National Credentialing Forum 2025
San Diego, CA Bahia Resort February 6-7, 2025

Assuring Continuing Competence – View from the Accreditors

Industry Leaders	CIHQ – Rick Curtis, President/CEO DNV – Troy D. McCann, Director or Accreditation & Mandy Burden, Standards Application and Interpretation Specialist TJC – Kathryn Petrovic, VP Global Standards Application & Interpretation ACHC – Donna Gorby, Standard Interpretation Specialist & Surveyor NCQA – Gerald Stewart, Senior Policy Manager AAAHC – Ben Snyder, Surveyor URAC – Donna Merrick, Product Enhancement Principal
CIHQ	Age specific competencies – both staff and physicians. Basic purpose is to ensure a practitioner granted clinical privileges can exercise those privileges in a safe manner. If yes, then considered competence. How you determine the competency is in place varies between organizations. CIHQ's perspective is that proficiency is determined by repetition and the use of muscle memory. Look at the core expectations at completion of residency and work experience. Focus monitoring on high risk or problem prone procedures or diagnostic specific privileges. Appraised guidance from CMS, look at scope of training, education, criteria for specific privileges, proctoring – give latitude to hospital but want to ensue the focus is on the scope of this to determine current competency. Focus resources on effective evaluation and measurements rather than a broader scope. Terminology used is an appraisal process. Expect medical staff when initially granting privileges there is a mechanism to evaluate the competency of that practitioner within a short amount of time. No prescriptive requirements for specific timeframes for appraisal; however, it cannot exceed 36 months. Expect a peer review process to be enacted at the time of identifying a quality concern. Do not use FPPE/OPPE terminology. Ensure medical staff has competencies in place to measure competence but it is not appropriate for the accrediting body to adjudicate the process the hospital utilizes to measure and review. Find APPs are not truly being monitored because they work under a physician and the care is tied to the supervising physician not the care provided by the APP.
DNV	Performance evaluations of physicians is always in the top 10 issue on surveyors. Expansion of APPs also is showing not good evaluation. Aligned with CMS CoPs – expecting sudden, rapid deregulations – concerns about privacy and data.

	Major trend finding 1st assists with no privileges. RNFAs typically are brought in on the HR side and are not being granted privileges. Scrub techs are also an issue and there is no scope of practice is they are not licensed scrub techs. If manipulating tissue they need to be privileged. Important to evaluate the state nursing practice act to truly identify if a privilege should be part of the scope of practice. 3 yr appointment cycle – more organizations making the change from 2 to 3 year cycles. Look closely at contracted services and vendors to identify if there are any deficiencies. Not considering any changes to the standards at this point.
TJC	Going through huge transformation with new CEO Dr John Pearlman. Aligning all divisions/silos within TJC into an Enterprise environment. Evaluating medical staff, putting together a CMO advisory council (large and small entity physician leaders). Intention is to reduce burden while improving value. Focusing on patient experience and patient safety. Want accreditation standards to be meaningful and relevant to current patient care. 2 partnerships – 2023 National Quality Forum (NQF) = standardized measurement – how to connect quality and safety. Focus on reducing competing measures but streamline the data National Association for Healthcare Quality = certification professional in healthcare quality (CPHQ) – all surveyors will be required to obtain the certification Recommendation to consider requirements for CPCS and CPMSM. Biggest deficiency – lapse in verification of licensure and education Not moving the needle on having quality FPPE/OPPE programs – need better mechanisms to look at the data to make the process more meaningful.
ACHC	Patient safety – 100% of the published standards relate to patient safety. Frequent findings relate to staff members who are manipulating tissue in the OR without being granted the privilege to do so. New standards: related to RNFA and consent includes all personnel who will be in the room to include RNFA or PAs who will be participating 03.15.01 – professional practice data – 36-month cycle but the ongoing monitoring needs to be done at least annually.

