

# Connecticut Valley Hospital Credentialing and Privileging Manual

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## **Section 1: Introduction to Credentialing and Privileging**

### **Introduction to Credentialing and Privileging of the Medical Staff at CVH**

Per the Medical Staff By-Laws, Section 8, the Credentialing and Privileging (C&P) Committee shall consist of the appointed chair, the Chief of Staff and Chief of Professional Services as ex-officio members, at least one psychiatrist from each division and two physicians from Ambulatory Care Services. The Executive Committee may appoint additional physician or non-physician members if it deems this necessary.

The duties of the committee shall be:

- A. To gather, authenticate and evaluate all necessary information to assure that an applicant possesses the necessary qualifications for appointment and reappointment to assure that an applicant possesses the necessary qualifications for appointment and reappointment to the Medical Staff and is appropriately trained, maintaining competence and capable of carrying out any privileges granted to him/her.
- B. To revise any forms and procedures in the process to comply with any changes in Medical Staff By-Laws, information sources and State Statutes.
- C. To provide the Executive Committee of the Medical Staff Committee recommendations regarding Credentialing and Privileging of any applicant, or Medical Staff member, applying for or reapplying for clinical privileges and having available for the Executive Committee's inspection documentation to support the recommendations. The Committee will meet at least quarterly and more frequently if necessary. Minutes will be recorded.

The Credentialing and Privileging meeting currently meets on the second (2nd) Thursday of each month at 10:00 a.m. in the Arafah Conference Room.

## Section 2: Credentials and Required Categories

### ARTICLE V. ORGANIZATION OF THE MEDICAL STAFF

#### Section 1 – Categories of Medical Staff Membership

The Medical Staff shall consist of (1) Active members, (2) Adjunct members, (3) Advanced Practice Registered Nurses, and (4) Physician Assistant members.

1. Active Members: The Active members shall consist of physicians and dentists licensed to practice medicine or dentistry, respectively, in the State of Connecticut who are employed or contracted by the Department of Mental Health and Addiction Services to work at CVH. Only those physicians and dentists who work at least twenty (20) hours per week at the Hospital are eligible for Active membership, and such physicians and dentists shall have full voting privileges and may hold office in the Medical Staff organization.
2. Adjunct Members: The Adjunct members shall consist of the following categories:
  - A. Associate Staff: The Associate Medical Staff shall consist of physicians and dentists who are licensed to practice medicine or dentistry in the State of Connecticut, and who are contracted to work at CVH for a limited period of time (e.g., 120 day employees) or who work at the Hospital less than twenty (20) hours per week. They shall be eligible to serve on committees and to vote on matters before such committees. They shall be ineligible to hold office in the Medical Staff organization.
  - B. Consulting Staff: The Consulting staff shall consist of physicians and dentists of recognized professional abilities who are engaged in specialized medical or dental practice. The duties of the Consulting Staff shall be to provide their services at the Hospital upon request of a member of the Medical Staff. The Consulting Staff shall not have voting privileges in the Medical Staff Organizations. They will not be required to serve on committees.

There are two categories of Consulting Staff, which are delineated by their clinical privileges as follows:

- i. Consultants privileged to provide consultation and treatment. These Consultants shall be privileged to provide consultation and treatment within the scope of their delineated clinical privileges, including writing orders and clinical findings in the patient's medical record.
- ii. Consultants privileged to provide consultation only. These Consultants shall be privileged to provide consultation within the scope of their delineated clinical privileges but shall document on a consultation form or separate consultation report and shall not write orders.
- C. Night and Weekend Duty Staff: The Night & Weekend Duty Staff shall consist of physicians employed by the Department of Mental Health and Addiction Services to provide after hours, holiday and weekend medical and psychiatric services at CVH. Physicians in this category shall not have voting privileges or be eligible to serve on committees.

3. Advanced Practice Registered Nurse Members: The Advanced Practice Registered Nurse members shall consist of Advanced Practice Registered Nurses licensed in the State of Connecticut and employed by the Department of Health and Addiction Services to work at CVH as an Advanced Registered Practice Nurse and provide direct clinical care. Only Advanced Practice Registered Nurses who work at least twenty (20) hours per week at the Hospital are eligible for membership and shall have voting privileges at Medical Staff meetings.
4. Physician Assistant Members: The Physician Assistant members shall consist of Physician Assistants licensed in the State of Connecticut and employed by the Department of Health and Addiction Services to work at CVH as a Physician Assistant. Only Physician Assistants who work at least twenty (20) hours per week at the Hospital are eligible for membership and shall have voting privileges in committees and at Medical Staff meetings. .

