

Taking the Fear and Confusion Out of Core Privileges: What Do The Joint Commission and CMS Really Require?

WHITE PAPER



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Confused about what The Joint Commission (TJC) and the Centers for Medicare & Medicaid Services (CMS) really require for privileging? If so, you're in good company. With the introduction of ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) in 2007, TJC focused a harsh spotlight on privileging that continues today. Since that time, there have been increased rumors and rumblings about what TJC and CMS really require regarding privileges. It's time to clear away the confusion and find a way to privilege practitioners that is grounded in common sense and built on best practices.

Understanding what laundry lists and core privileges really are (and are not)

Today, the vast majority of hospitals utilize one of two popular methods for delineating privileges, laundry lists and core privileges, with some hospitals using a combination of both. To understand laundry lists and core privileges, we need to remember how they developed. Prior to the 1950s, a physician who applied to a hospital would have been authorized to practice in the hospital, but without any specifically delineated privileges. As the medical profession evolved, some hospitals differentiated between those granted privileges in medicine and those in surgery.

During the 1950s, the American College of Surgeons began recommending physicians be granted privileges using what became known as "laundry lists." The impetus for this change was the fact that physicians throughout the United States had, in many instances, not completed approved residency programs in specific specialty areas. Many were general practitioners or physicians trained in specialties "on the job" after completion of medical school and an internship only. There was a need to identify what these physicians were specifically trained to do and what was outside their training. Then, as medical technology exploded, so did the laundry lists. In other words, the field of privileging experienced a pendulum swing from the original methodology for delineating privileges, which could be termed a "lumper" approach, to the "splitter" approach of laundry lists.

Beginning about 20 years ago, medical staffs began to seriously reconsider the utility of these long, unwieldy lists of procedures or conditions. They found that delineating clinical privileges using laundry lists was fraught with the following difficulties:

1. Maintenance of such laundry lists is an administrative and clinical nightmare. As new procedures or new conditions are identified, laundry lists must be updated and maintained on an almost continuous basis.
2. A laundry list can never be complete but can only serve as a representative sample of what physicians do in practice. (As an exercise, we at The Greeley Company once created a truly comprehensive laundry list for ophthalmology. It filled six pages and was out of date the moment it was finished.)
3. Legal issues arising with the use of laundry lists are quite complex. How can an institution defend against a negligent credentialing lawsuit alleging a physician was not competent to perform one of the privileges on the laundry list? How can the institution demonstrate that it meaningfully evaluated a physician's competence to perform a requested privilege when such request was one of 60 or 80 check marks on a form? If a physician fails to check a particular procedure on the list and performs that procedure anyway, is the institution liable for a charge of corporate negligence for allowing the physician to practice outside of his or her privileges?
4. On what basis was the physician deemed competent and therefore warranted being granted each privilege on the laundry list? The only possible answer to this question when using laundry lists is, "No news is good news." In other words, if one or more adverse findings are found that involve a particular privilege on the laundry list, the physician might be deemed incompetent to perform that privilege. That means decisions regarding competence will most often be based on small numbers, sometimes only one or a few cases. Assessing competence with such small numbers often leads to significant conflict and charges of bias. The flip side of this is that the absence of such findings, meaning no egregious cases "fell out" in the peer review process, forms the only basis for saying the physician is competent to perform that particular privilege. Obviously, such a "no news is good news" approach often fails to produce meaningful information about a physician's competence.

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In addition to these problems, laundry lists do not reflect how department chairs and credentials committees really think about the scope of a practitioner's practice. This became abundantly clear when the field of credentialing matured to the point that we began to talk about criteria for privileging. TJC introduced language for criteria that included license, training, experience, current competence, and the capacity to perform each privilege. Nobody really expects a department chair to ask and answer the question, "Does this practitioner have the license, training, experience, evidence of current competency, and capacity to perform this specific line item on the list?" Instead, department chairs began to mark the delineation of privileges form with a line from the top to the bottom of the page. That is because the chair

recognized that any well-trained, reasonably busy physician practicing in that specialty would be deemed competent to fulfill each of those privileges on the list.

The combination of the no-brainer nature of most items on laundry lists and the need for more careful attention to the truly complex and higher-risk privileges became the underlying logic for core privileges.