	Clarification – unified medical staff – Med Staff Bylaws need to define the voting process to opt in or opt out of the unified medical staff Deficiencies identified in Ongoing practice evaluation standards – metrics required to be specific to the department. Must include 2 clinical criteria and 2 administrative criteria. Seeing a shift from multiple departments or service lines. Questions regarding how the metrics should be developed – should they be specific to the specialties rather than the department as the standards are written.
NCQA	President retiring at the end of the year. Many different programs including the Health Equity Standards – concerned about new administration. New application fields 2025 standards revisions: Reduce burden Verification time frames – been in place since the 1990s, many automated changes reduces the time to process an application (90 days CVO, 120 days CRA) Ongoing monitoring – changed to monthly and added requirement for organizations to increase oversight of adverse events requiring reporting to the credentials committee – organization determines what is reported. Added expiration of licensure; monitoring exclusions was added. Required to query for all even if not enrolled in those programs. Credentialing Information Integrity Standards – changed because too much emphasis on the systems and reports Create and FAQ – detailing the OMB language used in the Health Equity Standards identifying race/ethnicity. Does not need to be separate fields; however, may need an FAQ because payers will require it as written. NAMSS – Lorna Bream initiative – recommended language in the ideal credentialing standards. NCQA standards do not align with the ideal credentialing standards "which you are appropriately being treated". Look for FAQ regarding language accepted by NCQA.
AAAHC	Founded in 1979 spin off of the TJC. Focus is ambulatory care, initially primary care but focused has shifted to include ASC and Ambulatory medical practices. Accredit about 6,500 organizations that are surveyed every 3 years. 325 surveyors send survey teams that match the type of facility being surveyed. Have a contract with the Coast Guard. Focus is on patient safety. Standards have been modified with the biggest change in July, 2024 went from 25 chapters to 18 categories. This eliminated duplication.

	Most common deficiencies – each year publishes a quality report that will be submitted: Credentialing, Privileging policies are in place but not followed Expired reappointments Expired documents Hospital privileges used but not appropriate for the ASC setting Privilege criteria not being followed APP scope is not appropriate for the facility Privileges missing for procedures performed – supervision APPs, anesthesia No peer references obtained at initial credentialing Residency privileges not consistent with the year of training Levels of anesthesia – monitored anesthesia care has morphed into a level of anesthesia – conscious sedation Competencies – curate standards based on what the organization state is their standard of care Certification program for ASCs doing specialty orthopedic care (to differentiate as a center for excellence in orthopedics doing same day joint surgeries) – if requested by an organization the expectation is to evaluate education, minimum first 3 cases are proctored and additional 7 records are peer reviewed via chart review.
URAC	Donna Merrick, Product Enhancement Principal – Unable to attend

National Associations' Current Initiatives

Industry Leaders	ABMS – Jennifer Michael, COO AOIA – Gloria Bocanegra, AOA Profiles Service Manager AANP/NCB – Kevin Letz, CEO FSMB – Misty Wolfe, Director, FCVS (Includes licensure changes – IMGs) ECFMG – Liz Ingraham, Assistant Vice President NCCPA/PA/AAPA – Greg P. Thomas & Sondra DePalma AMA – Tammy Weaver – VP, Physician Professional Data CAQH – Cheryl Hughes, Senior Manager NAMSS – Karen Claxton, President NPDB – David Loewenstein, HRSA, Director
ABMS	Top initiatives: Additional models for International graduates regarding being able to obtain certification At the end of 2024, the defense health agency put a definition of a certifying body into law which affects government clinicians – VA did not have a requirement for certification prior to this being enacted. The standard was set – must maintain a process to enforce knowledge and skills, has to be a psychometrical valid

	standard for initial and maintenance, code of professional conduct, physicians are required to satisfy each certifying bodies criterion. Will send out the press release regarding this definition. Colorado established a definition at the end of 2024. Other states may follow suit in establishing definitions in line with the federal government. ABMS eligibility time frame remains the same. Not sure if the legislation allows for grandfather capabilities. DHA manages all department of defense hospitals and clinicians. Bringing together a diverse group to evaluate the implementation of automation, AI and other healthcare innovations into the board process. DEI and physician self-regulation initiatives will remain in place. Moving away from MOC to continuing certification. FSMB webinar last Fall – can provide a link to the webinar – education why certification is important. Certification report document on the website with aggregate statistical data. Moved to an on-line interactive document to pull filtered data. Lifetime 2010 – must recertify Now annual check - 2/3 of board are on a continuing certification process
AOIA	Major modernization initiative which is delayed right now due to some IT issues. Launched digital health initiative to create a comprehensive program to increase engagement of DO physicians use of digital health. Approved to take CPCS exam through NAMSS. Goal is to be able to prepare the organization to improve the information needed by MSPs.
AANP/NCB	Largest certifier of NP – family, adult/gerontology, behavioral health and ED. Part of LACE group of organizations that looks at scope of NP. Independent practice for NPs continue to increase at the state level. Google - APRN consensus model for more information about the LACE group. Criteria – active RN license, graduate from MSN program, pass exam – computer based exam 150 questions 3 hour exam. Recertification every 5 years = CEU, practice hours and

