

National Credentialing Forum 2009

Meeting notes

We met February 5-6, 2009 in Phoenix, Arizona at the Embassy Suites North.

Quick Roundtable round-up

ABMS – Barb Rosenthal

New CEO – Kevin Weiss, MD, MPH; COO – Margaret Jung, MBA; Senior Vice President for Scientific Affairs – Richard Hawkins, MD, FACP

Maintenance of Certification Standards (MOC) will be specific, measurable and reported

AMA – Patrick McDonald/Melissa Basich

AMA has launched a sanctions alert (state and federal as reported) that will go out to all organizations who have ordered a specific physician profile for the previous 2 or 3 years. In addition, the AMA pricing structure for profiles and reappointment profiles was discussed.

AMA also offers a Physician Assistant profile.

CAQH – Sorin Davis

Presentation attached

There are over 690,000 unique practitioners using the database. Providers are asked to re-attest to their data every 120 days. Practitioners own their data in the system and must authorize release to participating organizations. This is not a public database.

500 organizations participate and 12 states have recognized or mandated the use of the CAQH application as the state form. Service is free to providers; organizations who participate pay a yearly subscription fee plus an annual per completed practitioner fee.

CAQH has added a on-going sanctions monitoring service that updates the practitioner data in the system is near real time.

NAMSS – Sheryl Davis, 2009 President

Presentation attached

PHDB – Andy Lock

Has affiliation information for physicians, both hospitals and managed care organizations. NPI has been added as well. PHDB is developing an alert system for changes in status.

NPDB – Shirley Jones

Section 1921 will add actions taken against AHPs to the NPDB. In addition, negative accreditation findings will also be added. The Corporate Shield issue is still being reviewed. One query will generate reports from both the NPDB and the HIPDB (If the organization qualifies to receive both reports). The compliance monitoring team is now targeting hospitals as only 50% have ever reported loss of hospital privileges to the Data Bank.

The Joint Commission – John Herringer (by phone)

There is a new numbering system for standards

There is a new scoring system A/C—Category A elements of performance (EP) require 100% compliance. Category C EPs are scored on occurrences of non-compliance and can be clarified by demonstrating 90% compliance. There are 4 C category EPs and the remainder are A category

There are 2 criticality level EPs that contribute directly to an adverse decision.

All other EPs are criticality level 4 -- Although all deficiencies must be corrected, no level 4 EP will contribute to an adverse decision.

There are 13 new EPs to sync with CMS COP requirements. These may be revised after further negotiation.

There is a new requirement that licensed independent practitioners are educated on pain management

Task force on MS1.20 (MSD.01.01.01 in 2009) is still meeting. Earliest foreseeable change is July 1, 2010 but more likely January 1, 2011.

DNV Healthcare – Rebecca Wise (by phone)

9,000 employees worldwide

NAIHO standards to meet CMS Conditions of Participation + ISO 9001

Must meet ISO 9001 after 2 years. Then annual surveys

CMS deeming authority for Acute Care Hospitals September 2008

Looking at Critical Access Hospitals; Ambulatory Care Centers; Long Term Care Centers

Unless required by state, re-credentialing required every ____ years

HFAP – George Reuther

Accrediting hospitals and other HCFs since 1945 and under Medicare since inception its inception in 1965. Recognized as a national accreditation organization with full deeming authority from CMS:

Current areas of accreditation:

- Hospitals and their clinical laboratories
- Ambulatory care/surgical facilities
- Mental health facilities
- Substance abuse facilities
- Physical rehabilitation facilities
- Clinical laboratories
- Critical access hospital
- Stroke center (certification)

HFAP staff has moved to the AOIA from the AOA. Same building/different floor, same staff. Transparent to our customers. Why?

HFAP has been a business running inside a membership organization, with all the challenges that that entails. HFAP customers are healthcare facilities and not physicians and the mind set is different.

