

Low-Volume/No-Volume Practitioners: Best Practices for Competency, Privileging, and Strategy

WHITE PAPER



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● Introduction

The accelerating exodus of physicians from hospitals today creates a challenge for most medical staffs: what to do with low-volume and no-volume providers. These are often primary care physicians who have happily turned over their inpatients to the hospitalists. Increasingly, specialists find they can earn a better living working in surgicenters and endoscopy suites than caring for hospitalized patients. At reappointment time, department chairs, credentials committees, and medical staff professionals wonder what to do with these providers for whom they have no performance data. The Joint Commission's increasing emphasis on ongoing professional practice evaluation (OPPE), focused professional practice evaluation (FPPE), and demonstrating current competency means it is no longer acceptable to continue to grant privileges to providers whose only presence in your hospital is their credentials file. Hospitals that have dropped Joint Commission accreditation in favor of one of the other options are not exempt from this challenge, as the Center for Medicare & Medicaid Services' 2009 *Conditions of Participation* require that surveyors determine how medical staff members who do not provide patient care at the hospital undergo periodic appraisals of their current clinical competency during an appropriate evaluation time frame.

The forces driving this shift of providers from inpatient to outpatient care are powerful and growing. The most important of these forces include:

- Rapid growth of hospitalist programs
- Outpatient settings offering better productivity with fewer hassles
- Physicians seeking enhanced revenues from provider-owned outpatient facilities
- Technological advances expanding the minimally invasive procedures that can safely be performed in outpatient settings
- Increasing numbers of women in medicine seeking a better balance for their professional and personal lives
- Active efforts to reduce or avoid emergency department (ED) call responsibilities

Thus, at a time when regulatory forces require improved and objective measures of current clinical competency, there is a mass exodus of healthcare

practitioners into the ambulatory setting, resulting in a paucity of accessible data upon which to make evidence-based privileging recommendations. At the same time, many third-party payers still require that physicians maintain membership on a medical staff to participate in their network. This collision course makes it imperative for every healthcare organization to create a methodology to strategically and safely privilege practitioners that satisfies regulatory concerns and addresses these contemporary social and economic forces.

To develop the best approach to low-volume/no-volume practitioners for your unique market and healthcare community, it is helpful to utilize a step-by-step process. These steps are:

1. Identify strategic and competency goals
2. Design and implement an outreach program for low-volume/no-volume practitioners
3. Separate medical staff membership from privileges
4. Create gradations in your delineations of privileges
5. Strengthen information gathering from references
6. Create an effective OPPE and FPPE policy and process
7. Summarize your results in a strategic approach to assessing competency for each type of practitioner

Let's look at each of these steps a little more closely.

Step 1: Identify strategic and competency goals

As your hospital or healthcare organization begins rethinking its approach to low-volume/no-volume practitioners, it is important to tease out strategic goals from competency goals. Strategically, most hospitals want to maintain a robust relationship with physicians in their community who serve as an important source of patient referrals, even if they no longer practice in the hospital. At the same time, due to quality, risk, and regulatory concerns, no hospital wants to grant privileges that providers are not competent to carry out. As you develop your strategy for low-volume/no-volume providers through the remaining steps, always keep these two types of goals in clear focus and develop approaches that accomplish both.

Step 2: Design and implement an outreach program for low-volume/no-volume practitioners

As primary care physicians and other specialists spend less time practicing at the hospital in their community, their relationships with the hospital and other physicians practicing there weaken. It becomes easier for competing hospitals to attract their referrals. So an important focus of developing an approach to low-volume/no-volume practitioners is to design a program to keep the hospital's relationship with these providers as strong as possible. In each community, different strategies may be effective. Some physicians may want to remain involved in the activities of the organized medical staff (see Step 3 on p. 5). Others may want optimized communication with the

An important focus of developing an approach to low-volume/no-volume practitioners is to design a program to keep the hospital's relationship with these providers as strong as possible.

hospitalist program, including easy referrals to the program, ongoing communication during their patients' admissions, and timely information upon discharge. Some may be interested in maintaining collegial relationships with a medical community that reduces their isolation in clinical practice. Other strategies may include helping physicians with their electronic medical records and ease of accessing the hospital's information technology system. Access to continuing medical education and stimulating discussions of clinical issues may draw in some physicians. One pediatric hospital made every pediatrician in the surrounding counties an affiliate member of its medical staff, along with providing a handsome plaque for their office wall announcing this relationship with the prestigious hospital. From this list of possibilities, it is important to take away the need to be creative, listen to what physicians in your community are asking for, and be prepared to try multiple options rather than assuming one size will fit all.

