LOW AND NO VOLUME PRACTITIONERS: 
CHANGING PRACTICE PATTERNS - 
NEW CREDENTIALING CHALLENGES 
OUTLINE

I. TYPES OF LOW/NO VOLUME PRACTITIONERS

If your medical staff is like most, you have a growing number of members who have little or no clinical activity in your facility. Even some "active" physicians may have privileges that they no longer routinely exercise. It is important to recognize the various reasons a practitioner may have little or no volume, because these reasons will directly affect the hospital's credentialing efforts:

(A) Practice centered at another hospital. It is relatively common for physicians to practice primarily at one hospital but attempt to retain their privileges at other hospitals due to managed care requirements or the desire to satisfy patient preferences.

(B) Limited practice in certain areas. As physicians change their practices, they do not always think to change their clinical privileges. For instance, the general surgeon with vascular privileges may do few, if any, vascular cases, or the family medicine physician may deliver just a handful of babies a year. In these situations it is very difficult to assess the current clinical competence of the physicians in the area where their practice is low/no volume.

(C) Office-based practice. Given the hospitalist and other related movements (laborist, traumaist, etc.), many low/no volume practitioners may not have clinical activity at any hospital. Instead, they are centering their practice in the office setting.
(D) **Gaps in practice.** In some cases, physicians may stop practicing medicine altogether for a period of time. They may have resigned their privileges and taken time off to care for a young child or a sick family member or they may have taken a leave of absence to try their hand at hospital management or a related career.

II. **BENEFITS AND DRAWBACKS OF "STAYING CONNECTED" WITH THE LOW/NO VOLUME PRACTITIONER**

(A) **Potential Benefits**

Depending on the type of low/no volume practitioner, there may be benefits to the hospital in maintaining a relationship with the practitioner. These include:

1. improving care in the community;
2. providing needed service;
3. fostering continuity of care;
4. building or maintaining ties with referral base; and
5. assisting practitioners to maintain their status within managed care plans.

(B) **Potential Drawbacks**

There may also be liability risks or other drawbacks that hospitals and medical staff leaders should consider in deciding how to approach the low/no volume practitioner. These include:

1. a lack of information to make informed decisions;
2. difficulty in satisfying Joint Commission requirements for ongoing professional practice evaluations;
3. the time and expense of recredentialing physicians who are not active;
4. the potential liability for "negligent credentialing" or for actions of "apparent agent" of hospital.
III. SETTING THE BAR FOR LOW/NO VOLUME PRACTITIONERS

There are some steps that can be taken to "raise the bar" in credentialing low/no volume practitioners. One step is to address the issue in qualifications or criteria for appointment, reappointment, and clinical privileges. Another option is to assess higher reappointment fees.

(A) Threshold criteria for minimum patient contacts/minimum activity

(1) Require applicants to have had an active practice in a hospital setting within the last two years. (See Attachment A.)

(2) Require minimum activity for the grant of reappointment.

(3) Require minimum activity for the grant of clinical privileges as an eligibility criterion.

(4) Consider consequences of these criteria on specialists you need, but who are not often in the hospital (i.e., dermatologists).

(5) Consider whether exceptions can or should be made for consultants?

(B) Reappointment fees

(1) Use reappointment fees as a way to offset increased costs associated with processing applications from low/no volume practitioner by charging higher fee for low/no volume practitioners.

(2) How high is too high? Can/should reappointment fees be used as a way to discourage low volume practitioners from seeking reappointment?

IV. ASSESSING COMPETENCE OF LOW/NO VOLUME PRACTITIONERS

(A) General Principles.

(1) The burden to demonstrate competency initially and on an ongoing basis is always on the practitioner. This general principle applies to the low/no volume practitioner too. Like any other practitioner seeking appointment
and privileges or any other member of the medical staff seeking reappointment, the low/no volume practitioner must provide information that is requested to demonstrate current competence. This may mean that the practitioner has to provide information from other hospitals or managed care organizations ("MCOs"). The practitioner may also be required to provide medical records or other information regarding his or her office practice.

(2) Another important general principle regarding credentialing that is particularly applicable to the low/no volume practitioner is "Don't process an incomplete application." If you decide you need the quality profile from another hospital or MCO, or if you think an evaluation form is needed, or if you have determined it will be necessary to review the physician's office records, then the physician's application is incomplete and should not be processed until this information is received.

(3) As in all medical staff matters, it is also important to remember that the collegial intervention approach often works best. There may be situations where the low/no volume practitioner really doesn't have a need or interest in renewing certain privileges or remaining on the medical staff. Talking to these practitioners might be the best way to reach a common ground and understanding.

(B) Physicians whose practice is centered at another hospital or facility.

(1) Obtain information from that hospital or facility.

(a) Joint Commission Standard MS.4.70, Element of Performance 2, states "[u]pon renewal of privileges, when insufficient practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations."
(b) Send detailed reference requests to other hospitals to obtain information about the core competencies of low/no volume practitioners. (See Attachment B.)

(c) Provide the other facility with a release signed by the applicant granting immunity to the fullest extent permitted by law.