Benefits:

AOIA has a business focus rather than a membership organization focus. It will be easier to respond to business needs rapidly: marketing, infrastructure, expansion.

- Refreshed the logo and marketing materials (see tri-fold brochure at coffee table.)
- Focus on computerization of all systems
- Website redesign for e-commerce and interactive customer privacy
 - First focus is on a better electronic application system for user convenience

HFAP accreditation activities will remain with the AOA under its Bureau of Healthcare Facilities Accreditation. (Deeming authority is with the AOA)

Other new stuff:

- New manual for Hospitals,
- New manual for Critical Access Hospitals
 - CAH manual combines the Medicare standards for both general hospitals (482) and CAHs (485) codes.
- New manual for clinical laboratories (same format as all other manuals will facilitate computerized scoring.
- New ASC manual due out soon.

ESAR-VHP – Jennifer Hannah

To date, 124,000 practitioners have volunteered. Over 20 professions are represented. A volunteer PR blitz is planned for April 2009. The Dept HHS—Office of Assistant Secretary of Preparedness and Response provides: technical assistance and deployment protocols; access to national databases; and is responsible for recruitment and retention.

NCQA – Frank Stelling Credentialing Standards

- No changes for 2009.

- May be some minor changes in 2010, mainly in cultural and linguistic appropriate services (CLAS).

Physician Performance

NCQA is now providing certification and recognition programs to recognize quality of physician performance. The two major programs are Physician and Hospital Quality and the Physician Recognition Programs.

Physician and Hospital Quality Certification

- NCQA's Physician and Hospital Quality (PHQ) certification program evaluates how well health plans measure and report the quality and cost of physicians and hospitals.
- Four key principles serve as the foundation of PHQ Certification:
 - **Standardization and sound methodology**, allowing results to be compared across organizations. Organization must use standardized measures such as those from the National Quality Forum (NQF) and the Ambulatory Care Quality Alliance (AQA).
 - **Transparency**. Organizations should offer physicians the opportunity to provide input on measurement programs. Organizations should also provide clear, understandable information about how the results will be used.
 - **Collaboration**. Where possible, organizations should pool their data on standardized measures to produce results with greater statistical reliability.
 - **Action on quality and cost**. Organizations should not sacrifice quality for cost reduction. Organizations must not use results of cost measurement alone.

New York Attorney General Physician Measurement Review

In 2007, seven health plans that had implemented a physician performance measurement program in New York reached agreement with the Attorney General's office on a set of requirements for physician measurement programs. NCQA is designated as a Ratings Examiner under the agreement. The results are available at nyrxreport.ncqa.org. The Web site provides details on the extent to which health plans comply with provisions of the agreement. Such provisions include verification of the accuracy of measurement methods, the involvement of physicians in the program's development, and the right of physicians to request changes or corrections to data accuracy of measurement methods, the involvement of physicians in the program's development and the right of physicians to request changes or corrections to data.

Physician Recognition Programs

NCQA provides five recognition programs for physician performance. The programs are: Diabetes Recognition, Heart and Stroke Recognition, Back Pain Recognition, Physician Practice Connection and Physician Practice Connection – Patient Centered Medical Home. The Diabetes and Heart and Stroke programs are also recognized by the ABIM as acceptable for meeting part of Maintenance of Certification. Each of these programs requires physicians to provide data on how well they are performing on specific measures of quality. For further information go to our Web site at: <http://www.ncqa.org/tabid/58/Default.aspx>.

Veteran's Administration – Kate Enchelmayer

The VA has a number of “joint ventures” with the DOD This concept will be expanding with consolidated facilities For example, the Former Great Lakes Naval Base Hospital and Training facility and the North Chicago VA Medical center will open in October 2010 as the James A. Lovell Federal Healthcare Center.

The VA is issuing an MS.01.01.0 bylaws template document. For example the Chief of Staff must be the President of the Medical staff.

