Indian Health Service Medical Staff Credentialing and Privileging Guide

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Prepared by:

Martin L. Smith, D.Ph., M.B.A.
Medical Staff Credentialing Coordinator
USPHS Claremore Indian Hospital
Claremore, OK

Michele F. Gemelas, R.Ph.
Portland Area IHS Credentialing Consultant
Warm Springs Health and Wellness Center
Warm Springs, OR

Developed under the direction of the Office of Clinical and Preventive Services Indian Health Service Headquarters

A special thanks to the following reviewers for their valuable contributions:

Mark F. Carroll, M.D.
IHS Telehealth Program Director
Phoenix Indian Health Service
Phoenix, AZ

Steven W. Heath, M.D., MPH
Risk Management Consultant
Indian Health Service
Rockville, MD

Clare Helminiak, M.D., MPH
Clinical Director
Colorado River Service Unit
Parker, AZ

Clark T. Marquart, M.D.
Deputy Director/Chief Medical Officer
Portland Area Indian Health Service
Portland, OR

Richard D. Olson, MD, MPH
Director (Acting), Office of Clinical and Preventive Services
Indian Health Service Headquarters
Rockville, MD

Phillip L. Smith, M.D., MPH
Division of Clinical and Community Services
Indian Health Service
Rockville, MD

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I Introduction

The purpose of this guidebook is to assist the medical staffs and governing bodies of the Indian Health Service (IHS), tribal, and urban (I/T/U) health care facilities in carrying out their responsibilities to carefully credential and privilege all medical staff members.

Note: *This guidebook is meant to be a resource manual, not a statement of IHS policy. See Indian Health Service Circular No. 95-16, Credentials and Privileges Review Process for the Medical Staff (Referred to throughout this document as IHS Circular 95-16), revised by Indian Health Service Circular No. 96-06 Errata Notice for IHS Circular 96-16, or most current version for the applicable policy.*

The fundamental concepts of credentialing and privileging have not changed since the second edition of the Indian Health Service Credentialing Resource Handbook (1997). However, advances in technology and the development of the Internet have significantly changed and enhanced the process in which we collect and verify credentials information.

In addition to providing resource information, this document attempts to provide the reader with a more detailed description of the credentialing and privileging process. It attempts to incorporate both Accreditation Association for Ambulatory Health Care (AAAHC) and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) concepts. JCAHO and AAAHC standards and guidelines are dynamic in nature and change periodically. Therefore, this guide should only be utilized as a supplement to and not as a substitute for current IHS, JCAHO, or AAAHC guidelines.

This guide provides:

- a description of the credentialing process and the steps that must be taken to verify the credentials of any practitioner applying for medical staff membership or clinical privileges,
- a list of credentialing websites,
- sample letters and forms, and
- a glossary of commonly utilized credentialing and privileging terms.

The various forms, letters, etc. are sample formats that have been found to be useful in some facilities; they may be copied and used as-is, modified to meet local needs, or ignored.

Credentials are a practitioner's documentation of education, clinical training, licensure, experience, current competence, health status, and ethical behavior.

Verification of credentials data is required to ensure:

- The individual requesting privileges is in fact the same individual who is identified in the credentialing documents
- The applicant has attained the credentials as stated
- The credentials are current
- There are no challenges to any of the credentials

The IHS requires, at a minimum *primary source verification* of the following:

- Licensure
- Professional education, post graduate training, and experience
- Current competence
- Ability to perform (health status)

This means that an outside authority, such as the medical school from which a medical degree was received, or the state licensing board that granted a license, supplies the evidence or attests to the validity of the credential, preferably in writing.

The privileging process is a process in which the medical staff and the governing body of an I/T/U health care facility establish the manner in which a health care provider will be allowed to practice in the facility taking into consideration the capabilities of the provider, limitations of the facility, support staff, and mission of the health care facility.

Clinical privileges must be assigned to all practitioners permitted by law and by the health service organization's (HSO) bylaws to independently provide clinical care. The privileges should be both provider specific and facility specific, therefore two individuals rarely have exactly the same clinical privileges. Likewise, many small and remote clinics cannot support all that the practitioner may have the skills to do.

The privileging process must be applied to all individuals providing independent clinical services within the HSO. No licensed independent practitioner (LIP) should ever be allowed to practice independently in an I/T/U health care facility without current clinical privileges.

Medical staff appointment refers to the process by which a practitioner is granted membership to the facility's medical staff. The process for granting clinical privileges and/or medical staff membership (one may be granted without necessarily granting the other) should be applied uniformly to all applicants.

The facility's medical staff can only make *recommendations* relating to the practitioner's clinical privileges and/or medical staff membership. The facility's governing body has the authority to *grant* clinical privileges and/or medical staff membership.

II Reasons for Aggressive Credentialing

The primary reason for aggressive credentialing is patient safety!

A major cause for the formalization of the credentialing and privileging process throughout the health care industry was the *Darling v. Charleston Community Hospital* lawsuit in 1965, which established the principle of corporate negligence and liability for hospitals. Corporate negligence is defined as the failure of the corporation to follow the established standards of conduct in providing accommodations and facilities necessary to carry out the purposes of the corporation, in this case, the hospital. These standards of conduct have been held to include establishing the competence of the members of the medical staff. The *Darling* case also established that the standards promulgated by the JCAHO, standards of a government licensing authority, and the provisions of the hospital's medical staff bylaws are admissible as evidence of negligence. Over the years since the *Darling* case, courts have held that hospital liability includes cases where the hospital should have known of substandard conduct or practice by members of its medical staff.

The main purpose of the credentialing and privileging process is to ensure that qualified and competent practitioners are granted medical staff membership and/or privileges. In the course of ensuring quality, the process can also protect the HSO from corporate liability, as well as assist the organization's leaders in projecting needs for programs to be developed, changed, or discontinued.

The Office of the Inspector General (OIG) has developed a practitioner exclusionary listing. Practitioners listed in the OIG exclusions database are not eligible for employment in the IHS for reasons such as convictions relating to Medicare or Medicaid fraud.

The processes and criteria used to grant clinical privileges must be applied uniformly to all applicants. This is to ensure a uniform level of quality throughout the HSO, regardless of the specialty or medical discipline of the independent practitioners. Such uniformity fulfills both legal and accreditation requirements and is part of the HSO's ethical responsibility to the patients it serves.

III Key Players and Their Responsibilities in the Credentialing Process

A Definition of Roles

Roles in the Credentialing Process may vary from facility to facility. The following is a guide to the customary roles in the process.

1. **Clinical Director (CD):** The CD at an I/T/U facility is responsible for the Medical Staff Credentialing and Privileging Records system. Often another person is designated to perform the routine credentialing functions and for the security of the credentialing records. The credentialing process must be directly supervised by the CD. The CD is often the first point of contact for applicants, and s/he must maintain an open line of communication with the local/Area personnel departments, the facility's administration, and the Medical Staff and the Credentialing Coordinator. In a small facility, the CD's signature is usually the first recommending signature on the Application for Appointment/Request for Reappointment and the Request for Clinical Privileges and the signature indicates his/her recommendation that an applicant be admitted to the medical staff and/or be granted clinical privileges. In a larger facility, the first recommendation usually comes from the Chief of Service (see #3 below).
2. **Medical Staff Credentialing Coordinator (MSCC):** The MSCC is the person usually designated to perform routine credentialing functions on behalf of the facility. This includes all clerical aspects of credentialing: file creation, tickler file maintenance, distribution of paperwork to applicants, and verifications. S/he is often a member of the Credentialing Committee and is often responsible for assuring that reappointment processes are initiated when they are due.
3. **Chief of Service:** Usually a position found only in larger facilities and hospitals. Provides a discipline specific review of an applicant. Responsible for reviewing applications for medical staff membership and delineated privileges that have been requested, as well as all other credentialing documentation. S/he recommends appointment/privileges to the Credentialing Committee.
4. **Chief Executive Officer/Tribal Health Director:** This person is responsible for reviewing the recommendations of the CD, Chief of Service, the Medical Executive Staff, the Credentialing Committee and any other recommending bodies. S/he is the final recommendation prior to submitting an applicant's file to the Governing Board. (See "Delegated Authority", page 10).
5. **Governing Board (GB) Chairperson:** The role of the GB Chair is to assure that the IHS Circular 95-16 and the local credentialing process has been followed and that all the proper information has been gathered during the credentialing process. This person is the last to sign all credentialing documents on behalf of the Governing Board, and this signifies the approval of privileges.
6. **Area Contracting Officer:** Responsible for assuring personnel and payment functions for contracted individuals. This person should have some knowledge of the malpractice insurance requirements and should integrate with the Credentialing Process so that the organization enters

into appropriate contracts with providers.

B Committees

1. **Medical Staff:** Led by the Clinical Director in most facilities, this is the first point of contact for most applicants to the Medical Staff.
2. **Medical Staff Executive Committee (MSEC):** A subset of the Medical Staff, usually consisting of the various Chiefs of Service, the CD, the President of the Medical Staff, facility Chief Dental Officer and other executives of the Medical Staff. Required by JCAHO in hospital settings, the composition of this Committee should be specified in the Medical Staff Bylaws.
3. **Credentialing Committee:** Usually an interdisciplinary group of Medical Staff members. Responsible for reviewing completed applications and clinical privileges and the recommendations that are received from the CD (small facility) or the Chief of Service (larger facilities and hospitals). This Committee's recommendations are forwarded to the Medical Staff Executive Committee.
4. **Governing Board:** Receives recommendations from the Medical Staff Executive Committee and approves or denies medical staff membership and/or privileges on a routine or regular basis. In IHS, the Board usually includes the Area Director and others from the Area Office.

Note: *In smaller clinics/facilities, many of the Committee functions are combined due to the number of people involved in the process. Often a group known as the Credentialing Committee will perform the functions of the MSEC as well. Membership of consolidated committees in smaller clinics must include, at minimum, the CD, Chief Dental Officer, CEO/THD, MSCC and another member of the Medical Staff.*

C Delegated Authority

In remote areas in Indian Country, the efficiency of the credentialing and privileging process has been sometimes been impeded by the distance between the Area Offices or Health Boards and the facilities where care is being provided. Since Governing Board meetings usually occur annually, some Areas are moving toward "Delegated Authority" for approval of medical staff membership and privileges. In the case of delegated authority, the Governing Board determines that the involved facility has a well established and consistent credentialing and privileging program. The Chair of the Governing Board, in conjunction with the Area Chief Medical Officer, may then delegate routine signature authority for the approval of medical staff appointments/reappointments and privileges at the Service Unit or the facility level. The delegated authority should be designated in writing by the Governing Board and should specify any limitations, special situations, and a plan for monitoring the ongoing integrity of the program.

IV Essential Resources for the Credentialing Process

The following resources provide vital information on the credentialing process for IHS and tribal facilities:

A Indian Health Service Circular No. 95-16, Credentials and Privileges Review Process for the Medical Staff, dated December 8, 1995 and revised by Circular No. 96-06, dated June 5, 1996. (Or most current version)

B Federal Register Notice Vol.63, No. 144, pages 40297-40300, dated July 28, 1998. This Notice can be found at: http://www.gpoaccess.gov/privacyact/2003.html (go to "Indian Health Service" which is listed under the "Centers for Medicare and Medicaid". Note: CMS is not in alphabetical order in the pull down menu)

C Medical Staff Bylaws and/or Rules and Regulations of the facility.

D JCAHO Accreditation Manual for Hospitals, Accreditation Manual for Ambulatory Health Care, the Accreditation Manual for Mental Health, Chemical Dependency, Mental Retardation/ Developmental Disabilities Services, AAAHC Accreditation Manual.

E The Internet. See Attachment 1 for various credentialing websites. These web addresses may change between edits of this publication. Although the authors do not endorse any particular search engine, using Google to search for websites and contact information during the credentialing process is extremely effective.

Resources utilized during the verification process will be identified in the section of this handbook entitled "The Independent Verification Process."

V Who to Credential

Licensed independent practitioners (LIP) should always be credentialed and privileged if they provide care within an IHS facility. In some cases such as telemedicine (see the Special Situations section of this handbook), the LIP may require credentialing even though they are never physically present in the facility. JCAHO defines an LIP as *"any individual permitted by law and by the organization to provide care, treatment, and services, without direction or supervision"*. In other words, if the practitioner could open an office in the private sector and deliver patient care directly without physician orders or supervision, then he/she is most likely an independent practitioner or LIP.

Non-physician primary care providers such as Physician Assistants (PAs) in the IHS should be credentialed and privileged through medical staff mechanisms even though JCAHO and AAAHC standards may allow an alternate process. Privileging via normal medical staff mechanisms ensures that relevant practitioner-specific performance improvement data is available and considered during the credentialing and privileging process. As a result, the provider would normally be extended the right to the fair hearing and appeals process for adverse privileging actions.

Individual states may license certain categories of practitioners differently. For example, some states license Advanced Practice Registered Nurses (APRNs) and Certified Registered Nurse Anesthetists (CRNAs) as non-physician primary care providers while other states may license them as LIPs. Physician Assistants (PAs) are never LIPs. APRNs may also be referred to as Family Nurse Practitioners (FNPs) or Advanced Registered Nurse Practitioners (ARNPs) by some states or organizations. Even though federal facilities are not required to follow state law, IHS tends to look to the state of licensure when determining what an individual will be allowed to do in our facilities. The individual states provide excellent guidelines, usually in a Scope of Practice document, for credentialing and privileging these types of providers.

Other health care providers such are nurses and pharmacists are generally not privileged via medical staff mechanisms. However, their license should be verified initially and at each subsequent licensure renewal to be sure that it is in good standing and is unrestricted. In larger facilities, this is usually done by the department head, but may be done by the Credentialing Coordinator in smaller clinics. The provider's current license, verifications, and documentation of continuous training and education should be maintained in a file and periodically assessed.

The National Clinical Pharmacy Specialist (NCPS) would generally not be privileged via medical staff mechanisms. However, the protocols allowing them total therapeutic management in referral clinics such as lipid clinics and anticoagulation clinics should be approved and signed by the appropriate medical staff representative(s) and facility administration. The **pharmacist practitioner** or the National Clinical Pharmacy Specialist- Pharmacist Practitioner (NCPS-PP) would most likely be privileged via medical staff mechanisms since they practice in a manner similar to a physician assistant.

