is this technology used now? What facilities, hospitals, and so on?

Figure 3.5

Worksheet requesting purchase or introduction of new technology (cont.)

6. How many physicians on staff might use this technology?

7. What will be the significant difference in patient outcome if this technology is used?

8. Will this technology require additional training for nursing/OR staff or the physicians who would use the technology?

9. Is this technology approved for your intended purpose?

10. Where is this technology available? What manufacturers sell or distribute it?

11. Are there any continuing medical courses addressing the use of this technology?

Figure 3.5

Worksheet requesting purchase or introduction of new technology (cont.)

12. Would you be available to work with a team to assess the benefit of this new technology to the hospital and the community?

If you have any of the following materials, please submit:

- a) Research concerning the proposed technology procedure
- b) Course materials
- c) Manufacturer's materials
- d) Food and Drug Administration approvals as necessary

MD or group representative signature: _____

Date: _____

Figure 3.6

Algorithm for processing clinical privilege requests

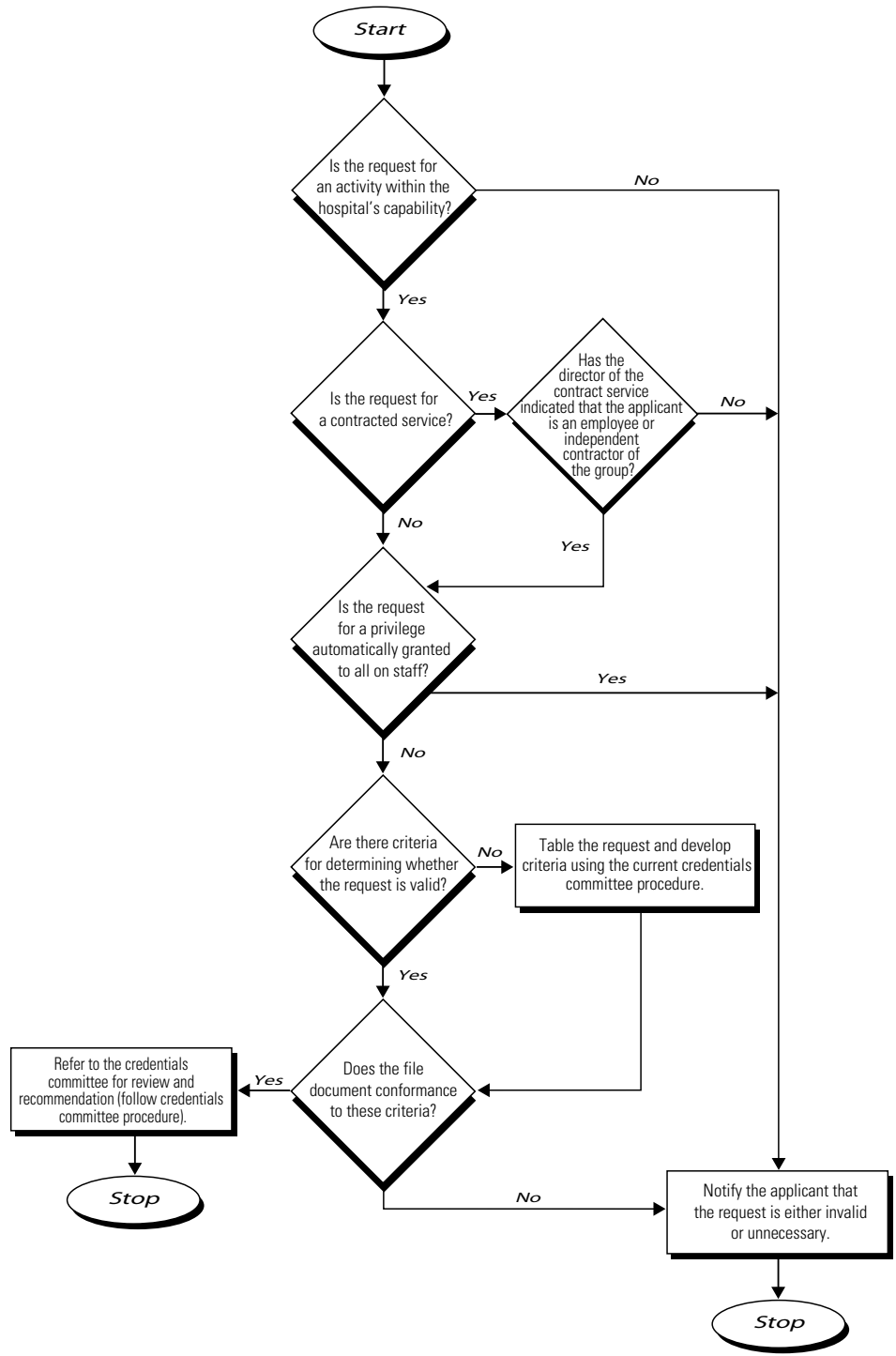
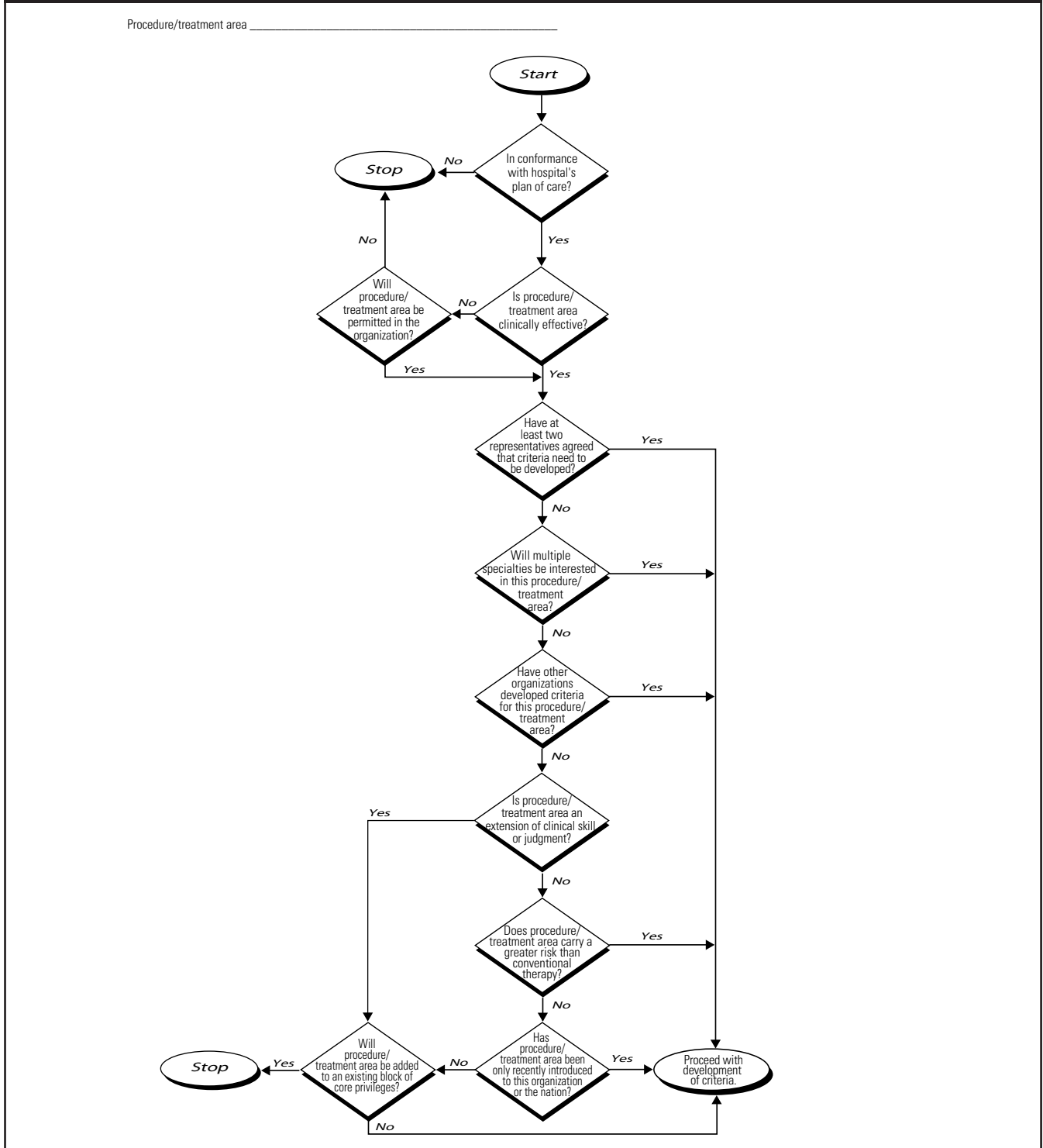


Figure 3.7

Algorithm for deciding whether to develop privilege criteria



Clinical privileges task force/ specialty recommendations

Figure 3.8

Instructions

- One form should be completed for each area in which privileges may be requested.
- When a privilege may be requested by multiple specialties, this form should be completed by each relevant department chair or by a task force and submitted to the credentials committee.
- All possible combinations of qualifications should be listed. (For example, if completion of an interventional radiology fellowship or an interventional cardiology fellowship are required to perform peripheral caths, both should be listed.)
- If a particular category is not required, indicate n/a.

