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Credentialing & Peer Review
LEGAL INSIDER

Collect valid OPPE data on telemedicine providers

Collaboration between sites creates a full peer review picture

Collecting ongoing professional practice evaluation (OPPE) data on telemedicine providers who may be based hundreds or thousands of miles away from your facility seems like a daunting challenge. However, it doesn't have to be rocket science. It's simply a matter of adjusting the focused professional practice evaluation (FPPE) and OPPE that you currently conduct on active members of your medical staff who practice in the hospital regularly.

"It is not that much different than the old days where you sent a pathology specimen out for a second opinion from a reference lab and you considered that consultation and used it in your plan for the patient," says **Vikki Gore, CPMSM,** medical staff services and continuing medical education coordinator at Yakima (WA) Regional Medical & Cardiac Center.

The responsibility for conducting adequate OPPE rests with the site that provides the telemedicine services, says **Geneva Harris,** director of clinical affairs at the University of California at Davis Medical Center (UCDMC). The medical center provides telemedicine services to 90 clinics and hospitals serving 37 counties throughout California.

However, if a telemedicine provider provides services that ultimately harm a patient, the liability rests with the site where the patient resides. Therefore, it is essential that both the distant and originating sites work together to collect adequate OPPE data on telemedicine providers.

If a telemedicine provider provides services that ultimately harm a patient, the liability rests with the site where the patient resides.

Collecting adequate OPPE data requires that the distant site share performance data with the originating site and vice versa. If the distant and originating sites each collect OPPE data and share them with each other, they can fill in each other's gaps.

"We have a good idea of what [physicians] do at our facility, but when one of our telemedicine providers consults for another facility, we would like feedback about how that went," says Harris.

CMS' website provides the following definitions of distant and originating sites:

- **Distant site:** The site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via a telecommunications system. It is also called the hub site.
- **Originating site:** The location of the Medicaid patient at the time the service is being furnished via a telecommunications system. It is also called the the spoke site.

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Telemedicine

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To collect data on physicians' performance at the originating sites, UCDMC includes a physician assessment form in its contract with the telemedicine services provider. The originating site fills out this form, which is based on the six general competencies originally developed by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties and adopted by The Joint Commission (formerly JCAHO), to provide UCDMC with performance feedback.

UCDMC's telemedicine contract requires the originating site's quality assurance (QA) committee or the attending physician requesting a consultation at the originating site to rate the telemedicine practitioner's performance as acceptable, marginal, unacceptable, or "unable to assess," according to the following measures:

- **Patient care:** Provider is compassionate, appropriate, and effective
- **Medical/clinical knowledge:** Provider demonstrates knowledge of established and evolving sciences
- **Practice-based learning and improvement:** Provider uses scientific evidence and methods to investigate, evaluate, and improve care
- **Interpersonal communication skills:** Provider establishes and maintains professional relationships with patients and families
- **Systems-based practice:** Provider understands the context and systems in which care is provided and applies this knowledge
- **Professionalism:** Provider demonstrates a commitment to professional development, ethical practice, diversity, and responsibility to patients, the profession, and society

The assessment form helps connect the originating site with the distant site, keeping everyone informed of the performance of the telemedicine provider. In addition to filling out the form, some originating sites wish to proctor their telemedicine providers; a physician on staff or the QA committee reviews the diagnosis and advice provided by the telemedicine provider, and those data are included in the OPPE assessment.

In return for the information provided on the form, UCDMC alerts its contracted facilities if the UCDMC medical staff takes a privileging action against one of the physicians on its telemedicine panel. "We would never risk having on the telemedicine panel someone who was not 100% in good standing here. It's a two-way street," says Harris.

When working with telemedicine providers, it's important to have a strict quality review process in place.

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At Yakima, the radiology department uses NightHawk Radiology Services. NightHawk telemedicine providers conduct initial reads on all images, but a radiologist on staff at Yakima rereads each image to verify that the initial read is correct, explains Gore.

If the on-staff radiologist notices a significant discrepancy between an initial read and a final read, that information is passed on to the medical staff's QA committee. "We track and trend [performance] through our QA committee for the medical staff and provide that feedback also back to NightHawk and to the individual teleradiologist," says Gore.

Yakima's medical staff also looks at delays. If a teleradiologist takes more than 30 minutes to read an image and respond, the QA department takes note and shares that information with NightHawk. Usually delays are caused by system issues or a poor Internet or phone connection, but delays are still important to track as they may indicate that a teleradiologist isn't able to keep up with the work volume or is not responsive enough to meet the facility's needs.

