Operational Manual

Credentialing & Privileging Committee

CREDENTIALING AND PRIVILEGING MANUAL

INDEX

INTRODUCTION TO
CREDENTIALING AND PRIVILEGING
AT
CONNECTICUT VALLEY HOSPITAL

Introduction to Credentialing and Privileging of the Medical Staff at CVH

Per the Medical Staff By-Laws, Section 8, the Credentialing and Privileging Committee shall consist of the Chief of Professional Services, Medical Director of Ambulatory Care Services, one Medical Director from each division and at least four (4) physicians appointed by the Executive Committee, at least one psychiatrist coming from each division. One of the four physicians shall be an internist 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 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 C&P meeting currently meets on the third (3^{rd}) Thursday of each month, except if it coincides with the Total Medical Staff Meeting, in which case, it will meet the following Thursday (4^{th}).

CREDENTIALING AND PRIVILEGING PROCESS FOR INITIAL APPOINTMENT

Credentialing and Privileging Process

The privileging process takes place at the time of hiring and appointment and also at the time of reappointment which occurs every two (2) years.

Initial Process (New Applicants)

When 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 should include:

1. New applicant application
2. Health Form
3. Acceptable CPR
4. Core Privilege Application
5. Delineation of Privileges requested
6. Letter of information regarding On-call interview

Once the application is received in the COPS/Medical Staff Office:

1. Send the Hospital and Institution Reference Letter and Questionnaire along with Release of Information Consent Form; Core Privileges form(s)
2. Request National Data Bank Queries and HIPDB queries. "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).
3. Query the Office of Inspector General's List of Excluded Individuals via the Internet to ensure that the applicant is not excluded from participation in Medicare/Medicaid/other federal programs. This report should be printed out and signed off on by person doing the inquiry.
4. Verify Medical License via Internet. Print out and sign off on both the report and copy of medical license with name of person verifying and the date.

5. Verify Connecticut Controlled Substance Registration via Internet. Print out and sign off on both the report and copy of the registration with name of person verifying and the date.
6. Verify DEA via the internet and print out a duplicate certificate, sign and date with name of person verifying the form.
7. Verify Physician Assistants at AMA profile website.
8. Query other states where medical licenses have been held.
9. Send to the schools and hospitals the Residency, Internship and Fellowship Reference Questionnaire along with Release of Information Consent Form. If you receive no response from a school that is out of the country there is no need for follow-up. Please note this in the folder.
10. Request and use AMA Profile as primary source verification.
11. Send verification form to ECFMG if applicable (see ECFMG Verification).
12. Verify current Board certification through AMA Profile.
13. Once all the credentials are received, sign off as "reviewed".
14. Contact appropriate C&P Committee member for review of file. The C&P member will review file. They will then contact the appropriate medical director(s) to review and sign off on privilege requests. The reviewer will then sign off on the Credentialing and Privileging Checklist.
15. Verification of an Applicant's Identity is accomplished by means of viewing an Applicant's Drivers License or Passport Photograph, and completion of the appropriate Verification Form by Administrative Assistant.

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

16. The C&P physician reviewer will present the file to C&P for recommendation. Upon approval, the Chair will be sign off in the C&P approval section and the C&P Checklist.
17. Add to the ECMS agenda for the next EXECUTIVE COMMITTEE OF THE MEDICAL STAFF meeting.
18. If applicant is denied a particular privilege, send the memo to applicant explaining this.
19. On the day of the EXECUTIVE COMMITTEE OF THE MEDICAL STAFF meeting, the President of the Medical Staff will come and pick up the files for presentation. Upon approval, the President will sign off on the ECMS approval line.
20. The applicant's credentialing and privileging binder should be brought to Governing Body and presented by the President of the Medical Staff.
21. Upon Governing Body approval, the appropriate granting of approval letter and acceptance form should be signed by the CEO.
22. Fill in notification dates at the bottom of the Record of Action.
23. Notify Division/department Education Coordinator and MOSD contact in order to initiate required Orientation program for the new member. Confirm appointment with Human Resources.
24. Notify Pharmacy of new member's DEA number, Connecticut Controlled Substance Registration number, Medical/Physician Assistant License number and a copy of the new member's signature.

CREDENTIALING AND PRIVILEGING PROCESS FOR INTERIM PRIVILEGES

Interim Privileges

"When necessary, interim clinical privileges may be granted and renewable by the Chief Executive Officer at the request of the President of the Medical Staff (or designee) based on the recommendation of the Chair of the Credentialing and Privileging Committee (or designee) for up to one hundred twenty (120) days. (Page 14, Article VII section 3 of the By-Laws).

