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PERFORMANCE MANAGEMENT AND PROCESS IMPROVEMENT

Chapter 4-5

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Effective Meetings:

- Meetings are more than just showing up at a certain time and sitting in a room until it is completed.

- The leader's job is to be certain of the need for the meeting, conveying the need to the participants and conducting the meeting in an organized and productive manner.

- No matter how well the meeting planning is done, if the members in the meeting are not willing to participate, the meeting will not be successful. Therefore, the meeting leader must have a set of skills that can be effective in keeping participants engaged and also keeps the meeting moving through the agenda in a timely manner.

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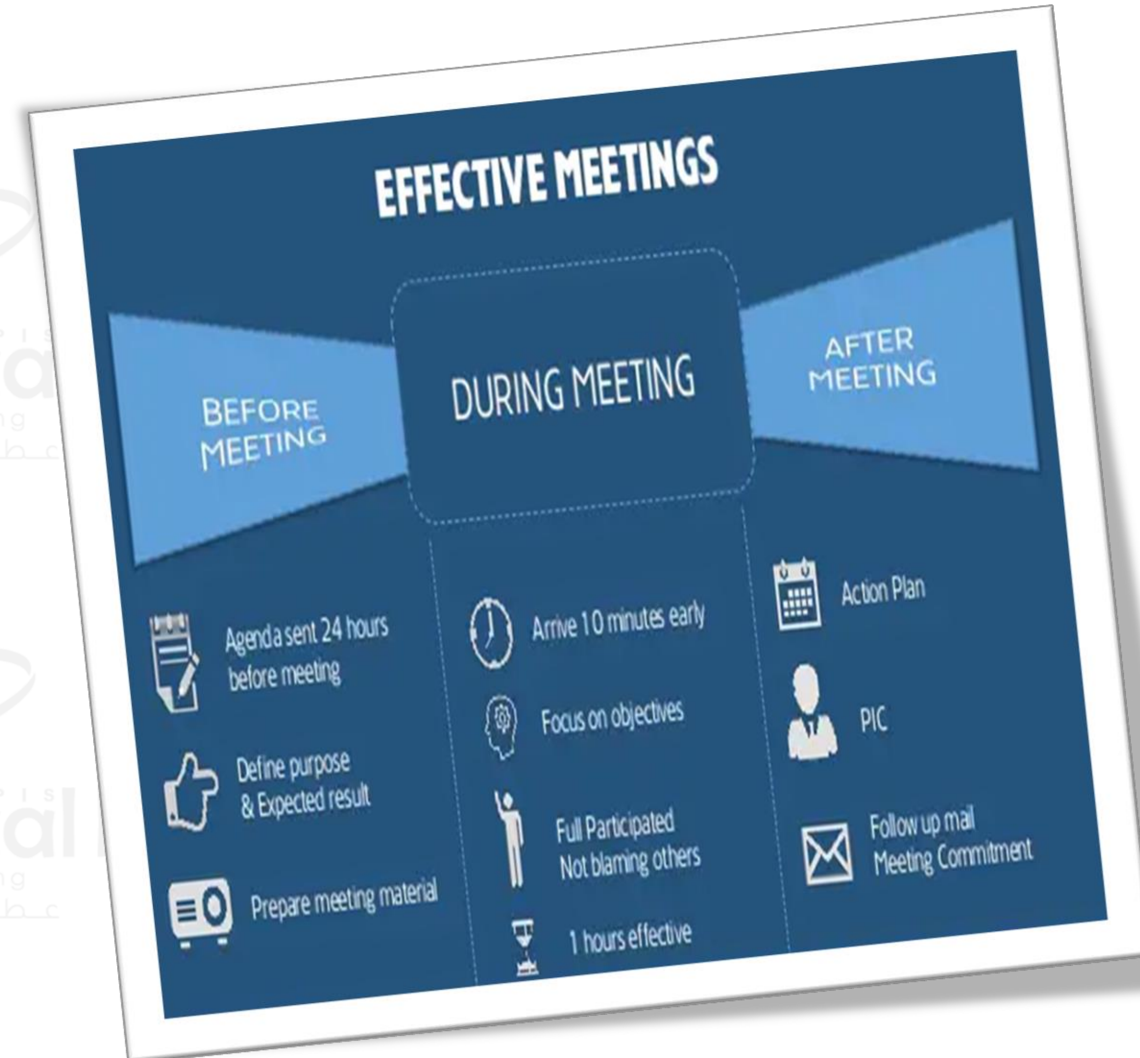
➢ seven steps to an effective meeting:

1. Clear objective for the meeting.
2. Consider who is invited to the meeting. It should be determined who really needs to be at the meeting.
3. Rule is to stick to the agenda. The agenda should include the amount of time allotted to each specific item. All participants should have a copy of the agenda.
4. keep the meeting moving. Do not allow one individual to monopolize the conversation.
5. Start on time and end on time. Do not conduct the meeting for longer than 60 minutes
6. Ban technology'. Do not allow attendees to use their phone
7. The leader must follow-up.



It is important to send out the minutes or the highlights of the meeting to all who attended and others that need to have the information, including any team members who were not present, within 24 hours of the meeting. Document the responsibilities and tasks assigned, as well as the deadlines.

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Before the meeting	During the meeting	End of meeting
Everyone know the time and place	Start the meeting on time	Time for feedback (5 m-10 m)
Any one will not attend inform us ahead of time	Attendees have copy of the agenda	End on time
Send reminder + Agenda	Quorum (start with the approval of previous meeting)	Review the action taken and assignment
Any one will present should be ready	NO quorum (start with items need discussion)	Set a time for next meeting
Old business should be mentioned	Share the goal& purpose Clarify the agenda	Remind all the attendees with their responsibilities
Put the important item in the beginning of the agenda		
Time limit for each item in agenda		

- If the planned time on the agenda is not sufficient to close a topic, ask the group what they wish to do.

- If this is the first meeting of the group, ground rules should be established.
- Four ground rules should always be followed, with the addition of others deemed as appropriate.
- The four ground rules are a must and apply to all attendees.
  - Participate
  - Focus
  - maintain momentum
  - reach closure.
- The ground rules should be posted at all times during the meeting.
- If the conversation is wandering off the topic, bring it back by announcing to the group that they need to get back on topic.
- If there are sidebar conversations, ask those in the conversation if they would like to share what they were discussing with the group.

➢ Meeting Minutes & Documentation:

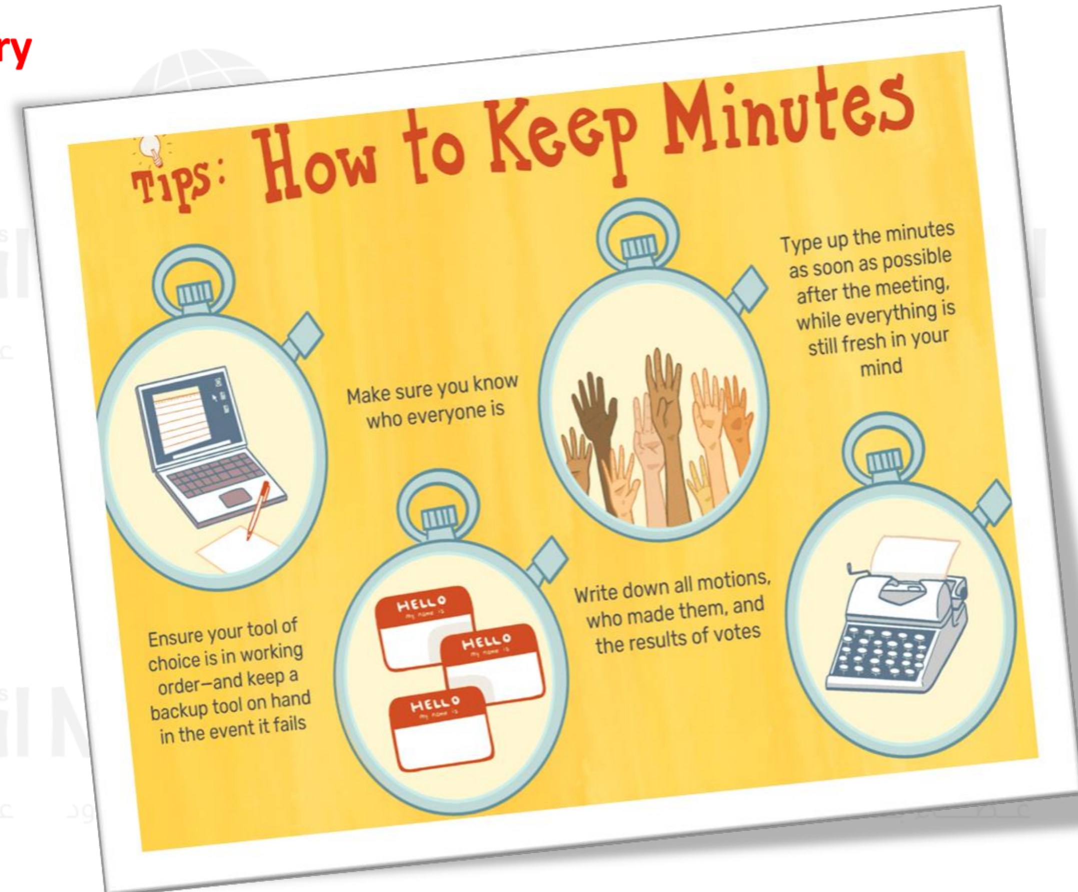
- Following the meeting, the best practice is to send the attending members, and others as appropriate, a summary of the meeting or the meeting's minutes within 24 hours