FSMB	FCVS – last year released 78,000 profiles 17 state medical boards require FCVS – focus on initial cycle times. 20 days to get FCVS report out. Lean organization. Project – new uniform application combined with FCVS application to improve physician engagement. Guides physicians regarding particular state regulations they need to be made aware of. Digital ID verification – no longer requires notary – this identifies if there may be forgery in the documents also live camera so cannot be delegated to another user other than the physician. NBOME and MBME – now being delivered electronically FSMB medical board portal – state medical boards can go in and get all documents needed. Working on centralizing the USMLE process taking it away from ECFMG. Also moving to a centralized customer service model to support the initiative with USMLE. Licensure pathway – advisory commission put out a list of guidance (will send out links and the document) – states proposing better pathways for IMGs
ECFMG	Intealth ECFMG Intealth: New brand for ECFMG and Faimer united under a shared vision with common values 39,000 IMGs engaging in ECFMG process Designated deans office Sole agency J-1 VISA sponsorship program Domestic and International CVS services Increased trend volume of ECFMG certificants To fulfill clinical and communication skills need to complete ECFMG pathway and communication If expired pathway = expired ECFMG. July, 2025 – Canadian medical school graduates will be considered IMGs if graduate after July 1, 2025. Recognized accreditation policy implemented in November, 2024. If school meets requirements it is noted in the World Directory of Medical Schools. It is not a requirement for ECFMG certification. Sponsor note in directory will indicate if accredited. Advisory commission additional licensure models and pathways for IMGs to improve access. June, 2024. FSMB, ACGME and Intealth.

	Concerns: State legislatures are putting into statute regarding the ECFMG pathways allows for licensing without any US training. The statutes are lacking in standards and direction regarding assessment of competencies, ethical issues in our culture. Physician well-being: Invested in well-being and as the sponsor for J-1 visa recipients – conducting outreach to them, developed resources and publishing on government relations initiatives. Building communities with blogs, partnered with ACGME and department of state a wellness grant program – 5 grants are awarded.
NCCPA/PA/AAPA	Greg Thomas & Sondra DePalma – Unable to attend report submitted
AMA	Physician Professional Data previously called the Masterfile. Physician satisfaction and sustainability – been measuring burn out traditionally 42-48% which is 20% higher than the workforce. COVID – burn out dropped to 30%, after COVID rose to 60% due to fatigue and backlog of work. Updated benchmark now down to 45%. Available programs – Joy in Medicine 6 pillars 150 hospitals/health systems have participated in the program free and administered by the AMA. How to support physician well-being – impairment. Focus on current impairment not past impairment due to the Lorna Breem initiative. Developed recommended language along with NAMSS and others. 2024 30 licensing boards have adopted the language and 500 hospitals/health systems have adopted the language. Want to see continued increase in use of this language. Launched Vericre – how best to redirect resources to patient care instead of administrative. Pre-populate applications (working with MDStaff) 400 individual facilities are using this service with great feedback and statistics 25% increase in efficiencies and good turn around times on applications and the completeness of the applications. 2024 added 16 of the 25 states that require CDS registration. Doing daily downloads from SAM. Looking at doing continuous monitoring. Alternate IMG pathways – 25% of current residents and fellows are IMGs. ¼ are US citizens who went to medical school abroad another majority are coming from 2 schools. Intention is to assist with physician shortages. If you are a us MD or DO physician we enroll you to the data. Currently if IMG not added to the data until cleared by ECFMG. 4 states allowing circumvention of ECFMG certification. 500 IMGs have been licensed without ECFMG.

CAQH	Been working with NCQA on the discrimination statement being required. Entities use our application and CVO but CAQH does not make any approvals so concerns about have the discrimination statement on the CAQH application. Providers are currently answering the Race/Ethnicity question in the portal but it is not on the printed application. Using a source of truth OMB for defining race/ethnicity. Will be adding language field. State applications – analyzing all of them to determine if they have the fields and the discrimination statement. Will be adding supplemental pages to tailor what is not in their current applications. The applications unable to add an addendum are reaching out to these states to advise them regarding the requirement. The template form will be posted on-line – date not determined yet. Some states mandate the use of the CAQH form but do not use the service so we need to make it accessible. Applications will be updated prior to the July 1, 2025 deadline. Currently discussing the ability to allow for proxy access; however, nothing to report at this time. The proxy would allow access; however, the physicians needs to sign and date the attestation. Reattestation every 120 days – need to evaluate only meaningful information is being required.
NAMSS	Celebrated 32nd annual MSP week in November, 2024. High engagement from members. 13 webinars and New certification for Provider Enrollment professional. Working on quality and OPPE/FPPE resources available to assist members. Denver annual conference 1,600 + attendess. 5th consecutive year of organization growth. Finalized new strategic plan, mission, vision and values. Strengthening partnerships. Looking at developing benchmarks for the members. Strengthening leadership pipeline – started Leadership program toward higher volunteers New Vision New Mission New Values

