PRACTICE MANAGEMENT: THE ROAD AHEAD

Credentialing for Endoscopic Practice: The Mayo Clinic Model

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Credentialing and privileging is a process that all institutions must undertake, however, the methods that institutions and health care delivery systems use have not been well described in the literature. For many institutions, the process does not typically engage physicians actively for input. Most performing gastroenterologists understand the vetting process when hired, but not what happens subsequent to that time. For most of us, this process includes a periodic completion of forms with checklists for certain privileges, which subsequently are granted by some administrator with possible input from a physician in a leadership role. With the advancement of endoscopic technologies but a finite number of patients, it is clear that not all physicians should be performing all procedures. Is everyone qualified to perform every procedure? Are they performing sufficient numbers to maintain an acceptable skill level?

As suggested in the American Society for Gastrointestinal Endoscopy (ASGE) guideline for privileging, credentialing, and proctoring, it is the responsibility of each institution to develop and maintain guidelines detailing the methods and frequency required to grant and renew privileges in endoscopic procedures.[1] The Joint Commission can ask to review faculty personnel files and the means by which credentialing occurs. Recredentialing has been mandated by national accrediting organizations to occur every 2 to 3 years. The goal of this process is to ensure continued clinical competency, promote continuous quality improvement, and maintain patient safety. In this article we present a credentialing process that has been developed and implemented successfully in a large tertiary care practice with a large-volume endoscopic practice. This process includes the necessary infrastructure, responsibilities of committee members, and administrative controls.

Regulatory Requirements

To make the decision of privileging more objective and continuous, in 2007, the Joint Commission introduced its Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) processes.[2] These tools were created to help determine if the level of care delivered by a practitioner falls below an acceptable level of performance. It is important to note that neither tool on its own is capable of making an adequate assessment, but instead it is the thoughtful and judicious use of both tools that is required to make this determination.

OPPE is a screening tool to evaluate all practitioners who have been granted privileges and to identify those clinicians who might be delivering an unacceptable quality of care. It is important to emphasize that the OPPE is not designed to identify clinicians who are delivering good or excellent care. As with all screening tests, a positive finding must be followed with a more rigorous diagnostic test, one with a high specificity for poor care.

FPPE is the follow-up process to determine the validity of any positives (whether true or false) found through OPPE. This process is applied only to the small number of clinicians who were identified by OPPE. Because the outcome of the FPPE is so important, the review, decision, and follow-up process developed by the hospital—usually at the department level—must be objective and capable of accurately determining when a clinician's performance is falling below an acceptable norm. To accomplish this goal, it is important that a thorough and thoughtful process be developed by each department with substantial input from peers.

In 2008, our divisional leadership initiated a program that included endoscopic procedural metrics into the OPPE, and follow-up assessments into the FPPE tools in accordance with the Joint Commission. The vision at that time was to select a committee of peers to review certain standard endoscopic metrics and report any issues that required further investigation to the Division Chair using a reproducible written format.

Abbreviations used in this paper: **ADR, adenoma detection rate; ASGE, American Society for Gastrointestinal Endoscopy; EGD, esophagogastroduodenoscopy; FPPE, Focused Professional Practice Evaluation; OPPE, Ongoing Professional Practice Evaluation; PDR, polyp detection rate.**

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1542-3565/$36.00
https://doi.org/10.1016/j.cgh.2018.06.020

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This program has evolved over time, and has engaged different resources within our Division.

Information Technology Role

Annually, our systems analysts supply endoscopic data from Provation for review. Secure SharePoint was chosen as the platform to host the electronic data. A folder was created for each endoscopist, and only members of the Credentialing Committee are given access to these folders.

Data collected includes the number and nature of screening/routine procedures performed by each individual in our outpatient units (colonoscopies and esophagogastroduodenoscopies [EGDs]). This list includes procedures performed with or without a trainee. We chose to focus only on the routine procedures because the national quality metrics available for quality assessment are applicable only to these procedures. Faculty with highly specialized practices focused on endoscopic retrograde cholangiopancreatography and endoscopic ultrasound are included in the review, but it is noted that the number of qualifying procedures may be quite small.

Specific information collected on a performance sheet for each endoscopist includes cecal intubation rate, polyp detection rate (PDR), patient tolerance as rated by the endoscopist after the procedure (good, fair, poor), advancement and withdrawal time, and drug doses administered for conscious sedation as well as the number of times reversal was necessary (Supplementary Table 1). Each variable is stratified by quartiles based on aggregate scores and each individual is compared with the Division average as a whole. Metrics for each provider from the preceding year also are provided for historical comparison. In addition, an analyst pulls a random list of 10 procedures performed in a year for detailed peer review as described later. Patient satisfaction data currently are not included as part of our credentialing process.

A third file uploaded to each folder is a spreadsheet of complications that occurred during the past review cycle. The Chair of the Committee is responsible for tracking all endoscopic complications. Individual sheets within the Excel spreadsheet include perforations, postprocedure bleeding, postprocedure hospitalization, missed lesions, and the need for reversal of conscious sedation. Each complication is scored based on the ASGE scoring system in which a ratio of a severity of complication score is divided by the score of the procedure complexity.[3,4] An average of these ratios for each type of complication is reported for each individual and compared with the averages for the entire Division.

Committee Peer Review

The Committee comprises 8 faculty members with diverse interests and skill sets. The Chair assigns reviews to each member based on expertise and the ability to fairly assess their peers who perform similar procedures. For example, a member who does not perform endoscopic retrograde cholangiopancreatography would not be asked to review the complications and performance of a colleague whose practice is mainly in this area. On average, there are 6 assigned reviews per committee member and each take anywhere from 10 to 40 minutes to complete, based on the number of complications reported. Committee members are given 4 weeks to complete all of their assignments. Committee members rotate through every 3 to 5 years.

The review consists of an assessment of the total number of procedures performed per year to determine if that number is adequate for continued privileging (Table 1). It has been shown that adenoma detection rates decrease considerably for endoscopists performing fewer than 100 colonoscopies per year.[5] As such, it is the expectation that clinicians will perform 100 colonoscopies per year. For EGDs, there are little to no data to indicate the recommended minimum annual volume to maintain skills. Based on our own empiric experience, we use 30 EGDs as the minimum requirement per year. Clinicians performing fewer than these 2 thresholds are required to maintain performance in the top 25th percentile on other monitored metrics of the Division. Those who fail to meet these higher standards may be asked either to alter their schedule or to spend more time in the procedure unit or to discontinue endoscopy.

After the number of procedures is determined, the individual's other performance metrics are compared

Table 1. Quality Measures for Endoscopy Credentialing

Parameter	Minimum expectation
Cecal intubation rate	≥90% (all colonoscopies) ≥95% (screening only)
Withdrawal times (colonoscopy)	≥6 min
PDRs	≥35% (≥30% for females, ≥40% for males)
Complication scores	Average severity/complexity ratio: <1
Minimum procedures, n	EGD: ≥30/y Colonoscopy: ≥100/y

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