Performance Based Privileging

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What is "Performance Based Privileging"?

Why is it necessary?

How do you do it?

Performance Based Privileging

Construction

Credentialing

• Attestation of a practitioner's qualifications for appointment to medical staff
  – Education history, State license, Board Certification
  – Malpractice, criminal, hospital personnel occurrences
  – References
  – Joint Commission
  – Medical staff & department bylaws
  – Medical Executive Committee & Board of the Hospital

• All clinicians (MD, DO, CRNA, NP)
  – Initial appointment, then every 2 years

Credentialing example

Credentials: Pediatric Anesthesiologist
  – MD: University of Vermont 2000
  – Anesthesia residency: University of Vermont 2004
  – Peds anesthesia fellowship: Cincinnati Children’s 2005
  – State License: Ohio current
  – ABA boards 2007
  – No occurrences NPDB, FBI, Hospitals
  – References: excellent

Privileging

• Approval for practitioner to provide specific services or perform a specific procedures
  – Education history, Board Certification
  – Experience with specific procedures
  – Malpractice, hospital personnel occurrences
  – Defined by department/division/section
  – Joint Commission
  – Medical Executive Committee & Board of Hospital

• All clinicians (MD, DO, CRNA, NP)
  – Initial appointment, then every 2 years
Privileging example
Privileges: Pediatric Anesthesiologist

<table>
<thead>
<tr>
<th>Category I - General &amp; Regional Anesthesia</th>
<th>Privilege Requested</th>
<th>Privilege Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of procedures rendering insensible to pain.</td>
<td></td>
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<tr>
<td>Life support during anesthetic and surgical manipulations.</td>
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<tr>
<td>Clinical management of the unconscious patient.</td>
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<tr>
<td>Management of problems to induce pain.</td>
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<tr>
<td>The management of cardiac and respiratory resuscitations.</td>
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<td></td>
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<tr>
<td>The application of specific methods of resuscitation.</td>
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<td></td>
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<tr>
<td>Management of fluids, electrolyte and metabolic disturbances.</td>
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Credentialing vs Privileging

Credentialing (every 2 yrs)

| MD CRNA NP | Reviewed by Mod staff specialist | Approved by Department, Medical Exec, Hospital Board | Join the Clinical Staff |

Privileging (every 2 yrs)

| MD CRNA NP | Reviewed by Clinical Chief | Approved by Department, Medical Exec, Hospital Board | Provide specific Services & procedures |

Joint Commission: rule 2007

Credentials & Privileges
- Ongoing professional practice evaluation
  1. Link to quality of care
  2. Involve six competencies of ACGME & ABMS
  3. Use performance management principles
- "Performance based privileging"


Quality

How to assess it?
- Credentials of the providers & institution (ABA, JCH)
- Experience of the providers (number of cases)
- Processes that the providers adhere to (antibiotic compliance)
- Outcomes that the patient experiences (surgical infection rate)

ACGME & ABMS competencies

1. Professional Performance
Demonstrate understanding of established and evolving sciences in the context of patient care

2. Interpersonal communication skills
Care that is appropriate, timely, safe, evidence based, and compassionate

3. Medical/Clinical Knowledge
Care that is effective, highly reliable, and safe

4. Clinical Judgment
Care that is appropriate, timely, safe, evidence based, and compassionate

5. Clinical/Technical Skills
Care that is effective, highly reliable, and safe

6. Systems-Based Practice
Demonstrate understanding of the system properties in which care is provided, and evidence to continually improve care

Performance Management

Organizational input
Vision Mission & values Strategies, goals Improve quality

Setting expectations
Individual goals Measures Numbers indicating quality Threshold: pass/fail

Reviewing performance
Recognition, compensation Performance bonuses Improvement plans for fails

Supporting performance
Feedback, coaching Measurement processes Provider evaluations
Why do it?

Hospital Performs Brain Surgery on Wrong Side Three Times
Most Recent Error Occurred Despite Safety Measures From Last Two Mix-Ups

How to implement performance based privileging

Cincinnati Children’s

- Transformation & Transparency
- Business Units
  - Teams: MD, RN, PhD, Administration
  - Manage: Clinical, Research, Education, Finance
- Quality Improvement Science

Institute for Healthcare Improvement
"Crossing the Quality Chasm", 1998

Define Quality
1. Safe
2. Effective (outcomes)
3. Patient centered (family experience)
4. Efficient (flow)
5. Timely (on-time with schedule)
6. Equitable

Anesthesia division

Quality indicators
- Safety: Serious adverse events, PACU respiratory complications
- Efficacy: anesthesia induction, PACU comfort, antibiotics compliance, SSI bundle compliance
- Patient Centered: parental satisfaction
- Efficiency: ASA units/FTE/day
- Timeliness: PACU discharge time for PET, T&A on-time start for ENT, GI
- Equity: race, insurance for safety, efficacy, patient centered
How to measure Quality

- Independent of clinician
- Careful definition
- Sample size
- Methodology varies

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How did we implement it?