Although this is honestly how most department chairs think, it often leads to carelessness and lack of critical thinking when it comes to high-risk or technically complex privileges. The combination of the no-brainer nature of most items on laundry lists and the need for more careful attention to the truly complex and higher-risk privileges became the underlying logic for core privileges. Thus the pendulum began to swing from the excessively “splitter” nature of laundry lists to a more refined “lumper” approach to privileges. The physicians and medical staff professionals in the United States Navy were the first to pioneer what eventually became known as core privileges. They developed the first verbal descriptions of the scope of practice that any well-trained, reasonably busy physician in a particular specialty would be deemed competent to perform and defined this as the core privileges for that specialty. They then pulled out of the core the privileges that constituted the most complex, high-risk conditions or procedures for that specialty. These became known as “special requests” because before these privileges would be granted, the applicant needed to provide evidence of additional training, experience, and current competence. With core privileging, the number of items on a typical privilege delineation form dropped from 60–80 down to perhaps six to eight. This became a manageable number to work with, allowing for development of eligibility criteria to request each of these items. It also allows the peer review system to generate data that can be aggregated to create meaningful information about the physician’s competence in each of the six to eight elements on the privilege form. This is the logic that has made core privileging state of the art for the field.

Why do TJC and CMS have concerns with core privileging?

If core privileging represents such an improvement over laundry lists, why is there persistent concern that TJC and CMS frown upon core privileging? The concerns of TJC and CMS regarding core privileging can be summarized as follows:

- Providers who meet threshold criteria to be eligible to request privileges should not automatically be granted those privileges without assessing their demonstrated competence in performing those privileges
- The core should not be too broadly defined to correlate with competence in all aspects of the core
- Hospital staff must be able to answer the question, “Does Dr. X have privileges to do that?”
- Physicians who limit their practices through specialization should not be forced to accept the full core

In the face of these concerns, what should medical staffs do? The faint of heart may want to fall back to laundry lists, but what does this truly accomplish?

We have already established that the logic underlying core privileges is significantly more consistent with how physicians actually think about and practice medicine. Later in this White Paper we will address the problems laundry lists create for complying with OPPE and FPPE requirements. So the best option is to do core privileges right. This means implementing core privileges in a manner that addresses the legitimate concerns raised by TJC and CMS.

Will implementation of core privileges allow your hospital to pass your next TJC survey without RFIs regarding privileging? The answer is an unequivocal YES! In fact, TJC took the fear out of doing core privileges (as long as you do core privileges right) when it published its FAQ of November 24, 2008.

- But will this allow your hospital to pass your next TJC survey without RFIs regarding privileging? The answer is an unequivocal YES! In fact, TJC took the fear out of doing core privileges (as long as you do core privileges right) when it published its FAQ of November 24, 2008. In that publication, TJC clearly stated that its standards do not “suggest or promote a particular format for granting privileges.” TJC identified its concerns with core privileging and how these concerns can be addressed. The URL for this FAQ is:

www.jointcommission.org/AccreditationPrograms/Hospitals/Standards/09_FAQs/MS/Core_Bundled_Privileges.htm

The most definitive statement from CMS on the subject of privileging was published in its *Requirements for Hospital Medical Staff Privileging* memo of November 2004, which stated:

The process must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners. It cannot be assumed that a practitioner can perform every task/activity/privilege listed/specified for the applicable category of practitioner. The individual practitioner's ability to perform each task/activity/privilege must be assessed and not assumed. If the practitioner is not competent to perform one or more tasks/activities/privileges, the list of privileges is modified for that practitioner. Hospitals must assure that practitioners are competent to perform all granted privileges.

Any procedure/task/activity/privilege requested by and recommended for a practitioner beyond the specified list of privileges for their particular category of practitioner would require evidence of additional qualifications and competencies, and be an activity/task/procedure that the hospital can support and is conducted within the hospital. Privileges cannot be granted for tasks/procedures/activities not conducted within the hospital despite the practitioner's ability to perform the requested tasks/procedures/activities.

In its FAQ, TJC stated that its position regarding privilege delineation was consistent with this CMS memo, meaning that the two most important regulators are in agreement that when it comes to laundry lists and core privileging, no single methodology for delineating privileges is preferred over another. In addition, DNV, the newest accreditor with deemed status that tied its standards closely to CMS' *Conditions of Participation* in Medicare,

explicitly states in its interpretive guidelines that “core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined.”