(d) Recipients of reference requests should include the department chairperson and might also include the chief of staff, Vice President of Medical Affairs, medical staff office managers and directors of medical records. Additionally, the director of nursing and the OR supervisor might have valuable information.

(e) Also obtain a quality profile from other facilities and MCOs, including volume and outcomes data.

(f) Another option is to obtain copies of medical records to conduct a focused professional practice evaluation (see below).

(g) Anticipate objections to such requests based on the state peer review privilege, the HIPAA Privacy Rule, and state laws governing patient privacy. Based on applicable law, use a credentialing services agreement with appropriate releases, point to the existence of an "organized health care arrangement" between the hospital and the medical staff, de-identify the medical records, or use a Limited Data Set and Data Use Agreement.

(2) Conduct a Focused Professional Practice Evaluation.

Another option is to conduct a focused professional practice evaluation of the individual to assess his or her competence. For example, as part of the reappointment process, the individual could be required to perform several procedures while being observed, or there could be a focused review of
the individual's charts. Relevant policies should be amended to add low volume as a "trigger" for a focused professional practice evaluation.

(C) Physicians with limited practice in certain areas.

(1) Review quality profile with physician, sharing comparative data, in terms of activity of other practitioners, and his or her overall activity.

(2) Discuss liability risk with physician.

(3) Remind physician of burden of demonstrating competency.

(4) Consider information from other practice sites like other hospitals and ambulatory surgery centers.

(5) Have physician attend physician assessment program and/or complete additional and ongoing training sufficient to maintain competence.

(D) Physicians with an office-based practice.

(1) Recognize that the nature of care being provided in the office may not be relevant to the clinical privileges requested at the hospital, so this information may be of limited value in confirming current clinical competency for inpatient work.

(2) Have low/no volume physician provide information as to the types of patients, including procedures being performed in the office. Medical staff leadership knows what information might be available to review.

(3) Obtain copies of office medical records (address HIPAA objections by pointing to "organized health care arrangement" between hospital and medical staff, by de-identifying information, or through use of Limited Data Set/Data Use Agreement). Review and evaluate the following information:

(a) completion of H&Ps and medical records generally;

(b) management of high risk patients;
(c) adherence to established guidelines;
(d) appropriateness and timeliness of referrals to specialists;
(e) appropriate ordering of tests.

(4) Consider results from patient satisfaction surveys.

(5) Obtain and consider reference evaluations from physicians who are in referral relationships with the low/no volume practitioner.

(6) Obtain and consider the quality profile from the physician's MCO.

(7) Have physician attend physician assessment program and/or complete additional and ongoing training sufficient to maintain competence.

(8) If physician does not intend to use inpatient privileges but wants to maintain affiliation with hospital, appoint to Ambulatory Staff, Community Affiliate Staff, or similar staff category without inpatient privileges (see below).

(E) Physicians with gaps in practice.

(1) Consider adopting eligibility criterion requiring physicians to have demonstrated recent active clinical practice in hospital setting during previous two years.

(2) Require physician to complete additional training, such as a residency or mini-residency, depending on the time away from practice.

(3) Use a conditional appointment subject to a proctoring requirement.

V. ADDRESSING CONCERNS INVOLVING LOW/NO VOLUME PRACTITIONER

(A) Concerns at another facility

(1) If there has been a concern at another facility, the hospital has a legal duty to review the issues that have been raised.
(2) The hospital can hold the application incomplete until the applicant authorizes the other facility to provide sufficient information to allow the concern to be reviewed.

(3) If the other facility is reluctant to release information based on the state peer review law, the HIPAA Privacy Rule, or state laws governing patient privacy, consider use of a confidentiality agreement, de-identifying the medical records, or using a Limited Data Set and Data Use Agreement.

(B) Other concerns

(1) There may be concerns raised about the low/no volume practitioner because of a number of malpractice claims, settlements, or judgments. Or there may be a concern because a practitioner is currently being investigated by the state board. The hospital can follow the same approach and hold the application incomplete until all relevant information can be obtained and reviewed.

VI. USE OF MEDICAL STAFF CATEGORIES

(A) Ambulatory Staff. (See Attachment C.)

(1) The Ambulatory Staff typically includes:

   (a) appointment with ambulatory (outpatient) privileges only.

   (b) practitioners with limited outpatient privileges – typically patients are admitted to the service of hospitalists.

(2) The Ambulatory Staff is most often used for employed physicians or physicians who contract to provide services at hospital outpatient facilities or clinics.
(3) This category might include service call obligations, such as providing follow-up care, on an outpatient basis, for unassigned patients presenting to the Emergency Department.

(4) Consider whether non-reappointment triggers any hearing and appeal rights.

(B) Community Affiliate Staff. (See Attachment D.)

(1) The Community Affiliate Staff typically includes:

(a) appointment without privileges;

(b) an obligation for members to arrange for the referral of patients to a member of the Active Staff instead of a referral to the Emergency Department.

(2) Consider whether general appointment criteria should be applied to members of the Community Affiliate Staff.

(3) Consider whether non-reappointment triggers any hearing and appeal rights.

(4) Consider whether this staff category satisfies MCOs' requirements for "appointment to the active staff."