VI Who to Privilege

The IHS currently employs 16,000 staff, many of whom are credentialed and privileged within the IHS system each year. According to accreditation standards, all LIPs should have clinical privileges delineated, but other practitioners may be privileged as well. Practitioners eligible for clinical privileges in the IHS system include the following categories:

- physicians
- dentists
- optometrists
- physician assistants
- certified registered nurse anesthetists
- nurse midwives
- nurse practitioners
- podiatrists
- clinical psychologists
- social workers (MSW)
- pharmacist practitioners
- audiologists
- physical therapists

It is recommended that State laws and Scope of Practice documents be obtained from the state in which a practitioner is licensed, and that they are considered when privileging non-LIP providers.

Contract, consultant, and locum tenens providers should be credentialed and privileged by the same mechanisms as other providers when they practice inside the IHS facility. Evidence of medical liability insurance coverage should be documented on all practitioners in this category unless they are covered by the Federal Tort Claims Act (see page 16). A copy of a current Drug Enforcement Act (DEA) certificate should be obtained for any contract, consultant, or locum tenens provider that is allowed to prescribe controlled drugs.

Residents who are "moonlighting" and/or working within an I/T/U facility for a locum tenens company should have an unrestricted medical license and should be credentialed and privileged by the same medical staff mechanisms as any other provider who is independently delivering health care within the facility.

However, many I/T/U facilities have affiliations with teaching institutions and medical residents and/or medical students rotate through the facilities as part of their formal training program. Residents are normally paid via their residency program. Therefore, the I/T/U facility should have a formal Collaborative Agreement with the affiliated teaching institution before allowing the residents to rotate through the facility. The residency program will normally provide these individuals with malpractice insurance, and this should be documented and verified. In addition, the facility should have well defined written description of how resident(s) will be supervised by a licensed independent practitioner(s) (LIPs) with appropriate

clinical privileges. The written description is normally in the medical staff rules and regulations and/or the departmental rules and regulations and should, at a minimum, include the identification of mechanisms by which the supervisor(s) makes decisions about each resident's independence in specific patient care activities. In addition, the medical staff rules and regulations should delineate which residents or students may write patient care orders and what entries must be countersigned by the supervising LIP.

The scope of practice and/or supervision of residents or medical students may be documented by one of the following methods.

A A detailed description of supervision mechanism(s) and scope of practice in the clinical department rules and regulations.

B A delineated clinical duties listing signed by the applicant and/or the appropriate Chief of Service or Clinical Director.

C A delineated clinical privileges list granted through normal medical staff mechanisms (for privileges performed independently by residents). In a longitudinal experience, it is expected that this would be a dynamic document as residents are proctored and periodically approved to perform more procedures independently.

In addition, current JCAHO and/or AAAHC guidelines should be reviewed for additional guidance.

Categories of the Medical Staff

There are several different categories of medical staff membership that can be granted by a facility's governing body. The IHS credentialing circular (IHS Circular 95-16) should also be consulted. In addition, the facility's medical staff bylaws should be reviewed since various facilities may have slightly different categories and professional criteria. Examples of some of the different categories are as follows:

Temporary: Those members who have completed a medical staff application and are awaiting full review by the Medical Staff Executive Committee and Governing Body, and their services are needed immediately to fulfill an important patient care need. No member should be in this category for a period longer than 120 days.

Provisional: New members of the medical staff who are serving a required probationary period as specified in the local medical staff bylaws. During this time, their qualifications for membership on the Active (or Courtesy, Consultant, etc) medical staff category are assessed. The staff member may be deemed Provisional-Courtesy or Provisional-Consultant, etc.

Active: Those members who served their probationary period and have been found fully qualified to function at the level they are clinically privileged. These members are almost always voting members of the medical staff.

Associate: Those members who have served their Provisional period and who generally provide medical services on a periodic or episodic basis.

Allied Health: Members generally include non-physician primary care providers such as Physician Assistants (PAs), Advanced Practice Registered Nurses (APRNs), Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse Midwives

(CNMs), etc. that are eligible for medical staff membership by virtue of the local facility bylaws. Some facilities may refer to this category as Associate Practitioners. In addition, some facilities may place non-physician primary care providers that are LIPs in one of the other medical staff categories.

Consultant: Those members that hold specialty clinics and/or provide clinical consultation on a periodic or episodic basis. They are normally not voting members of the medical staff.

Courtesy: Those members functioning in a similar fashion as members of the Consultant medical staff category. Some facilities may have a Courtesy category instead of a Consultant category. Some sites may have both categories with some minor distinction.

VII Licensure Requirements

Licensure requirements in the IHS are established in Federal personnel regulations and IHS policy circulars:

A PHS Commissioned Corps Personnel Manual, Personnel Instruction 4, Subchapter CC23.3, "Appointment Standards and Appointment Boards". (http://dcp.psc.gov/INDEX-B.asp)

B Licensure requirements for Civil Service employees can be found at www.opm.gov and searching by discipline, i.e., "physician licensure requirements"

C IHS Circular 95-16, Credentials and Privileges Review Process for the Medical Staff, 12/8/95, revised by Circular No. 96-06, date June 5, 1996.

Tribal programs require caution in interpreting applicability of the federal authority to allow clinicians to practice with out-of-state licenses. If the provider is a federal employee assigned to a tribal program, there is no question: the federal rules apply. For clinicians employed by the tribe, however, experience has shown that attitudes vary between professional licensing boards and from state to state. The best practice for tribal sites is to obtain the view of the appropriate licensing board in writing if there is a desire to use a provider licensed in another state. While a tribe may eventually prevail in a legal dispute over licensing jurisdiction, meanwhile the provider may be placed in an awkward or risky position. Urban programs, with rare exceptions where a federal employee may be assigned to them, must have clinicians licensed in the local state.

VIII Federal Tort Claims Act (FTCA)

Medical staff credentialing should reflect proof of malpractice insurance for those not reasonably believed to be covered for their acts or omissions by FTCA. In general, federally employed clinicians are covered by FTCA for acts or omissions occurring within their scope of their federal employment. Providers working for locum tenens companies are generally NOT covered by the FTCA. Tribal employees are deemed to be federal employees for the purposes of FTCA coverage while acting within the scope of their employment in "carrying out" contracts/compacts under the Indian Self-Determination and Education Assistance Act (ISDEAA). The ISDEAA also extends FTCA coverage to an individual under a personal services contract with a Tribe if the individual is acting within the scope of his/her employment pursuant to the Tribe's ISDEAA contract/compact and the services are provided in an IHS or tribal health facility. FTCA coverage is also allowable for personal services contracts in direct (IHS) programs. The facility should seek an opinion from General Counsel on any situation where FTCA coverage is unclear.

IX Storage, Access, Disposal of Credential Files

For information on storage, access and disposal of credential files, see the Federal Register Notice Vol.63, No. 144, pages 40297-40300, dated July 28, 1998. This Notice can be found at: http://www.gpoaccess.gov/privacyact/2003.html (go to "Indian Health Service" which is listed under the "Centers for Medicare and Medicaid". Note: CMS is not in alphabetical order in the pull down menu).

The files should be maintained in accordance with AAAHC and JCAHO standards as well. Credential files can be subpoenaed, and therefore performance improvement/ peer review data should be stored separately. The Clinical Director at each facility is the system manager for this system of records, and is responsible for developing and maintaining a list of personnel authorized to access these files, as well as for keeping a log of disclosures of information from them.

X File Organization

Credential files should be organized and uniform, allowing reviewers to efficiently locate the necessary documents in any file. Checklists are an excellent way to take a snapshot of the contents of a credential file, and can be a concise way to show reviewers that your credentialing process is uniform from file to file. They also can help you to keep track of documents that you have requested multiple times and can alert you to the expiration of various credentials within the file (see also "Tracking Systems") For examples of Initial Appointment and Reappointment Checklists , see Attachment 3 and Attachment 4.

XI Tracking Systems

Components of an individual's credential file such as clinical privileges, licensure, certifications, etc. should be routinely tracked in order to prevent a lapse in any dated credential, medical staff membership or clinical privileges. There are various computerized software packages available for purchase to assist with tracking credentials, and the IHS Resource Patient Management System (RPMS) has a Credentialing Tracking package as well. Others may prefer to use databases or spreadsheets that they create themselves. (An example: Attachment 5) Regardless of what method you use to monitor the currency of the credentials and privileges at your facility, it is recommended that a system be in place in order to help you to monitor your entire system at a glance.

XII Pre-employment Screening

Many private sector hospitals utilize a hospital questionnaire or "pre-application" screening application prior to offering a practitioner an application for medical staff membership and/or clinical privileges. Although the use of a pre-application is not common practice in the IHS, several sites may use a similar process since the IHS Human Resources Department (HRD) does not routinely perform primary source credentials verification prior to qualifying an applicant for an employment selection panel.

A hospital questionnaire with an understanding for release of information signed by the applicant allows the HSO to perform many of the credentials verification functions prior to hiring the applicant. This process can be significant if the HRD qualifies the applicant

for an employment panel based on a copy of his/her professional license and the HSO hires the applicant and later discovers that the applicant's license is restricted.

The following verifications ideally should be performed prior to hiring an applicant:

A License(s) verification

B NPDB query

C OIG sanctions verification

D Two letters of professional reference (some peer related questions can incorporated)

XIII Independent Verification Process

There are two categories of information sources utilized during the independent verification of credentials: ***A) primary sources, and B) secondary sources.***

A Primary source verification

Primary source verification of credentialing information is required by JCAHO and AAAHC. Directly contacting a medical school or state medical board to verify education and licensure, respectively, are examples of primary source verification. Centralized credentials verification organizations (CVO's) can be utilized, but they must meet accreditation/certification standards. For example, the AMA Physician Profile Service is now considered a primary verification source by the JCAHO and AAAHC (see Attachment 1 for websites).

Primary source verification should be performed on the following ***core criteria*** when a practitioner applies for medical staff membership and/or clinical privileges:

1. current licensure
2. relevant training and experience (e.g. medical school, internship(s), residency(s), board certification)
3. current competence
4. ability to perform requested privileges (e.g. confirmed health status relative only to a provider's ability to perform the requested privileges)

1. **Licensure:** Primary source verification of licensure status is extremely important, and most states permit verification of the information via telephone (see Attachment 6). Many states also now allow verification via the internet. This should always be performed at the time of initial appointment, and at the time of each reappointment and/or reprivileging, and is recommended at the time of license expiration. If telephone verification of licensure is performed, the following should be documented:
   - date and time
   - state of licensure, license number, date of original licensure and expiration date
   - phone number called for verification
   - name (first and last) of the person initiating the verification call
   - name (first and last) of the person verifying the information
   - important questions to ask:
   - Are there any current, past, or pending restrictions on the license?
   - Are there any current, past, or pending disciplinary actions against the practitioner?

   There are significant differences in the types of licensure information released by various state medical and/or professional boards. Most state medical boards will respond to a licensure inquiry by simply stating "the license is active, in good standing, and expires on a given date." However,

"active" may mean active but on probation. "In good standing" may mean in good standing, but the practitioner's practice is restricted. Many states will acknowledge whether or not there are any restrictions and/or disciplinary action(s) against a practitioner's license, but require a written request (and often payment) to obtain details of the action(s).

2 **Federation of State Medical Boards (FSMB):** The FSMB is comprised of the medical boards of all the states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. It also includes fourteen of the fifteen separate osteopathic boards in the United States. The Federation maintains the FSMB Board Action Data Bank (FSMB Bank) that contains actions reported by state licensing and disciplinary boards, and actions reported by other agencies. Actions included in the FSMB Bank are revocations, probations, suspensions, and other regulatory actions such as license denials and reinstatements; Medicare sanctions and Department of Defense (DoD) adverse privileging actions are also included. The FSMB contains information on physicians and physician assistants only.

The IHS performs centralized FSMB queries on civil servant IHS physicians and physician assistants. However, the results of a query with adverse information often takes weeks or months to reach the appropriate people at the Service Unit level. Large IHS hospitals/medical centers may want to query the FSMB directly from a Service Unit level on certain physicians, such as those hired via personal services contracts and/or locum tenens companies. However, it is probably cost prohibitive for small IHS facilities to query the FSMB directly. Requirements and query costs for directly querying the FSMB can be obtained by contacting them directly (See Attachment 1).

3 **Professional education, training, Board Certification:** These elements can be verified by either sending letters to each institution individually (professional school, residency training program, specialty board, etc.), or by using an organization considered by JCAHO and AAAHC to be a primary source. Verifications of these elements need only be done at initial appointment unless additional training and/or Board Certification is obtained after the initial appointment.

American Medical Association (AMA):A physician profile is available from the AMA that contains a summary of information such as the physician's training, education, certifications, and licenses. JCAHO and AAAHC consider the AMA Physician Profile primary source verification. Information that has been verified with the primary source is separated and identified on the profile. The AMA Physician Profile can be obtained via mail, fax or internet. Mail requests require approximately 10 business days to process. Faxed requests are processed within 72 hours, if paid via credit card. Online queries are available the same day. (See Attachment 1 for website)

American Board of Medical Specialties (ABMS): The board certification status of a physician can be verified by using the CertiFAX Service (or the hardbound reference book) of the American Board of Medical Specialties

(ABMS). Refer to Attachment 1 for the website. In addition, board certification information is often verified on a physician's AMA or AOA profile. The AMA is officially recognized by JCAHO as a display agent for the ABMS

American Osteopathic Association (AOA): The AOA compiles a physician profile for osteopathic physicians that is very similar to the AMA Physician Profile. See Attachment 1 for website.