- Whenever someone asks you for a copy of the minutes, they are given only the minutes and not all the attachments.

- The minutes should not be vague, the reader cannot tell what really happened.

- The golden rule to follow when writing minutes is to "close the loop".

- At the time the minutes are completed, items that need follow up should be added to the agenda for the next meeting.



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THE PRACTITIONER APPRAISAL PROCESS:

- **The medical staff bylaws:**

  rules, and regulations establish a framework for medical/professional staff activities and accountability and are subject to governing body approval.

- They relate to all licensed independent practitioners with clinical privileges in the care of inpatients, emergency care patients, and patients in home care, ambulatory care, and long-term care.

- ***Membership on the medical staff*** requires an application process, including:

  credentialing, ***privileging***, and ***appointment***.

- The credentialing and privileging processes are extremely important in that there are legally required processes that protect the patient, physician and the organization.

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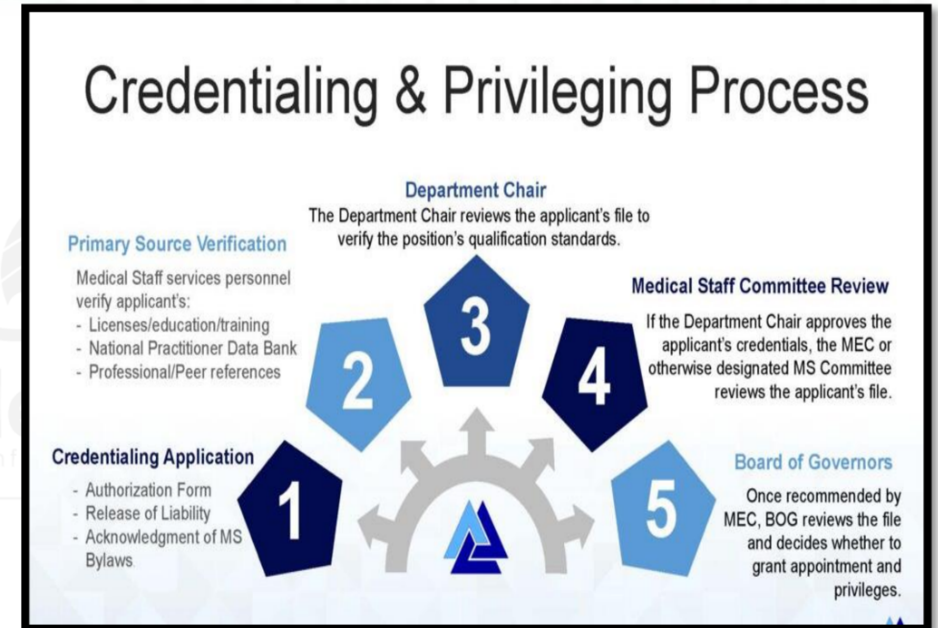
- The credentialing and privileging processes are utilized in healthcare to assure that licensed professional practitioners have the credentials required for the position and the ability to perform the tasks or privileges required.