## Section 3: Process for Initial Appointment

### Credentialing and Privileging Process

The privileging process takes place at the time of hiring, appointment, reappointment (which occurs every two years), granting of Interim Temporary Privileges and the request for additional privileges.

### Initial Process for New Applicants

The Medical Staff Office is notified of a new hire, an application packet is put together by the Medical Staff Office Coordinator and sent out.

The initial application packet includes:

- New applicant application
- Health Form
- Acceptable CPR information
- Core Privilege Application
- Delineation of Privileges
- New applicant letter
- Current copy of By-Laws and Rules and Regulations
- If they are a Locum Tenens they receive an LMS form and Background Check form

Once the application is received in the Medical Staff Office:

1. Past employer reference letter and questionnaires are sent out along with the Release of Information Consent Form and the Delineation of Privilege form(s). It is our policy to go back to every employer from completion of Residency to the present.
2. Peer Recommendation letters and forms are sent out along with the Release of Consent form. One peer must be in the practitioner's specialty.
3. Request National Data bank for NPDB/HIPDB reports. ***“The hospital and its Medical Staff shall comply with the requirements of the Health Care Quality Improvement Act of 1986 by reporting adverse actions and obtaining necessary information from the National Practitioner Data Bank” (Page 11, Article 6, Subsection 5 of the Medical Staff By-Laws).***
4. Verify Medical License via Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired Medical Licenses. Practitioners are pulled from clinical duty until the license is renewed.\*
5. Verify the Connecticut Controlled Substance Registration via Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired Connecticut Controlled Substance Registrations. Practitioners are unable to write orders without a co-signature until it is renewed.\*
6. Verify DEA via the Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired DEA Registrations. Practitioners are unable to write orders without a co-signature until it is renewed.\*
7. The AMA profile is requested via the AMA website. Verify education, Residency, Internship, Fellowship and Boards.
8. If medical licenses were held in other states, verification is attempted.

### **Section 3: Process for Initial Appointment (continued)**

9. Residency, Internship and Fellowship is verified by sending the appropriate questionnaire and Release of Information Consent Form. If there is no response from a school that is closed or out of the country, there is no need to follow-up. A note is kept in the file indicating that there was no response.
10. If the applicant supplied a copy of an ECFMG, verify via mail with the ECFMG Verification Service. They do not offer an Internet option.
11. Applicant identification is taken in the form of a valid driver's license or US Passport. The photocopy is signed off and dated.
12. Verify current CPR. If the applicant completes CPR certification during orientation, note the date on the checklist. If it is expired, the applicant may not do clinical work until the CPR is complete.
13. Prepare the Record of Action and Checklist. Review and check-off items received.
14. Once all the credentialing material is received, the MSO reviews and signs off as complete. Any questionable items are noted and pointed out to the Chair, Chief of Staff, Chief of Professional Services and the reviewer to be brought up and discussed at the meeting.
15. The appropriate Medical Director, or if the applicant will be in a Medical Director position, in which case the Chief of Staff or Chief of Professional Services, is called to review the file, any issues and sign off on the Health Request Form and Privileging Request Form. In the event that a Medical Director is unable to sign off on said forms, the Chief of Staff or Chief of Professional Services may do so.
16. A member of the Credentialing committee is called upon to review the file. The reviewer will note any concerns or missing items they discover.
17. If the file is a Locum Tenens, it is necessary to receive clearance from Deb Marquis before bringing the file forward to C&P.
18. If the file is a Locum Tenens, the LMS Form must be returned to Meari Avery.

#### **The application is now ready to be presented to the C&P Committee**

19. The Credentialing physician review will present the file for recommendation at the scheduled meeting. Upon approval, the Chair will sign off in the C&P approval section and on the C&P Checklist.
20. Approved physicians are added to the next ECMS agenda. In the event a file is not approved, a particular privilege is denied, or the file is deferred until the next meeting for clarification of issues, the applicant is notified by the Chair of the committee to discuss the reasons why and what steps need to be taken. In the event that it is of a serious nature, the Chief of Professional Services will address the applicant.
21. Upon approval at ECMS, the President of the Medical Staff will sign off on the ECMS approval line.
22. The files are then requested to be added to the next Governing Body agenda. Upon Governing Body approval, the appropriate Granting of Privileges letter is generated by the MSO and given to the Chief Executive Officer (CEO) or designee for signature. They also sign the Governing Body approval section on the Record of Action.
23. MSO fills in the notification dates at the bottom of the Record of Action.
24. Pharmacy is notified of the new member's DEA, Connecticut Controlled Substance Registration number and Medical/ Physician Assistant, RN/APRN license number and copy of the new member's signature.