Note: *AAAHC considers ABMS and AOA "acceptable secondary sources" as they have "performed the primary source verification"*

4 **Current Competence:** This is an element that needs to be assessed at initial appointment and at least every two years thereafter, normally at the time of reappointment/reappraisal. Here is what you should look for to determine current competence:

Initial Appointment

a **Competency Verification:** (See Attachment 7) This can be sent to the Medical Director or Medical Staff Credentialing office of any hospital that the applicant has been affiliated with in the recent past. Additionally, something similar should be obtained from a new graduate's Residency Program Director and any hospitals at which they may have moonlighted. In the case of more advanced procedures (e.g. colposcopies or colonoscopies) being requested by non-specialists such as a Family Medicine physician, the competency documentation may need to include specifics about the training institution, date of training, and the number and types of procedures (both supervised and unsupervised).

b **Peer Recommendations:** (See Attachment 8) The applicant is asked to list two or three references on the Application for Initial Appointment to the Medical Staff. Each of these listed references should receive a letter/form to have them comment on the current competence of the provider to the best of their knowledge.

c **Current Competency:** The provider's current competency to perform the clinical privileges that he or she has requested needs to be established: Normally, the applicant's completed privilege request form is sent along with a letter asking the peer (normally the Chief of Service or Department Head) to attest to the applicant's abilities in relation to the clinical privileges requested. It is imperative that the peer used for this verification is one that has recent knowledge of the applicant's performance. (See Attachment 9)

d **Red Flags:** In the event that one or more competency verifications or peer recommendations lacks clarity, or falls short of full endorsement of the applicant, or for any other reason "red flags" are perceived, additional information should be sought. Telephone consultation with professionals in a position to attest to competence of the applicant may sometimes be more revealing than their written responses. Also, the HSO should not limit itself to the individuals listed as references when seeking additional information.

Reappointment

a **Competency Verification:** (See Attachment 7) Used if the applicant has privileges at another hospital and does not work enough at your facility to have adequate performance improvement information.

b **Peer Recommendations:** (See Attachment 10) At least two peers should be consulted concerning the applicant's current competence.

c **Reappointment Profile:** (See Attachment 11). This document is developed via ongoing performance improvement activities and addresses Medical Staff issues (attendance at meetings, participation on committees, etc.), performance in relation to his/her peers (includes mortality, utilization review, blood usage, etc.), whether or not the applicant meets CME requirements, and risk management issues.

5 **Physical and mental ability to perform requested privileges:** This can be accomplished by asking a peer, normally the Department Chair, Chief of Staff or designee if the applicant's health status and/or mental status will have any effect on the ability of the applicant to perform the requested privileges. (See Attachment 12)

B Secondary source verifications

1 **National Practitioner Data Bank (NPDB):** IHS policy requires that the NPDB be queried at the time of application for employment by a health care practitioner (HCP) and /or when the practitioner applies for medical staff membership and clinical privileges. JCAHO standards indicate that the NPDB must also be queried at least every two years on each practitioner at the time of reappointment to the medical staff. JCAHO also requires the NPDB to be queried each time there is an expansion in clinical privileges. This report provides information related to adverse licensure actions, adverse privileging actions, and a malpractice claims history. NPDB queries are conducted via the website at www.npdb-hipdb.com.

Note: *Simple typographical errors in name spelling can result in an erroneous, seemingly "clean" query result indicating "No reports on file." There will be no tip off that the report may be invalid. You must catch such errors yourself, before the query is submitted.*

2 **Department of Health and Human Services (DHHS), Office of the Inspector General (OIG):** The DHHS OIG maintains records of administrative sanctions the Department has made against individuals or entities found guilty of fraud and abuse in DHHS-supported programs. The sanctions include exclusion, whereby an individual or entity is prohibited from participating in or receiving funds for payment for services provided under Federal programs specified under Titles V, XVIII, XIX, or XX (includes Medicare and Medicaid). The exclusion actions have government-wide effect, and a DHHS supported program may not contract with the health care practitioner if the individual has been excluded from participation in the Medicare and Medicaid programs. The sanction of exclusion results in an individual or entity being prohibited from receiving funds for payment for services provided under those programs.

Under the Social Security Act, provisions also provide for exclusion for conviction related to controlled substances; conviction for patient abuse or neglect; quality of care issues, such as provision of excess and/or unnecessary services or failure to meet nationally recognized standards; fraudulently obtaining funds from Medicare and Medicaid; licensure revocation or suspension for cause; and default on a health education loan or scholarship obligation. In the case of student loan defaulters, OIG will stay the exclusion order if they agree to repay the loan.

A DHHS-supported program may not contract with a health care practitioner who has been excluded from participating in a Federal program, such as the Medicare, Medicaid and CHAMPUS programs, or a State health care program. In addition, the IHS will not hire individuals who have been excluded from participation for quality of care issues or who have been convicted of fraud.

The HHS OIG "Cumulative Sanctions Report" (www.oig.gov) of exclusion information includes the health care provider's name, date of birth, medical specialty, address at the time of sanction, sanction, and date of sanction. The sanctions are referenced to the specific section of the Act, which identifies the reason for the exclusion. The Medicare and Medicaid sanctions are also available by querying the NPDB/HIPDB.

XIV Medical Staff Appointments and Privileging Process

A Initial Appointment

The process of Initial Appointment brings together many of the things discussed earlier in this guide. Two things to remember when entering the initial appointment process:

- **The burden of proof is on the applicant.** Notifying the applicant of what is still missing as you move through this process will make it more efficient. There is no obligation to process an application that is incomplete, and it is not viewed as a "denial" of medical staff membership or privileges to refuse to do so.
- This process may take up to 8 weeks if the process involves mailing vs. electronic methods of communication and verification.

Typical Process: Based on JCAHO, AAAHC and NCQA standards, as well as IHS Circular 95-16, the following is a typical step-by-step initial appointment process for a new Medical Staff member. This assumes concurrent or completed Personnel hiring processes. The goal of the process described below is to immediately request the information that takes the longest to receive and/or the information that is the most critical. This approach should minimize the risk of granting medical staff membership and/or clinical privileges to a health care provider who has licensure or competency problems.

1. **Applicant contact information:** Obtain the name, address, phone, email address of the applicant. In IHS, this information is often supplied by the personnel department (local or Area), and is usually found in a curriculum vitae (CV) that was sent by the applicant.
2. **Send:**
   - **a** An *Application for Appointment to the Medical Staff*
   - **b** A *Statement of Release and Understanding*
   - **c** A *Request for Clinical Privileges*
   - **d** A copy of your local *Medical Staff Bylaws* and a statement for the applicant to sign and return indicating that s/he has read and understands this document.
   - **e** For IHS facilities, the *Privacy Act Notice* for the IHS credentialing and privileging system of records must be attached to each *Application for Appointment to the Medical Staff*, whether the application form in Circular 95-16 is used or not. Additionally, a cover letter containing a list of required documents and the due date for completion should be included.
3. Take a copy of the cover letter and establish a file for the applicant. The due date should be noted and adhered to. Begin a checklist for the file to track documents and verifications as they arrive (See Attachment 3). KEEP COPIES OF EVERY DOCUMENT YOU SEND OUT. If a second request is made for a document or verification, note that on the letter/request and file a copy of the second request as well.
4. The list of required documents listed on the cover letter should include:
   - **a** A completed *Application for Appointment to the Medical Staff*

b A government sponsored photo ID, eg copy of drivers license, military ID, etc

c A signed *Statement of Release and Understanding*

d A completed *Request for Clinical Privileges*

e A signed *Bylaws Statement* indicating that the applicant has read and received a copy of the local Bylaws

f A *Health Statement* that provides information about any health problems that might affect his/her ability to exercise clinical privileges. Alternatively, a statement from a physician can be submitted.

g ***A copy of:***

- **i** A current, unrestricted license
- **ii** All previous licenses ever held (at minimum, license numbers and the state)
- **iii** Professional school diploma
- **iv** Internship/residency certificates
- **v** Board Certifications and/or letters from the Board
- **vi** DEA registration
- **vii** BLS/ACLS/ATLS/PALS, etc. certifications
- **viii** Malpractice Insurance carriers names/addresses. If possible, verify ten-year history.

h Any relevant billing forms such as Medicare or Medicaid forms.

5 Once all the required documents have been received **review them for completeness** and compare the information provided in the Application for Appointment to the applicant's CV. Be sure that everything is signed and dated, that all questions have been answered (avoid "see CV"), that all supplemental documents are attached (including detailed explanations to "yes" answers on liability questions, adverse privileging actions, or adverse licensure actions) and that all time since graduation from professional school to the present has been accounted for and explained.

6 Begin the process of **verifying the gathered credentials** by letter and/or the internet. Verification of licensure by telephone is acceptable. In some cases, more than one source may need to be consulted.

Verify the following using primary sources (see Section XII):

a **Licensure verification:** All professional licenses since graduation from professional school/residency, even those that have expired or been inactivated. Ask if there are or were restrictions or suspensions. If you use a State Board's website and it indicates that you need to obtain information about restrictions or suspensions by mail, then send a letter. See Attachments 1 for websites and Attachment 6 for Licensure Verification Worksheet.

Note: *If a State Board's website is considered "primary source", it will indicate this on the site. If it does not, telephone verification is recommended.*

b **Education/training/certifications:** Professional school, internship/residency, Board Certification. For MDs and DOs this can also be

accomplished by verifying these credentials individually by mail or by using the American Medical Association (AMA) Physician Masterfile or the American Osteopathic Association for a fee. (See Attachment 1).

c **Malpractice insurance:** Verify a ten-year history where applicable (See Attachment 13). Be sure to indicate that you are requesting the details of claims made and compare any claims/lawsuits/settlements with the NPDB results, the applicant's explanation to "yes" answers on liability questions and the State Board's responses to licensure verification.

d **Current Competence**

i **Competency Verification:** (See Attachment 7) This can be sent to the Medical Director or Medical Staff Credentialing office of any hospital that the applicant has been affiliated with in the recent past. Additionally, something similar should be obtained from a new graduate's Residency Program Director and any hospitals at which s/he may have moonlighted.

ii **Peer Recommendations:** (See Attachment 8) The applicant is asked to list three references on the Application for Initial Appointment to the Medical Staff. Each of these listed references should receive a letter/form to have them comment on the current competence of the provider to the best of their knowledge. Consider seeking additional "non-listed" references when initial responses or other circumstances warrant.

iii The provider's **current competency** to perform the clinical privileges that he or she has requested needs to be established. Normally, the privilege request form is sent along with a letter asking the peer (normally the Chief of Service or Department Head) to attest to the applicant's abilities in relation to the clinical privileges requested. It is imperative that the peer used for this verification is one that has recent knowledge of the applicant's performance. (See Attachment 9). In addition, the peer can be asked if the applicant's health status and/or mental status will have any effect on the ability of the applicant to perform the requested privileges.

7 **NPDB/HIPDB Query:** Submit a request for a NPDB/HIPDB query. This is often done through the Area Office. (To establish your own account, see Attachment 1 for website). This can be done early in the process if all the necessary information for the query is available to you. Keep in mind that there may be several months or years of litigation process following an adverse event before a malpractice payment is made and a report documented in the NPDB.

8 Consult the Office of the Inspector General (OIG) website to assure that the applicant is not on the sanctions list for Medicaid/Medicare. Provider Medicare/Medicaid sanctions are also displayed on the provider report obtained via a NPDB/HIPDB query.

9 **FSMB Query:** Submit a request for an FSMB query. In most Areas, this is an automatic process that is triggered by the hiring process, and these

queries are conducted at the Headquarters level. Check to see how this is handled in your Area. These results may not arrive until weeks after the provider has been practicing in your facility, so you may want to consider querying this yourself if you credential a large number of providers (See Attachment 1)

10 CNACI Clearance: Assure that proper security clearance has been established using CNACI (Child Care National Agency Check and Inquiries) procedures. The IHS requires that several categories of health care providers involved in the delivery of care to patients under the age of 18 be screened against a national database of individuals that have been convicted of crimes involving children. The facility's Human Resources Department is primarily responsible for performing CNACI clearances. However, the Medical Staff Credentialing Department may be involved with initiating the clearance process on providers that will eventually be members of the medical staff and/or be granted clinical privileges. The providers should be given the following forms:

- **a** Declaration for Federal Employment (OMB Form No. 3206-0182)
- **b** Addendum to Declaration for Federal Employment (OF 306)
- **c** Questionnaire for Non-Sensitive Positions (Standard Form 85)
- **d** Fingerprint card RD-258 (Rev. 5-11-99) for contract providers
- **e** Fingerprint card SF 87 (Rev. 4/98) for IHS providers

Completed CNACI forms are sent by the Human Resources Department to a contracted security clearance agency for clearance, and the provider should not be involved with direct patient care until the final clearance is received. However, since clearances often take weeks or months, many facilities use an "In-Sight-Of-Memorandum" (See Attachment 14) while waiting for the provider's final CNACI clearance.

11 Red Flags: Be cautious of "red flags" such as:

- **a** **High mobility:** A physician who has moved from state to state or from hospital to hospital every couple of years, who is licensed in several states, or who is a member of the medical staffs of several hospitals in several cities may be attempting to cover up some sort of professional problem.
- **b** **Professional liability suits:** While malpractice claims are not necessarily an indication of a problem, the hospital should be wary of physicians who have been involved in a number of professional liability suits.
- **c** **Professional disciplinary actions:** The hospital should be concerned about physicians who have been disciplined, sanctioned, or suspended, or whose privileges have been restricted by a licensing board or another hospital.
- **d** **Substance abuse:** A practitioner impaired by alcohol or drug abuse may apply for medical staff membership and privileges.
- **e** **Time gaps:** If an application reveals an unexplained time gap in training or professional practice, it should be investigated, (anything over 30 days).

f **Incomplete application:** Any incomplete sections of the application should be returned to the applicant for completion, along with a letter stating that the application will not be processed until it is complete. Be wary if the incomplete sections relate to questions about licensure, hospital disciplinary actions, liability claims history, and health status.

12 Once core criteria have been verified (which includes, licensure, education and training, current clinical competence, and the ability to perform the requested privileges), the Clinical Director and/or Chief of Service (depending on the size of the facility and whether it is a clinic or a hospital) will be asked to recommend or not recommend privileges on the Privilege Request Form, and to review the credentials and verifications. This recommendation is then forwarded to the Credentialing Committee where it is again reviewed. In larger facilities, it is then forwarded to the Medical Executive Committee. Finally, the Governing Board receives the recommendations and grants or denies membership and privileges. (See Attachment 2).

Note: *Only the Governing Board can grant or deny membership and privileges.*

13 If granted, a new Medical Staff Member is given one Provisional Year of privileges (see IHS Circular 95-16 or most current version). This allows for further evaluation of provider performance during their first year on the Medical Staff.