	Government relations – 10th annual roundtable Guiding quality performance via continuous monitoring. Evaluated MSPs role in quality and challenges with EMRs. Identified several next steps. Report on website. August, 2024 – submitted formal request to US Bureau of Labor and Statistics lobbying for a category specific to Medical Services Professionals. Report is posted on website. They will review the report this year and request any additional information. Proposed draft will be published 2028. NAMSS PASS - Repository for history of hospital affiliations. Provides a complete audit trail of the physician's history allowing to identify gaps provided by the practitioner. Collecting data is the challenge. NAMSS PASS is now a centralized portal. NAMSS PASS is now utilizing a direct connection (ECP) with the credentialing software platform to pull data from a portal within 24 hours. You can be contributing entity without uploading data to NAMSS PASS. The intention is to develop a comprehensive single source of information to increase patient safety. Currently working with CredentialStream and MDStaff. There is no charge for NAMSS PASS to make this connection. No charge for the profile. There is a charge to print the letter from NAMSS PASS. Use of NAMSS PASS has been slow growth. Need to create an educational campaign once the portals have been finalized. As part of the strategic plan we will be developing a task force to determine what NAMSS can do to improve use of NAMSS PASS to increase the number of facilities participating. Updated the Ideal Credentialing Standards recommended to include hospital and other work history for past 5 years. Plans to update this document annually. Recommendation: Evaluate statistics of members collection of work history data (# years, detailed locums data) Recommendations: Include Locum and TeleRad companies as partner facilities to include information into NAMSS PASS If there is a gap have the dates turn RED.
NPDB	David Loewenstein, HRSA, Director – Unable to attend

Moderated Discussion – Peer Review in Ambulatory Care Sharon Beckwith, MD Review/Hardenbergh Group
Increased care moving to ambulatory setting that includes more complex surgical procedures. What is being done to monitor quality? Do we have the same safeguards implemented in the ambulatory setting that we have in the hospital setting? More comfortable to be home soon after surgery, but is it the most appropriate for complex surgical procedures. Standards are ambiguous and broad regarding monitoring quality and peer review practices in the ambulatory setting. Concerns: Free standing ASCs and Large System ASCs Distinction regarding what should be happening in these ambulatory settings Office based practice especially being brought into large health systems– procedures are being done but no mechanism to monitor what is happening in the offices FQHC practices – HR processes and very vague ASCs traditionally require they must be credentialed at a hospital and then they were considered credentialed at the ASCs – but the performance processes is not collected or measured within the ambulatory setting Ambulatory includes external practices and are not always tied to a hospital. They also do not grant privileges and there is no oversight of the competency. Physician practice setting should be evaluating competency from a risk management perspective tied to professional liability. State specific regulations regarding peer review protections if you are not a hospital. DNV – oversight of CMS – need to be specific with provider type categories. Participating ASC as defined by CMS then standards. Ownership and branding sometimes dictates oversights. Ambulatory settings = independence and entrepreneurship Rural emergency hospitals are beginning to be recognized by CMS Acute hospital care at home – waiver to provide hospital care in the home setting CIHQ – A gap ambulatory entities because CMS does not recognize some ambulatory centers – free standing emergency rooms, micro-hospitals (emergency centers small patient population) licensed by the state 99% outpatient ED 1% inpatient not recognized by CMS. Accreditation is often a condition of state licensure – then you can require them to be in compliance with credentialing and privileging. CMS does not certify health systems they certify individual

hospitals so if a hospital bills under the hospital Medicare provider number then it is dictated by CMS.