- Licensed Independent Practitioners:
  - Active member in organization
  - Provide independent patient care service

Appointment/Reappointment:

- Process Leading to Appointment:

1. Application (submitted by applicant)
2. Credentialing complete & specific clinical privellidge granted
3. Raise it for approval from GB Or the designated committee

1. Application
2. Credentialing and privileges
3. Medical executive committee
4. Governing body > appointment

➢ Credentialing:

Is the verification of the practitioner's right and competency to provide patient care in the appropriate setting
The credentialing and re-credentialing process involves verification of compliance with predetermined standards and criteria concerning

1. Current, valid (state in U.S.) license to practice
2. Relevant training and education
3. Current competence
4. Board certification, if so stated
5. Work history
6. History of loss of license and felony conviction
7. Professional liability claims history resulting in settlements or judgments paid
8. Current malpractice insurance coverage
9. Evidence of physical ability to perform the requested privilege (or) inability to perform essential functions of the position

Primary source verification:

- Is required at the time of initial credentialing and re-credentialing for all elements required by the state or the applicable accreditation organization.

- This means that direct contacts must be made with licensing states, certifying agencies, educational institutions, insurance carriers , state medical boards, and perhaps other institutions where the practitioner has privileges Copies of these documents are not allowed to be accepted as verification since these copies could be digitally altered.

- ✓ **Centralized credentialing:**

is another attempt to refine this verification process to streamline the demands on practitioners to complete multiple applications, credentialing and privileging processes, and perhaps medical staff appointments.

- A centralized credentialing process, healthcare organizations have one center that completes all the credentialing verification for a given practitioner at one time for all facilities within the system.
- The practitioner has one reappointment date, which is the same throughout the organization.
- The essence of the system is one credentialing application and one-time primary source verification for all providers, and then one reapplication and information collection process, including profiling for current competency for re-credentialing and perhaps reappointment.
- Instead of organizations performing this centralized credentialing themselves, many organizations delegate the credentialing/re-credentialing function to credentials verification organizations (CVOs). CVOs are accredited themselves by accreditation organizations, so they musts meet identified standards.

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Privileging of Licensed Independent Practitioners:

- Once the applicant's credentialing process is completed, it is time to move into the privileging process. Once the centralized credentialing office or CVO has completed the credentialing, the application and file are returned to the specific facility where the applicant wants to practice.

- **Privileging**

  - Is granting permission to provide specific medical or other patient care services in the organization, within well-defined limits, based on the *individual's professional license* and his or her *experience*, *scope of practice*, *competence*, *ability*, and judgment and on the organization's ability to provide and support the service.
  - Granted for the time period specified in the bylaws or policies and procedures, but for no more than three or two years as defined by the accrediting organization.

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- Upon initial application, the information concerning the competency of the practitioner is obtained through the credentialing process
    1. Review of education
    2. Malpractice findings
    3. Reference checks

- During the periodic reappraisal process set by the organization, the privileges must be *re-requested* and be *renewed*, *revised*, *added*, or *deleted*, based on information from the practitioner's practice patterns and review for the reappointment period.

- A practitioner may also apply for a new privilege at any time during the reappointment cycle. However, when this occurs, the practitioner must demonstrate the competencies required for that privilege.

Delineation of Privileges

- Clinical privileges are granted individually, based on criteria established by the organization

  1. usually using privilege lists or groupings that are specific to each department, section, service, or specialty.
  2. The criteria is established by the medical staff to determine the level of competency appropriate for each privilege, e.g. the number of procedures that must be performed every reappointment cycle for the practitioner to be considered currently competent and to retain the privileges.

- A practitioner may also apply for a new privilege at any time during the reappointment cycle. However, when this occurs, the practitioner must demonstrate the competencies required for that privilege.

- Advanced practice practitioners may be awarded clinical privileges as defined by the medical staff bylaws, yet they are not members of the medical staff.

Special Privilege Statuses:

The majority of the time privileges are awarded for the three or two year period, or until the next reappointment time. However, there are two exceptions to this rule, and these are based on the clinical needs of the facility.