B Reappointment Process

Medical Staff Reappointment is a process that will occur at the end of a medical staff member's Provisional Year and every two years thereafter. Tickler systems and/or other tracking systems should be consulted monthly to anticipate the expiration of privileges, and the process of reappointment should begin approximately three months prior to the expiration date of the current privileges in order to be sure that the reappointment process is completed prior to the expiration of the provider's clinical privileges and/or medical staff membership. Reappointment to the Medical Staff requires that the basis for renewal of privileges is well documented. The following is a step-by-step process for reappointing a Medical Staff member.

1 Three months prior to the expiration of the provider's current privileges send a Request for Reappointment to the Medical Staff (see Circular 95-16), a copy of the provider's current delineated privileges, and a cover letter containing a list of required documents and the due date for completion. It is recommended that the due date be conservative, usually one month from the date it is mailed.

2 Take a copy of the cover letter and keep it in the applicant's file. The due date should be noted and adhered to. Begin a reappointment checklist for the file (see Attachment 4) to track documents and verifications as they arrive. KEEP COPIES OF EVERY DOCUMENT YOU SEND OUT. If a second request is made for a document or verification, note that on the letter/request and file a copy of the second request as well.

3 The list of required documents listed on the cover letter should include:

a A completed *Request for Reappointment to the Medical Staff*

b All licenses currently maintained

c DEA registration if renewed since last appointment

d Board certification if renewed since last appointment

e Current BLS/ACLS/ATLS/PALS, etc. certifications

f Any malpractice coverage renewed since last appointment

g Any requests for additional privileges, proctoring plans currently in progress, or any requests to alter privileges. In addition, any expansion or decrease of clinical privileges should be addressed in the documentation or a new clinical privilege request form should be initiated.

Note: *NPDB query should be done every time privileges are granted or expanded, but no less than every two years at the time of reappointment.*

h The name of two peers who can attest to the applicant's ability to perform current privileges.

i Documentation regarding applicant's health status. This can be a self-proclaimed statement confirmed by the corresponding Chief of Service in departmentalized hospitals.

j A current curriculum vitae

k The last two years of continuing medical education (CME) if it has not been continuously submitted

4 Once all the required documents have been received, be sure that everything is signed and dated, that all questions have been answered, that all supplemental documents are attached (including detailed explanations to "yes" answers on liability questions) and that all time since the last appointment/reappointment to the present has been accounted for and explained.

5 **Verifications:** Begin the process of verifying the gathered credentials by letter and/or the internet. Verification of licensure by telephone is acceptable (See Attachment 6). In some cases, more than one source may need to be consulted. Verify the following:

a **Licensure:** All current licenses

b **Board Certification:** Any Board Certification renewal that has occurred since the last reappointment

c **Health Status:** Ability of the applicant to continue his/her delineated privileges and any effect that the individual's health may have on the requested privileges. An evaluation of the applicant's health status in relation to their ability to practice is often achieved through confirmation by the department chair, chief of staff, or designee.

d **Malpractice insurance:** Be sure to indicate that you are requesting the details of claims made and compare any claims/lawsuits/settlements with the NPDB results, the applicant's explanation to "yes" answers on liability questions and the State Board's responses to licensure verification.

Note: *Many I/T/U providers do not carry additional malpractice insurance.*

6 **NPDB/HIPDB Query:** Submit a request for a NPDB/HIPDB query. This report provides information related to adverse licensure actions, adverse privileging actions, and a malpractice claims history.

7 **OIG Sanctions:** Consult the Office of the Inspector General (OIG) website to assure that the applicant is not on the sanctions list for Medicaid/ Medicare. The Medicare/Medicaid sanctions are also available by querying the NPDB/HIPDB.

8 **Establish current competence:** This can be accomplished by obtaining results of ongoing performance improvement activities and provider performance monitors such as peer review, morbidity and mortality data, ability to work with staff, rapport with patients, etc., and summarizing them in a document (See Attachment 11). You can also generate letters to references listed by the applicant and include a criteria based questionnaire to determine competence (See Attachment 8). Ask if the individual's health status will have any effect on the ability of the applicant to perform the requested privileges.

9 Once current competence has been established, the Clinical Director and/or Chief of Service (depending on the size of the facility and whether it is a clinic or a hospital) will be asked to review the credentials and verifications and recommend or not recommend reappointment and re-privileging on the Request for Reappointment. This recommendation is then forwarded to the Credentialing Committee where it is again reviewed. In larger facilities, it is then forwarded to the Medical Executive Committee. Finally, the Governing Board receives the recommendations and grants or denies the reappointment and/or clinical privileges. (See Attachment 2).

Note: *Only the Governing Board can grant or deny membership and privileges.*

C Temporary Privileges

All temporary privileges are granted by the CEO or authorized designee upon the recommendation of the Clinical Director (Medical Staff President) or authorized designee. In I/T/U facilities, the Clinical Director is commonly the Medical Staff President. In larger facilities, the chief of service (clinical department chairperson) is also normally involved with the recommendation(s).

Temporary privileges should be time limited (up to 120 days per JCAHO) and may be used in one of the two following situations:

- An important patient care need requires immediate clinical privileges be granted to a provider.
- An applicant's completed application is awaiting review by the next scheduled meeting of the medical staff executive committee and subsequent approval by the governing body.

Temporary privileges should NOT be routinely used as a substitute for a structured and timely reappointment process (see section entitled "reappointment process").

The following resources should be considered, and the granting of temporary privileges should be in compliance with the following:

- Current JCAHO or AAAHC guidelines.
- The facility's medical staff bylaws.
- The IHS Circular 95-16 (revised by Circular No. 96-06, dated June 5, 1996) the Credentials and Privileges Review Process for the Medical Staff (or most current version).

At a minimum, the process and the documentation that should be performed and reviewed prior to granting temporary clinical privileges should include:

1. A completed medical staff application and completed request for delineated clinical privileges.
2. Primary source verification of the core criteria (current licensure, training and experience, current competence, and ability to perform the requested clinical privileges).
3. NPDB query.
4. OIG sanctions query.

Telephone verifications are appropriate for temporary privileges, but verification in writing or via internet primary source websites should be completed prior to presentation to the medical staff executive committee and governing body.

Applicants involved with licensure problems, involuntary termination of medical staff membership, or adverse privileging actions at a previous practice site are generally not candidates for temporary privileges.

D Orientation

All new members of the medical staff should, at a minimum, be oriented to the medical staff bylaws and safety and infection control procedures prior to working. This "Day 1" orientation minimally addresses JCAHO requirements for Infection Control and Life Safety, but is not as inclusive as a complete and should not be a substitute for a comprehensive departmental orientation. The provider(s) should acknowledge their orientation to the bylaws with their signature. The orientation to the bylaws is often conducted by the Medical Staff Credentialing Department and/or the Clinical Director.

In addition, other facility departments normally orient providers to at least the following:

1. Privacy Act
2. Health Insurance Portability and Accountability Act (HIPAA)
3. Computer security
4. Facility policies and procedures
5. Department policies and procedures

E Expedited Credentialing and Delegated Authority

In remote areas of the Indian Health Service, the efficiency of the credentialing and privileging process has sometimes been impeded by the

distance between the Area Offices or Health Boards and the facilities where care is being provided. Some areas are moving toward "Delegated Authority" for approval of medical staff membership and clinical privileges.

In the case of delegated authority, the Governing Board determines that the involved facility has well established and consistent credentialing and privileging program. The Chair of the Governing Board, in conjunction with the Area Chief Medical Officer, may then delegate routine signature authority for the approval of medical staff appointments/reappointments and privileges at the Service Unit or the facility level. The delegated authority should be designated in writing by the Governing Board and should specify any limitations, special situations, and a plan for monitoring the ongoing integrity of the program.

JCAHO guidelines describe a very similar process referred to as the "expedited credentialing and privileging process" in which a facility's medical staff may expedite initial appointments, reappointments, granting of clinical privileges, and the renewal/modification of clinical privileges. Please refer to the most recent JCAHO standards for a complete description of the guidelines.

F Disaster Privileges

In the event of a disaster situation in which the emergency management plan has been activated and the current Medical Staff are unable to handle the immediate patient needs, the Chief Executive Officer, the Clinical Director, or his/her designee may grant disaster medical staff privileges to practitioners who are not members of the facility medical staff but wish to volunteer their services. Below is an example of a Disaster Privilege process.

Disaster Privileges will be granted on a case-by-case basis after the receipt of one or more of the following documents:

- A current hospital picture identification (ID) card
- A current medical license and a valid picture ID issued by a state, federal or regulatory agency
- Identification indicating the practitioner is a member of a state or federal Disaster Medical Assistance Team (DMAT)
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)
- Presentation by a current hospital or medical staff member with personal knowledge of the practitioner's identity

Should the disaster occur during normal working hours the Medical Staff Credentialing Coordinator and/or the Credentialing Clerk will be assigned to copy and log the required documents, after hours and on weekends an employee from the manpower pool will be assigned this duty.

Disaster privileges will only be granted within the capabilities of the practitioner and the facility and for only as long as the need exists. Licensure and current hospital affiliation will be verified by the Medical Staff

Credentialing Department as soon as possible when the emergency situation is under control. The verification process is considered a high priority and is identical to the process established under the medical staff bylaws for granting temporary privileges to meet an important patient care need.

XV Special Situations

A Emergency Privileges

This category of privileges is normally reserved for true emergencies. This category may be appropriate for the isolated situation in which the surgeon at a small remote town has a medical emergency while performing surgery. The surgeon across town may be immediately granted emergency privileges to come to the facility and complete the surgery on the patient.

B New Technology Procedures

New technologies and/or equipment are periodically developed that allow procedures to be performed that were not previously taught in medical school or residency programs.

Proctoring is one approach used in the process of granting clinical privileges for new technology procedures. The concept of proctoring involves allowing a practitioner to observe the performance of a procedure, and subsequently the practitioner performs the procedure while being observed by another practitioner with clinical privileges to perform the procedure. At a minimum, the following elements should be considered when developing a proctoring plan for a new technology procedure:

1. The ability of the facility's support staff to accommodate the procedure.
2. The proctoring plan should be pre-approved by the medical staff and the Governing Body.
3. The plan should outline didactic and/or observation requirements. In addition, any JCAHO required training should be considered
4. The person serving as the proctor(s) (teacher) should be identified in the plan. In addition, the proctor should provide evidence that they themselves have been trained and have current privileges to perform the procedure(s).The proctor should be responsible for initially determining when the practitioner being proctored is competent to perform the procedure(s). The proctor's recommendation should subsequently be forwarded to the Clinical Director, Credentials Committee, and/or Medical Staff Executive for recommendation to the Governing Body before the practitioner is allow to perform the procedure independently.

C Telemedicine

1. Credentialing and Privileging of "distant site" LIPs:

   Each medical staff department should determine, as needed, which services provided by the specific department should be provided by telemedicine. Provision of patient care, treatment, and services (including official readings of images, tracings, or specimens) via a telemedicine link must be recommended to and approved by the Medical Executive Committee (acting on behalf of the medical staff) prior to implementation. The proposal to the MEC recommending telemedicine services may include information concerning how the recommended service will enhance access to care, health care value, and quality of care. It should also include

information regarding how the telemedicine service will occur and how it will be coordinated.

Consultant/Contracted Licensed Independent Practitioners (LIPs) at a "distant site" (i.e. referral site where the LIP is located) who have either total or shared responsibility for patient care, treatment and services through a telemedicine links (as evidenced by having the authority to write orders and direct care, treatment and services) should be appropriately credentialed and privileged by the "originating site" (i.e. the I/T/U hospital or clinic receiving the services).

JCAHO currently permits use of one of the following three methods to credential and privilege distant site LIPs who have either "total or shared responsibility for patient care, treatment, and services through a telemedicine link". Importantly, selection of which option the originating site uses to credential and privilege LIPs providing telemedicine services from distant sites is *at the discretion of the originating site Medical Executive Committee and subsequently the Governing Body*. While there is no individual recommended method for each clinical discipline, there is potential prudence in erring towards full credentialing and privileging at the originating site for distant site LIPs who can prescribe medications or direct care for patients without prior consultant with the originating site primary care clinician (e.g. tele-psychiatry).

a The originating site may fully privilege and credential the LIP providing telemedicine services according to JCAHO standards.

b The LIP providing telemedicine services may be privileged at the originating site, using credentialing information from the distant site - if the distant site is a JCAHO-accredited organization;

OR

c The originating site may use both the credentialing and privileging information from the distant site, if all the following requirements are met:

- **i** The distant site is JCAHO-accredited.
- **ii** The LIP providing telemedicine services is privileged at the distant site for those services to be provided at the originating site.
- **iii** The originating site has evidence of an internal distant site review of the LIP's performance of these privileges and the originating site sends, as indicated, information to the distant site that is useful to assess the LIP quality of care, treatment, and services in routine distant site privileging and performance improvement. At a minimum, this information should include all adverse outcomes related to sentinel events considered reviewable by the Joint Commission that result from the telemedicine services provided, and complaints about the distant site LIP from patients, LIPs, or staff at the originating site.

Note: *This participation in performance improvement at the "distant site" should occur in a way consistent with any hospital/clinic policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.*

2. In the event of a pressing clinical need, temporary privileges may be utilized to cover services rendered by telemedicine providing the I/T/U facility's criteria for granting temporary privileges have been met.
3. Consultant/Contracted LIPs under the control of a JCAHO-accredited organization who provide official readings of images, tracings, or specimens through a telemedicine link should have a contract that clearly defines the nature and scope of services provided. The contract should specify that the distant site will ensure that all services provided by the contracted LIPs will be within the scope of their privileges at that site. The contract should also specify that a copy of the privileges of any provider providing telemedicine services will be made available to the originating site immediately upon request. The originating site (i.e. I/T/U) medical staff office will be responsible to verify the current JCAHO accreditation status of contracted organizations at the time of original and recurrent credentialing/privileging or contract negotiations.
4. Some I/T/U medical staff members may request to provide clinical services to other I/T/U hospitals and clinics through a telemedicine link. These LIPs should receive privileges to provide such telemedicine services through their local facility medical staff prior to actual service provision.
5. LIP(s) who ONLY provide official readings of images, tracings, or specimens through a telemedicine link and NEVER practice inside your facility can be processed like other contracted providers per JCAHO contracted services standards (Refer to JCAHO leadership chapter).

D Reporting to the National Practitioner Data Bank (NPDB)

In addition to querying the NPDB, the IHS reports medical staff adverse actions to the NPDB as well. It is the IHS practice for all reporting of adverse medical staff actions to the NPDB to be done by the Area CMO. This is not to be done at the Service Unit level.