AAAHC – Medicare certified ambulatory surgery center you need to credential and privilege based on the bylaws of the organization. No specifics from CMS it is left to the subjectivity of the organization. Standards are specific for lasers requiring the organization to recognize the specific lasers in use with specific competencies for each type of laser. Look for ongoing monitoring and tied to performance improvement. Do they have meaningful criteria for evaluations? Are they in compliance with the intent of the standard? 75%-80% of 6,500 accredited ambulatory centers. Huge number of independent practitioner practices are not accredited. Reviews of incidents in the ambulatory setting is used to determine quality; however, that is reactive not proactive.

TJC ambulatory used the hospital framework in the ambulatory standards. Creates a burden for the smaller ambulatory settings. Difficult to find the right balance for the ambulatory settings to want to get accredited because not required. Can it be driven by state regulations for licensure of the ASC? Performance evaluations are done in the ambulatory setting for quality outcomes and performance improvement but not as robust as the hospital setting FPPE/OPPE.

NCQA very limited ambulatory standards because other accreditors have the standards. Responsibility is at the payor level not necessarily the group level.

What can be done?
Every facility has the burden of demonstrating their ability of competence.
Payor monitoring can warp outcomes data because it is geared toward what the physician needs to do to get paid.
Payors are pushing ASCs to be accredited to ensure there is monitoring of quality in place.
Some liability carriers offer a discount if the ASC is accredited.
ABMS develop meaningful ambulatory criteria to monitor quality outcomes and performance improvement as part of the MOC process.
Licensure and payment can dictate measurement of quality to ensure maintain licensure and are able to get paid. Loss of CMS payments can be disastrous. Medical groups stepping up to ensure reputation of quality care.
Financial component to medical care; however, it should not drive measurement of quality.
Do HEDIS measurement questions need to be changed to drive evaluations toward the measurement of quality and performance improvement?
Providers who own insurance companies tend to have more involvement with measuring quality.
Telemedicine – concerns of oversight and quality of care.
Prison medicine becoming part of hospital – never done credentialing prior
Problem getting enough data so not a lot of national benchmarks because just now getting national data – this can be used to set some national benchmarks as we get more data.
Specialty societies should be the drivers using data from EPIC and better would be a national repository of that data.
Onset of EMR in ambulatory setting – use tracers – what is said in the exam room is not what is documented because the documentation is templated and geared toward what is needed for billing purposes.

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Credentialing Legal Update
Brian Betner, JD, AHLA

Healthcare operates under notion of predictability, stability and significant compliance. Healthcare operational design is most significantly influenced by how they get paid for the services.

Supreme court overturned June, 2024 Chevron deference – EPA enforcement issue – courts were required to apply agency deference to decisions – any federal cases will now be evaluated under the plain meaning of the law no longer relying on precedent cases and federal sub-agency regulations.

Getting ready to see the greatest boom of federal legislative lawsuits to challenge existing federal sub-agency regulations.

House ways and means committee (healthcare budget) – 50 page budgetary issues they were going to address:

1. Organizations that lose money on Medicare payments get 65%
2. Fully enable facility fees for off campus clinics – will effect
3. Number of surgical privileges can only be billed in ASC or outpatient surgical departments
4. Telehealth expansion
5. Cutting all market place subsidies for exchange products

Priority will be given to initiatives that will save Medicare money. Significant cost cutting at the provider level some symbolic some significant implications.

Do we have protections – courts have been good at protecting immunity privileges; however, some states are more likely to waive immunity protections for peer review protected practices. Surprise billing – litigation to have it properly enforced as it as passed.

X factor:
Presidential administration transition is overhauling the way government operates.

How will organizations be affected?

1. Federal funding
2. Staffing and resources
3. Enforcement

Currently we do not have a stable healthcare system. Will start to see limitations on the ability to deliver healthcare. Funding is the most important of the three issues and if experience losses will have a steep climb back up.

Leadership –

1. RFK Jr – likely approved HHS Sec – Dr Oz Sec CMS –
   Dramatic overhaul
   Frustrated with commercial payors

Budgetary federal freeze
Resource blackouts – removed in 48 hours including CDC directives

Federal court froze deferred retirement plan 91,000 were HHS employees.

Discretionary spending – cannot fill federal vacancies, cannot hire additional people who are there.

There will be push back when things are not getting done. Organizations will need to self-police.

Tariffs – Mexico and Canada on hold for 90 days. 70% all medical equipment not made in US. Most drugs come from Canada and elsewhere. Single digit margins will influence what we buy, how we buy it and when we buy it.

Industry self-enforcement period – Risk Management and Accrediting body compliance which will have potential implications of less enforcement.

