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INSTITUTE FOR HEALTH METRICS

Bringing the New Joint Commission Standards for Credentialing and Privileging Within Reach of the Community Hospital

An Institute for Health Metrics White Paper

Executive Summary

In January 2007, the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) dramatically changed its standards for credentialing and privileging at all accredited hospitals. The new standards are meant to move hospitals away from a "no news is good news" stance toward their practitioners and toward an evidence-based credentialing and privileging process. Recent studies published in the *New England Journal of Medicine* and other medical journals[1, 2, 3, 4] have found that patient outcomes after a procedure are significantly better when the practitioner performs a high-volume of such procedures, regardless of hospital volume. These studies underscore the importance of carefully monitoring volume and performance on each procedure that a particular practitioner is privileged for. With the old standards, performance issues might only come to light every two years at reappointment time. Now, the Joint Commission is mandating that hospitals collect data on practitioner performance and volume in an ongoing fashion, meaning less than every 12 months. The data are to be analyzed as they are collected, and then utilized to determine the status of each practitioner's privileges in as close to real time as possible.

Community hospital administrators have reacted with dismay to the new standards. While in principle such an ongoing analysis of each practitioner is an excellent method of improving quality and enhancing patient safety, in practice, the immense effort required to collect and analyze such a large amount of data in real time can exhaust hospital resources. The majority of medical staff and quality improvement departments are simply not equipped to deal with the new requirements.

In this white paper, we will look closely at the new standards to determine what kind of changes hospital administrators will have to make to maintain compliance. In most cases, hospitals that desire to avoid hiring new staff will need to consider purchasing a software solution in order to keep up with the ongoing practitioner evaluations. This white paper will examine what features hospitals should look for in such software. We will also hear from two community hospitals who have successfully used the Physician Quality Management System (PQMS) from the Institute for Health Metrics (IHM) to comply with the new standards without adding employees or overburdening existing employees.

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[1] Birkmeyer JD, Stukel TA, Siewers AE, et al. Surgeon volume and operative mortality in the United States. *N Engl J Med*. 2003;349:2117-2127.
[2] Ho V, Heslin MJ, Yun H, Howard L. Trends in hospital and surgeon volume and operative mortality for cancer surgery. *Ann Surg Oncol*. 2006;13:851-858.
[3] Katz JN, Barrett J, Mahomed NN, et al. Association between hospital and surgeon procedure volume and the outcomes of total knee replacement. *J Bone Joint Surg Am*. 2004;86-A:1909-1916.
[4] Katz JN, Losina E, Barrett J, et al. Association between hospital and surgeon procedure volume and outcomes of total hip replacement in the United States Medicare population. *J Bone Joint Surg Am*. 2001;83-A:1622-1629.

After as little as one calendar quarter of membership with IHM, these hospitals have seen real world benefits, because PQMS requires no training of hospital staff, no software installation at the hospital, and no manual data entry. Using the web-based interface, medical staff and quality improvement personnel can easily access data on procedure volume, complications, readmissions, and mortality. The data can be broken down by provider, procedure, diagnosis, and department, and can be reported monthly, quarterly, or annually. With these tools in hand, hospital personnel are no longer tied to manual data extraction; they need not wait for information requests to be filled by a myriad of departments, and they are no longer dependent upon overburdened information systems departments in order to comply with the new credentialing and privileging standards.

The New Joint Commission Standards for Credentialing and Privileging: Why?

In January 2007, the Joint Commission implemented a substantially revised set of credentialing and privileging standards. According to the Joint Commission, these revisions were designed to improve the clarity of the standards as well as to improve their objectivity and validity. “We will be expecting more evidence-based processes to back up the decisions that are being made,” explained Dr. Robert Wise, vice president of Standards and Survey Methods at the Joint Commission, in a Joint Commission question-and-answer conference call.[5] “We will move away from the idea that privileging is done by exception, meaning that no news is good news.”