E Credentials Verification Organization (Centralized Credentials Services)

Some Areas and service units have elected to employ centralized credentials services to assist in the primary verification of credentials. Care must be taken to assure that the credentialing process is carried out properly. For criteria to evaluate the performance of centralized credentials services, please review the most current JCAHO or AAAHC guidelines.

F Department of Defense Reservists

Another category of providers to consider from the credentialing standpoint may be reservists from the Department of Defense (DoD) serving their reserve component assignments in IHS facilities under the auspices of the U.S. Public Health Service - Department of Defense Health Professionals Program. Assuming that the reservist has been properly credentialed by his/her branch of the service, the following mechanism may be satisfactory to meet JCAHO guidelines:

1. The reservist is granted temporary privileges at the IHS facility. For

temporary privileges, the facility must verify licensure and current competence.

2. Primary source verification of licensure can be performed by DoD.
3. DoD needs to supply the IHS facility with copies of the documents concerning licensure and current competence from their credentials files on the reservist (i.e. copies of the primary source verification documentation).
4. DoD needs to indicate whether or not they have any other information concerning the reservist's license or current competence (e.g. adverse actions).
5. DoD needs to provide the name of a contact person for matters concerning the reservist's credentials.
6. The IHS credentials file on the reservist must contain documentation that contact was made with the contact person at DoD.

G Volunteers

Volunteers are routinely utilized in IHS facilities to provide health care services. A volunteer is defined as a person that is working without compensation or in a "non-paid" status. Residents that perform clinical rotations through IHS facilities are normally paid by their respective residency program and are not usually considered volunteers. The IHS facility should have a signed Collaborative Agreement with the appropriate teaching institution for these residents. The residency program will normally provide these individuals with malpractice insurance, and this should be documented and verified. Medical students, physician assistant students, and/or other non-paid volunteers would generally require a Volunteer Service Agreement if there is not a Collaborative Agreement with the teaching institution. Current IHS policy regarding volunteers should always be reviewed.

Bibliography

Accreditation Association for Ambulatory Health Care, *2005 Accreditation Handbook for Ambulatory Health Care.*

Joint Commission on Accreditation of Healthcare Organizations, *Comprehensive Accreditation Manual for Hospitals, 2005*

Pelberg AL, *Credentialing: A Current Perspective and Legal Background*. Qual Assur Util Rev 1989; 4 (1), p 8-14.

Southwick AF. *The Law of Hospital and Health Care Administration*. Health Administration Press, Ann Arbor, Michigan 1988; p 565-566.

Attachment 1—Credentialing Websites

Website	Organization	Cost	Misc
www.aaahc.org	Accreditation Association for Ambulatory Healthcare		
www.abms.org	American Board of Medical Specialties (ABMS) 1-800-776-2378	$10 per query if faxed, minimum of $30	Faxed verification considered primary source, but electronic verification not primary source with this site
www.ama-assn.org	American Medical Association (AMA) (312)464-5140	$29 per query, credit card payment	Web-based, same day results, considered primary source verification. The AMA ePhysician Profile website link is https://profiles.ama-assn.org/amaprofiles/
www.DO-Online.org	American Osteopathic Association (AOA) 1-800-621-1773	$16 per query, credit card payment	Web-based, immediate results, considered primary source verification. The AOA Physician Profile Report website link is https://secure.aoa-net.org/webprof/
www.ncsb.net/	Audiology—National Council of State Boards of Examiners for Speech-Language Pathology and Audiology (NCSB)		
www.studentdoctor.net/dental/state_boards.html or www.fatrat.com/state_dental_boards.htm	Dental Board Listing		Also see dental specialty listing at www.nlm.nih.gov/medlineplus/directories.html
www.ecfmg.org	ECFMG (215)386-5900	$25, currently by mail	Will be web-based soon
www.fsmb.org	Federation of State Medical Boards (FSMB) (817)868-4072	Signed contract & one time connection fee of $200 with FSMB required. $35 Connection cost plus $4 per query, facility billed monthly	Web-based, immediate results. Links to state medical boards and to medical specialty organizations. The facility based querying website link is https://secure.aoa-net.org/webprof/
www.google.com	Google Internet Search	Free	This can be used to find any medical board, dental board, etc. by using a logical search. Hospital addresses and phone numbers can also normally be located.
www.jcaho.org	JCAHO	N/A	Credentialing issues updates

Attachment 1—Credentialing Websites

Website	Organization	Cost	Misc
www.namss.org	National Association of Medical Staff Services	N/A	National organization for medical staff credentialing professionals.
www.npdb-hipdb.com	National Practitioner Data Bank (NPDB-HIPDB)	$4.25 per query, credit card payment	Web-based, same day results
www.ncsbn.org	Nursing - National Council of State Boards of Nursing		
http://oig.hhs.gov/	Office of Inspector General	Free	Medicare and Medicaid sanctions
www.arbo.org/index.php?action=arboDirectoryOfBoards	Optometry—Association of Regulatory Boards of Optometry		
www.fsbpt.org/	Physical Therapy—Federation of State Boards of Physical Therapy		
www.docboard.org	Physician Board Listing	Free	Links to DocFinder, ABMS, State Medical Boards, FSMB ECFMG, AMA, AOA, AAPA
www.docfinder.org	Physician Board Listing	Free	Website links to some state medical boards for electronic verification of license. Links to www.certifieddoctor.com
www.nlm.nih.gov/medlineplus/directories.html	Physician, Dental, and Hospitals Listing	Free	Also listing of physician and dental specialty organizations.
www.fpmb.org/memberboards.asp	Podiatry State Boards	Free	
Directory of Medical Schools Worldwide	U.S. Directory Service	Out of print - limited quantities via Amazon.com	Several others by different authors via Amazon.com
Hospital Telephone Directory	Unicol, Inc. 655 N.W. 128th Street PO Box 1690 Miami, FL 33168	Approximately $100	

Attachment 2—Flowchart of Credentialing/Privileging

Medical Staff Application Package
Medical Staff Application with Statement of Understanding and Release,
request for clinical privileges, and ability to perform (health status) statement

Primary Source Verification of Core Criteria
Verification of licensure, training and education, current competence, ability to perform,
and other relevant credentialing documents

Medical Staff Coordination
Coordination and review by the Medical Staff Credentialing Coordinator,
the Chief of Service (Department Head), and the Clinical Director.

Temporary Privileges
Temporary privileges may be issued if the application is complete and an urgent patient care need exists
and/or the provider needs to work prior to the next Medical Staff Executive Committee meeting.

Credentials Committee and/or Medical Staff Executive Committee Review
Recommendations are made to the Governing Body

Governing Body
The Governing Body grants or denies medical staff membership and/or clinical privileges
OR
The Governing Body requests additional information

Attachment 3—New Appointment Checklist

PROVIDER NAME _____

CLINICAL SERVICE _____

DATE _____

DOCUMENT	RECEIVED	VERIFIED	COMMENTS
Application			
Licensure			
State			
DEA/OSBN			
Certification(s)			
Board Certification			
Residency			
Internship			
Medical Diploma			
CPR/ACLS/ATLS/PALS			
Health Statement			
Immunization History			
Current CME Summary			
Privilege List			
Standing Orders / Skills List			
Profiles			
NPDB/HIPDB			
AMA or AOA Profile			
FSMB			
OIG Query			
Provider PI Profile			
Consultant Statement			
Reference Letter #1			
Reference Letter #2			
Liability Insurance			
Orientation Checklist			
Bylaws Summary			
In Sight of Memo / CNACI			
Contractor Certification Statement			
Declaration of Fed Employment			
Federal Employment (Contract) Clearance			
Medicare Form (admitting providers)			

NOTE(s):
NA = Does Not Apply
PI Profiles are moved to a separate file after being reviewed by the Medical Staff Executive Committee and Governing Body.

Attachment 4—Reappointment Checklist

PROVIDER NAME _____

CLINICAL SERVICE _____

DATE _____

Last Appointment _____ Expiration _____

DOCUMENT	RECEIVED	VERIFIED	COMMENTS
Reappointment Request			
Licensure			
State			
DEA/OSBN			
Certification(s)			
Board Certification			
Residency			
Internship			
Medical Diploma			
CPR/ACLS/ATLS/PALS			
Health Statement			
Current CME Summary			
Privilege List			
Standing Orders / Skills List			
Profiles			
NPDB/HIPDB			
OIG Query			
Provider PI Profile			
Consultant Statement			
Peer Recommendation #1			
Peer Recommendation #2			
Liability Insurance			

NOTE(s):
NA = Does Not Apply
PI Profiles are moved to a separate file after being reviewed by the Medical Staff Executive Committee and Governing Body.

Attachment 5—"Tickler" File

Employee/Provider Credentialing Expiration Dates 2002/2003/2004

Licensure/Privileges/ACLS/ATLS/BLS/DEA Expiration Date

Employee	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Doe, John, R Ph						CPR 0604			USA Rph 0905			
Tooth, Tommy, DDS			Priv 0403		II DDS 0502 BLS 0502		DEA 0700					
Flowers, Petunia, RN			CPR 0303									NC RN 1202

TEMPORARY/CONTRACT

Employee	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
VALENTINE, Lucy, MD	PRIV 0104			WA MD 0402			DEA 0702					

Attachment 6—License Verification Worksheet

MEDICAL PRACTITIONERS
PORTLAND AREA INDIAN HEALTH SERVICE

Practitioner's Name _____ Date of Birth _____ SSN _____

Degree [ ] MD [ ] DO [ ] PA-C [ ] NP

Speciality _____

State _____

License # _____

Initial Issue Date _____

Expiration Date _____

Status [ ] Active [ ] Inactive [ ] Retired [ ] Other (explain)

Comments _____

In Good Standing [ ] Yes [ ] No

Restrictions/Suspensions [ ] Yes [ ] No

Comments _____

State Board Address _____

Verified By _____

Title _____

Date _____

Attachment 7—Competency Verification

Date: April 15, 2005

From: Martin Smith
Medical Staff Credential Coordinator

Re: Richard Kimball, MD. DOB: 09-10-42

To: ATTN: Robin
Medical Staff Credentialing Coordinator
Halifax Memorial Hospital
250 Smith Church Road
Roanoke Rapids, NC 27870 Fax: (252) 535-8383

The provider named above has requested clinical privileges/reappointment at our facility. The Application indicates a recent affiliation with your organization.

Please respond to the following:

As a result of performance improvement activities, does the provider's credentials file contain trends, adverse findings, or information that could prevent reappointment or result in a reduction and/or restrictions of his/her clinical privileges? [ ] Yes [ ] No

Do you have any knowledge regarding this practitioner which involves:

1. Malpractice claims (current, past, or pending? [ ] Yes [ ] No
2. Challenges to licenses(s), certification(s), or DEA? [ ] Yes [ ] No
3. Sanctions by Medicare, Medicaid, or other Federal Agency? [ ] Yes [ ] No

Comments:_____

Dates of Medical Staff Membership: **From**_____ **Until**_____

Is your facility a JCAHO or AOA approved facility: [ ] Yes [ ] No

Signature **Title** **Date**

Thank you for your time and contribution to quality patient care! A self-addressed envelope, stamped envelope and a signed release of information are enclosed for your convenience.

Sincerely,

Martin Smith
Medical Staff Credentialing Coordinator
Claremore Comprehensive Indian Health Facility
101 South Moore Street
Claremore, OK 74017
Phone: (918) 342-6430 Fax: (918) 342-6517

Attachment 8—Professional Reference Questionnaire

Applicant Name: Richard Kimball, MD

Please rate the professional abilities of the applicant named above on a scale of 1 to 10 for the criteria listed below. **The best rating is 10.**

CRITERIA	SCORE
Basic medical knowledge appropriate to the speciality	
Professional judgement	
Sense of responsibility	
Ethical conduct	
Cooperativeness	
Participation in medical staff affairs	
Promptness in completing medical records	
Performance as compared to peers	

How long have you known the applicant?

What has been your relationship to the applicant?

To your knowledge, have the applicant's clinical privileges ever been suspended, withdrawn, supervised, approved with limitations, reduced, modified, or denied? In addition, did the applicant ever voluntarily withdraw a request for privileges in lieu of a formal denial or pending adverse action? [ ] Yes [ ] No

To your knowledge, has the applicant ever had any mental or physical illness, alcoholism or drug abuse and/or misuse that interfered or could potentially interfere with professional performance? [ ] Yes [ ] No

Is the applicant fluent in the English language? [ ] Yes [ ] No

Please select one of the following

_____ I would recommend the applicant without reservation

_____ I would recommend the applicant

_____ I would not recommend the applicant

Comments:

Signature **Title** **Date**

Printed Name

Address **City/State/Zip** **Phone**

Please return questionnaire to:

Clinical Director
Claremore Comprehensive USPHS Indian Health Facility
101 South Moore Avenue
Claremore, OK 74017-5091
Phone: (918) 342-6430 Fax: (918) 342-6517

Attachment 9—Privilege Verification

Date: April 15, 2005

From: Martin Smith
Medical Staff Credentialing Committee

Re: **Richard Kimball, MD, DOB: 09/20/21**

To: Jose Jiminez, MD
Director, Internal Medical Services
185 E. Texas Avenue, Suite 315
Hermit, CA 92544

The provider named above has requested clinical privileges at our hospital. Since the application indicates a recent affiliation with your organization, your evaluation of this person's clinical competence with respect to the privileges being requested would be most helpful in our determination of the privileges to be granted.

In addition to completing the attached Professional Reference Questionnaire, please review the attached clinical privileges that he/she has requested and select one of the following:

_____ I concur, the privileges requested are appropriate. In addition, in my opinion the above named person is mentally and physically capable of exercising the requested privileges

_____ I do not concur for the reasons listed below

_____ I concur but with the exceptions listed below

Comments: _____

_____

_____

_____

Signature **Title** **Date**

I would like to thank you in advance for your time and contribution to quality patient care!