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- A best practice is to develop your approach to low-volume/no-volume providers, including the design and implementation of an effective outreach program, as part of a comprehensive strategic medical staff plan. In the past, healthcare organizations created physician recruitment plans based upon the demographic analysis of current physician-to-population ratios and an aging analysis of current members on the medical staff roster. Such medical staff development plans were adequate for demonstrating community need and justifying recruitment and salary guarantee support, but they are no longer adequate to meet today's challenges. Now, a strategic medical staff development plan needs to begin by recognizing the medical staff as one of the hospital's most valuable resources. That resource includes not only the number of physicians in each specialty, but also the relationship of physicians to the hospital, physician alignment with hospital goals, strategies for growth of physician practices and important hospital service lines, maintenance of adequate ED coverage, and the need for strong physician leadership. In developing this plan, hospital leaders should carefully consider how they will keep strong relationships and alignment with low-volume/no-volume physicians, including preventing competing hospitals from pulling away their referrals.

To achieve these goals, the best practice is for the governing board to carry out a periodic strategic medical staff development planning process. This process includes data gathering through the usual demographic analysis, interviews with physicians, and thoughtful deliberations with key members of the medical staff and senior management. These deliberations should address how best to build and maintain relationships with low-volume/no-volume providers, as well as the growth and development of the medical staff in light of local quality, economic, and strategic concerns. The result should be a strategic medical staff development plan that not only maps out medical staff recruitment and retention strategies, but also defines the relationships between the healthcare organization and medical staff members, services, and practices with regard to the quality and scope of services, qualifications

of members, leadership roles, call responsibilities, and strategies for addressing physician-hospital competition and collaboration. (For more information regarding strategic medical staff development planning, you may wish to consult the book *The Greeley Guide to New Medical Staff Models: Solutions to Changing Physician-Hospital Relations*, authored by William K. Cors and Richard A. Sheff and available from HCPro, Inc., at www.hcmarketplace.com/prod-6525.html.)

One of the most important decisions within such a planning process is to determine the degree of inclusivity or exclusivity of the medical staff. Inclusivity reflects the traditional open medical staff model in which all physicians are encouraged to join the staff, regardless of specialty, expertise, level of commitment, or split loyalties between competitive entities. Exclusivity, in its pure connotation, would be a closed medical staff similar to that at some academic medical centers or large multidisciplinary practices (e.g., Mayo Clinic)—an invitation-only model that maintains absolute control over the size, number, and quality of medical staff members and specialties represented. The challenge with the open medical staff model is that many physicians will be on staff who contribute little to the mission of the medical staff or have split loyalties between competing entities. In addition, there will be a larger number of low-volume/no-volume physicians who have little clinical activity in the organization and often little awareness of the political and operational issues confronting the medical staff. With closed medical staffs, physicians will be loyal to the organization's mission; however, there will be less diversity and fewer opportunities to interact with community-based physicians who may be an important source of referrals and collegial interaction. Thus, many organizations are looking at hybrid models that combine the best of inclusivity with a more controlled approach to the growth and development of the medical staff and the best of exclusivity with the recognition that the organization may want to create strategic relationships with low-volume/no-volume practitioners or groups who provide value through referrals, ancillary testing, and collegial interactions with the medical staff.

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- Such a strategic medical staff development plan creates the foundation for a low-volume/no-volume strategy by recognizing the difference between medical staff membership and privileges (see Step 3 on p. 5). Not all physicians want or should be permitted to have full independent hospital-based privileges. On the other hand, many of these physicians should have a key role in the medical staff through leadership, committee membership, and input to the medical staff, management, and the board regarding strategic community-based issues and relationships. Leaving this relationship to chance only invites the inadvertent dissolution of the organized medical staff into factions with competing interests and goals. Performing this process well enables an increasingly heterogeneous medical staff to utilize its diversity and richness of experience to optimize the scope of services available to the healthcare organization.