The tightening of the Joint Commission standards for credentialing and privileging falls in line with an increasing push for quality improvement in the American health care system. Significant changes have been made since our healthcare system was shown to be lacking in the Institute of Medicine’s pivotal 2001 report, *Crossing the Quality Chasm.*[6] The Joint Commission has dramatically increased the number and stringency of requirements for hospital accreditation, and the Medicare and Medicaid reimbursement process continues to evolve to reflect a new focus on quality and patient safety. Understandably, therefore, hospital CEOs are very concerned with quality, ranking it their number four most pressing issue in 2007.[7]

For hospitals, the credentialing and privileging process is a key checkpoint on the road to quality improvement. During the privileging process, organizations can take the opportunity to evaluate patient outcomes as broken down by practitioner—and all practitioners are not created equal. Of note for hospital administrators, the volume of a particular procedure that a practitioner performs seems to be a major harbinger of patient outcome. A study published in the *New England Journal of Medicine* in 2003[1] found that

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[5] The Joint Commission Credentialing and Privileging Conference Call, April 30, 2007. Transcript available at http://www.jointcommission.org/NR/rdonlyres/8AB389E2-412D-49F0-BAC9-996D7EF098B1/0/audio_conference_043007.pdf.
[6] Committee on Quality of Health Care in America, Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* The National Academies Press, 2001.
[7] The American College of Healthcare Executives. “Top Issues Confronting Hospitals: 2007”. Available at http://www.ache.org/pubs/research/ceoissues.cfm.

surgeon volume is inversely related to operative mortality. This relationship held true for all of the eight procedures studied (coronary-artery bypass grafting, carotid endarterectomy, aortic-valve replacement, elective repair of an abdominal aortic aneurysm, pancreatic resection, esophagectomy, lung resection, and cystectomy). When the authors compared the patient outcomes of low-volume surgeons to those of high-volume surgeons, they found that patient mortality was 25 to 300% higher for low-volume surgeons, depending upon the procedure in question. This increased risk was seen *regardless* of the surgical volume of the hospitals in which the surgeons practiced. The association between volume and mortality has been confirmed in studies of other procedures, including cancer resections[2] and joint replacements.[3, 4] Complication rates are also much lower for high-volume surgeons.[3, 4, 8, 9]

These studies underscore the importance of carefully monitoring volume and performance on *each* procedure that a particular practitioner is privileged for, and doing so in an ongoing fashion. This is exactly what the Joint Commission is moving toward with the new standards.

An Overview of the New Standards

According to the Joint Commission[10], organizations now must:

- Conduct an ongoing professional practice evaluation for each practitioner—and collect data on good performance, not just outlier or trending data
- Use the data to trigger a focused professional practice evaluation when issues affecting care are identified
- Use the ongoing review and focused review data to determine the status of each practitioner's privileges

Ongoing Professional Practice Evaluation

The Joint Commission has dramatically raised the bar on *how often* practitioners must be evaluated. The new standards now require that practitioners' performance be evaluated in an ongoing fashion. "We're not yet defining for hospitals what ongoing means, but once annually would definitely be considered periodic and not ongoing," said John Herringer, the associate director of the Joint Commission's Standards Interpretation Group, in a recent seminar.[10]

The ongoing evaluation is meant to result in *evidence-based* privileging. By performing the ongoing evaluation, hospitals can identify performance problems and resolve them as

[8] Bianco FJ Jr, Riedel ER, Begg CB, et al.Variations among high volume surgeons in the rate of complications after radical prostatectomy: further evidence that technique matters. *J Urol*. 2005;173:2099-2103.
[9] Stavrakis AI, Ituarte PH, Ko CY, Yeh MW. Surgeon volume as a predictor of outcomes in inpatient and outpatient endocrine surgery. *Surgery*. 2007;142:887-899
[10] "2008 Medical Staff Standards Update". Presented by John Herringer at the Institute for Health Metrics Seminar, Los Angeles, March 6, 2008.

they occur, instead of waiting until the end of a two-year cycle. The Joint Commission suggests that the following methodologies be used for data collection: periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and discussion with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing, and administrative personnel).[10] It is still up to individual departments to decide *what type* of data will be collected to best reflect practitioner performance—but the data must include information about good performance. It is not enough for an organization to track only the data on high rates of complications, readmissions, and mortality. Further, the data need to be analyzed and used to determine the status of privileges at the time of collection. “It is unacceptable to find at the two-year reappointment that someone has not performed a privilege for the past two years!” said Herringer.