1-Temporary Privileges:

Temporary privileges are awarded to practitioners in only two circumstances. Both types of temporary privileges may only be awarded for a period of up to a total of 120 days. If the practitioner is needed for a longer period of time, the practitioner must apply for membership in the medical staff of the facility. The length of time that a practitioner can provide patient care under temporary privileges should be closely monitored

- The first type of temporary privileges are those given to a locum practitioner. Locum privileges are given to a practitioner who will be working at the facility to either meet an identified clinical need or to replace a practitioner who will be absent from the facility for a period of time.

- The second type of temporary privileges are awarded to applicants to the medical staff during probation period who have been through the credentialing and privileging processes and who are needed or wish to practice in that facility prior to the completion of the approval process.

The application must have no red flags.

- **Red flags could include:**
  - gaps on a physician's resume
  - resignations from healthcare facilities
  - insurance reduction in coverage over a period of time

2-Emergency & Disaster Privileges:

Emergency privileges are **awarded during an emergency** to existing members of the medical staff that **allow them to perform tasks outside of their delineated privileges to save a patient's life**, limb or organ. **When a practitioner with the appropriate privileges arrives, the emergency privileges are relinquished** by the first practitioner.

- In a disaster, any volunteer independent licensed practitioner who has a picture identification badge demonstrating membership in a hospital medical staff, and/or membership on one or more disaster management teams, or other specific organizations, may be allowed to practice at a healthcare facility during the disaster.
- Any volunteer practitioner is permitted to do everything possible to save a life or protect a patient from further or serious harm within the scope of his/her license, regardless of membership status, credentialing status, or approval of specific privileges.
- Once the disaster has been declared as being over, or if a practitioner on the medical staff of the facility arrives to take over, then the volunteer practitioner must relinquish those privileges.

Initial Appointment:

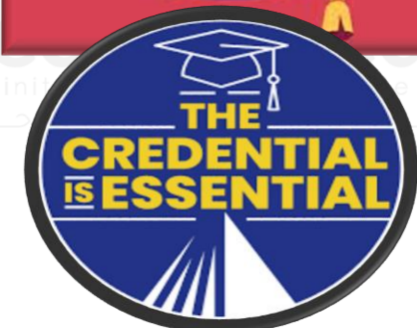
- Is often provisional, with a time period consistent for all applicants, generally 6 months to 1 year, as determined by the medical staff bylaws.
- The full appointment period is also determined by the bylaws, but cannot exceed ***three years*** in managed care organizations or two years in other organizations such as those accredited by The Joint Commission.
- At the time of appointment, or once the provisional time period has elapsed and required **proctoring** (under supervision) is completed, the practitioner is awarded a specific category of membership depending on the categories listed in the medical staff bylaws.

Reappointment:

- ✓ Reappointment includes reappraisal of the activity of the practitioner over the time period from last appointment, including both credentialing and privileging.
- ✓ Reappointment is granted for the time period specified in the bylaws or policies/procedures, but never for longer than three years or two years depending on whether it is a managed care organization or not.

Recredentialing:

- ✓ Consists of submission of an application as previously occurred during the initial credentialing, and updating the information concerning current activity, licensure and certifications/registrations.
- ✓ All information that was reviewed at the time of appointment, except information that does not expire, such as education achieved.
- ✓ If any new credentials, education, or other information has been obtained since the last appointment, it must also be verified at this time.



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Re-privileging:

- Consists of a review of the current competency , quality management activities , and peer review activities of the practitioner.

➢ It also includes:

- Review of other reasonable indicators of continuing qualifications, peer and departmental recommendations.

- Review and renewal of specific clinical privileges, and compliance with continuing medical education requirements.

- Following the re-credentialing and re privileging processes, the information is sent from the appropriate department who recommends reappointment to the Medical Executive Committee, which then sends their recommendation to the governing body.

Credentialing of Licensed Independent Practitioners:

- Credentialing and privileging are two distinctly different processes. The credentialing process occurs before the privileging process is begun.

Licensed Independent Practitioner (LIP):

is any individual who is professionally licensed by the state (U.S.) and permitted by the organization to provide patient care services without direction or supervision, within the scope of that license.

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Evaluation of the Practice of Licensed Independent Practitioners:

- An ongoing process that begins when the first privileges are delineated and continues until the individual no longer practices at the facility.
- Is any individual who is professionally licensed by the state (U.S) and permitted by the organisation to provide patient care services without direction or supervision with in the scope of this license.
- Only LIP who are appointed has the authority to approve admission of patient.