Step 3: Separate medical staff membership from privileges

Medical staff and hospital leaders should be encouraged to separate medical staff membership from privileges in their minds.

Medical staff and hospital leaders should be encouraged to separate medical staff membership from privileges in their minds. Determining whether physicians are members of a medical staff and to which category of membership they are assigned is a political decision related to medical staff self-governance. Members of the active medical staff are eligible to vote, hold office, and constitute a quorum. Members of the associate medical staff typically are not. Historically, some categories received benefits that others did not, such as participation in ED call. (Although this seems absurd today, ED call was originally a benefit only available to active medical staff members, as there was a time when covering the ED was considered essential to building a practice.)

Privileges, on the other hand, determine what a provider can and cannot do when providing patient care. He or she may be granted privileges to perform surgery, practice internal medicine, or provide anesthesia services. But the medical staff and hospital leaders often confuse these privileges with medical staff categories. So we frequently hear someone saying, “This physician has courtesy privileges, and that physician has active privileges.” Actually, both physicians may have the same privileges, but one has more political rights in the self-governed medical staff than the other.

Let’s apply this distinction to low-volume/no-volume providers. For example, we can imagine a primary care physician who strongly supports the hospital, refers all her patients to its hospitalist program and specialists associated with the hospital, and wants to maintain a meaningful connection with the hospital. It would be reasonable for her to be assigned to the active medical staff. After all, this category should apply to physicians who are committed to the medical staff and fulfillment of the hospital’s mission, and this physician fits that description. But if she only refers patients to the hospital, she doesn’t actively practice in the hospital. In this case, the only privileges she needs are to refer and follow. She can see her patients in the hospital if she chooses, review the medical record, and provide advice to physicians and nurses caring for her patients. But she cannot write an order and cannot do a procedure. This means there is no need to assess the physician’s competence at reappointment time. We can also imagine an orthopedist who is primarily active at another hospital and only wants privileges at your hospital to provide coverage to another orthopedist. In this case, the orthopedist would be assigned to an associate category with few or no political rights (other than the right to due process). At the same time, his privileges might include the full spectrum of general orthopedic procedures. For this orthopedist, the medical staff must do something to assess his competence at reappointment (see Step 7 on p. 11).

Separating membership from privileges allows medical staffs to accomplish several important goals. The first is to have flexibility and options in how to

maintain strong relationships with important physicians in the community who no longer practice at the hospital, including continuing to offer them membership in the active category of the medical staff. Developing strategies for accomplishing this goal should be part of the strategic medical staff development planning process described in Step 2. Enfranchisement of physicians in medical staff governance can be an important tool for maintaining these relationships. Yet, if a large number of physicians opt for privileges to refer and follow, a significant burden for assessing competence is removed from the department chairs, quality management department, and medical staff office.

If physicians who no longer practice at the hospital prefer not to be burdened with medical staff obligations, or if the hospital's strategy is to focus increasingly on those physicians actively practicing in the hospital, the active category of the medical staff can be allowed to shrink to the smaller but more committed group of physicians for whom all or a significant portion of their practice occurs within the hospital. The success of these physicians—hospitalists, exclusively contracted specialists, and surgeons busy in the hospital's operating room—is tied to the hospital's success, which creates greater physician-hospital alignment.

Another design option for medical staff categories is to establish a category specifically for physicians who do not practice at the hospital but want to remain affiliated with the hospital. This could be called the affiliate medical staff category, which would only be eligible for privileges to refer and follow. Though this creates an unnecessary link between medical staff category and privileges, it can provide clarity regarding a physician's relationship with the medical staff and hospital.

Active members are those committed to the medical staff and healthcare organization in the fulfillment of its mission.