**\*It is only necessary to keep verifications on file from the Primary Source Verification website.**

## **Section 4: Process for Interim Temporary Privileges**

The Medical Staff Office is notified of a new hire, an application packet is put together by the Medical Staff Office Coordinator and sent out.

The initial application packet includes:

- New applicant application
- Health Form
- Acceptable CPR information
- Core Privilege Application
- Delineation of Privileges
- New applicant letter
- Current copy of By-Laws and Rules and Regulations

Upon receipt of the completed application and verification of at least the most recent employer verifying competency; (3) peer recommendations, one of which must be in the practitioners specialty; a clean NPDB/HIPDBOIG and license verifications, the file can go forward. Interim Temporary Privileges are granted upon the recommendation of the Chief of Professional Services as designee of the Chair of the Credentialing and Privileging Committee. They are based on the request of a Medical Director who requests them, in writing, to the Chief of Professional Services based on urgent patient care need.

The Chief of Professional Services generates a letter with the request to the President of the Medical Staff. The President of the Medical Staff then generates a letter to the CEO for approval as Chair of the Governing Body.

Upon approval from the CEO, the acceptance letter is generated with the acceptance form and sent to the applicant.

The rest of the credentialing information is gathered and any questions are brought forward with the file to the Credentialing and Privileging Committee. The file, once approved, is put through the regular credentialing and privileging process.



## Section 5: Process for Reappointment Process

### Reappointment Process

“Each member shall be considered for reappointment by the Executive Committee of the Medical Staff every two (2) years.” (Page 12 Section 2 of the By-Laws).

Approximately 4-5 months before a term expires, a reappointment packet is sent by the MSO. This packet will include the following:

- Reappointment application
- Reappointment letter
- Health Form
- CME Form
- Committee and Peer Reference list form
- Release of Information Consent Form
- Delineation of Privileges.

Once the application for reappointment is received:

1. If the applicant is an ACS doctor, the ACS Supervisor Recommendation is sent to the ACS Medical Director.
2. Peer Recommendation letters and forms are sent out along with the Release of Consent form. One peer must be in the practitioners specialty.
3. Request National Data bank for NPDB/HIPDB reports. ***“The hospital and its Medical Staff shall comply with the requirements of the Health Care Quality Improvement Act of 1986 by reporting adverse actions and obtaining necessary information from the National Practitioner Data Bank” (Page 11, Article 6, Subsection 5 of the Medical Staff By-Laws).***
4. Verify Medical License via Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired Medical Licenses. Practitioners are pulled from clinical duty until the license is renewed.\*
5. Verify the Connecticut Controlled Substance Registration via Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired Connecticut Controlled Substance Registrations. Practitioners are unable to write orders without a co-signature until it is renewed.\*
6. Verify DEA via the Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired DEA Registrations. Practitioners are unable to write orders without a co-signature until it is renewed.\*
7. The AMA profile is requested via the AMA website. Verify education, Residency, Internship, Fellowship and Boards.
8. ECFMG verification is not required for reappointment.
9. Verify current CPR. If it is expired, the applicant may not do clinical work until the CPR is complete, unless a letter certifying competency by the Medical Director or Chief of Professional Services granting a 30-day grace period is filed. There is no grace period beyond 30-days unless there is proof of a medical condition. In this case, other arrangements must be made.
10. Prepare the Record of Action and Checklist. Review and check-off items received.
11. Once all the credentialing material is received, the MSO reviews and signs off as complete. Any questionable items are noted and pointed out to the Chair, Chief of Staff, Chief of Professional Services and the reviewer to be brought up and discussed at the meeting.