Performance based privileging

- Measure quality
- Define quality

Performance based privileges

1. Professional Performance
   Attendance at divisional meetings ≥ 75%

2. Communication skills
   Parent satisfaction survey: top rating ≥ 75% and bottom rating ≤ 3%?

3. Medical/Clinical Knowledge
   Anesthesia & Neurobiology: PALS, ACLS certified
   Pain: BBA training 100%

4. Clinical Judgment
   Anesthesia: Induction Compliance & PACU comfort ≥90%?
   Pain: serious safety events ≥ 2 per yr
   Neurobiology: success with sedation ≥ 30%

5. Technical Skills
   Anesthesia: PACU respiratory complications < 2%
   Pain: 15 mesoscale blocks per year
   Neurobiology: monitored modality > 80%

6. Systems-Based Practice
   Safety training 100%
Observed/expected (O/E)

Case-mix adjustment
- The observed rate is the provider's raw rate
- The expected rate is the rate the provider would have if it performed the same as the reference population given the provider's actual case-mix

Threshold: \( O/E = 2 \) (arbitrary)
- \( O/E = 1 \) provider did as expected
- \( O/E < 1 \) provider did better than expected
- \( O/E > 1 \) provider did worse than expected
- \( O/E > 2 \) triggers an investigation by clinical chief

Performance Management

Organizational input
- Mission & values
- Strategies, goals
- Improve quality

Setting expectations
- Individual goals
- Measures
- Numbers indicating quality
- Threshold: pass/fail

Reviewing performance
- Recognition, compensation
- Performance bonuses
- Improvement plans for fails

Supporting performance
- Feedback, coaching
- Measurement processes
- Provider evaluations

Annual Evaluation

Meeting 1 hr
- Faculty with Department Chair
- CRNA with Division Chief
- NP with Division Chief

Review individual
- Last year performance
- Goals for next year
- Performance based privileging results

Performance based privileging

If needed, Why is your number "off"?
- Provider, division chief, quality officer meet
- Review raw quality data together
- Determine the reason
- Prepare action plan
  - to department chair
  - In file if audited by JC

PACU respiratory complications

Reasons
- Sample size: 3
- Deep Extubations: 1
- Research study: 1

Plan
- Report data every 2 yrs to increase sample size
- Individual coached & monitor technique
- Publish study

Where are we going?

- Medical/Clinical Knowledge & Technical Skills
  - Ongoing experience: cases or simulations
- Risk adjustment
  - Improve O/E methodology
- Research
  - Evidence base for thresholds
- Link to Compensation
  - Privileging documents done
  - Eligibility for bonus
### Quality: Experience

<table>
<thead>
<tr>
<th>Experience Division</th>
<th>FY 08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia Division</td>
<td></td>
</tr>
<tr>
<td>Pediatric cases per staff</td>
<td>894</td>
</tr>
<tr>
<td>Cardio cases per staff</td>
<td>906</td>
</tr>
<tr>
<td>Neurosurgery cases per staff</td>
<td>78</td>
</tr>
<tr>
<td>Fetal surgery cases per staff</td>
<td>116</td>
</tr>
<tr>
<td>Liver transplant cases per staff</td>
<td>2</td>
</tr>
<tr>
<td>Pediatric Division</td>
<td></td>
</tr>
<tr>
<td>Acute pain cases per staff</td>
<td>1322*</td>
</tr>
<tr>
<td>Endoscopy cases per staff</td>
<td>193</td>
</tr>
<tr>
<td>Palliative care cases per staff</td>
<td>517</td>
</tr>
<tr>
<td>Chronic pain cases per staff</td>
<td>366*</td>
</tr>
<tr>
<td>Neurobiology Division</td>
<td></td>
</tr>
<tr>
<td>Neuronavigation cases per staff</td>
<td>225*</td>
</tr>
<tr>
<td>Diagnostic imaging cases per staff</td>
<td>420*</td>
</tr>
</tbody>
</table>

* Subspecialty teams

### Performance Based Privileging

- juggler

- construction

- surprise
DEPARTMENT OF ANESTHESIOLOGY  
CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER

**Provider Performance Based Privileging Plan**

**The Joint Commission-ACGME-ABMS 2007-2008**  
1/1/07 thru 12/31/08

**1. The Joint Commission Standards**

- Conduct ongoing professional practice evaluation including provider-specific, time-trended, peer-aggregated, and externally benchmarked appraisal of individual performance representing the six dimensions specified by the ACGME/ABMS. The purpose is to demonstrate an ongoing, objective, data-driven, peer-reviewed process for granting, renewing, and restricting/denying clinical privileges.