Focused Professional Practice Evaluation

When issues affecting care are identified in the ongoing evaluation of an existing privileged practitioner, hospitals should conduct a focused professional practice evaluation, according to the new standards. What kinds of issues does the Joint Commission feel should trigger a focused evaluation?

- Sentinel events
- Complaints
- High infection rates
- Small number of admissions/procedures over an extended period of time
- Increasing lengths of stay compared to other practitioners
- Increasing number of returns to surgery
- Frequent/repeat readmission for the same issue
- Patterns of unnecessary diagnostic testing/treatments
- Failure to follow approved clinical practice guidelines[10]

The focused evaluation is to be a period of intensive review, which should last either for a specific time period or for a specific number of procedures completed.

Community Hospitals React to the New Standards

How have community hospitals reacted to the news? Often, their response has been similar to this question posed to the Joint Commission in the conference call:

“We have, as probably many hospitals across the country have, followed the ‘no news is good news’ precept for ongoing evaluation. My question is….without hiring 15 new [full time employees] for chart review, how can we expect to continuously evaluate a doctor’s

performance? It would seem to me that the data gathering process to evaluate a physician continuously is not doable by a community hospital."[11]

In other words, community hospital staff are overwhelmed with the new requirement to extract and analyze performance data for each practitioner, and to do so on continuous basis. It is no wonder—this kind of data collection and analysis is simply not realistic with a manual process or with the existing data infrastructure in place at most community hospitals, and the hiring of new staff is simply not feasible given budget constraints. Many hospitals are therefore looking to data analysis software to solve the information problem created by the new credentialing and privileging standards.

Evaluating a Product for Credentialing and Privileging Data Extraction

There are a number of software products on the market that are designed to assist with the type of data collection and analysis that the new standards demand. When evaluating a product, here are some key questions to consider:

1. Does the software need to be installed on-site?
2. Are interfaces required: who builds them, who maintains them?
3. Does the software need to be run on-site by the quality or medical staff departments?
4. What kind of reports are generated by the software?
5. Do reports need to be generated by manual queries, or are they automatically created by the software?
6. Is the software able to display the data in different ways (i.e., by provider, by procedure, by diagnosis, by department)?
7. Does the software perform trend analysis?
8. Is the software user-friendly? Does it have an intuitive interface?
9. What kind of training is required, if any?
10. Are vendor staff helpful and responsive to inquiries and suggestions?
11. What is the anticipated ROI of the product?

Meeting the New Standards with PQMS

IHM can help your organization meet the new privileging and credentialing standards. The Physician Quality Management System (PQMS) extracts physician quality measurement data directly from the Meditech Health Care Information System. No on-site software installation or manual data input is required—the data are automatically gathered from the Meditech system, analyzed, and presented in an easy-to-use secure Web-based interface.

PQMS provides:

[11] Call-in question during The Joint Commission Credentialing and Privileging Conference Call, April 30, 2007. Transcript available at http://www.jointcommission.org/NR/rdonlyres/8AB389E2-412D-49F0-BAC9-996D7EF098B1/0/audio_conference_043007.pdf.

- Data views by provider, diagnosis, procedure, and department
- Data on readmits, complications, mortality, blood usage, drug therapy
- Provider and case drill downs for quality improvement intervention
- Trend analysis
- Reports compiled on a monthly, quarterly and annual basis

With PQMS, a monthly or quarterly evaluation of each practitioner becomes feasible for the community hospital. Department heads and quality improvement personnel can quickly locate information on procedural volume, complications, readmits, and other quality indicators for each provider, and then compare those numbers with those of other providers. With these tools in hand, quality improvement and medical staff personnel are no longer tied to manual data extraction; they need not wait for information requests to be filled by a myriad of departments, and they are no longer dependent upon overburdened information systems departments.