Process for approving Visas for foreign trained physicians will be slowed with more scrutiny.

Medicare fee schedules are fixed right now for the year but it does not prevent a reconciliation bill to change so self-interests are protected during this process.

Senate approved Loren Breem legislation on a bipartisan basis.

2 Lawsuits that states should not be issuing licensure. Supreme court clear on police powers of things recognized as the responsibility of the states. These lawsuits would create havoc on the system and federal government is not equipped to be licensing physicians.

Due to Chevron decision – existing laws that creates harm can create new lawsuits with new facts to possibly overturn regulations.

Concerns lack of enforcement of HIPAA securities with decreased employees in Office of Civil Rights.

Moderated Discussion – Non-Traditional Physician Licensing

Mark Smith, MD & Erin Muellenberg, JD

Licensing is determined at the state level. Each licensing board establishes its own criteria and requirements. Traditionally IMG graduates who were certified by ECFMG would be granted acceptance for US training.

Traditional exceptions were connections with providing educational services in the medical schools based on their extensive training and experience abroad.

25% resident positions are currently filled by IMG candidates due to shortages. FQHCs are allowing IMGs to be licensed without US training.

US medical school classes have been expanding but now there are less options for IMG students because more options are available for US students. GME is paid for through Medicare.

FQHCs has basic credentialing standards but the competency evaluations in HRSA Chapter 5 it is a general statement that a supervisor can evaluate competency, which could mean an HR representative.

Concerns –
How do we ensure competence of the foreign grad is equal to US training competence?

Being placed in Rural areas with the expectation that they will be supervised but the supervision is not happening due to shortages.

Can a Rural health system accept an IMG with no US training and confidently ensure they are competent with the knowledge and skills learned in a US training program because they have no knowledge about how the American healthcare system works?

Some are granted hospital privileges.

Continued decline in the number of people going to medical school. IMGs will expand and regulations may become more laxed due to shortages and needs in rural areas.

CO – 9 month readiness program to get them into a US residency. Evaluating them based on their current readiness levels of knowledge and judgement. Qualified candidates can go through a re-entry program.

AL preceptorship for IMG – licensed for 3 years and then can get a full license.

Perception US training program quality exceeded other training programs; however, maybe that is not really accurate.

FSMB advisory board will be developing a task force to evaluate best practices. They will look at physician licensure practices for granting initial to full licensure.

Need to focus on preceptorships. The laws do not establish any criteria for preceptors and their capabilities. IMGs not enrolling in GME are sometimes required to be under the supervision of a preceptor. Concerns as to whether or not they will be supervised by PAs.

The need is in the rural areas; however, the licensing regulations are not always requiring them to work in the rural areas. We are reacting to a perceived need and it is going through the licensing process which is an all or none license not granting specialized licenses.

Concern also regarding Visa issues. See fraud & abuse issues due to not understanding how the US healthcare system operates. Need through orientation regarding culture, ethics, billing practices.

FSMB – medical boards are doing background checks but not sure how they are obtaining background checks on IMGs.

Recruiters are being asked to fill positions in rural areas, recruiting IMGs through Locum agencies, and then requesting the Governing Board to make exceptions to the facility minimum credentialing criteria.

CMO large system including academic centers – 3 years ago they would not accept IMGs with no ACGME training but the pendulum is swinging more the other way where they would consider granting them privileges.

Can we use the Peer Review assessment processes over the IMGs that are being sent to work in rural areas under supervision? This is a state licensing board decision; however, licensing boards are not afforded the immunity protections.

How are IMGs with no ACGME training being insured? Most payers will not accept them with no US training.

What does NCF want to do about this as a charter organization?
Should a representative from NCF be on the FSMB task force to further discuss the IMG issue?

Moderated Discussion – Privileging Dilemma

Todd Sagin, MD

Competence has become a moving target. New challenges are developing due to the speed of change in healthcare. Sub specialization has become more narrow and focused and the PCPs have been shrinking.

Licensure:
What are they competent to do?
Evaluated physician licensed in 45 states primarily providing weight loss diagnosis and medications. Successful in weight management but not successful in basic medical knowledge evaluations.

If you sub specialize and your practice is narrow and evaluation shows competence; however, did not perform well on basic skills of a 3rd year resident assessing patients regarding co-morbidities of patients with a weight loss diagnosis. Should you be able to obtain a license.