The OPPE report that Gore uses for teleradiology tracks how many discrepancies each teleradiologist has per quarter, which the medical staff reviews for trends. If a teleradiologist experiences a negative trend, Yakima may ask NightHawk to remove that particular teleradiologist from the service contract. "We are very comfortable with the people NightHawk credentials, so this has never happened, but it is a possibility," Gore says.

Unlike Yakima, which has radiologists on staff to review the work of teleradiologists, some facilities may not have specialists in place to review the work of telemedicine providers. If this describes your facility, your data collection may be limited to the overall interaction between the attending physician at the originating site and the telemedicine provider at the distant site. To gather this data, consider creating an evaluation form that includes the following questions:

- Was the information that the telemedicine provider offered helpful for your treatment with your patient?
- Was communicating with the teleneurologist easy?
- Was the consult performed in a timely manner?
- Were you satisfied overall with the treatment plan?

Whether practitioners treat patients in the flesh or via the Internet, OPPE indicators vary depending on each practitioner's scope of practice. In general, the scope of practice for a telemedicine provider is likely small because the practitioner is a consultant and does not write orders for the patients they treat.

"[NightHawk radiologists] are not doing procedures here, so we are not measuring their use of moderate sedation or procedure complications," says Gore. Rather, Yakima is simply measuring whether the radiologists read each image accurately. In many cases, it is a simple yes-or-no question. "But there still has to be a process. That is the bottom line," she says.

Although it is rare, there are times when a telemedicine provider oversees the care of a patient. For example, one of the sites to which UCDMC provides telemedicine services does not have any intensive care physicians to work in the pediatric ICU. Therefore, qualified medical staff members on UCDMC's telemedicine panel write orders for patients in the PICU and communicate with nurses several times per day.

According to Harris, the OPPE report isn't any different than a physician treating PICU patients in person. The only difference is that both facilities must work together to collect all of the necessary data.

Harris and Gore say that telemedicine providers are not treated any differently than other medical staff members in terms of peer review. If a telemedicine provider makes an error, the peer review committee at the originating site still reviews the case even though the physician may be thousands of miles away. Therefore, hospitals don't have to bend over backward to collect adequate OPPE data. As long as the originating and distant sites are collecting data that adequately reflect a physician's performance and sharing it, they both meet The Joint Commission's standard. ■

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Step-by-step guide to suspending clinical privileges

General guidelines to follow even when facts differ

Medical staff leaders and MSPs may spend more time implementing new privileges than suspending them, but when it comes time for the latter, it's important to know what steps to take to ensure a fair and legal suspension.

Each type of suspension may have a slightly different use depending on the individual organization, but the general consequences are universal. In each instance, the medical staff suspends some or all privileges.

- **Automatic suspension.** This type of suspension is an instant response taken to ensure patient or employee safety. For example, if a surgeon arrives to work intoxicated, the chief medical officer would automatically suspend him or her.
- **Voluntary suspension.** This type of suspension is the result of failure to follow an administrative process, rather than failure to meet quality or clinical benchmarks. For example, if a practitioner repeatedly fails to pay her medical staff dues, the medical staff leadership may give her the option to voluntarily suspend privileges. Most practitioners will accept the voluntary suspension when offered because it is not reportable to the databanks. However, if a practitioner doesn't voluntarily suspend privileges, the medical staff can automatically or summarily suspend privileges, depending on the circumstances.
- **Summary suspension.** This type of suspension, due to clinical or quality concerns, happens at the beginning or end of an investigation. For example, if a practitioner's quality of care is called into question and the medical staff reviews the practitioner's cases and finds problems, it could issue a summary suspension for those privileges.

Suspensions start and end with the bylaws

When it comes time for medical staffs to suspend a practitioner's privileges, the first question they should ask themselves is, "What actions do our bylaws allow us to take?"

The answer to that question will provide a blueprint for the entire suspension process.

"When I am working on suspensions for clients, the first thing I tell them is, 'Don't do a thing until you've looked at the bylaws,' " says **Andrew E. Thurman, PC,** an independent healthcare lawyer in Pittsburgh. "If you don't have a process [in your bylaws], then you have a whole other set of problems, but I've never had that happen and I've been doing this for 30 years."

In the rare instance that your medical staff discovers it does not have a predefined suspension process in the bylaws, it should create such a policy as soon as possible.

It's important for medical staffs to follow their bylaws because they outline a legally sound path to follow that's likely already been vetted by legal counsel. Additionally, medical staff leadership and members know what's in the bylaws, so there are no surprises in an already stressful suspension process. Courts also look to see that medical staffs act within the scope of their bylaws; this is especially important in states where bylaws are considered a binding contract.

Tip: If your medical staff wants to revise its suspension process as outlined in the bylaws, there are other resources to turn to aside from your legal counsel. You may want to contact area hospitals to see what considerations they address in their documents. Additionally, your state licensing board may use suspension

Questions? Comments? Ideas?