- In summary, active members are those committed to the medical staff and healthcare organization in the fulfillment of its mission. Associate members are new members of the medical staff undergoing closer scrutiny through FPPE (discussed in the next section) or individuals who do not wish to make a significant commitment to the medical staff but who fulfill an important role. Affiliate members could be those ambulatory-based practitioners who are not interested in any inpatient privileges but who also fulfill an important role through referrals, the ordering of ancillary tests, and collegial networking. Honorary/emeritus members are those practitioners in the community whom the medical staff wishes to honor for their years of contribution to the community or the profession. These options are summarized in Table 1 below:

Table 1

Membership category	Political rights of membership	Privileges allowed
Active	Full	Based upon provider's practice or none
Associate	Partial	Based upon provider's practice or none
Affiliate	Partial	Refer and follow or none
Honorary/emeritus	Partial	Refer and follow or none

Full political rights could include holding medical staff office, voting for officers and bylaws amendments, and serving as chairperson of a committee. Partial political rights could include the ability to serve on a committee with or without a vote. The key point is that having anything less than full independent privileges should not preclude a medical staff member from making important contributions to the medical staff and receiving political rights as a member of that staff.

Step 4: Create gradations in your delineations of privileges

It is becoming increasingly necessary to think of privileges in a more nuanced manner, with gradations of independence.

Traditionally, physicians either received full privileges or none at all. With the growing diversity of practitioners, including physicians, dentists, podiatrists, and advanced practice providers such as nurse practitioners, certified registered nurse anesthetists, midwives, and physician assistants, it is becoming increasingly necessary to think of privileges in a more nuanced manner, with gradations of independence. Key elements that should be considered in developing different categories of privileges include:

- Does the practitioner hold a license to practice independently in the state?
- Does the institution authorize the practitioner to practice independently within the institution?
- Does the organization generate adequate quality data to determine practitioner competency?
- Is it likely the organization will generate quality data adequate to determine practitioner competency in the near future?
- Does the organization have access to quality data generated in other institutions where the practitioner practices and/or references that are adequate to determine competency?
- Does the practitioner have adequate recent practice volume to determine competency (e.g., providers returning from a leave of absence or hiatus from practice due to bearing and raising children)?

Table 2 below summarizes the gradations of privileges based upon answers to these questions:

Table 2

Privilege level	Licensed independent practitioner	Authorized to practice independently in the institution	Adequate quality data and/or references to determine competency	Likely to generate adequate quality data in the near future
Independent	Yes	Yes	Yes	N/A
Comanagement until precepting demonstrates competence	Yes	Yes	No	Yes
Comanagement	Yes	Yes	No	No
Dependent	Yes or no	No	N/A	N/A
Refer and follow	Yes or no	No	N/A	N/A

Let us apply this way of thinking about privileges to some common examples:

- **Active surgeon on your medical staff.** This physician is licensed to practice independently, authorized to practice independently within the hospital, and has adequate data to demonstrate competence. Hence, the surgeon would be granted independent privileges.
- **OB/GYN returning to practice after taking five years off to bear and raise children.** This physician is licensed to practice independently and authorized to practice independently within the hospital, but has no recent experience or data on which to base an assessment of current competence. This physician could be granted comanagement privileges until current competence is demonstrated. (This physician might also be required to participate in required continuing medical education and/or a mini-residency before being allowed to practice under the comanagement privileges.)
- **Physician assistant (PA) working on the hospitalist service.** This PA is not licensed to practice independently and not authorized to practice independently within the hospital. Availability of data to demonstrate competency is not relevant to the privilege level granted, which would be dependent privileges.
- **Cardiologist requesting privileges only to cover other cardiologists one weekend in eight.** This physician is licensed to practice independently and authorized to practice independently within the hospital, but has no clinical performance data in this hospital upon which to assess competence. Due to her infrequent coverage, she is not likely to generate adequate data over time. However, she is actively practicing at another hospital across town. Your hospital could obtain peer review data from the other hospital and/or references adequate to determine competency, and the cardiologist could be granted independent privileges.

Step 5: Strengthen information gathering from references

One of the key challenges low-volume/no-volume providers present is how to assess their competence when you have little or no data on their performance in your organization.