Sincerely,

Martin Smith
Medical Staff Credentialing Coordinator
Claremore Comprehensive USPHS Indian Health Facility
101 South Moore Street
Claremore, OK 74017
Phone: (918) 342-6430 Fax: (918) 342-6517

Attachments: *Provider Privilege Request Form* and *Provider Reference Questionnaire*

Attachment 10—Peer Recommendation for Reappointment

Date: April 15, 2005

From: John Doe, MD
Surgery Service

Re: **Richard Kimball, MD, DOB: 09/20/21**

To: Medical Staff Executive Committee

I believe **Richard Kimball, MD** is qualified for reappointment on the **Surgery Service** of the Claremore Comprehensive USPHS Indian Health Facility based upon the following appraisals:

Level of activity	[ ] Satisfactory	[ ] Needs Improvement	[ ] Unsatisfactory
Clinical Competence	[ ] Satisfactory	[ ] Needs Improvement	[ ] Unsatisfactory
Technical skill/judgement	[ ] Satisfactory	[ ] Needs Improvement	[ ] Unsatisfactory
Professional performance based on results of performance improvement activities	[ ] Satisfactory	[ ] Needs Improvement	[ ] Unsatisfactory
Adherence to Medical Staff Bylaws	[ ] Satisfactory	[ ] Needs Improvement	[ ] Unsatisfactory
Health Status	[ ] Satisfactory	[ ] Needs Improvement	[ ] Unsatisfactory

Comments: _____

_____

_____

Therefore, I am recommending **him** for reappointment on the **Surgery Service** for a period of **two years** in the **Active** medical staff category.

John Doe, MD

John Doe, MD
Surgery Service

Attachment 11— Reappointment Profile

MEDICAL STAFF REAPPOINTMENT PROFILE PHS INDIAN HOSPITAL CLAREMORE, OKLAHOMA

Name		Department/Service

Reappointment period	Last Appointment	Current Staff Status

CLINICAL ACTIVITIES STATISTICS

	2003	2004
Outpatient visits	1023	1023
Admissions	164	157
Deaths	2	0
Timely completion of medical patient records	0 # delinquent 0 # suspensions	0 # delinquent 0 # suspensions
Surgical Procedures	0	0

MEMBERSHIP FACTORS

	2003			2004		
General Staff (Bylaws require attendance of 50% at regular meetings and mandatory attendance at annual meeting)	Meeting	1/3/2003	P	Meeting	1/2/2004	P
	Meeting	3/7/2003	P	Meeting	3/5/2004	P
	Meeting	5/2/2003	P	Meeting	5/7/2004	P
	Meeting	7/5/2003	E	Meeting	5/21/2004	P
	Meeting	7/11/2003	P	Meeting	7/9/2004	P
	Meeting	10/3/2003	P			
	Meeting	11/7/2003	P			
Committee memberships appointed to						
Continuing Education (Bylaws require 50 CME's per year)	hours documented			hours documented		

CLINICAL PERFORMANCE REVIEW

PERFORMANCE MEASURE	Number records reviewed/deficiency			
RISK MANAGEMENT	2003—Complaints received			
	Date	Complaint	Category	Code
	1/1412003	care/wanted another Dr.	1	0
	4/1512003	Refused to give meds	3	0
	5/3012003	meds needed	3	0
	6/1012003	would like another Dr.	3	0
	9/512003	care given	2	0
	10/912003	Unsatisfactory care	2	1
	2004— Complaints received			
	7/3012004	Refill on narcotics	3	0

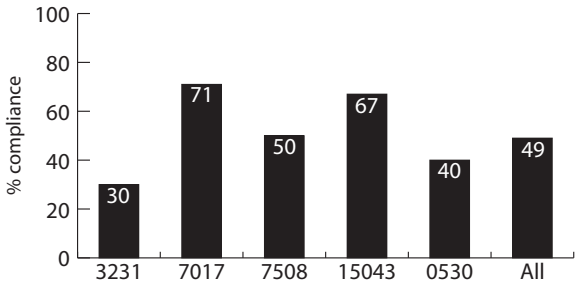
MEDICAL STAFF REAPPOINTMENT PROFILE

PERFORMANCE MEASURE	Number records reviewed/deficiency	
MORTALITY REVIEW	2003—2 in hospital deaths 2004—0 in hospital deaths	Management and treatment appropriate. Code O. on all cases
BLOOD USAGE REVIEW	No problems identified.	
UTILIZATION REVIEW	2003—9 denials, 5% denial rate 2004—5 denials, 3% denial rate	ALL—20 denials, 3.5% denial rate
P&T	No problems identified.	

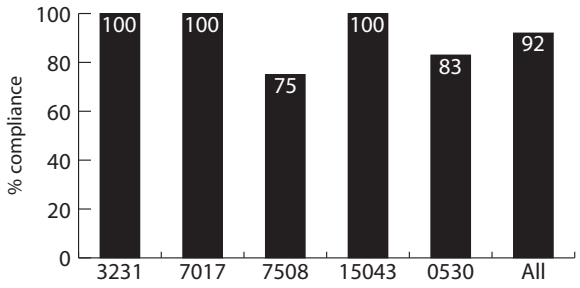
Prepared November 2, 2004/df

Community Acquired Pneumonia 2003

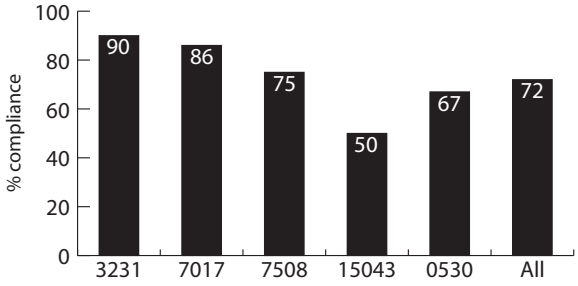
Appropriate antibiotic given



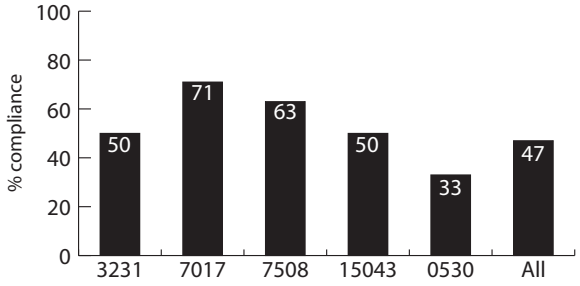
BC within 24 hrs prior to of after arrival to hospital

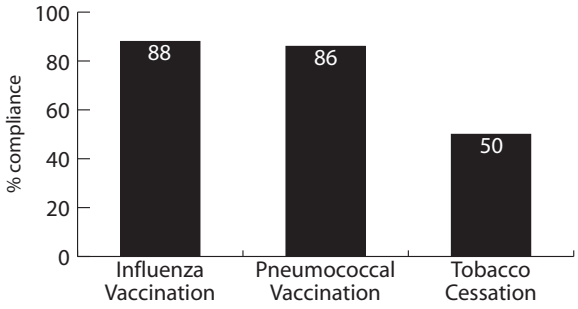


Antibiotic given within 4 hours

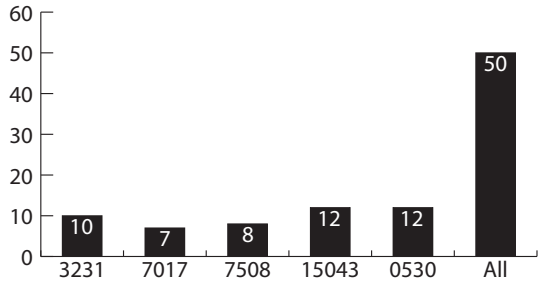


BC obtained before antibiotic given



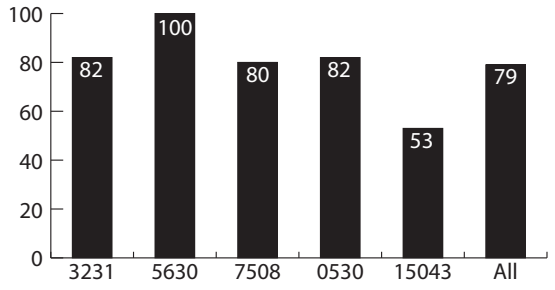


Admissions per provider

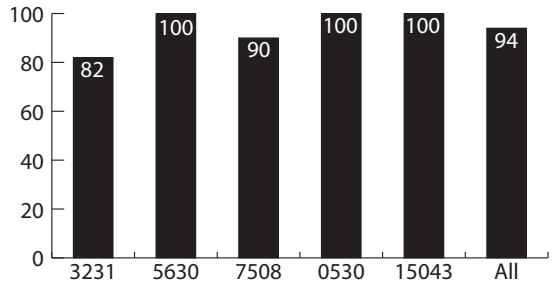


Community Acquired Pneumonia 2004

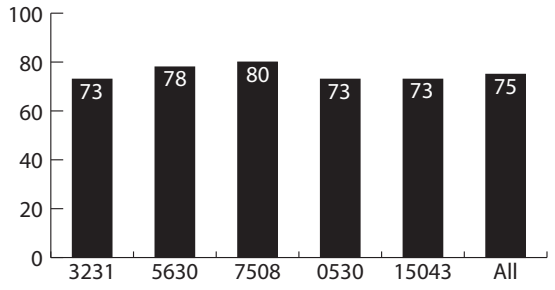
Appropriate antibiotic given



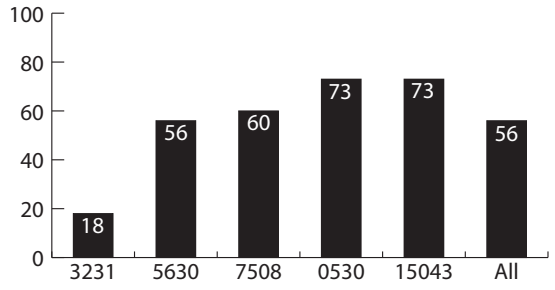
BC within 24 hrs prior to of after arrival to hospital



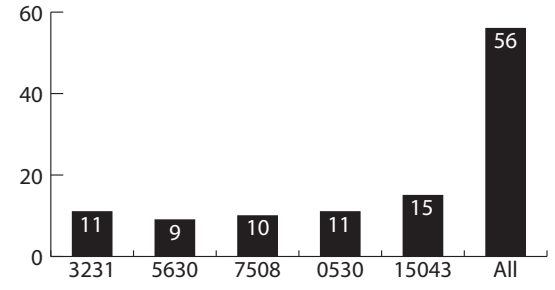
Antibiotic given within 4 hours



BC obtained before antibiotic given

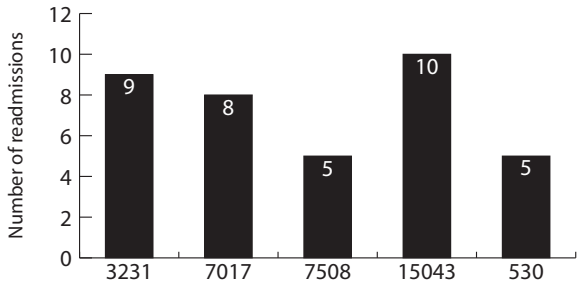


Admissions per Provider



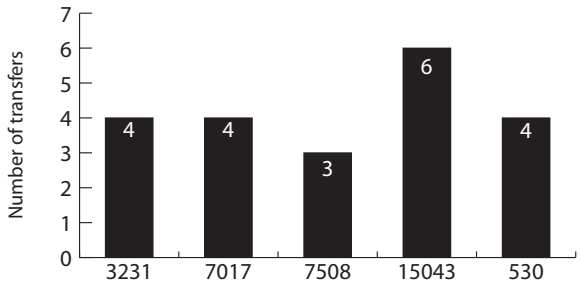
Service—2003 Annual Progress Report

Readmissions—2003



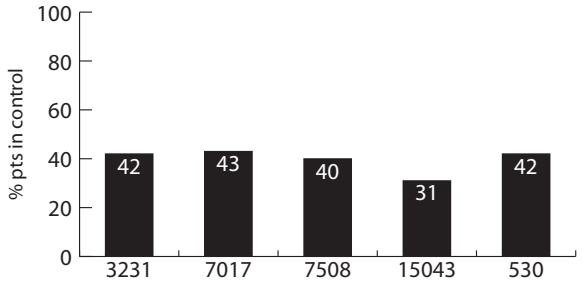
All readmissions were managed appropriately

Transfers from GMS to ICU—2003

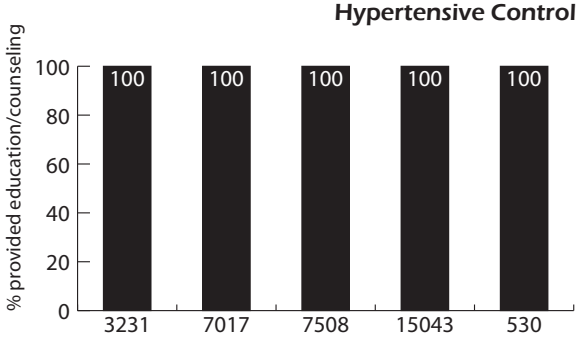


All transfers from GMS to ICU were managed appropriately

Hypertension Control—2003



Hypertensive Control



Attachment 12—Health Status Statement

Re: Health Statement

To: Claremore Comprehensive USPHS Indian Health Facility
Medical Staff Executive Committee

In my opinion, **Richard Kimball, MD** is mentally and physically capable of exercising clinical privileges as a physician on the **OB/GYN Service** at the Claremore Comprehensive USPHS Indian Health Facility.

_____
Physician Signature **Date**

_____
Printed Name

_____
Address

_____
City/State/Zip

_____
Phone

Return to:

Clinical Director
Claremore Comprehensive USPHS Indian Health Facility
101 South Moore Avenue

Attachment 13—Verification of Malpractice Insurance

Warm Springs Health & Wellness Center
1270 Kot-Num Rd., P.O. Box 1209
Warm Springs, OR 97761

September 24, 1998

Underwriting Department
Insurance Company Name
Street Address
City, State, Zip

Re: (Practitioner's Name)

DOB: (Date of birth) SSN: (Social Security Number)

Policy #:

The above has applied for medical staff membership and clinical privileges at (HOSPITAL/ CLINIC NAME) and has informed us that he/she had been insured by your company. Please complete the information below and return it in the enclosed envelope. Enclosed is a copy of his/her "Release and Waiver of Application for Medical Staff Appointment."

If you have any questions, you may contact me through Medical Staff Department at 541-123-4567. Thank you.

Name
Title
Department

Liability Insurance

Inception Date_____

Expiration Date_____

Policy Limits_____

Primary or Secondary_____

Type of Policy_____

Please attach a copy of any history of suits and third party claims on which you have made payment while applicant had been insured.