All VA policies are online at www.va.gov – just click the Health Care link and on the Health Care page you will find a link to Forms and Publications

The GAO and VA IG are looking at credentialing and privileging in the rural healthcare areas. They are also looking at policies in the Community-based outpatient clinics.

Latest issue is the practice of **Brachytherapy** [(from the Greek *brachy*, meaning "short"), also known as **sealed source radiotherapy** or **endocurietherapy**, is a form of radiotherapy where a radioactive source is placed inside or next to the area requiring treatment. Brachytherapy is commonly used to treat localized prostate cancer, cervical cancer and cancers of the head and neck.] The NRC is looking into the standards for this practice.

The VA has analyzed the malpractice history of over 56,000 VA practitioners and established three malpractice triggers for secondary review based on data from the NPDB-HIPDB. The three triggers are:

- \$550,000 payment
- Payments of \$2 million or more
- 3 or more malpractice payments

The VA goes to the FSMB as well as the NPDB as they receive non-disciplinary actions as well. All VA LIPs are enrolled in the NPDB-HIPDB PDS. The VA accepts web verification for licensure to appoint a provider but then follows up with a written verification that encloses a Release of Information that authorizes the .SLB to release open/pending information.

Delineation of Privileges – Discussion Leader, Mark Smith, MD

- What should the standard practice be?
 - Evaluate every 6-9 months and 2 years at reappointment
 - CORE with specialty under periodic assessment
 - The VA has quality data triggers
 - How many procedures per time period?

- The ACGME “green book” standards are now online, but are difficult to decipher as they are now tied to the 6 core competencies
- This practice is uneven among hospitals as volunteer department chairs are asked to do this and this practice can be subjective.
- Best practice standards that are non-convoluted would be welcomed.
- A timely article in the latest Journal of Pediatrics addresses the issue of physician re-entry into practice and how to protect the public.
www.pediatrics.org/cgi/content/full

Maintenance of Certification Update – Barb Rosenthal, ABMS

Presentation attached

Continuous Certification

/Continuous Osteopathic Learning Assessment – Annette Gippe

- Reported on progress of the American Osteopathic Board of Emergency Medicine now entering year 5 of their 10 year continuous certification cycle. www.aobem.org
- In addition to the continuous assessment modules, there is a formal exam at 10 years
- Also look at the AOA’s Clinical Assessment Program (CAP)
 - Go to www.do-online.org CAP is listed under the quality tab.

Discussion related to how this would relate to the credentialing process. At this time, there are no plans from the AOA or ABMS to report whether or not a given physician is participating in the process or not. However, that and other such details are not yet finalized.

Consumer Websites – Who’s Watching – Jo Ann Amore

With the explosion of consumer websites, where is the quality control?

- URAC has standards to accredit consumer websites
<http://www.urac.org/resources/privacySecurity.aspx>
- NCQA standards require that information appearing in provider directories must be verified through the medical staff
- NCQA can certify public websites <http://www.ncqa.org/tabid/572/Default.aspx>
- State and County Medical Societies work to educate the public in this regard

- There is a Consumer Health Website seal of approval
<http://www.consumer-health.com/sealofapproval.htm>
- Is there a way to control the use of websites by the public that may not have high standards that are nationally recognized???? No, all we can do is educate the public.

State Alliance for e-Health and the Health Care Practice Taskforce – Betsy Ranslow

- The 2008 report can be found at
<http://www.nga.org/Files/pdf/0809EHEALTHREPORT.PDF>
- Once the report of the meeting with the licensing boards (that occurred at the same time as the NCF) is complete, Betsy will forward to us

Information submitted by Carol Walker – National Alliance for Physician Competence

- Attached:
 - “Guide to Good Medical Practice – USA” Version 1.0, September 22, 2008
 - Explanatory memos
- Recommended for discussion and update at the 2010 NCF