Basic competence – 4 years medical school, sometimes 1 year internship and 3 years residency
AI study – who performed best: physician, physician + AI, or just AI – AI alone performed the best.

Discussion:
Licensing Boards – are they truly assess competence or are they granting a license because they meet the education/training requirements and depending on the hospitals to evaluate competence when granting privileges.

Industry responds best to what MUST be done. Best to be proactive rather than reactive to how best to develop criteria and how best to evaluate.

Need to define competence. How do we identify competence? Organizations get to decide what is acceptable for that organization. This is easy when practicing in the hospital; however, many physicians practice outside of the hospital environment so it is harder to evaluate and measure.

Licensing boards determine competence at the time the license is issued. They do not affirm knowledge after the granting of the license. Only evaluate physicians after they receive complaints about a physician.

Licensing boards evaluate physicians based on minimal competency requirements, not competency based at the level expected in the hospital environment. However, when granting a license based on sub specialization they are not being granted a restricted license for that sub specialization only they are being granted a full license to practice medicine.

Concerns also surrounded by litigation.

Is it possible for the licensing boards to begin to offer tiered licenses. Grant full, broad medical license for those fully practicing or Specialized license based on the sub specialization actually practicing.

Boards struggle with core and specialized procedures. How is the board testing competency of how the physician is currently practicing.

Privileging and Credentialing:
Core privileges are no longer working as well due to the granular practice of medicine. Seeing shift back toward more laundry list of privileges do to the focus on sub specialization.

DOP does not determine competency. Still need to collect data of # performed, observations, preceptorship, proctoring.
Ensure at the time of reappointment privileges are assessed regarding meeting criteria. Need to place of FPP if want to keep privileges or have an opt out for more specialized physicians to not select privileges they have not performed.

Board certification is a useful tool in determining competence; however, as physicians practice their scope of practice becomes more specialized.

Medical school curriculum exposure to all levels of medicine has not truly trained. There has been a reduction of patient exposure to medical students. Some post-graduate training

programs are allowing for sub specialization without requiring a general exposure to a residency prior to sub specializing.

With team-based care and technology is it possible to get the holistic patient care while allowing practitioners to be practicing in very narrow scopes. Increased sharing of information across the teams.

Accreditors:
DNV – competence evaluation is left up to the organization

CIHQ – standards around the organized medical staff and standards regarding the membership and privileging process; however, they do not allow them to evaluate specific physicians and their competence. Latitude is allowed for organizations to implement practices more stringent than the standards. Standards do dictate periodic assessment or physicians to determine competence which is determined by the organization not the accreditor.

AAAHC – surveyors are evaluating process not competence – did they evaluate the education and training against established criteria to determine competence and did they continue to evaluate the physician's competence throughout their time at the facility.

National & Local Trends/Initiatives/Hot Topics

Sharon Beckwith, Hardenbergh/MD Review

Artificial Intelligence – issue Physicians uploading the patient visit comments into ChatGPT to have AI generate the EMR notes.

Most organizations have not yet developed policies to guide employees and physicians on the appropriate use of AI.

Along with policies there need to be established Code of Ethics on the use of AI.

Need to establish organization specific domains where AI is being used so that the information if not available to the public.

Using AI to review case logs to determine # procedure categories.

Generative AI has very different capabilities then just database AI. They can assess body language, show empathy, personal connections. Need to evaluate the full capabilities of AI not just the clerical.

Is AI it a tool to assist in decision making or is it the decision maker.

NAMSS has AI on the radar. Have has a few presentations regarding the use of AI. Strategic plan will be looking at AI and technologies and assessing appropriate policies.

Co-pilot built within the organization so there are established boundaries so AI only collects information from the organization. Summaries of teams calls rather than putting it into ChatGPT so it uses the organization terminology not information from the public.

Healthsystem have AI governance groups to determine parameters of use from a risk management perspective. Have to be able to override AI recommendations when appropriate.

AI is here and we need to evaluate the best use of AI and create policies and boundaries appropriate to the organization as well as appropriate training that needs to be provided for its use.

Government institutions are heavily discussing the use of AI and developing policies.

80% healthcare CEOs and states are evaluating what they need to put into place for safe and appropriate use of AI.

Access to primary source verifications:
Been tracking unobtainable verifications for a few years.

1. International training
2. Insurance companies – do not provide history of claims, or takes months to receive, or have to pay for it, sometimes delay in getting a certificate – inquire is insured at standard rate
3. Minute clinic verifications or other employment where clinical care is provided

Burden on the applicant, if required by the organization enlist the applicant in intervening to obtain the information from the insurance company.