Verified by:

_____

Signature **Title** **Date**

_____

Company

Attachment 14—In-Sight-Of Memo for CNACI

Date: February 8, 2004

To: Supervisor of Child Care Worker

From: Martin Short, Acting Director, Division of Human Resources

Re: In-Sight-Of Statement for CNACI Clearance

William Kildare, MD has been selected for a position covered under P.L. 100-630 and P.L. 101-646, which involves background checks for child care service workers. Under these provisions, this employee MUST work in sight of an employee that has had a NACI clearance, until the Child Care NACI of this employee has cleared. The interpretation by IHS includes all positions where direct contact with children may be made.

You will be notified as soon as the Child Care NACI is complete. At that time, the "in sight of" requirement may be lifted. If you have not received a release within 6 months, you may contact Mrs. Sally Smith at ext. 429 in Human Resources or Ms. Tonya Johnson at 405-951-3777 in OCAO, Human Resources Department.

Please list five workers this employee will be "in sight of" until clearance is complete.

1 _____

2 _____

3 _____

4 _____

5 _____

Signature	Title	Date

M Smith

Martin Short
Acting Director, Division of Human Resources

Attachment 15—Verification of Residency

Date: September 25, 1998

From: John Doe
Medical Staff Credentialing Coordinator

Re: Dr. R.U. Unnahnah (or R.U. Unnahnah, MD)

To: Director, Internal Medicine Residency Program
Harper Hospital
3990 John "R" Street
Detroit, MI 48201-2097

The medical staff applicant of the physician named above indicates he/she began an Internal Medicine residency at your institution in 1981 and completed the residency in 1984.

Please review the information in the preceding paragraph and respond to one of the following:

_____ *The information above is correct and the physician completed the residency in good standing.*

_____ *The information above is NOT correct and/or the physician DID NOT complete the residency in good standing*

Signature	**Title**	**Date**

I would like to thank you in advance for your time and contribution to quality patient care!

A signed release for information and a self-addressed envelope is enclosed for your convenience.

Sincerely,

John Doe, MD

John Doe
Medical Staff Credentialing Coordinator
1001 Documents Road
Healthcare City, OK 74100

Attachment 16—Verification of Professional Education

Date: April 3, 1996

From: John Doe
Medical Staff Credentialing Coordinator

Re: **Richard Kimball, M.D. DOB 02/25/27**

To: Registrar
University of Oklahoma College of Medicine
801 N.E. 13th Street
Oklahoma City, OK 73190

The medical staff application of the physician named above indicates he/she received a **Doctor of Medicine** degree from your institution in 1992.

Please review the information in the preceding paragraph and **select one of the following:**

_____ the information is **correct**

_____ the information is **not correct**

Comments:_____

_____

_____

_____

Signature **Title** **Date**

Thank you for your time and contribution to quality patient care! A signed release for information and a return envelope are enclosed for your convenience.

Sincerely,

John Doe, MD

John Doe
Medical Staff Credentialing Coordinator
Watertown Indian Health Service Hospital
1001 Waterhole Drive
Watertown, AZ 85539

Attachment 17—Verification of Board Certification

Date: January 21, 2000

From: Mikey Looneytunes
Area Credential Coordinator

Re: Dr. Micky Tooney

To: American Board of Pathology
P.O. Box 25915
Tampa, FL 33622-5915

The medical staff application of the physician named above indicates that he is Board Certified in "Anatomic and Clinical Pathology" with a subspeciality certificate in "Cytopathology" through your organization.

Please review the information in the preceding paragraph and respond to one of the following:

_____ *The information above is correct and the physician is in good standing.*

_____ *The information above is NOT correct and/or the physician is NOT certified or in good standing with the Board*

Signature **Title** **Date**

I would like to thank you in advance for your time and contribution to quality patient care!

A signed release for information and self-addressed envelope is enclosed for your convenience.

Sincerely,

CDR Maggie R. Bee
Warm Springs Health & Wellness Center
P.O. Box 1209
Warm Springs, OR 97761

Attachment 18—Verification of Current Residency Program

Date: June 06, 2005

From: Martin Smith
Medical Staff Credentialing Coordinator

Re: **John Glenn, DO DOB 06/21/56**

To: Thomas Pickard, DO, Associate Professor
Department of Family Medicine
Oklahoma State University College of Osteopathic Medicine
2345 SW Boulevard
Tulsa, OK 74107-2705 Phone (918) 561 8525

The medical staff application of the physician named above indicates he/she is currently enrolled in the following program(s) at your institution:

Family Medicine Residency

Please review the information in the preceding paragraph and respond to one of the following:

_____ *The information is correct and the physician is expected to complete the program in good standing. Expected completion date: _____. In addition, the provider is authorized for moonlighting activities by the program director.*

_____ *The information is NOT correct and/or the physician is NOT enrolled in the program or is not in good standing.*

_____

Signature **Title** **Date**

I would like to thank you in advance for your time and contribution to quality patient care.

Sincerely,

Martin Smith, Medical Staff Credentialing Coordinator
Claremore Comprehensive Indian Health Facility
101 South Moore Ave.
Claremore, OK 74107
918-342-6416

Attachment: Statement of Release and Understanding

GLOSSARY

AAAHC—The Accreditation Association for Ambulatory Healthcare

Founded in 1979, this peer based organization assesses, educates and accredits ambulatory health care organizations. It is an accreditation alternative to JCAHO for ambulatory care facilities.

ABMS Compendium of Certified Medical Specialists

The ABMS Compendium of Certified Medical Specialists lists all physicians who had been certified by an examining board approved by the American Medical Association. It contains biographical and education information on each physician. The ABMS Compendium of Medical Specialists includes statements on the requirements for certification by each specialty board.

Accreditation Council on Graduate Medical Education—ACGME

The accreditation Council of Graduate Medical Education (ACGME) of the American Medical Association accredits graduate education programs, which meet the "General and Special Requirements of the Essentials for Accredited Residencies". ABMS - see American Board of Medical Specialties

ADA—see American Dental Association, American Disabilities Act

Admitting Privileges

Privileges granted by the Governing Body to an individual practitioner that allows the individual to admit a patient to inpatient services (hospitalize the patient).

AHP—see Allied Health Professionals

Allied Health Professionals—AHP

Allied Health Professionals (AHP) are individuals other than physicians who are qualified by training, experience, and current competence in a discipline which the hospital governing body has determined by policy to allow to practice in the hospital. There are two categories of Allied Health Professionals:

- Independent AHP has a recognized but limited scope of practice and is licensed and permitted to provide services independently in the hospital without the direction of immediate supervision of a physician, i.e. podiatrist, clinical psychologist.
- Non- independent AHP or Physician-directed AHP functions in a medical support role to a physician, i.e. certified nurse midwife, certified nurse anesthetist, physician assistant, nurse practitioner. These may have a job description vs. privileges.

Allopathic Physician—see MD

AMA—see American Medical Association

American Board of Medical Specialties—ABMS

The American Board of Medical Specialties (ABMS) was founded in 1933 to establish and maintain minimal standards of organization and operation of specialty boards. There are 23 approved specialty boards, pertaining to MDs only.

AMA Physician Profile

The American Medical Association maintains a profile on all physicians who have graduated from medical school regardless of whether they are members of the AMA. The information is provided to the AMA by the various colleges, training programs, and specialty boards, which are accredited or recognized by the AMA. The physician provides address and specialty. The AMA Physician Profile can be used to correlate information provided by the applicant, and may be used for primary source verifications.

American Dental Association—ADA

The American Dental Association (ADA) is the primary professional organization representing dentists. The Council on Dental Education of the ADA accredits dental schools.

American Hospital Association—AHA

The American Hospital Association (AHA) is the primary professional organization representing hospitals. There also local and state hospital associations.

American Medical Association—AMA

The American Medical Association (AMA) is the primary professional organization representing allopathic physicians (MDs). It was founded in 1845 with a primary goal of improving medical education.

American Osteopathic Association—AOA

The American Osteopathic Association (AOA) is the primary professional organization representing osteopathic physicians. The Bureau of Professional Education of the AOA accredits osteopathic medical schools. The development and approval of undergraduate and postdoctoral training programs has been the most significant activity of the AOA.

American Podiatric Medical Association—APMA

The American Podiatric Medical Association (APMA) is the primary professional organization representing podiatrists. The Council of Podiatric Medical Education is the accreditation entity of the APMA. Its purpose is to accredit podiatric schools, post-graduate training, and CME. Its recognized specialty boards are American Board of Podiatric Orthopedics, American Board of Podiatric Surgery, and the American Board of Podiatric Public Health.

American Psychological Association—APA

The American Psychological Association (APA) is the primary professional organization representing psychologists. The APA accredits doctoral programs and pre-doctoral internships and operates the National Registry of psychologists.

American with Disability Act—ADA

The Americans with the Disability Act (ADA) created a national mandate to eliminate discrimination against individuals with disabilities. Two principle components of the ADA deal with (1) discrimination in employment (Title I) and (2) public accommodations (Title III).

AOA—see American Osteopathic Association

AOA Committee of Hospital Accreditation

The American Committee of Hospital Accreditation is the accrediting agency for designated osteopathic hospitals. The accreditation process is similar to the JCAHO.

AOA Physician Profile

The American Osteopathic Association maintains a profile on all physicians who have graduated from medical school regardless of whether they are members of the AOA. The information is provided to the AOA by the various colleges, training programs, and specialty boards, which are which are accredited or recognized by the AOA. The AOA Physician Profile can be used to correlate information provided by the applicant, and in some cases may be the only source available for verification. The AOA physician profile may be used for primary source verifications.

AOA Yearbook and Directory of Osteopathic Physicians

The AOA Yearbook and Directory of Osteopathic Physicians contains osteopathic physicians listed alphabetically, geographically, and by specialty certification. It also includes information about the American Osteopathic Association and its affiliated organizations and approved institutions. Information about osteopathic education is published and distributed by the AOA Department of Education.

APA—see American Psychological Association

APMA—see American Podiatric Medical Association

Appointment

Appointment and granting of clinical privileges is the initial admittance to the medical staff. In making these decisions, the governing board relies on recommendations from the organized medical staff. Appointment decisions are based on a thorough investigation of the applicant based on the JCAHO core components. They are:

1. Licensure
2. Education/Training
3. Clinical competence
4. Health status as it pertains to privileges requested privileges; to comply with ADA requirements, health.

BME—see Board of Medical Examiners

Board Certification

Board certification is the process by which a non-governmental association grants recognition to an individual who has met certain pre-determined qualifications specified by that association. The most common physician-related example is certification by the ABMS specialty boards or the AOA specialty boards. Components of certification can include a written examination and an oral examination. There are also subspecialty certifications. In the past, board certification was for life. However, the ABMS endorsed the principle of recertification in 1973 and 1978. Board certification is becoming time-limited, and the physician must be re-certified to continue to be board certified. Recertification requirements now exist in a majority of the specialty boards.

Board Eligible, Board Admissible, or Board Qualified

The ABMS recommends that the terms, Board Eligible, Board Admissible, or Board Qualified, not be used because they are not useful as indicators of a physician's progress toward board certification. Inquiries should request the physician's status in the certifying process.

Board of Medical Examiners—BME or BOMEX

The Board of Medical Examiners (BME or BOMEX) are state licensing boards that are responsible for the licensure of physicians, which emerged as states started to enact medical practice acts in the 1870s. Some states have combined MD/DO boards while others have separate boards.

Board of Trustees—see Governing Body

Bylaws

Medical staff bylaws, the authoritative guidelines for the organized medical staff, define the organizational relationships among physicians and the relationship between the physicians as a group and the hospital as an entity. They are the rules governing the responsibilities of the staff as a whole and of individual staff members. Bylaws are adopted by the governing body after recommendation by the medical staff. Medical staff bylaws should be relatively simple with general rules carefully stated and supplemented by related documents detailing implementation.

- Medical Staff Rules and Regulations
- Clinical Department Rules and Regulations

Central Verification Organization—CVO

A Central Verification Organization is a contracted credentials verification service, usually part of a county medical society. The JCAHO has guidelines to follow in the selection and re-evaluation of CVOs.

Certified Medical Staff Coordinator—CMSC

A Certified Medical Staff Coordinator (CMSC) is an individual who primarily is responsible for medical staff service functions. Since 1981, the NAMSS certifying examination for medical staff coordinators (CSMC) has become a bench mark of excellence and a measure of knowledge. Re-certification is required every three years.

Certified Provider Credentialing Specialist—CPSC

A Certified Provider Credentialing Specialist (CPSC) is an individual who primarily credentials physicians and allied health practitioners for a healthcare entity. Re-certification is required every three years.

Chief Executive Officer—CEO

The hospital Chief Executive Office (CEO) or administrator is the liaison between the medical staff and the governing body. For day to day activities, the CEO is the authorized governing body of representative.

Chief of Staff

The Chief of Staff is the chairman of the Medical Executive Committee and acts as the liaison between the CEO, nursing, and governing body. This position is also known as the President of the Medical Staff.

Clinical Competence

Current clinical competence is that practitioner's actual clinical performance and technical skills for the scope of practice. At appointment, clinical competence is based on training and experience. For reappointment, it is based on results of performance improvement activities and recommendations from peers and the department chairperson.

CME—see Continuing Medical Education

CMSC—see Certified Medical Staff Coordinator

Continuing Medical Education—CME

Continuing medical education (CME) should relate to the physician's scope of practice and in renewal of clinical privileges at reappointment. Most states have mandatory continuing medical education requirements for re-licensing or for membership in the state medical association.

Category I CME credit refer to programs accredited by the AMA.

Core Components

Core Components of appointment and reappointment are:

- Licensure
- Education/Training
- Clinical Competence
- Health Status or the ability to perform requested privileges; to comply with ADA requirements, health status is not mentioned.

Corrective action

A physician whose practice or conduct results in unacceptable standard of care or behavior may become subject to correct action. The process for corrective action and the process for a Fair Hearing should be described in the medical staff bylaws.

CPSC—see Certified Provider Credentialing Specialist

Credentialing

Credentialing is the process of collecting and verifying a medical staff applicant's credentials. The information is utilized by the medical staff to evaluate an applicant's qualifications and previous experience to determine if he/she is competent for appointment and/or clinical privileges. Hospitals must make reasonable attempts to verify an applicant's experience and training.