What does it mean to do core privileges right?

As noted above, the key to not running afoul of TJC or CMS in doing core privileges is to “do core privileges right.” The key elements required to do core privileges right are:

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- **■ Don’t make the core too broad.** In creating the verbal description of the core, the ultimate goal is to make sure the core reflects what the majority of practitioners within that particular specialty are currently performing at your facility. In addition, organizations must be careful not to include everything physicians in that particular specialty happen to do at your hospital because this may not correlate with the generally recognized standard for competence in that specialty. For example, one hospital received a justified finding during a TJC survey because it had defined the core for general surgery to include orthopedic procedures and cesarean sections because, as a small, rural hospital, its general surgeons performed these procedures. Instead, it is best to link your definition of the core to the scope of training typically covered in approved residency programs, which can be found in the *Graduate Medical Education Directory* published by the AMA (the “Green Book”). The AOA residency requirements (available for download at www.do-online.org/pdf/sir_postdoctrainproced.pdf) do not provide specific clinical content in the training program requirements and therefore are less helpful in defining the core for any particular specialty. (In a future Greeley Company White Paper we will address the next generation of criteria-based privileging, sometimes referred to as Competency Clusters, which seeks to create clusters of privileges for some specialties that are somewhat smaller than the core, but without going back to laundry lists.)

- Ensure that everyone can answer the question, “Does this doctor have privileges to do X?”** through backup sample condition and procedure lists. Hospital staff cannot be assumed to know what is and is not included in the core for each specialty. First of all, they are not trained as physicians, and secondly, there will clearly be judgment calls regarding whether a particular procedure is within the core as verbally described in a core privileging form. For this reason, each core privileging form should include a backup list of sample conditions and procedures included in the core. The key word here is “sample” because a comprehensive list would be impossible to maintain. As noted above, a comprehensive laundry list for ophthalmology covered six pages and was out of date the moment we finished it, so it is impractical to do this for every specialty. The sample condition and procedure list should be prefaced by language similar to the following: “The core includes the following conditions and procedures and such other conditions and procedures that are an extension of the same knowledge and skills.” Such a list, if well designed,

should cover the vast majority of what physicians do in that specialty. Yet judgment calls will still remain, especially regarding new technology. Therefore, the hospital's policy should state that whenever uncertainty arises regarding whether a particular condition or procedure is in the core, the staff should be instructed to contact the department chair or appropriate section chief to make this judgment. Operationalizing core privileges in this manner has proven very effective in many hospitals.

Some credentialers question whether the backup list is the same old laundry list repackaged, which would make the difference between laundry lists and core privileges a trivial matter of packaging. The first difference between a laundry list and a backup list is in that key word "sample." When using laundry lists, the items on the list are the privileges being granted. If physicians perform any clinical activities not on the list, they are practicing outside of their privileges. Given the discussion above regarding the difficulty of making a laundry list adequately comprehensive, this poses significant challenges. With core privileges, the privileges granted are those described in the core. The backup list is only a sample, so the risk of physicians practicing outside of their privileges is minimized.

The second and even more important difference is that for most items on a laundry list, peer review data will inevitably be limited to review of small numbers of events, if any occur at all. This means that assessing competency will almost always be based on such small numbers that little meaningful information can be claimed about the provider's actual competency for any particular privilege. In contrast, when using core privileges, data to review can be gathered from all of the physician's clinical activities that fall within the core, which means we have a much better chance of assessing the physician's competence in the spectrum of activities generally practiced by that specialty. This clustering of the data makes it easier to identify patterns of performance, whether positive or negative, than can be accomplished using laundry lists. The final result is a privileging process that is significantly more "objective and evidence based" (which is the goal established by TJC's standards) than anything that can be accomplished with laundry lists.

Just because an applicant is eligible to request the core does not mean the applicant automatically is granted the full core.

- ■ **Just because an applicant is eligible to request the core does not mean the applicant automatically is granted the full core.** The key here is to recognize that in designing core privileges, you are developing criteria to be eligible to request privileges. This is different from determining whether to grant the privileges. The department chair, credentials committee, and medical executive committee must still assess the practitioner's performance, which means looking at peer review data. Only after the appropriate peer review data have been assessed should a decision be made about the practitioner's competence and, hence, whether to grant the requested privileges.