**2. Professional Performance**

<table>
<thead>
<tr>
<th>Clinical Division</th>
<th>Standard Performance Measures</th>
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</thead>
<tbody>
<tr>
<td><strong>Anesthesiology</strong></td>
<td><strong>Professional Performance</strong></td>
</tr>
<tr>
<td>- Medical Assessment &amp; Management, including use of evidence and appropriate consultation</td>
<td></td>
</tr>
<tr>
<td>- Outcomes of high risk procedures &amp; effective management of complex clinical conditions</td>
<td></td>
</tr>
<tr>
<td>- Patient satisfaction survey favorable rating ≥ 75% and unfavorable rating ≤ 25%</td>
<td></td>
</tr>
<tr>
<td>- Pain management providers – MDA, MDP</td>
<td></td>
</tr>
<tr>
<td>- Pain management survey favorable rating ≥ 75% and unfavorable rating ≤ 25%</td>
<td></td>
</tr>
<tr>
<td>- Sedation providers – MDA, MDP</td>
<td></td>
</tr>
<tr>
<td>- Sedation satisfaction survey favorable rating ≥ 75% and unfavorable rating ≤ 25%</td>
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**3. Interpersonal/Communication Skills**

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<tr>
<td><strong>Anesthesiology</strong></td>
<td><strong>Interpersonal/Communication</strong></td>
</tr>
<tr>
<td>- Attendance at monthly Clinical Division meetings ≥ 75%</td>
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<td>- Pain management providers – MDA, MDP</td>
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<td>- Pain management survey favorable rating ≥ 75% and unfavorable rating ≤ 25%</td>
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**4. MEC Approved (3)**

- Anesthesiology providers – MDA, MD, CRNA, NP
- Pain management providers – MDA, MDP
- Neurophysiology providers

**5. MEC Approved (6)**

- Anesthesiology providers – MDA, MD, CRNA, NP
- Pain management providers – MDA, MDP
- Neurophysiology providers

**6. Professional Development**

- Medical staff reappointment with clinical privileges requires ongoing clinical performance assessment. Particular focus should include clinical performance assessment, professional practice patterns, assessment of morbidity & mortality, and use of outcomes of patient care. Anesthesiology providers should:
  - Attend mandatory monthly Neurobiology Division meetings ≥ 75%.
  - Attend mandatory monthly Anesthesia Division meetings ≥ 75%.
  - Attend mandatory monthly Pain Management Division meetings ≥ 75%.

**7. Dean Kurth, MD**

- Patient satisfaction survey favorable rating ≥ 75% and unfavorable rating ≤ 25%.
- Pain management providers – MDA, MDP
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**8. Provider Performance Based Privileging Plan**

- Conduct ongoing professional practice evaluation including provider-specific, time-trended, peer-aggregated profession performance assessment.
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<td><strong>Anesthesia providers – NP</strong></td>
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<tr>
<td>≤ 2% Selection error: complication rate - maintain an observed/expected ratio</td>
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<td><strong>Seclusion providers – MD, MPA, MDP</strong></td>
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<td>≤ 2% Failure to respond: complication rate - maintain an observed/expected ratio</td>
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<tr>
<td><strong>Pain Management providers – MD, MPA, MDP</strong></td>
<td></td>
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<tr>
<td>&gt; 90% Post-operative complication rate: complication rate - maintain an observed/expected ratio</td>
<td></td>
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<tr>
<td><strong>Neurophysiologist providers</strong></td>
<td></td>
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<tr>
<td>≥ 3.6 or 90%</td>
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### Medical/Clinical Knowledge

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### Clinical Judgment

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### Clinical Technical Skills

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Clinical Division

Standard

Performance Measures

**Safety Training**
- Meet all requirements

**Pain Management**
- MD
- Complete 15 neuraxial blocks (spinal, caudal, epidural) per year
- Pain Management – NP
- Complete 15 neuraxial blocks (spinal, caudal, epidural) per year
- Pain Management – MD
- Pain Management categories: Excellent

**Neurophysiologist Providers**
- Percentage of cases successfully monitored with modalities > 90%

**Systems-Based Practice**
- Continuously improve and optimize care
- Apply knowledge and evidence to system properties and contexts in provision of care

Last Updated 08/01/07