Interim privileges may be granted by the Chief Executive Officer only in the following circumstances:

1. Upon receipt of a written request for specific care of one or more patients.
2. When absence of the temporarily privileged practitioner would result in lack of specific attention to patient needs.

   a) Medical Director or Chief of Professional Services (COPS) reviews those credentials which have thus far been received. Copy of Applicant's CT Medical license must be on file along with verification. Every effort will be made to obtain verification of Board Certification, ECFMG, Medical Degree, and evidence of clinical competency in a timely fashion.

   b) If Medical Director/COPS feels that the applicant has sufficient credentials to ask for Interim Privileges, he/she will write a memo to the Chair of the Executive Committee of the Medical Staff (Executive Committee of the Medical Staff) asking that they make a recommendation that the Chief Executive Officer grant interim privileges (Interim Executive Committee of the Medical Staff).

   c) Executive Committee of the Medical Staff will then ask Chief Executive Officer to grant interim privileges until such time as the credentials folder is complete and the credentials committee has met, reviewed, and recommended appointment to the medical staff and granting of privileges. Letter from EXECUTIVE COMMITTEE OF THE MEDICAL STAFF Chair to CEO (#37) will be sent from Secretary II.

   d) After approval from CEO, draft letter from CEO to applicant (#16), attach signature sheet stipulating Interim Privileges (#18).

   e) The same process for gathering and documenting information shall be followed as in the regular initial privileging packet.

CREDENTIALING AND PRIVILEGING PROCESS FOR REAPPOINTMENT

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 Medical Staff Office Coordinator. This packet should include the following:

1. Reappointment Application
2. Health Form
3. CME Form
4. Acceptable CPR
5. Peer Recommendations
6. Committees
7. On-call Interview letter
8. Release of Information Consent Form
9. Delineation of Privileges

Once the application for reappointment is received:

1. On all applicants Include Release of Information form.
2. On consultants, send memo (#26) to medical staff members regarding the usefulness of the consultant.
3. Request National Data Bank Queries and HIPDB queries. Request should include: **Name, home address, date of birth, Social Security Number, medical license number, DEA number, name of medical school, and year graduated**.
4. Query the Office of Inspector General's List of Excluded Individuals via the Internet to ensure that the applicant is not excluded from participation in Medicare/Medicaid/other federal programs. This report should be printed out and signed off on by person doing the inquiry.
5. Verify Medical License via Internet. Print out and sign off on both the report and copy of medical license with name of person verifying and the date.
6. Verify DEA (240-3700) and sign/date copy and include name of person verified with.
7. To verify Physician Assistants, call NCCPA (770)734-4500 #4. Complete form NCCPA-verif.
8. Query other states where medical licenses have been held.
9. Send to the schools and hospital (#8) to verify the medical degree, residency training, and fellowships if not already accomplished. If no response from non-US schools after a reminder letter, there is no need for follow-up. Please note this in the folder.

10. Request and use AMA Profile as primary source verification if there is not one already on file.
11. Send memo and reply form to Peer references (#27 and #28) include delineation of privileges and release of information form.
12. If ambulatory care physician/PA send evaluation of performance (#29) to medical director in the Division in which the applicant is currently assigned to.
13. If board certified, verify through AMA Profile.
14. As of 10/07 at reappointment a copy of Drivers License or Passport.
15. Once all the credentials are received, sign off as "reviewed."
16. Contact appropriate C&P Committee member for review of file. The C&P member will review file. He/she will then contact the appropriate Medical Director(s) to review and sign off on privilege requests. The Medical Director should also view the Performance Appraisal and sign off that they saw them. The reviewer will then sign off on the Credentialing and Privileging Checklist
17. The application is now ready to be presented to the C&P Committee.
18. C&P physician reviewer will present the file to C&P for recommendation. Upon approval, the Chair will sign off on the first page of the DMH form. He/she will review, date, and sign page 2 of the DMH form.
19. Notify Recording Secretary via e-mail that recommendations need to be presented at the next EXECUTIVE COMMITTEE OF THE MEDICAL STAFF meeting.
20. If applicant is denied a particular privilege, send the memo to applicant explaining this (#13).
21. Prepare the files for presentation on the day of the scheduled meeting of EXECUTIVE COMMITTEE OF THE MEDICAL STAFF on which C&P issues appear on the agenda. Upon approval, the President will sign on the 3rd page of the DMH form.
22. Type the cover memo to the Chief Executive Officer (Chair of the Governing Body) from the President of the Medical Staff (Chair of the ECMS) for presentation at the next GOVERNING BODY meeting.
23. The files should ready for the President of the Medical Staff on the day of scheduled presentation before the GOVERNING BODY.
24. Upon approval, type a memo (#17) granting privileges to be signed by the CEO and mailed to the applicant; attach the signature sheet (#18); if applicant has been granted interim privileges, the memo should state this (#16). Include a copy of the Medical Staff By-Laws and Drug Therapy Guidelines with letter to applicant.
25. Fill in dates on bottom of page 3 of DMH Form.
26. Note date applicant was notified (the date the letter from the Chair of the Governing Body was sent to applicant) on page 3 of the DMH form.