- Proctoring: FOCUS review:
  Observation and evaluation of new LIP or with newly request of privellidge.

Patient Care	Clinical Knowledge	Practice-based Learning and Improvement	Interpersonal and Communication Skills	Professionalism	Systems-based Practice
▪ Appropriate and Effective	▪ Demonstrate knowledge to patient care	▪ Utilize scientific evidence	▪ Establish and maintain professional relationships with patients and health care teams	▪ Behaviors reflect commitment, development, ethical practice & responsibility	▪ Understandi ng of systems

Practitioner Profiling

- **Profiles** are practitioner-specific data and information summaries are used in the reappraisal process, usually in conjunction with re-credentialing and re-privileging activities.

- Closing of the loop for performance monitoring and analysis, helping to effectively communicate appropriate findings to those leaders who need to know.

- Provide information (ongoing measurement) to assist Department chairs, section chairs, must review the profile data for both positive findings and any areas of concern then the Medical Executive Committee in the determination of the privileges to be renewed, discontinued, and so forth with each practitioner.

➢ This profile should be constructed utilizing the information from.

1. the Ongoing Professional Practice Evaluation (OPPE)
2. the Focused Professional Practice Evaluation (FPPE)
3. the peer review that has been completed
4. other indicators

- ➢ Ideally profiling should be as concurrent as possible, with review, analysis, and reporting at least quarterly
- ➢ Practitioner profiles must be maintained in a strictly confidential environment, electronic or hard copy and should **NOT** be kept in the Credentials file

Ongoing Professional Practice Evaluation (OPPE)

- The ongoing measurement (evaluation) and analysis of each (all) practitioner's performance relative to existing privileges, including licensed independent practitioners and others with clinical privileges granted by the organization.
- **The purpose of OPPE is to provide an ongoing practitioner's performance evaluation to assist the practitioner in making improvements in his/her practice and patient safety.**
- **designed for the practitioner to identify his/her weak spots and then undertake efforts to improve those areas of care and performance.**
- **This intervention could include additional focused review, proctoring for a period of time, up to limiting or revoking existing privileges for that practitioner.**
- The purpose of OPPE is making ongoing improvements, must be completed at least three reports every two years.

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Focused Professional Practice Evaluation (FPPE)

A privilege-specific, time-limited process to validate practitioner competency when:

1. there is no current performance documentation for the requested privilege(s) at the organization(new applicants and to existing practitioners).
2. when concerns arise about a practitioner's ability to provide safe, high quality patient care (Peer Review) based on criteria determined by healthcare providers (triggers).

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Peer review process

- **It is the review of an individual practitioner by a "like" practitioner who has the same training and expertise.**

It is used **for in-depth analysis for licensed independent practitioner** performance.
- It is a **main component in practitioner appraisal**.
- Peer review documents are considered to be "**Confidential**".
- It is the responsibility of **the appropriate department or specialty**, but is **usually delegated to a committee "Peer review Committee".**

JCI focuses on the design and function of peer review process which must be consistent ,useful ,timely , balanced and ongoing.

- **Professional practice evaluation (PPE) types :**
  1. **Focused**
  2. **Ongoing**

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The indications of peer review:

1. ongoing performance measure data collection and initial analysis
2. utilization review
3. infection surveillance activities
4. occurrence or event reporting, a sentinel event
5. team QI/PI activities, and/or data aggregation with internal or external comparisons (averages or benchmarks)

The purpose of peer review:

1. identify patterns outside recognized standards, behavior problems, or other circumstances, which endanger the safety or care of patients
2. upgrading the practitioner's clinical knowledge, enhancing his/her medical practice, reducing medical errors and improving patient safety and care
3. protect patients, assure due process to the practitioner under investigation and preserve the immunity of the medical facility and medical staff.

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The analysis of cases should be reviewed for the following factors:

1. clinical management
2. timeliness of medical interventions
3. adherence to a facility's clinical pathways and/or established guidelines for medically appropriate care
4. medical record documentation
5. professional conduct, and other reasons as requested by the facility

Confidentiality

Peer review committee / QM committee

Ranking score:

1 = Peers would have managed care in the same manner
2 = Patient outcome unaffected by the variance
3 = Peers would have managed care differently
4 = Negative outcome resulted from the variance

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