12. The appropriate Medical Director provides a current OPPE/FPPE signed by both the Medical Director and employee. This is noted in the file and is a requirement to move forward through the process for reappointments or requests for additional or changes in privileges.
13. The appropriate Medical Director, or if the applicant will be in a Medical Director position, in which case the Chief of Staff or Chief of Professional Services, is called to review the file, any issues and sign off on the Health Request Form and Privileging Request Form. In the event that a Medical Director is unable to sign off on said forms, the Chief of Staff or Chief of Professional Services may do so.
14. A member of the Credentialing committee is called upon to review the file. The reviewer will note any concerns or missing items they discover.
15. The Credentialing physician reviewer will present the file for recommendation at the scheduled meeting.
16. Upon approval, the Chair will sign off in the C&P approval section and on the C&P Checklist.
17. Approved physicians are added to the next ECMS agenda. In the event a file is not approved, a particular privilege is denied, or the file is deferred until the next meeting for clarification of issues, the applicant is notified by the Chair of the committee to discuss the reasons why and what steps need to be taken. In the event that it is of a serious nature, the Chief of Professional Services will address the applicant.
18. Upon approval at ECMS, the President of the Medical Staff will sign off on the ECMS approval line.
19. The files are then requested to be added to the next Governing Body agenda. Upon Governing Body approval, the appropriate Granting of Privileges letter is generated by the MSO and given to the Chief Executive Officer (CEO) or designee for signature. They also sign the Governing Body approval section on the Record of Action.
20. MSO fills in the notification dates at the bottom of the Record of Action.
21. Pharmacy is notified of the new member's DEA, Connecticut Controlled Substance Registration number and Medical/ Physician Assistant, RN/APRN license number and copy of the new member's signature.

**\*It is only necessary to keep verifications on file from the Primary Source Verification website. It is noted that the MSO reminds the medical staff two months prior and regularly after that to renew licenses to help to avoid lapses.**

## **Section 6: Process for Additional Privileges**

When additional privileges are requested by a practitioner, (on-call or other), the following form is submitted:

1. A signed Request for Privileges.
2. Once this form is received, the MSO obtains a new AMA, NPDB/HPDB and FACIS profile on the practitioner.
3. The Medical Director is asked to review the request and sign-off.
4. If it is for on-call, the practitioner, is requested to have a brief review with the ACS Medical Director who then signs off on competency in Medicine.
5. 11.12. The appropriate Medical Director provides a current OPPE/FPPE signed by both the Medical Director and employee. This is noted in the file and is a requirement to move forward through the process for reappointments or requests for additional or changes in privileges
6. Upon completion of this information, the Record of Action and Checklist is prepared.
7. The Credentialing physician review will present the file for recommendation at the scheduled meeting.
8. Upon approval, the Chair will sign off in the C&P approval section and on the C&P Checklist.
9. Approved physicians are added to the next ECMS agenda. In the event a file is not approved, a particular privilege is denied, or the file is deferred until the next meeting for clarification of issues, the applicant is notified by the Chair of the committee to discuss the reasons why and what steps need to be taken. In the event that it is of a serious nature, the Chief of Professional Services will address the applicant.
10. Upon approval at ECMS, the President of the Medical Staff will sign off on the ECMS approval line.
11. The files are then requested to be added to the next Governing Body agenda. Upon Governing Body approval, the appropriate Granting of Privileges letter is generated by the MSO and given to the Chief Executive Officer (CEO) or designee for signature. They also sign the Governing Body approval section on the Record of Action.
12. MSO fills in the notification dates at the bottom of the Record of Action.

## **Section 7: Review of Psychiatric Residents and Forensic Fellow Applicants**

**In 2011, a process for reviewing Forensic Fellows was put in place. They are not granted privileges but are acknowledged after their review by the C&P Committee, ECMS and Governing Body. The process is as follows:**

