Credentialing Pearls:
Tales of Bumps, Bruises & Success

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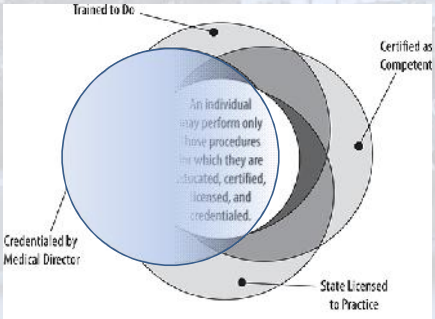
Conflicts of Interest with…

- public and patient safety? No
- provider competence? Nope
- medical oversight sanity? Umm…Nada
- advancing EMS medicine? Not really

– None of the presenters have any COI to disclose

Role of Credentialing



"Treat others the way you'd like to be treated." - Mom

Domain:	Physician:	EMS:
Accredited Education	LCME/ACGME & AMA PRA Cat 1	CoAEMSP/CAAHEP & CAPCE
Certification	ABEM	NREMT
Licensure	Medical License	State license/certificate
Local Oversight	Hospital Privileges	Medical Director Credentialing

Medical Director Responsibilities

- "Adequate supervision"
- Patient beneficence
- Patient safety
- Advancing EBM standards in EMS practice

Resources:Responsibility Mismatch

- Resources
  - NAEMSP textbook
  - NAEMSP/NREMT Position Paper Clinical Credentialing of EMS Providers (12/2016)
  - ACEP Policy Statement: Role of the Physician Medical Director in EMS Leadership (10/2017)
- Responsibilities
  - Direct & indirect

Who's Responsible? You

- The EMS physician medical director must have final authority and accountability for credentialing of EMS providers providing care under their oversight. While the physician medical director may delegate evaluation of an EMS provider's competencies, the EMS physician medical director must be actively involved in the EMS organization's clinical credentialing process.

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- Credentialing involves at a minimum 1) demonstration of sufficient cognitive knowledge; 2) demonstration of mature, responsible affective ability; 3) demonstration of a command of all involved psychomotor skills; and 4) integrating the three previous domains in the application of critical thinking in the provision of clinical care for all acuities of patients that may be reasonably encountered in the jurisdictionally relevant practice of EMS medicine.

- Credentialing at a minimum involves:
  - Cognitive knowledge
  - Mature, responsible affective ability
  - Psychomotor skills
  - Integration of the above in critical thinking towards application of clinical care

Who Should Be Credentialed?

- **Anyone that clinically influences patient care**
  - **Education/Training Officers**
  - **Dispatchers**
  - **First Response**
  - **Transport**
  - **Field Supervision**
  - **Special Operations**
    - **Tactical; Dive Team**

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Axiom #1 – Accepting "Gifts"

- "When someone gives you the gift of showing you they are unfit for your practice of EMS medicine…accept their gift, unwrap it, enjoy their thoughtfulness, and then "return it" to another EMS service or recommend another career besides medicine!"
  - J. Goodloe

Axiom #2 – Credentialing has Pre-Reqs

- Initial Education
  - Completed? Seriously, verify it.
  - Trends from that institution? Good or bad?
- National Certification
  - Certified? Seriously, verify it.
  - Number of attempts to pass skills? Didactic?
- State/Provincial Licensure
  - Licensed? Seriously, verify it. Could save $$$$

Axiom #3 – Kick Their Tires *Before* Your Patients' Lives Ride on Them

- How many patients should they care for before you determine their competency?
  - Unsupervised = Zero
  - Supervised (FTO, 3rd rider, etc) = ?

Axiom #4 – First, Train your Delegates

- Who are your delegates? What are their biases or conflicts of interest?
- When it comes to credentialing, some people want to do it…and some people are good at it. You need someone who is both.
- Uniformity in assessment: fair and consistent?
- We all practice a bit differently, but we can't have "critical fails"
- Be accessible to your delegates

Axiom #5 – Learn from Our Success*

- Time ≠ experience ≠ competency
  - Number of required shifts before credentialing?
  - Minimum of critical patient contacts?
  - specific illnesses, injuries, procedures, ages?
  - Time "saved" on the front = time "spent" ahead
- "Meets expectations" works for some areas, but others need more detail/description
  - Affect, leadership, etc
- FTOs/Mentors/Delegates need a break

Axiom #5 – Learn from Our Success*

- Credential to the scope of practice
  - Not based on type of delivery (fire based/ambulance based, first response/transport services, part time/fulltime etc)
- Goal of simulation should be "suspension of disbelief."
  - What level of fidelity is needed?

Axiom #6 – EMS Isn't A Supreme Court

- Establish term limits on credentials
  - 1-2 years are commonly used and safe limits
  - "the public is best served when re-verification…occurs no less frequently than every two years."

Axiom #7 – Re-credentialing MAY be same or different than initial credentialing

- Skills (classroom demonstration? simulation? procedure logs? direct observation in the field?)
- Didactic (written exam? oral cases? simulation?)
- Critical Thinking (query of actual patient care cases? simulation?)
- May be very influenced by volume of providers and volume/types of patients

Axiom #8 – Be the Advocate

- No one is guaranteed credentials
  - Everyone has to earn credentials
- Know your "hills to die on"
- Utilize the NAEMSP/NREMT & ACEP documents to support your FDM-ability
- The most important person you credential every day is you (and your earned authority)

Want to read some examples?

- Wichita/Sedgwick County EMS System
  - Credentialing Manual
- EMS System for Metro Oklahoma City & Tulsa
  - Credentialing Policy at okctulomd.com
    - "MCB OMD Policies" tab on homepage toolbar
    - "OMD Credentialing Policy" (PDF)

Your Questions & Our Non-Attorney Answers

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