Unfortunately, increasing specialization and the desire of many physicians to get out of emergency department (ED) coverage through dropping some privileges in their specialty is creating a toxic mix that is contributing to the crisis regarding ED coverage across the country.

- ■ **There should be a method for the applicant to request only certain items in the core if he or she does not want the full set of core procedures.** There is wisdom in this requirement because physicians are increasingly specialized, meaning they frequently do not practice the full scope of the core in their specialty. The hospital does not want to grant privileges to physicians to do things they are not currently competent to do simply because they fall in the core. Physicians do not want to be forced to practice aspects of their specialty because they have been granted privileges they do not seek. Unfortunately, increasing specialization and the desire of many physicians to get out of emergency department (ED) coverage through dropping some privileges in their specialty is creating a toxic mix that is contributing to the crisis regarding ED coverage across the country.

The solution to this challenge is to address it in two ways. The first is to allow practitioners to literally cross out portions of the core they no longer practice. The second, however, begins by recognizing that the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) requires hospitals to perform the following activities:

- Evaluate patients presenting to their ED to determine whether an emergency condition exists
- If an emergency condition is found to exist, stabilize the patient
- Determine disposition

Note that EMTALA does not require that the patient receive definitive treatment. Therefore, the core for each specialty should include the following language that cannot be crossed out by any practitioner: “to evaluate, stabilize and determine disposition for patients presenting with emergency conditions within the specialty of [physician’s specialty].”

Finally, it is important to recognize that many hospitals across the country have implemented core privileges without receiving any adverse findings on surveys from TJC or CMS. The rare findings that have occurred have been due either to core privileging not “done right” or to personal idiosyncrasies of individual surveyors, which are typically overturned when appealed.

TJC’s OPPE and FPPE create greater focus on the medical staff’s responsibility to determine current competence

In 2007, TJC began requiring OPPE and FPPE for all practitioners granted privileges. The goal of these new standards is to raise the bar regarding how effectively hospitals measure physician competence and manage physician performance. Effective OPPE requires three activities:

- Continuous, systematic measurement of physician performance
- Periodic evaluation of the results of that measurement
- Follow-through to address any performance issues identified through this evaluation

FPPE is a single term TJC uses to apply to two different activities:

- A drill-down to evaluate a concern identified through the OPPE process; and
- Evaluation of a practitioner's competency during a compressed time frame after the initial granting of new privileges (either for a provider new to your medical staff or for new privileges for an existing provider) to validate current competency since the new privileges were granted prior to the organization having any first-hand data on the provider's performance of the new privileges in the organization

The intent of these changes can best be recognized in the wording of standard MS.06.01.05, which states, "The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process." OPPE and FPPE are intended to promote a more "objective, evidence-based process" for privileging. The elements of performance (EP) under this standard that are most relevant to decisions regarding which privilege delineation methodology to utilize are:

- **EP 2:** The hospital, based on recommendations by the organized medical staff and approved by the governing body, establishes criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of privilege(s) requested. Evaluation of all of the following are included in the criteria:
 - Current licensure and/or certification, verified with the primary source
 - The applicant's specific, relevant training, verified with the primary source
 - Evidence of physical ability to perform the requested privilege
 - Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
 - Peer and/or faculty recommendation
 - When renewing privileges, review of the practitioner's performance in the hospital
- **EP 3:** All of the criteria used are consistently evaluated for all practitioners holding that privilege
- **EP 10:** The hospital has a process to determine whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privilege

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● How can medical staffs meet the OPPE and FPPE requirements using laundry lists?

Hospitals that still utilize laundry lists struggle to perform meaningful OPPE and FPPE to determine current competence for each specific privilege on the delineation of privileges form for any given specialty. Performance on only a small number of privileges can be evaluated by the types of data typically collected by hospitals today, such as core measure compliance and

Apgar scores. Other measures, such as patient satisfaction, medical records completion, blood usage, and drug usage, do not provide privilege-specific competence measurement for any of the individual privileges on the list. This leaves individual case reviews as the primary mechanism for assessing competence for each privilege. Such case reviews may be triggered by cases “falling out” because they meet predetermined criteria, such as unplanned return to the operating room (OR) or unexpected death, or through the hospital’s incident reporting system. The only meaningful way to link the peer review of individual cases found through either of these mechanisms to privilege-specific competence assessment is the logic of “no news is good news.” In other words, for each line on the laundry list, an absence of cases determined not to meet the standard of care is used as the basis of concluding that the practitioner is competent in that privilege. Everyone who works with peer review programs in the real world will recognize the major flaws in such an approach. They include:

- The hospital must be able to measure and report the number of procedures performed or cases managed that fall under each line on the laundry list, something most hospital information systems do not provide with adequate accuracy today. In other words, the measurement system must capture the number of opportunities for error before being able to say anything meaningful about what the presence or absence of errors (inappropriate care) means, and this is something most hospital systems cannot do accurately today.
- Even if one or a few problem cases are identified that can be linked to a particular line on the laundry list of a specific practitioner, it is difficult to determine what such small numbers mean about the practitioner’s competence.
- Any attempt to label a physician as incompetent and to threaten him or her with nonrenewal of a particular privilege based on one or a few cases faces great resistance, including being vulnerable to charges of bias and antitrust.
- Because of the notorious reluctance of physicians to score the care of a fellow physician as not meeting the standard of care, it is highly likely that the vast majority of items on the laundry list will have zero cases scored as inappropriate care. This means that very few privilege-specific data will be available for review either through the OPPE process or at reappointment.

Any attempt to label a physician as incompetent and to threaten him or her with nonrenewal of a particular privilege based on one or a few cases faces great resistance, including being vulnerable to charges of bias and antitrust.

Very few medical staffs have rigorously confronted these challenges created by their laundry list privileging methodology for OPPE and competency determinations. Even fewer have taken EP 10 seriously and created a process for determining when inadequate clinical performance information is available to make a decision to grant, limit, or deny a request for any specific privilege on the laundry list. To do so would paralyze most privileging systems based on laundry lists.

Once a medical staff recognizes the limitation on the amount of data it will have for any specific line in the laundry list, its usual fallback position is

found in MS.07.01.03, EP 3, which states, “Upon renewal of privileges, when insufficient practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations.” This brings us full circle back to the time when decisions about privileges were primarily based on references, which are usually far from “objective and evidence based.”

Laundry lists create perhaps even greater challenges for implementing FPPE. MS.08.01.01, EP 1 states, “A period of focused professional practice evaluation is implemented for all initially requested privileges.” It is impossible to proctor cases for FPPE for every line on the laundry list. Given the limited resources realistically available for FPPE, only a small sample of procedures or conditions can be proctored or otherwise measured. Assessment of the practitioner’s competence is then generalized from this small amount of data to the practitioner’s competence in all the other privileges he or she has been granted. In fact, TJC’s FAQs on FPPE from October 2008 stated, “While the EP would require an evaluation of each new privilege it could be possible to group very similar activities together and then evaluate a set number of any mix of the privileges for example, any ten from the group will be evaluated to determine competence for the whole group, but you cannot just look at one privilege from the group.” In other words, TJC is implicitly recognizing the difficulties laundry lists create for complying with FPPE and is saying it is acceptable to cluster privileges together when assessing competence. (The URL for this FAQ is www.jointcommission.org/AccreditationPrograms/Hospitals/Standards/09_FAQs/MS/Focused_Professional_Practice.htm.) This in essence is admitting that the only way to meet this standard in the real world is to apply some type of clustering methodology, which is the logic that underpins core privileges. (It is appropriate to recognize at this point that there is room to disagree about how broad these clusters should be, which is the topic that will be addressed in a future Greeley Company White Paper as noted above.)

Privileging with laundry lists makes it very difficult for a medical staff to meet OPPE and FPPE requirements in a manner that meaningfully raises the bar on assessing physician competency and linking this assessment to privileges granted through an “objective and evidence based process.”

- In summary, privileging with laundry lists makes it very difficult for a medical staff to meet OPPE and FPPE requirements in a manner that meaningfully raises the bar on assessing physician competency and linking this assessment to privileges granted through an “objective and evidence based process.”

How can medical staffs meet the OPPE and FPPE requirements using core privileges?