The Cost of Doing Business – How Can We Ensure Quality for Less?? – Bonnie Conley, CPCS (by phone) and Vicky Searcy, CPMSM

- Discussion centered around paper chase rather than evaluation of quality
- Bonnie’s notes are attached to summarize:
 - First problem is within our profession. (not trained)
 - Accrediting bodies
 - Standards can be misinterpreted
 - No exchange of quality information between entities
 - Static information repeatedly verified
 - Credentialing standards should have a patient-safety focus
- Should the NCF develop a position paper or is NAMSS in a better position to do so?
- Perhaps the NCF could develop an article for Synergy. List of ridiculous requirements and distilling the myths around what primary-source verified information is available and from whom. Outlining minimum standards (CMS) vs. best practices. Could start with a grid of credentialing requirements --
 - NCQA
 - TJC, HFAP, DNV
 - URAC
 - CMS
 - Others?????
- Hall of Shame for some legislative requirements?
- NAMSS developed a white paper on credentialing elements (as did the forerunner to NCF (Medical Society Credentials Verification Organizations of America)

- Hugh Greeley also developed a best practices document

ACTION – Annette, Bonnie and Sheryl Davis to discuss possible strategy on a conference call, develop a short outline/paper then send out to the group for comments and ideas.

Applications of Telehealth for Public Health Emergencies and Disaster Medical Responses – Lara Lamprecht, Office of the Assistant Secretary for Preparedness and Response (HHS-ASPR)

Presentation attached.

She will let us know when final report is delivered to Congress. Discussion summarized as follows:

1. Preparing a Report to Congress on the status of Telehealth Initiatives in the US related to Public Health Emergency Preparedness
2. Federal working group
 - Red Cross
 - National Biodefense Analysis and Countermeasures Center
 - CDC/NIH
 - Enterprise Governance Board
 - Institute of Medicine
3. Basically an Inventory of such initiatives applied to public health in order to develop a national strategy with interagency collaboration
4. With reimbursement for telehealth, (as well as EMR/HIT/RHIOs) there should be uniform information standards. What role should the federal government play in this endeavor and what is in place at this time?
5. The recommendations from this team will:
 - Expedite clinical care to non-ideal situations
 - Catalog what resources are currently available
 - Identify tracking systems
 - Identify appropriate decision-making strategies
 - Identify Electronic Patient Records best practices for quick recovery in an event
6. The National Biodefense Science Board (NBSB) is the external group advising HHS on this matter
7. The IOM has recommendations regarding HIT issues with innovative approaches needed for;
 - Consultation
 - Counter measures (i.e. patient education)
 - Tracking
 - Compensation
 - Confidentiality
 - Interoperability between federal agency systems

- Next step is to develop a national strategy for:
 - Credentialing
 - License portability
 - Reporting of adverse actions
 - Waiving of licensure requirements in time of emergency
 - DOD/VA/COMM/FCC/ONC

Future of the NCF Discussion – All

Action Items:

- Notes to those invited who did not come, giving them dates for next year/perhaps also ask why and what would entice them to attend – Annette
- Meeting will be held February 4 & 5, 2010 – To investigate venues: Cris Mobley (Palm Springs location); Kathy Lyman; Jodi Schirling; Susan Collier (Office locations in Florida)
- Who do we recruit to make our circle complete?
 - Health Systems (HCA/Tenet)
 - Large Insurers (Aetna/Cigna)
 - AHIP – Carol
 - URAC – Susan C
 - Nursing – Jodi/Linda Haack
 - ACHE/ACPE – Cris
 - State Board (invite in meeting state) – Annette
 - CMS/DEA/ others – contact regional offices
 - NAHQ – Vicky
 - Health Lawyers
- Chris Giles to look at charter that was drafted two years ago – one thing that we have been committed to is to remain non-commercial and work toward mutual problem-solving.
- Annette will send out very rough cut minutes for review and comment. Not to be distributed until final comments are received and package is put together with presentations, etc.