Are organizations routinely asking medical boards about any pending complaint cases against their physicians. Can software vendors create a webcrawler to also evaluate licensing board disciplinary websites of databases?

Laurna Breene – update
Have organizations changed the language and have they seen an increase in statistical data that reflects improvement in reporting or decrease in suicides/alcohol/drug use?

Feeback that organization are at least having the discussions and utilizing their wellness committees in a more meaningful manner.

Employers are seeking advice on how to set up meaningful programs to assist employees and physicians with wellness initiatives.

NCQA FAQ clarifications regarding the phrasing of their disclosure question regarding ability to perform.

Need feedback –
How many answered it No but really had an issue?

How many answered it correctly at the time of the applicant but then had an issue come up but did not see assistance?

The Big Exodus – retiring MSPs
50% of NAMSS members are over 50 years old – are we as an industry doing appropriate succession planning.

How are we working to get the younger generation interested in the profession?

SOC should be helpful if we are able to get recognized by the Department of Labor – but that is not until 2028 that we will know this.

Engage with school districts that are offering more career paths – Coding, Credentialing, Quality, Healthcare Administration. Prior attempts have been made to offer associate's degrees but they were not successful. If we make the outreach there needs to have a training program for entry level involvement in the profession to start in the work force.

Larger problem is that no one knows we exist, even within our hospitals.

ACHC has a standard that credentialing professional has to review.

Can NAMSS do a marketing pitch to advertise who we are, this is a career path, this is our opportunity to make a difference?

Can NAMSS provide a tool kit for effective succession planning?

ASC association – provide education opportunities to their staff. – NAMSS attended their conference and spoke at their conference and had a booth. Shocked that they did not know who did their credentialing. Positions relate back to medical secretaries. There is an ASC association in each state.

Possibly engage staffing companies who have stronger training programs to quickly train MSPs.

Internship programs sponsored by hospitals to help train entry level MSPs.

Think about the skills we need and what drew us to the profession and utilize that information to develop avenue to entice new professionals.

The profession needs to be marketed to show all the sides of healthcare outside of the clinical side.

Outside perspective: Andy's son
Sheriffs' office came to his college in the business classes – to educate them that accounting jobs are in other employment opportunities other than the big finance companies. Started in Freshman classes and would come every year.

Partner with local colleges offering Healthcare Administration, Business Degrees and having internships spend 6 weeks in medical staff offices and other.

Speak at Rotary Clubs about the profession.

Visit local community colleges ask to be a guest speaker for Healthcare administration or Business Degree programs.

Mohawk valley in NY Director MS whistleblower about non-privileged physicians and they were billing for their services. Organization reorganized and eliminated her position.

NAMSS recruit an MSP campaign with the membership and give out prizes.

De-Brief	Day 1 – Format Need standardized format for the accreditors: 1. Anticipated changes 2. So everyone is talking about things in a consistent manner 3. Statistics – helpful to have ahead of time or a few slides with the statistics Attendees submit questions ahead of time to accreditors etc. so they are prepared to speak on some specific pain points. Good having group discussions mixed between readouts from groups. Would like to have CMS attend and possibly someone from the insurance industry (maybe AHIP – American Health Insurance ???) Circle back with topics (i.e. ambulatory care peer review) Name tags would be helpful for new attendees. Day 2 Charter position: State Licensing Boards Notification of establishing structure around IMGs Establishing strong preceptorship programs Outreach success stories to educate about the profession to increase the number of people into the industry Statistics regarding burn out Request industry attendees who cannot attend to submit their normal report or attend via ZOOM.

National Credentialing Forum 2025
San Diego, CA Bahia Resort February 6-7, 2025

	Accreditors – would like a standardized template or specific questions we want answered so they can come prepared AAAHC – will send quality report
2026 Dates	February 5th & 6th
Future topics	Increased attendees: CMS Liability Insurance Company – Copic (Beth Kornick/Sharon Beckwith) Health Plan Representative – HHSC (Brianna) – Beth knows Regional from CIGNA State Medical Board – Reggie CA state medical board or CO state medical board (Sharon Beckwith) ATA – Telemedicine association (Karen Claxton) MSP newer into the profession to get their early career feedback Quality - since more MSOs are under the directorship of a quality director (NAMSS building a partnership with NAHQ association) Future Topics Progression of AI Share success stories of outreach as the year goes along