- One of the key challenges low-volume/no-volume providers present is how to assess their competence when you have little or no data on their performance in your organization. For years, medical staffs have depended upon references to provide information about such physicians, including initial applicants and reapplicants. But most medical staff leaders tell us it's hard to get any information of real value from references today. Sometimes the person giving the reference is afraid of being sued. Sometimes a hospital cuts a deal with a problem physician: The physician agrees to go away without suing, and in return, the organization doesn't say anything bad about him or her. Sometimes the number of reference requests has grown to be such a burden on medical staff offices that hospitals have adopted a standardized way to respond to inquiries about a provider's performance that gives little meaningful information. Yet for low-volume/no-volume providers, we often don't have any choice but to depend upon references for information about their competence.

It's important to strengthen your process for obtaining the most useful and accurate information you can from references.

- Because of these factors, it's important to strengthen your process for obtaining the most useful and accurate information you can from references. This begins with redesigning your reference form. Include all of the pertinent Accreditation Council of Graduate Medical Education (ACGME)/Joint Commission general competency areas on the reference forms, along with the Joint Commission–required components of a peer recommendation. It is important to translate each category into questions about specific performance and behavioral attributes that help you differentiate one provider's performance from another.

Next, be sure to train your credentialing staff and medical staff leaders in how to spot red flags in references. A red flag can be a rating of anything other than "excellent" for specific attributes such as "consistently acts in a professional manner" or "consistently complies with medical staff and hospital policies." It can be a question left unanswered. It can be damning with faint praise. Or it can be a hint in the form of "please feel free to call me if additional information about this applicant is required." Such a statement is almost a plea to be called so that the supplier of the reference can tell you the rest of the story.

Individuals and institutions may still be afraid of providing honest references. A tool for addressing such situations is a special release form signed by the applicant. Such a release commits the applicant not to sue with tighter language than the typical release. If the applicant refuses to sign such a special release, and the needed reference cannot be obtained, the application remains incomplete and cannot be acted upon. This approach places the burden on the applicant to ensure that you have enough information to make an informed decision about the applicant's request for membership and privileges.

Finally, it's important to engage your physicians in calling references personally. Far more information is gained in a "doc-to-doc" phone call than a written reference or a call by a medical staff professional. Getting the most out of calling references requires training your section chiefs and department chairs in a disciplined approach to call content and documenting the results of calls.

Step 6: Create an effective OPPE and FPPE program and policy

OPPE is the routine monitoring of all practitioners granted clinical privileges. It is a method for confirming current clinical competency, recognizing excellent performance, identifying opportunities for improvement, providing objective data through which practitioners may manage and improve their clinical practices, and providing the data for managing poor performance when necessary.

Although the methodology for adopting and implementing OPPE is beyond the scope of this paper, OPPE should include the following components:

- A framework for defining dimensions of performance (e.g., the ACGME/Joint Commission General Competencies)
- Clearly articulated expectations for performance in each identified dimension
- Measurable indicators linked to specific expectations
- Performance targets for evaluating practitioner performance
- Fair, efficient evaluation of individual case reviews
- Periodic performance feedback reports to all practitioners (usually every six months) with timely and constructive feedback from individual case reviews

FPPE is the timely monitoring of practitioners' granted clinical privileges to verify current clinical competence for physicians who are new to the medical staff, have been granted new privileges, or have potential performance concerns identified through OPPE. The term "timely" is coming to be interpreted as within three months or a suitable period based upon specialty volume and specialty-specific privileges. FPPE can evaluate cognitive or procedural skills as well as conduct and may be performed prospectively, concurrently, or retrospectively through chart review, performance monitoring, internal or external peer review, and morbidity/mortality reviews or discussion.

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- The intent of OPPE and FPPE is to provide an objective, evidence-based approach to quality oversight and privileging without placing an unsustainable burden on the scarce resources of healthcare organizations and their medical staffs. Clearly, applying your OPPE and FPPE processes to low-volume/no-volume practitioners creates challenges that could drain even more resources. The best approach, as noted above, is to move as many of your no-volume providers as possible into privileges to refer and follow. This relieves the hospital of the need to do any OPPE or FPPE for these providers. The remaining low-volume providers usually require prolonged periods of FPPE because they are unlikely to have enough volume to demonstrate competence, perhaps not at any time during the two-year appointment cycle. One option is to grant only comanagement privileges to these providers to ensure adequate oversight from another privileged provider on the medical staff. A second option is to ensure that your FPPE program is capturing information about low-volume providers and that leaders are reviewing and acting on these data on a timely basis.