CREDENTIALING AND PRIVILEGING
AMA PROFILES

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

CREDENTIALING AND PRIVILEGING
DATA BANKS

NATIONAL PRACTICTIONERS DATA BANK

This data bank is queried upon appointment, reappointment or change in privileges. This data bank reports on malpractice payments, adverse licensure actions, adverse clinical privilege actions, and adverse professional society membership actions. Information reported to the NPDB 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 HHS).

A data bank request is filled out on the data bank.

HEALTHCARE INTEGRITY AND PROTECTION DATA BANK
OFFICE OF THE INSPECTOR GENERAL LIST OF EXCLUDED INDIVIDUALS

This data bank is queried upon appointment, reappointment or change in privileges. This data bank reports judgments against a practitioner in Federal or State Courts related to the delivery of health care service: Federal or State criminal convictions against a health care provider related to the delivery of health care service; Actions by Federal or State agencies responsible for the licensing and certification of health care practitioners, including: formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, ensure or probation.

A) Any other loss of license or the right to apply for, or renew, a license of the practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise.
B) Any other negative action or finding by such Federal or State agency that is publicly available information.
    1) Exclusion of health care practitioner from participation in Federal or State health care programs.
    2) Any other adjudicated actions or decisions that the Secretary established by regulations.

CREDENTIALING AND PRIVILEGING
CPR REQUIREMENTS

CPR CERTIFICATION

Excerpted from: 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 satisfies the Medical Staff requirement for a one-year period. ACLS satisfies the requirement for two years."

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

- All on-call physicians
- Physician Assistants
- All Active Members of the Medical Staff
- 120-day physicians who are unit based (whether on Active or Adjunct status)
- All physicians other than consultants

Consultants are exempt from the CPR requirement and not 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 his/her application is being reviewed, arrangements will be made to have the individual receive appropriate CPR training as soon as possible. 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 Division and 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.

CREDENTIALING AND PRIVILEGING 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 completing 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 (Advanced Cardiac Life Support) - two [2] year certification

CREDENTIALING AND PRIVILEGING
CLINICAL COMPETENCE
CME REQUIREMENTS

Excerpted from: 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) continuing education credits per two-year period, at least forty (40) credits being category one credits. It is understood that resident physicians performing night & 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."

Proof of meeting the minimum CME requirements is sought at the time of re-appointment. 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.

CREDENTIALING AND PRIVILEGING
LICENSE UPDATES/EXPIRATIONS

License Updates/Expirations

A master list of all privilege expiration dates is kept, including Medical License, CPR, DEA, Connecticut Controlled Substance and Board Certification expirations. This list is reviewed at the beginning of each month for the upcoming month to review for licenses that will expire. A reminder note is sent (see copy) to each person who will be expiring. A listing of phone numbers of applicable agencies and a list of CVH CPR Classes is also included for their use. The appropriate Medical Director is copied on this. As updated license information comes in, the Secretary II verifies the licensing information via Internet, signs off on it and updates the information on the master list.

If updated information is not received, a second request is sent to the individual and the Medical Director. If no response is received and the license cannot be verified via internet or telephone confirmation, the COPS is notified. The member will be relieved of his/her duties

until the license, registration, or certification can be verified. Other than for CPR certification, there is no grace period on an expiration date.

- **Issue: Copies of Licenses**

  The question arose as to whether or not copies of licenses must be in a physician's binder for the credentialing and privileging process to proceed, or whether Primary Source Verification of licenses is sufficient. It was noted that some physicians are negligent in forwarding copies of their licenses to the Medical Staff Office. It was also noted that Primary Source Verification is the more important of the two, and is required by Joint Commission standards.

  It was decided that Primary Source Verification is sufficient for the credentialing and privileging process to proceed. Primary Source Verification is independently obtained through the appropriate web site, and that verification is initialed and dated when obtained by the COPS office staff. However, it was also decided that copies of all licenses will continue to be kept in the Credentialing and Privileging files.

CREDENTIALING AND PRIVILEGING DELINQUINCIES

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 on11/1/01].

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].

CONNECTICUT VALLEY HOSPITAL

CREDENTIALING AND PRIVILEGING

CLINICAL COMPETENCE
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.

CONNECTICUT VALLEY HOSPITAL

CREDENTIALING AND PRIVILEGING

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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.

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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 ~~by memo~~ 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.

Approved by Credentialing & Privileging Committee 3/8/07
Approved by ECMS 4/5/07