The logic behind core privileges is that procedures and conditions contained in the core require similar or overlapping knowledge, skills, technique, judgment, and the ability to manage complications. Therefore, information about a provider’s performance in one portion of the core can be used to draw conclusions about that provider’s competence in other portions of the core, which leads to more meaningful OPPE. This is especially true if the conditions or procedures measured include some of the more complex and technically demanding components of the core. Also, by clustering

multiple conditions and procedures into the core, it is possible to aggregate multiple sources of data about the physician's performance that will allow for recognizing trends of either good or poor care and getting away from the "no news is good news" approach to assessing competence forced on us by laundry lists. For example, rather than looking at each unplanned return to the OR or each case of a perforated viscus, aggregating a surgeon's performance with a metric such as unintended organ injury rate would say something very meaningful about that surgeon's competence in the range of procedures included in the core. If individual case reviews must be used as one of the measures of a physician's performance, aggregating the findings for peer review of all the cases for conditions or procedures within the core provides the greatest opportunity to identify patterns of care that correlate more closely with provider competence than any single case or any single line on a laundry list.

If the privileges granted are not individual items on a laundry list but a well-designed core, then a process that assesses a range of components of the core, especially the most complex and technically challenging elements, can be interpreted as assessing the "privileges requested."

● We can apply this same logic to FPPE. As noted above, MS.08.01.01, EP 1 states, "A period of focused professional practice evaluation is implemented for all initially requested privileges." If the requested privilege is a line on a laundry list, a great deal of proctoring or other review activities will be required to cover "all initially requested privileges." In the introduction to this section of the *Hospital Accreditation Manual*, TJC even uses the language "privilege-specific" when referring to FPPE. This is impossible to do given the realistic resources available to most medical staffs today (which is why the FAQ referenced above acknowledges that some type of clustering is appropriate). If the privileges granted are not individual items on a laundry list but a well-designed core, then a process that assesses a range of components of the core, especially the most complex and technically challenging elements, can be interpreted as assessing the "privileges requested." Remember that the backup sample condition and procedure list is to be utilized in helping hospital staff determine whether a provider has any specific privilege. It should not be interpreted as implying that every single item on the sample list must be measured through an FPPE process.

Any procedures or clusters that are pulled out of the core as special requests would require separate measurement of performance both for OPPE and FPPE. Accomplishing this for each of two to eight special requests is far more practical than attempting to do so for each of the 60–80 items on a typical laundry list.

Current challenges persist for matching demonstrated competence to privileges granted

Despite the advantages of core privileges described in this White Paper, considerable challenges remain. In fact, our field is still a long way off from a truly satisfactory approach to matching demonstrated competency with privileges granted. Increasing physician subspecialization is creating the need to design clusters of privileges somewhat smaller than the current core for specialties such as cardiology, orthopedics, family medicine, and others.

Our ability to measure physician performance in a manner that meaningfully assesses competence is still in its infancy. OPPE and FPPE systems have been implemented merely to meet TJC's requirements without buy-in from physicians and without adequate thoughtfulness about linking competency and privileges. And today's ED call challenges are so complex and emotionally and economically charged that they will never be adequately addressed by focusing on privilege delineation alone.

So let us accept that linking demonstrated competency to privileges granted is the current cutting-edge challenge for the field of credentialing and privileging. Let us roll up our sleeves and get to work on the next generation of quality metrics to more meaningfully measure physician performance. Let us also recognize that returning to laundry lists will do little if anything to address these challenges. Instead, we must learn to cluster what physicians in any particular specialty do in a manner that allows us to meaningfully measure and assess their competence and to delineate what they can do in the hospital in a manner that supports quality patient care. The next generation of clustering and criteria-based privileging will be the subject of an upcoming Greeley Company White Paper.

A call to action

The Greeley Company is committed to supporting healthcare organizations in their mission to serve patients and continuously improve healthcare for all—not just by meeting regulatory requirements, but by implementing practical, efficient best practices that achieve regulatory compliance as a byproduct of doing the right thing.

If you have received comments or RFIs from TJC indicating that core privileges do not fulfill regulatory requirements, we would like to hear from you. Please contact Maureen Clarke at 888/749-3054, Ext. 3741, or e-mail her at mclarke@greeley.com. We will also be happy to answer your questions about core privileges and are available to assist in implementing OPPE, FPPE, and privileging solutions when requested.

It's time we eliminate the confusion about whether core privileging helps medical staff organizations define and determine competency—and also helps them effectively and efficiently meet TJC's requirements for OPPE and FPPE. It's in patients' best interests that we do so. ■

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