As noted above, for low-volume providers, references play an important role in assessing competence. But simply using references without making a good-faith attempt to conduct FPPE on low-volume providers is probably inadequate. (For more information regarding best practices for FPPE, the reader may want to consult *Proctoring and Focused Professional Practice Evaluation: Practical Approaches to Verifying Physician Competency* by Robert Marder and Mark Smith, published by HCPro, Inc., and available at www.hcmarketplace.com/prod-4622.html.)

A word of caution may be helpful here. All too often, we see medical staffs inadvertently create unnecessarily cumbersome OPPE and FPPE processes out of fear of not meeting regulatory compliance. We encourage every medical staff to take a reasoned approach to designing and implementing their OPPE and FPPE processes so as to achieve the goal of safe and reliable care without creating excessive burdens that may not add value.

Step 7: Summarize your results in a strategic approach to assessing competency for each type of practitioner

A best practice is to establish within each clinical specialty minimum threshold criteria in terms of quantitative data (volume) and qualitative data (amount of meaningful quality data) that would trigger a low-volume/no-volume approach.

- Several types of practitioners will present before the credentials committee or medical executive committee requesting initial appointment or reappointment. A best practice is to establish within each clinical specialty minimum threshold criteria in terms of quantitative data (volume) and qualitative data (amount of meaningful quality data) that would trigger a low-volume/no-volume approach. Practitioners may then be classified as clinically active (meet minimum threshold criteria or required volume of quality data for specialty-specific privileges), clinically less active (below minimum threshold criteria, with some meaningful data), or inactive (without any meaningful quality data). This creates the opportunity for medical staff professionals and leaders to summarize a well-delineated approach to matching competency with privileges granted to each type of practitioner.

Following are the most common types of practitioners, with a best practices approach for each type:

- **Clinically active members of the medical staff with sufficient quality data:** Use FPPE for identified performance issues and new privileges and OPPE for other privileges.
- **Clinically active members of the medical staff with sufficient quality data elsewhere:** Create release documents that permit access to quality data (OPPE and FPPE) at other healthcare organizations. Use FPPE to confirm competence locally, even if excellent quality data and references are available. Your hospital counsel can assist in creating appropriate documents to permit the sharing of quality data.
- **Clinically active members of the medical staff who practice primarily in an ambulatory facility** (e.g., an ambulatory surgery center in which practitioners perform the same procedures or skills as in a hospital setting): If the ambulatory facility is part of the hospital to which they are applying or reapplying for privileges, the best approach is to create an OPPE and FPPE process that uses ambulatory-based quality data to supplement data available from hospital-based care. If the ambulatory facility is not part of the hospital, utilize the same approach used for medical staff members with sufficient quality data elsewhere.
- **Clinically active members of the medical staff who primarily practice in an outpatient practice** (e.g., a physician's office in

Refer and follow privileges may also be used when relevant quality data are extremely scarce and a practitioner has no desire to maintain inpatient privileges.

which practitioners perform some of the procedures or skills that they would utilize in an inpatient setting but mostly use skills confined to an ambulatory setting): Consider less independent privileges such as comanagement, dependent privileges (e.g., surgical assisting), or refer and follow privileges.