1. **A Medical Staff Application is filled out and returned in it's entirety including the signed Release of Information Consent Form; Health Form; Picture ID; CV.**
2. Peer Recommendation letters and forms are sent out along with the Release of Consent form. One peer must be in the practitioners specialty.
3. Request National Data bank for NPDB/HIPDB reports. "The hospital and its Medical Staff shall comply with the requirements of the Health Care Quality Improvement Act of 1986 by reporting adverse actions and obtaining necessary information from the National Practitioner Data Bank" (Page 11, Article 6, Subsection 5 of the Medical Staff By-Laws).
4. Verify Medical License via Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired Medical Licenses. Practitioners are pulled from clinical duty until the license is renewed.\*
5. Verify the Connecticut Controlled Substance Registration via Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired Connecticut Controlled Substance Registrations. Practitioners are unable to write orders without a co-signature until it is renewed.\*
6. Verify DEA via the Internet. The verification is printed, signed and kept in the credentialing file. There is no grace period for expired DEA Registrations. Practitioners are unable to write orders without a co-signature until it is renewed.\*
7. The AMA profile is requested via the AMA website. Verify education, Residency, Internship, Fellowship and Boards.
8. ECFMG verification is not required for reappointment.
9. Verify current CPR. If it is expired, the applicant may not do clinical work until the CPR is complete, unless a letter certifying competency by the Medical Director or Chief of Professional Services granting a 30-day grace period is filed. There is no grace period beyond 30-days unless there is proof of a medical condition. In this case, other arrangements must be made.
10. Prepare the Record of Action and Checklist. Review and check-off items received.
11. Once all the credentialing material is received, the MSO reviews and signs off as complete. Any questionable items are noted and pointed out to the Chair, Chief of Staff, Chief of Professional Services and the reviewer to be brought up and discussed at the meeting.
12. Upon Acknowledgement, the Chair will sign off in the C&P approval section and on the C&P Checklist.
13. Approved physicians are added to the next ECMS agenda. Once the file is Acknowledged by ECMS, it is signed off.
14. The files are then requested to be added to the next Governing Body agenda. Upon Governing Body Acknowledgement, the Acknowledgement letter is generated by the MSO and given to the Chief Executive Officer (CEO) or designee for signature. They also sign the Governing Body approval section on the Record of Action.

## **Section 8: AMA Profiles**

An AMA Profile is required upon appointment and upon each subsequent reappointment thereafter.

## **Section 9: National Practitioner Data Bank/Health Information Data Bank and OIG**

These entities are queried upon appointment, reappointment or change in privileges. The NPDB/HIPD reports on malpractice payments, adverse licensure action, adverse clinical privilege actions, and adverse professional society membership actions. Information reported to the NPDB/HIPD is maintained permanently unless it is corrected or voided from the system (a correction or void may only be submitted by the reporting entity or directed by the Secretary of the HHS).

## **Section 10: CPR Requirements**

### **CPR Certification**

#### **Excerpted from the Medical Staff Rules and Regulations (Article XIV: Professional Development)**

“All members of the Medical Staff except consultants are expected to maintain current certification in Cardiopulmonary Resuscitation (CPR), and must be CPR certified prior to performing direct patient care. The CVH, CPR course is the American Red Cross Adult CPR including “Standard First Aid with AED.” Only Advanced Cardiac Life Support (ACLS) can be substituted for the CVH mandated CPR course. Successful completion of the CVH CPR course satisfied the Medical Staff requirement for a one-year period. ACLS satisfies the requirement for two years.”

The following categories of the Medical Staff are required to maintain CPR certification:

- All on-call physicians
- Physician Assistants
- APRNs
- 120-day physicians (including Locum Tenens) who are unit based (whether on Active or Adjunct Status)
- All physicians other than consultants

Consultants are exempt from the CPR requirement and cannot be on the emergency response team.

If a new applicant in one of the Medical Staff categories for which CPR certification is required does not have acceptable CPR certification at the time of his/her application is being reviewed, arrangements will be made to have the individual receive appropriate CPR training during orientation. It is the responsibility of the Division/Department to assure that that staff member has completed the required in-service training programs commensurate with his/her assigned duties. At the divisional level, education coordinators should assure that physician's training is up-to-date. The Divisional Service Medical Directors assure that this is the case.

The Medical Staff bears the responsibility of clarifying to the Departments of Human Resources and Staff Development what a given Medical Staff member's in-service requirements are.

## **Section 11: Cardiopulmonary Resuscitation, First Aid and Automatic External Defibrillator use**

All medical staff who are privileged to provide direct patient care must receive either annual training or provide annual proof of satisfactory completion of a “re-challenge” test in order to receive certification in **adult CPR, basic first aid, and the use of the automatic external defibrillator.**

The DMHAS Department of Safety Services (DSS) provides trainers at each DMHAS facility so that each facility can meet its mandatory training requirements. All on-site CVH-employed medical staff are required to meet the CVH training requirements through a schedule of training opportunities arranged through his/her Division or Department.