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language that can be modified to suit your medical staff's needs.

Gathering data to make a case for suspension

The bylaws typically outline what type of information the medical staff needs to gather to suspend a practitioner, even if the bylaws don't specify details about what that information should include.

MSPs play a large role at this stage, according to **Deb Bass, RN, BS,** manager of medical staff services at The Nebraska Medical Center in Omaha.

"The MSP is usually involved in gathering information for the suspension depending on what the circumstances are," Bass says. "I'm usually the one collecting the data and providing it to the leadership team."

Bass gathers information from medical records about records completion or from individual clinical departments about quality benchmarks.

Tip: When developing orientation material for new MSPs, include information about suspension procedures. This may include scenarios defining what type of action triggered the suspension, what type of suspension the medical staff gave a practitioner, and what type of information the MSP needs to gather to support that suspension.

Alerting the suspended practitioner

After a medical staff has decided to suspend a practitioner and double-checked the bylaws to ensure that the action is reasonable, the next logical step is notifying the suspended practitioner.

The logistics around this notification can vary depending on the circumstances. For example, in some instances, it may be acceptable to notify a third party, such as an attorney, rather than notifying the practitioner directly.

"If this has been an ongoing process and the individual has a lawyer, then it is perfectly appropriate to inform the practitioner through their lawyer, depending on the degree of urgency in making sure the individual, say, doesn't come back on hospital grounds," says Thurman.

Tip: Whether the medical staff notifies a third party about the suspension or notifies the practitioner directly, chances are the notified individual will have some follow-up questions. Plan ahead to have prepared answers for these situations. Some of the follow-up questions a practitioner might ask include: When does the suspension take effect? Will the medical staff report this to the NPDB? How can I challenge the suspension?

In other instances, the medical staff may choose to notify the practitioner directly.

The individual who notifies the suspended practitioner can also vary.

"If a practitioner is suspended for an automatic, summary, or precautionary suspension, our chief of staff is required to contact that practitioner," says Bass. "When it comes to other suspensions where people are automatically voluntarily suspended for medical record [documentation] or [late] dues, it's common for the MSP to contact them on behalf of the medical staff leadership."

> **"The MSP is usually involved in gathering information for the suspension depending on what the circumstances are. I'm usually the one collecting the data and providing it to the leadership team."**
>
> ***—Deb Bass, RN, BS***

Alerting internal and external stakeholders

After the medical staff alerts the practitioner, it will likely need to notify others about the suspension.

"My advice to facilities has always been to have the appropriate department chairman take whatever steps are necessary to enforce the suspension," says Thurman. Using this method, each department will create a unique list of individuals to notify the practitioner based on the suspension case.

"The other people I always recommend notifying are security," says Thurman.

Tip: In some rare instances, your medical staff may want to alert the security department before

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Privileges

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notifying the practitioner about the suspension if the practitioner's behavior is a security risk. For more information about managing these situations, see "Keeping practitioners cool during high-pressure meetings" in the January 2010 **Briefings on Credentialing.**

From the MSP's perspective, Bass says it's usually her responsibility to notify others of the suspension so practitioners may no longer admit or schedule procedures. If patients are already scheduled, Bass notifies the department so arrangements can be made with another physician partner to see the patients.

"For us, if it's a medical records suspension, they can't admit patients or schedule procedures in the hospital, so you have to contact those departments and let them know so they can flag the computer system," says Bass.

Finally, the medical staff may need to notify the NPDB or a state licensing board about the suspension, depending on the circumstances.

"A suspension for more than 30 days for a clinical reason is going to have to be reported to the National Practitioner Data Bank," says Thurman. "States vary somewhat according to their requirements, but every state that I've dealt with requires a report to the licensure board for almost any type of suspension, even for a relatively short period of time."

For clarification on specific circumstances, medical staffs should consult their legal counsel.

Final thoughts on suspensions

Throughout the suspension process, there are a couple of issues of which the medical staff should take note.

"By far the biggest mistake, the most frequent mistake, is failure to essentially read and abide by the bylaws," says Thurman. "The other mistake is poor documentation of the rationale for the suspension activities taking place to review the suspension."

Both of these aspects, following the bylaws and documenting the process, are important steps to take as legal safeguards.

Keep in mind that the suspension process is rare. Bass says she'll see a handful of suspensions each year with a medical staff of 1,100 physicians and 300 advanced practice professionals. Most of those suspensions are due to failure to complete medical records or pay medical staff dues in a timely manner.

Rare, though not extinct, the suspension process is an important technique that medical staffs use to ensure patient safety. By learning the basics, your medical staff can ensure that it has an effective suspension process. ■

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