Privilege in question _____

1. Required basic education:

- MD
 DO
 DDS
 DPM
 Other _____

2. Training:

Completion of an approved residency training program

 Or _____
 Or _____

3. Continuing medical education (CME):

Specify required CME _____

4. Fellowship/board status:

Board certification required? Yes No
 Fellowship required? Yes No
 If yes, specify _____

Figure 3.8

Clinical privileges task force/ specialty recommendations (cont.)

5. Experience:

Direct experience required? Yes No

Specify _____

Indirect experience required? Yes No

Specify _____

6. Initial performance requires a team?

Yes No

7. Proctoring/supervision:

Is any form of proctoring or supervision required? Yes No

If yes, specify _____

Figure 3.9

Clinical privileges delineation—general policy

Exercise of privileges

Any practitioner who provides clinical services at this hospital may exercise only those privileges that the governing board granted him or her and emergency privileges as described herein.

Privileges requests

Each applicant must include in his or her application for appointment or reappointment to the medical staff a request for the specific clinical privileges that he or she seeks. An applicant must submit specific requests if he or she wishes to obtain temporary privileges or seeks modification of privileges in the interim between reappraisals.

Basis for privileges delineation

The hospital will consider a request for clinical privileges only when the request includes evidence of:

- Education
- Training
- Experience
- Demonstrated current competence (as specified by the hospital)

If the hospital has no threshold criteria for a requested privilege, the hospital will table the request for a reasonable period of time during which the board—after consulting with the credentials committee and MEC—will formulate the necessary criteria. Once the board has established threshold criteria for the requested privilege, the hospital will process the original request.

The hospital will evaluate valid requests for clinical privileges on the basis of:

- Prior and continuing education
- Training
- Experience
- Utilization practice patterns
- Current ability to perform the privileges requested
- Demonstrated current competence, ability, and judgment

Figure 3.9

Clinical privileges delineation—general policy (cont.)

The hospital might also consider patient care needs, its facility's capability to support the type of privileges being requested, and the availability of qualified coverage in the applicant's absence.

The decision to grant privileges at reappointment or to grant a requested change in privileges must consider the following:

- Observed clinical performance
- Documented results of the staff's quality improvement program activities
- Pertinent information from other sources—especially other institutions and healthcare settings in which professionals exercise clinical privileges

When processing requests for clinical privileges, the hospital will follow the procedure for granting medical staff membership that is described in the *Initial Appointment Policy*.

Special conditions

Dental privileges: The hospital will process requests for dental privileges in the same manner as it processes all other privilege requests. Surgical procedures performed by dentists/oral surgeons will be under the overall supervision of the chair of the department of surgery. Every dental patient will receive a basic medical appraisal by a physician member of the medical staff; the result of this appraisal will be recorded in the patient's medical record. Both the physician and the patient's dentist must assess the risks of any proposed procedure and the procedure's potential effect(s) on the patient's health.

The hospital may grant an oral surgeon the privilege of performing history and physicals on his or her patients if he or she submits documentation of completion of an accredited postgraduate residency in oral/maxillofacial surgery and demonstrated current competence.

A physician member of the medical staff will be responsible for the overall medical care of the patient, including care of any medical problems that are present at admission or that arise during hospitalization. The physician must agree to any surgical procedure performed on the patient. "Dental" as used in this policy does not necessarily include oral surgeons.

Figure 3.9

Clinical privileges delineation—general policy (cont.)

Allied health professionals: The hospital will process requests from allied health professionals to perform specified patient care services in the manner specified in the policies governing allied health professionals. An allied health professional may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of his or her professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care.

Podiatric privileges: The hospital will process requests for podiatric privileges in the same manner as it processes all other privilege requests. Surgical procedures performed by podiatrists will be under the overall supervision of the chair of the department of surgery. All podiatric patients will receive a basic medical appraisal by a physician member of the medical staff. The results of the appraisal will be recorded in the patient's medical record.