Those members of the medical staff who provide “on-call” (after hours and weekend coverage) can meet this obligation by one of several methods:

- Being scheduled into one of the Division’s courses (through one’s Supervising Medical Director);
- Contacting the DSS trainer at CVH (telephone (860) 262-5451 or 5172) to arrange an appointment for a personal re-challenge.
- Contacting a DSS trainer at a DMHAS facility more proximate to one’s home/regular place of work to arrange an appointment for a personal re-challenge.
- Successfully completed an American Red Cross “Standard First Aid with AED” course and providing a certificate of proof.

**Proof of satisfactory completion of this three-part annual training must be presented as a part of the Application for Appointment/Reappointment to the Connecticut Valley Hospital Medical Staff.**

**The only other program that meets the CPR requirement is: ACLS American Red Cross (Advanced Cardiac Life Support) – two (2) year certification.**

## **Section 12: CME Requirements**

### **Excerpted from the Medical Staff Rules and Regulations (Article XIV: Professional Development)**

“All members of the Active Medical Staff shall be encouraged to continue their professional development through in-house training opportunities, recognition and pay incentive for passing specialty boards, and an opportunity to receive additional training in areas found deficient through peer review mechanisms. Additionally, all members are encouraged to attend courses and conferences related to clinical or administrative work. It is expected that each Medical Staff member earn one hundred (100) continued education credits per two-year period, at least forty (40) being category one credits. It is understood that resident physicians performing night and weekend duty shall satisfy this requirement by means of their documented continued participation in an ACGME approved residency training program. The Continuing Medical Education Committee shall arrange for appropriate educational opportunities to be held at the Hospital” The CME requirement applies to all consultants, podiatrists and optometrists.

Proof of meeting the minimum CME requirements is sought at the time of reappointment. This should be in the form of a log of CME Category 1 activity on which the program date, program title, sponsor and credit hours earned are provided. It is the staff members responsibility to report the CME activity to the Office of Staff Development who tracks this information and provides input to the CME report for reappointment in addition to the log provided by the staff member.



### **Section 13: License Updates/Expirations**

A master list of all expirations being tracked is kept by the MSO. This list includes (and may expand as necessary):

- Privilege expiration date
- Medical license expiration date
- CPR expiration date
- DEA expiration date
- CT Controlled Substance Registration expiration date

This list is reviewed monthly to identify at least two months ahead of time, those expirations coming due. A reminder e-mail is sent to each doctor to remind them of the upcoming expiration and to urge them to renew the license before the expiration date to avoid lapse in coverage.

It is no longer required to submit copies of renewed licenses as the printed and signed copy from the Primary Source Verification from a JCAHO approved website is sufficient.

If verification of renewal is not received or able to be verified, the appropriate Medical Director is contacted. If still not action is taken, the Chief of Professional Services and the Chief of Staff are notified for further action. (Possible relieving of duties until renewal can be verified). Other than for CPR certification, there is no grace period on an expiration date.

## Section 14: Delinquencies

### Medical Staff Delinquencies

It is the policy of the Credentialing & Privileging Committee that effective January 1, 2002, various delinquencies on the part of Medical Staff members will be viewed more seriously, and certain steps will be taken at the time of reappointment.

Potential delinquencies include:

- Attendance at less than 50% of Medical Staff meetings by full-time Active members, or less than 25% of meetings by part-time (25 hours or less weekly) Active members [Bylaws, Article XII]
- Attendance at less than 50% of assigned Committee meetings by full-time Active members, or less than 25% of meetings by part-time (25 hours or less weekly) Active members [Bylaws, Article XII]
- Less than 40 Category One CME credits per two year period, or less than 100 total CME hours per two year period [Rules & Regulations, Article XV]
- Excessive Delinquencies in Medical Record documentation, including timeliness of Admission Psychiatric Evaluations, Integrated Clinical Summaries, Annual Psychiatric Reviews, Discharge Summaries, and legible Progress Notes [Rules & Regulations, Article IV]. The Credentialing & Privileging Committee will evaluate cases of Medical Record delinquency individually, and make a determination as to whether the physician's delinquencies are excessive.

Effective January 1, 2002, it became the policy of the Credentialing & Privileging Committee to first issue a warning letter at time of reappointment to each member of the Medical Staff who has been delinquent as described above. At the time of subsequent reappointment, the Medical Staff member, if still delinquent, will be recommended for reappointment for only a one year term, instead of the regular two year period. It is also understood that such matters will be referred to the applicable Medical Director for appropriate action [approved by Credentialing & Privileging Committee on 10/25/01; approved by Executive Committee of the Medical Staff on 11/1/01].