In Their Own Words: How Community Hospitals are Using PQMS

Hays Medical Center

Hays Medical Center is a 194-bed tertiary-care center in Hays, Kansas, accredited by the Joint Commission. Although Hays has only been a member of IHM for about six months, the staff has already seen demonstrable benefits. Both the Medical Staff office and the Quality Improvement Department have found PQMS to be a helpful tool, particularly in meeting the new requirements for credentialing and privileging.

The Medical Staff office at Hays is responsible for determining the volume of procedures that each practitioner has performed since their last reappointment. The number of practitioners up for reappointment is determined by birth date; thus, the workload can range from as few as seven practitioners to as many as 20 in a given month. Before they used PQMS, the employees in Medical Staff office gathered data on procedure volume through a manual process as well as through the use of another software program. “I had to request information from several different areas of the hospital, gather all that information together, and put it on one form. The process took time,” said Kay Werth of the Medical Staff office. With the PQMS reports, she has found that the process is more efficient. “Now I can zero right in on a specific procedure,” said Werth. “It saves time, and getting the data has become much more convenient. The information is right at our fingertips.”

On the quality improvement side, PQMS has proven useful as well, according to Judith Purdy, RN, Director of Risk Management and Quality Improvement at Hays. The new Joint Commission requirements for privileging have prompted Hays to evaluate physician performance once quarterly, a process that has been aided by PQMS. “It meets the ongoing quality assessment requirement under the new Joint Commission standards quite nicely,” said Purdy. “Numbers can be pulled once per quarter and put in front of the credentials committee to verify that we are indeed doing ongoing review of all our

physicians." In addition to meeting the Joint Commission ongoing performance review requirement, the department heads at Hays have found PQMS useful for looking at performance within each specialty. "It really helps us to compare physicians in a group, like the family practice group or pulmonology group." said Purdy.

Both Purdy and Werth have found IHM to be easy to work with and very responsive to their questions. "I'm probably a pest sometimes," joked Werth. "Everyone has been very willing to help and answer all my questions." Purdy added.

Goodall Hospital

Goodall Hospital is a 53-bed, not-for-profit, acute care hospital located in Sanford, Maine. They have been using PQMS for a little over a year, and have found it a valuable tool for their ongoing review process, according to Mary Finnegan, Director of Performance Improvement. "With the ongoing review, we are doing more frequent physician report cards—quarterly instead of annually. The PQMS data have been very helpful for us in that regard," said Finnegan. "The physicians that are directors of departments have been using the PQMS data to look at individual practitioners' rates of return visits and complications." When compared with the manual data extraction process that they had been using previously, Finnegan found that the PQMS reports were just as accurate, with the added advantages of a significant time savings and a Web-based interface. "IHM's products offer us a wealth of information. They just bring everything in together and are very user-friendly," she said. "IHM has been great to work with."

Conclusions

The revised Joint Commission standards for credentialing and privileging mean that hospitals must significantly increase the amount of data that is collected and analyzed and must do so far more frequently than was required under the older standards. Community hospital administrators have been understandably dismayed by the amount of work that would be required to maintain compliance using their existing data infrastructure. Yet, hiring new employees is not feasible for most hospitals. Maintaining compliance is doable, however, when hospital administrators choose the right data analysis solution—a product that automatically extracts and analyzes data, requires no on-site installation, and presents the data in useful, actionable ways. PQMS meets all these needs, making it an ideal choice for hospitals that use the Meditech healthcare information system.

For more information about how PQMS can help relieve the burden of the new Joint Commission credentialing and privileging requirements at your hospital, contact IHM today:

Jodie Imbriano | jodie.imbriano@healthmetrics.org | (516) 629-6368
Institute for Health Metrics
One New England Executive Park | Burlington, MA 01803
www.healthmetrics.org