Temporary privileges

Conditions

Temporary privileges may be granted only:

- In the circumstances described below
- To an appropriately licensed practitioner
- Upon written request
- When verified information reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability, and judgment to exercise the requested privileges

The department chair who is responsible for supervising the practitioner may impose special requirements regarding consultation and reporting. Except in unusual circumstances, the hospital will not grant temporary privileges to a practitioner unless he or she agrees in writing to abide by the bylaws, rules, regulations, and policies of the medical staff and the hospital in all matters relating to his or her temporary privileges. Regardless of whether the hospital obtains such written agreement, hospital and medical staff bylaws, rules, regulations, and policies shall control all matters relating to the exercise of clinical privileges.

Figure 3.9

Clinical privileges delineation—general policy (cont.)

Circumstances

Upon written agreement of either the chair of the department in which the privileges will be exercised or the chief of staff, the hospital president may grant temporary privileges in the following circumstances:

- To fulfill an important patient care, treatment, and service need
- When an initial applicant with a complete clean application awaits review and approval of the medical executive committee and the governing body

Temporary privileges may be granted on a case-by-case basis when an important patient care need exists that mandates an immediate authorization to practice, for a limited period of time. For the purposes of granting temporary privileges, an important patient care need is defined as follows:

- A circumstance in which one or more individual patients will experience care that does not adequately meet their clinical needs if the temporary privileges under consideration are not granted (e.g., a patient scheduled for urgent surgery who would not be able to undergo the surgery in a timely manner)
- A circumstance in which the institution will be placed at risk of not adequately meeting the needs of patients who seek care from the institution if the temporary privileges under consideration are not granted (e.g., the institution will not be able to provide adequate emergency room coverage in the provider's specialty, or the governing board has granted privileges involving new technology to a physician on your staff, provided that the physician is precepted for a specific number of initial cases and the precepting physician, who is not seeking medical staff membership, requires temporary privileges to serve as a preceptor)
- A circumstance in which a group of patients in the community will be placed at risk of not receiving patient care that meets their clinical needs if the temporary privileges under consideration are not granted (e.g., a physician who has a large practice in the community for which adequate coverage of hospital care for those patients cannot be arranged)

Figure 3.9

Clinical privileges delineation—general policy (cont.)

When granting temporary privileges to fulfill a patient care need, the hospital must obtain and verify the following information before granting temporary privileges to a practitioner:

- The practitioner's:
 - Licensure status
 - Drug Enforcement Agency (DEA) registration (if applicable)
 - Current amount of professional liability insurance and whether it meets the hospital's minimum requirements
 - Malpractice history
- One positive reference from a responsible medical peer regarding the applicant's competence, training, and ability to perform the requested privileges
- A National Practitioner Data Bank report

When granting temporary privileges to new applicants awaiting review and approval by the medical executive committee, the following items must be verified:

- Current licensure
- Relevant training or experience
- Current competence
- Ability to perform the privileges requested
- A query and evaluation of the NPDB information
- No current or previously successful challenge to licensure or registration
- No subjection to involuntary termination of medical staff membership at another organization
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges

Temporary privileges for new applicants are granted for no more than 120 days.

Figure 3.9

Clinical privileges delineation—general policy (cont.)

Termination of temporary privileges

The chief of staff or hospital president—after consultation with the appropriate department chair (or designee)—may terminate a practitioner’s temporary privileges at any time and must terminate a practitioner’s temporary privileges upon the discovery of information or the occurrence of an event that raises questions about the practitioner’s professional qualifications or ability to exercise any or all of his or her temporary privileges. If it is determined that the practitioner is endangering the life or well-being of a patient, any person who has the authority to impose summary suspension may terminate the practitioner’s temporary privileges.

If the hospital terminates a practitioner’s temporary privileges, the department chair who is responsible for supervising the practitioner will assign all of the practitioner’s patients who are in this hospital to another practitioner. When feasible, the department chair will consider the patients’ wishes in choosing a substitute practitioner.

Rights of the practitioner who has temporary privileges

In either of the following cases, a practitioner is not entitled to the procedural rights afforded by the hearing and appeal procedures outlined in the medical staff bylaws:

- When his or her request for temporary privileges is refused
- When all or any part of his or her temporary privileges is terminated or suspended

Emergency privileges

In an emergency situation, a medical staff member is authorized to do everything possible—to the degree permitted by his or her license but regardless of his or her department affiliation, staff category, or level of privileges—to save a patient’s life or to save a patient from serious harm.

Any practitioner who exercises emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up. When an emergency situation no longer exists, the practitioner must request the privileges that he or she needs to continue to treat the patient.