Percent attendance at Medical Staff meetings is calculated by dividing the meetings attended by the total number of meetings during the prior two years, without taking into account any excused absences [approved by Credentialing & Privileging Committee on 4/25/02; approved by Executive Committee of the Medical Staff on 5/2/02].

## **Section 14: Clinical Competency Peer References**

In accordance with the various CVH Core Privileges, peer references verifying current clinical competence at the time of reappointment shall consist of:

### **Reappointment in Psychiatry:**

Three letters of reference from members of the Connecticut Valley Hospital Medical Staff familiar with the applicant's current practice of psychiatry.

### **Reappointment in Medicine:**

Three letters of reference from members of the Medical Staff familiar with the applicant's current practice of medicine.

### **Reappointment as Consultant in Psychiatry:**

Three letters of reference from members of the Connecticut Valley Hospital Medical Staff familiar with the applicant's current practice of psychiatry.

### **Reappointment as Consultant in Psychiatry, Electroconvulsive Therapy:**

Three letters of reference from members of the Connecticut Valley Hospital Medical Staff familiar with the applicant's current practice of electroconvulsive therapy.

### **Reappointment as Medicine Consultants:**

Three letters of reference from members of the Connecticut Valley Hospital Medical Staff familiar with the applicant's current specialty practice.

For Psychiatrists and Ambulatory Care Physicians, at least one letter of reference (in addition to the Medical Director's Evaluation) shall be from a practitioner in the same area of practice.

For Medical Consultants (e.g. neurology, nephrology, infectious diseases, physiatry, podiatry, optometry, etc.), at least one reference shall be from a practitioner in the same specialty. If none are available on the CVH Staff, a practitioner outside the hospital may be used as a peer reference. If it is impossible to obtain any peer reference from a practitioner in the same specialty, then in addition to the usual three references, a letter shall be submitted by the Medical Director for Ambulatory Care Services documenting this and verifying current clinical competence in the specialty area.

## **Section 15: Ongoing Professional Practice Evaluation/Focused Professional Practice Evaluation**

### Ongoing Professional Practice Evaluation:

An ongoing professional practice evaluation is conducted for every member of the Medical Staff. The evaluation is carried out by the Medical Director responsible for supervising each practitioner, and in the case of the Medical Directors, it is carried out by the Chief of Professional Services.

A formal Competency Based Performance Appraisal or PARS is completed on a yearly basis and is forwarded to the Credentialing & Privileging secretary to be maintained on file. It is reviewed at the time of all reappointment and privileging decisions. A continuous, ongoing evaluation of each practitioner's professional performance is also carried out by the responsible Medical Director. It includes the following areas of general competencies:

- Clinical Skills / Competence and Patient Care
- Medical / Clinical Knowledge
- Clinical Judgment
- Interpersonal Skills
- Communication Skills
- Professionalism

The result of each ongoing evaluation, and whether it justifies the continuation, revision, or revocation of privileges, is communicated to the Credentialing & Privileging Committee at least every six months, and in any case immediately whenever a question arises as to a practitioner's professional competence and practice.

### Focused Professional Practice Evaluation:

A focused professional practice evaluation will be conducted by the responsible Medical Director whenever an issue arises as to a practitioner's competence or provision of safe, high quality patient care. The matter will be reviewed by the Executive Committee of the Medical Staff, and possible limitation of privileges or required supervision instituted, pursuant to the procedure set forth in Article VIII of the Medical Staff By-Laws (Corrective Action and Appeal Mechanisms).

Effective January 1, 2008, a six month period of focused professional practice evaluation will be implemented for all initially requested privileges. The period may be extended if professionally warranted. The responsible Medical Director will carry out the evaluation using the standards of the Ongoing Professional Practice Evaluation. The results of the evaluation will be communicated ~~by memo~~ to the Credentialing & Privileging Committee at the end of six months, or earlier if indicated.

In the event that at the time of Reappointment, change or addition or privileges, there is not an OPPE/FPPE in the file, it will be provided prior to the review of the file by the Credentialing Committee signed by both the Medical Director and employee. (added 5/8/14 per C&P committee).

Committee 3/8/07

Approved by Credentialing & Privileging

Approved by ECMS 4/5/07