- **Clinically active nonmembers of the medical staff who provide necessary clinical services** (e.g., teleradiologists and locum tenens practitioners): Utilize FPPE for new privileges or identified performance issues and OPPE for other privileges.
- **Clinically less active members of the medical staff who are reducing their inpatient practice:** Consider independent privileges with a narrower scope of practice (e.g., an orthopedist giving up total joints), less independent privileges such as comanagement, or dependent privileges with a vigorous FPPE process to confirm competency. Refer and follow privileges may also be used when relevant quality data are extremely scarce and a practitioner has no desire to maintain inpatient privileges.
- **Clinically inactive members of the medical staff who have taken time off or retired and wish to return to practice:** Consider requiring a reentry program (e.g., Center for Personalized Education for Physicians Clinical Practice Reentry Program or Drexel Medicine Physician Refresher/Reentry Course) or dependent privileges that may increase to independent privileges with sufficient data and a vigorous FPPE process to confirm competency.
- **Clinically inactive members of the medical staff with whom the organization seeks to maintain a strong relationship:** This is a perfect group for refer and follow privileges. This arrangement requires no monitoring of the members' quality or competency assessment.
- **Clinically inactive members of the medical staff who offer no strategic advantage to the organization through their affiliation:** These practitioners can be offered refer and follow privileges. Some medical staffs have adopted significantly higher application fees for providers who fit this description, which has resulted in a decrease in the number of providers on the medical staff who offer no benefit to the organization. Another option is to recognize that there is no obligation to credential or privilege these individuals. If a strategic medical staff development plan has been implemented that closes the medical staff to such providers, applicants and reapplicants who fit this description may be determined under the plan to be ineligible to apply for membership or privileges. It is also possible to grandfather existing medical staff members who fit this description and make new applicants ineligible.

Table 3 on p. 13 puts these scenarios together with the discussion regarding member rights and privilege delineation to provide a helpful guide to credentialing your low-volume and no-volume practitioners.

Table 3

Clinical scenario	Membership rights	Privilege delineation	OPPE	FPPE	Special considerations
Clinically active members of the medical staff with sufficient quality data	Full	Independent	Yes	As needed for new privileges or performance concerns	None
Clinically active members of the medical staff with sufficient quality data elsewhere	Full or partial	Independent	Yes	Yes, due to lack of firsthand observation	Consider addressing competitive issues in your strategic medical staff development plan
Clinically active members of the medical staff who practice primarily in an ambulatory facility (e.g., ambulatory surgery center or endoscopy suite)	Full	Independent	Yes	Yes, due to lack of firsthand observation	Consider creating a policy addressing the acquisition and utilization of ambulatory-based quality data
Clinically active members of the medical staff who practice primarily in an outpatient practice (e.g., physician office or clinic)	Full	Variable, but almost always less than independent	Yes, except none required for refer and follow privileges	Yes, due to lack of firsthand observation, except none required for refer and follow privileges	Consider standardized comanagement, dependent, or refer and follow privilege arrangements with a hospitalist, intensivist, or other hospital-based clinical service
Clinically active nonmembers of the medical staff who provide necessary clinical services	No	Full	Yes	Yes, due to lack of firsthand observation	Consider establishing a policy for quality oversight and monitoring of contracted practitioners and for contracted clinical services
Clinically less active members of the medical staff who are reducing their inpatient practice	Full or partial	Variable	Yes, except none required for refer and follow privileges	As needed for new privileges, performance concerns, or inadequate volume to perform ongoing professional practice evaluation	Consider minimum threshold volumes for privilege eligibility for each clinical specialty to determine necessity for FPPE. Consider comanagement, dependent, or refer and follow privileges for those who do not meet these criteria.

Table 3 (cont.)

Clinical scenario	Membership rights	Privilege delineation	OPPE	FPPE	Special considerations
Clinically inactive members of the medical staff who have taken time off or who are retired and wish to return to clinical practice	Full or partial	Variable	Yes	Yes, due to lack of firsthand observation	Consider a policy-driven process to allow physicians to safely reenter the practice of medicine
Clinically inactive members of the medical staff who offer a strategic advantage to the organization through their affiliation	Full or partial	Refer and follow	No	No	Ensure an effective outreach program to these practitioners
Clinically inactive members of the medical staff who offer no strategic advantage to the organization through their affiliation	No	No	No	No	For legal protection, implement a strategic medical staff development plan that addresses these providers to avoid antitrust risks

Conclusion

Low-volume/no-volume practitioners represent an increasingly significant demographic group on every medical staff. It's best to begin addressing this challenge through a strategic medical staff development plan. Once this is in place, creating a standardized approach will reduce conflict, ensure patient safety, and protect the rights of all healthcare practitioners.

The unsettling nature of the judgments required to assign appropriate privilege delineations to low-volume and no-volume practitioners can be minimized by a well-designed and well-implemented OPPE and FPPE process. Balancing strategy and safety will enable your hospital to navigate the challenges of low-volume/no-volume providers to best meet hospital, physician, and patient care needs. ■