Figure 3.10

Procedure for processing clinical privilege requests

The medical staff coordinator or administrative representative will be responsible for ensuring that each applicant for medical staff appointment or allied health professional receives the appropriate privileges request forms.

The privileges request forms should accompany the application and should include:

- The hospital's privileges delineation overview
- Instructions for completing the privileges request forms
- Privileges threshold criteria
- The appropriate requested section (e.g., an internist will receive internal medicine forms)
- A special procedures section (if applicable)

All requests for clinical privileges must be submitted, with supporting material, to the medical staff coordinator or administrative representative, who will:

1. Verify the supporting material.
2. Compile current privileges (if any) and administrative review (if any) with the application. (*Note:* This section routinely applies only to current medical staff appointees who are requesting additional clinical privileges.)
3. Make two copies of the completed privileges request package: one for the file and another for the applicable department chair.
4. Submit the application package, with supporting material, to the applicable department chair.

The department chair will:

1. Review the request and all supporting material against threshold criteria for granting clinical privileges and, where necessary, conduct a personal clinical interview with the requestor
2. Formulate a written report and forward it to the credentials committee

The credentials committee then evaluates the request and the department chair's recommendation.

If the credentials committee's recommendation is positive, its recommendation is forwarded to the medical executive committee. If the medical executive committee and governing board approve the credentials committee's recommendation, the chief executive officer will notify the applicant of his or her new privileges and any special conditions/observation requirements.

Figure 3.11

Privilege delineation overview

The following are the primary goals of this hospital's privilege delineation process:

1. Ensure maximum objectivity in the granting of clinical privileges.

Note: This goal is accomplished by medical staff adherence to previously developed criteria for granting specific privileges. For example, only physicians with at least 2,500 hours of previous practice in an equivalent-size emergency room are eligible for privileges in emergency medicine.

2. Avoid, where possible, the use of long "laundry lists" of diagnoses that require constant updating and redrafting. These lists are, in many disciplines, difficult to monitor and not generally considered realistic.
3. Grant privileges commensurate with education, residency, training, and experience.
4. Ensure, to the extent possible, that patients are cared for by individuals who possess the highest degree of competence.

Figure 3.12

Instructions for the applicant regarding the completion of privileges request forms

Note: This hospital's medical staff is divided into departments. Requests for privileges are reviewed by the applicable department chair. You must use the privileges request forms to document your requests and to provide additional information for the hospital's use.

Please note the following when completing your privileges request forms:

1. Most medical staff appointees are automatically granted "general" privileges. You must, however, specify any additional privileges you desire by completing the appropriate forms.

Note: This privileges delineation packet does not include every possible situation, diagnosis, or surgical procedure.

2. You are expected to practice within the bounds of your training and competence, and you should not attempt to treat those complicated cases for which there are individuals on this staff with higher levels of skill or training.
3. Newly developed or experimental treatment modalities not included herein must be cleared by the appropriate department chair before their performance.
4. Please become familiar with the capabilities and limitations of this facility, and do not attempt to treat conditions that require specialty care in other practice settings.
5. Ordinarily, applicants are given privileges request forms that correspond to their specialty or area of interest. If you desire additional privileges that are not included on the forms, please request assistance from the medical staff coordinator or administrative representative.
6. When questions require information concerning the number of times you have performed a procedure, you may generalize (e.g., 10–20, greater than 20).

Note: The hospital seeks general—not specific—information, unless your overall volume is low. You are not expected to have performed every core procedure.

Figure 3.13

General privileges for physician appointees

In general, physician appointees of the medical staff are granted privileges to:

1. Perform histories and physicals
2. Order diagnostic and therapeutic services
3. Make referrals and request consultations
4. Provide consultations within the scope of his or her privileges
5. Render any care in a life-threatening emergency

Privileges to admit patients are individually specified on each specialty form.

Exceptions

1. Emergency physicians may not write orders for care in the special care units. These activities must be performed by physicians with such privileges.
2. Radiologists and pathologists may not provide emergency room coverage.
3. See the special conditions for dentists and podiatrists section in the general policy for delineation of clinical privileges.

Figure 3.14

Request for modification of clinical privileges

Note: All requests for increased privileges must be accompanied by information demonstrating current clinical competence in the privileges requested. Supply information that demonstrates the education, training, and experience you believe qualifies you for the privileges. One letter from a recognized expert in the clinical discipline involved should be submitted as well.

I hereby request additional clinical privileges as follows (or see attached):

- A. _____
- B. _____
- C. _____
- D. _____
- E. _____

I have attached full details demonstrating my competence in these areas.

Appointee's signature

Date