Credentials

Credentials are the documented evidence of licensure, education, training, experience, or other qualifications.

Credentials Committee

The Credentials Committee has the responsibility for reviewing completed applications for initial appointment and reappointment, including membership and clinical privileges. This is a multi-disciplinary committee of Medical Staff members with an experienced medical staff leader as chairperson.

CVO—see Credentials Verification Organization

DDS—Doctor of Dental Surgery—see Dentists

DEA Certificate—Drug Enforcement Administration Certificate

A DEA certificate verifies registration with the Federal DEA, authorizing providers to prescribe narcotics. It has a certificate number, an expiration date, and the categories of narcotics the provider may prescribe.

Deemed status

The JCAHO and AOA accreditation programs have been granted "deemed status" to conduct accreditation surveys of acute care hospitals by Centers for Medicare and Medicaid Service (CMS). This means that a hospital accredited by the JCAHO or AOA is deemed to comply with the Medicare Conditions of Participation for Hospitals as published by CMS. AAAHC has been granted "deemed status" to conduct surveys for ambulatory surgery centers as well.

Delineation of Privileges

Clinical privileges are extended to each practitioner based on their training and experience. The privileges are provider specific and take into consideration the capability of the facility and support staff.

Dentists—DDS or DMD

Dentists practice comprehensive preventive and therapeutic oral care of the teeth. Oral and maxillofacial Surgery is that part of dental practice which deals with diagnosis and surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial regions, reconstructive surgery, surgical management of pathologic conditions and dentofacial and craniofacial deformities.

Department Chairperson

The department chairperson has the departmental responsibility for evaluating applications for appointment and reappointment membership and clinical privileges and forwarding recommendation to the Credentials Committee or the Medical Executive Committee.

Directory of Graduate Medical Education Programs

The Directory of Graduate Medical Educational Programs is published by the American Medical Association and is a list of graduate medical education programs in the United States. Popularly called, "The Green Book," it provides an official list of programs accredited to offer graduate medical training.

DMD—Doctor of Medical Dentistry. Equivalent to DDS.

DO—Doctor of Osteopathy

A Doctor of Osteopathy is one of the two groups which are educated, trained and licensed as physicians and surgeons. A DO, also known as an osteopathic physician, completes four years at an accredited osteopathic medical school.

DPM—Doctor in Podiatric Medicine

Drug Enforcement Administration Certificate—see DEA Certificate

ECFMG—Educational Commission for Foreign Medical Graduates

The Education Commission for Foreign Medical Graduates (ECFMG), through a program of certification, assesses the readiness of graduates of foreign medical

schools to enter residency or fellowship programs in the United States that are approved by the Accreditation Council for Graduate Medical Education (ACGME). ECFMG defines a "foreign medical graduate" as a physician whose basic medical degree or qualification was conferred by a medical school located outside the United States, Canada, and Puerto Rico. ECFMG certification provides assurance to directors of ACGME-accredited programs that graduates of foreign medical schools have met minimum standards of eligibility required to enter such programs. ECFMG certification is also pre-requisite for licensure of foreign medical graduates to practice medicine in most states in the United States. To earn ECFMG certification, graduates of foreign medical schools are required to pass a medical science examination and the English language proficiency test administered worldwide by ECFMG and to document completion of the educational requirements to practice medicine in the country in which they have received their medical education. A national of the country concerned must have obtained an unrestricted license or certificate of registration to practice medicine in that country.

Federal Tort Claims Act—FTCA

A Federal law which allows individuals injured by a Federal employee or in a Federal facility/program to file for compensation for this injury. The FTCA imposes liability on the Federal government for acts of its employees, rather than on the employees, as their sole means of remedy.

Federation of State Medical Boards

The Federation of State Medical Boards is a data bank containing physician disciplinary action information as reported by state licensing boards for MD's and DO's. There is a searchable data base regarding disciplinary actions taken against physicians with report of action taken, dates, and brief description. Information required for a search includes: full name, date of birth, and social security number.

Federation of State Podiatric Medical Boards

The Federation of State Podiatric Medical Boards, founded in 1982, parallels the Federation of State Medical Boards. Its purpose is disciplinary data collection from state licensing boards regarding podiatrists.

Fellowship

Fellowship is generally defined as a subspecialty training program following a residency, and these trainees are called fellows. For example, a cardiology fellowship is preceded by internal medicine residency.

Fifth Pathway

In 1971, the American Medical Association (AMA) established a special program to assist Americans wishing to return to the United States after attending a foreign medical school. This program, called "Fifth Pathway," is available only to persons studying abroad who have:

- Completed their pre-medical work in a U.S. accredited college of quality acceptable for matriculation in an accredited medical school;
- Studied medicine in a foreign medical school listed in the WHO World Directory of Medical Schools," and
- Completed all requirements for admission to practice **except** internship and/or social service in the foreign country.

If the aforementioned criteria are met, the Foreign Medical Graduate is able to

substitute the Fifth Pathway program for internship and/or social service in the foreign country. After having passed the required medical science examinations, these physicians are eligible to enter the first year of accredited U.S. graduate medical training.

FLEX

FLEX is a clinical competence examination, which is used by all states as the medical licensing examination. Those graduates who are not licensed by endorsement of a National Board certificate must pass the FLEX.

Foreign Medical Graduate (FMG)

A foreign medical graduate is a physician who received a basic medical degree at a medical school outside the United States, Canada, or Puerto Rico.

FSMB—see Federation of State Medical Boards

FTCA—see Federal Tort Claims Act

Governing Body

The hospital governing body or board of trustees is accountable for the quality of care delivered. Trustees are members of the community, although there is medical staff representation. The governing body grants medical staff membership and/or clinical privileges based on medical staff recommendations.

Health Care Quality Improvement Act of 1986—HCQIA

The Health Care Quality Improvement Act of 1986 (HCQIA) was enacted to encourage effective professional peer review by providing immunities to the participants. It also created the National Practitioner Data Bank, a national clearinghouse for reporting actions. IHS is not covered under this act, but does query and report to the National Practitioner Data Bank by policy.

Health Status

JCAHO requires that a practitioner's health status is to be considered at the time of appointment and reappointment, but the Americans with Disabilities Act prohibits employers from inquiring about an applicant's health status. To comply with ADA requirements, health status is not mentioned in the current JCAHO standards. Instead, the ability to perform requested privileges is addressed.

Hospital specific

Clinical privileges are hospital specific and practitioner specific based on the particular patient services of the hospital.

House Staff—see PGY and Resident

Individuals that have graduated from medical school, dental school, etc. and are appointed to the hospital's professional graduate education program. The housestaff participate in patient care under the direction or supervision of licensed independent practitioners of the same clinical disciplines who have clinical privileges and are members of the medical staff at the hospital.

Internship

Internship is a term used to identify the first year of post-graduate training after medical school. Interns are physicians in the first year of any residency program. However, the first year of graduate medical education has been integrated as the first

year of residency. For MDs, the term internship is becoming outdated. Osteopathic physicians are required to complete a one year internship regardless of whether they are entering an osteopathic (DO) or allopathic (MD) specialty training program. The internship offers a broad generalist clinical curriculum. After completion, the DO can enter either general practice or a residency program. Interns have a training medical license, but NOT an unrestricted license allowing them to practice independently.

Invasive Procedure

A procedure involving puncture of cutting of the skin, or the insertion of an instrument or foreign material into the body (biopsies, percutaneous aspirations, vascular catherizations, endoscopies etc). Intravenous therapy and venipuncture are not considered invasive procedures.

JCAHO —Joint Commission on Accreditation of Healthcare Organization

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) was formed in 1952 to assume responsibility for setting standards for hospital services and operating the system of voluntary survey for compliance with those standards known as hospital accreditation. It was formed by the American College of Physicians, the American Hospital Association, the American Medical Association, and the American College of Surgeons to continue the hospital standardization program started by the ACS.

JCAHO Standards

The 5 Minimal Standards established by the American College of Surgeons in 1919 has evolved into the multi-volume Comprehensive Accreditation Manual for Hospitals.

Liaison Committee on Medical Education (LCME)

The Liaison Committee on Medical Education (LCME) of the American Medical Association accredits United States medical schools.

Licensure

Licensure is the process by which a state grants permission to an individual to engage in an occupation upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected.

Malpractice

Malpractice is a dereliction from professional duty or a failure to exercise an accepted degree of professional skill or learning by one (as a physician) rendering professional services which results in injury, loss, or damage. An applicant's malpractice claims history should be investigated as a matter of routine during the credentialing process.

MBBS—Bachelor of Medicine & Surgery

Equivalent to an MD degree. Medical education for physicians varies in length. Some countries combine undergraduate and medical education. Some include internship and/or public/military services as a part of the medical education.

MBCH—Bachelor of Medicine & Chemistry

Equivalent to an MD degree. Medical education for physicians varies in length. Some countries combine undergraduate and medical education. Some include internship and/or public/military services as a part of the medical education.

MD—Doctor of Medicine

An MD or Doctor of Medicine is one of two groups which are educated, trained and licensed as physicians and surgeons. An MD, also known as an allopathic physician, completes four years at an accredited allopathic medical school.

Medical Executive Committee (MEC)

The Medical Executive Committee (MEC) is the highest authority of the medical staff and acts for the total medical staff membership. MEC meetings are chaired by the Chief of Staff. It is one of the committees that JCAHO requires. Its duties and responsibilities, as well as composition, should be specified by the medical staff bylaws. The usual composition is medical staff officers, department chairpersons, members at large, and ex-officio members, i.e. CEO, nursing administrator. Sometimes the Credentials Committee chairman is a member.

Mid-level practitioner—see *AHP, Allied Health Professional*

NAMSS—National Association of Medical Staff Services

The National Association of Medical Staff Services (NAMSS) is the primary professional organization for the medical staff services professional. Goals are networking, continuing education, role modeling, and certification. Since 1981, the NAMSS certifying examination for medical staff coordinators (CMSC) has become a bench mark of excellence and a measure of knowledge. Beginning in June 1996, NAMSS will offer a certifying examination for provider credentialing specialists (CPSC). Re-certification is required every three years. Other NAMSS activities include a professional journal, a national conference, and teaching seminars.

National Board of Medical Examiners

National Board of Osteopathic Medical Examiners

National Board of Medical Examiners certification is the basis for initial medical licensure for most United States medical school graduates.

National Committee for Quality Assurance (NCQA)

The National Committee for Quality Assurance (NCQA), founded in 1979, is an independent organization that assesses the quality of managed care organizations by performing external reviews. The objective of NCQA accreditation is to ensure that individual programs comply with the committee's national standards. NCQA is under contract to individual states, insurance companies, and other groups.

National Practitioner Data Bank Query (NPDB)

The National Practitioner Data Bank was established by the Health Care Quality Improvement Act of 1986 as a national clearinghouse for:

- Medical malpractice payments
- Licensure disciplinary actions
- Adverse clinical privileges actions
- Adverse actions affecting professional society membership

The establishment of the NPDB has minimized the ability of incompetent practitioners and/or practitioners with disciplinary actions to move from state to state without disclosure or discovery of prior adverse actions. JCAHO requires the NPDB to be queried at the time of the practitioner's initial medical staff appointment, reappointment, and anytime privileges are expanded or reduced. The National Data Bank became effective 1 September 1990.

NCQA—see National Committee for Quality Assurance

NPDB—see National Practitioner Data Bank

Observation

New medical staff members are appointed for a provisional period during which time the medical staff has the opportunity to evaluate the practitioner's skills directly to determine if they are commensurate with the privileges granted. Observation requirements are specified in department rules and regulations. If skills are found to be less than adequate on the basis of direct peer evaluation, the medical staff still has legally supportable recourse to adjust privileges or deny status based on the information derived from the proctoring program.

OGME—Osteopathic graduate medical education uses the initials

Osteopathic physician—DO

Osteopathic physicians practice medicine by using structural diagnosis and treatment along with all the other more traditional forms of diagnosis and treatment. By the year 2010, there will be an estimated 60,000 DO's.

Peer

A peer is a person who is of equal standing with another or belongs to the same group. Example of peers are physicians to physician, dentist to dentist, psychologist to psychologist, nurse practitioner to nurse practitioner, etc. For the purpose of privileging, it is recommended to also utilize peers from the same specialty (surgeon to surgeon, OB/GYN to OB/GYN, etc).

PGY—Post-graduate year

Post-graduate training is required for MD's and DO's with the length of time depending upon the specialty training.

PGY-1

Internship year or first year of residency, depending upon the specialty training. Most individuals in the transitional year programs are PGY-1 residents, have a training license, and cannot practice independently.

PGY-2

Second year of graduate training (residency), normally has a medical license.

PGY-3

Third year of graduate training

PGY-4

Fourth year of graduate training

Podiatrist—DPM

Podiatrists deal with the examination, diagnosis, treatment, and prevention of diseases, conditions, and malfunctions affecting the human foot, ankle, and its related or governing structures, by employment of medical, surgical, or other means.

Primary Source

A primary source is the original source of a specific credential that can verify the accuracy of a qualification reported by an individual healthcare practitioner.

Primary Source Verification

Primary Source Verification is a written verification sent directly to the entity which has first-hand knowledge of the information that needs to be verified. This includes medical schools, residency training programs, specialty boards, state licensing boards, professional liability insurance carrier, and hospital affiliations. JCAHO now allows primary source verifications from primary source internet websites.

Proctoring

The process in which a medical staff member observes and then is subsequently observed by another medical staff member with appropriate clinical privileges while performing a procedure(s). The proctoring plan/process should be pre-approved by the medical staff and the Governing Body. It is a valuable tool in establishing an individual's competence to perform new technology procedures.

Professional Liability Insurance

Professional liability coverage is the malpractice insurance a practitioner carries for liability in the event of malpractice litigation. A Certificate of Insurance provides the name of the carrier, amounts of coverage, and dates of coverage.

Provisional Appointment

The Provisional Appointment is specified in medical staff bylaws. The time period is defined, i.e. the first 12 months of staff membership, and is consistent for all appointees. It can be an established staff category. The provisional period is necessary to fully evaluate a practitioner prior to granting a more expanded delineation of clinical privileges and/or to confirm or deny that the initial appointment was justified. At the end of the provisional appointment, several options are available to the medical staff. They are:

1. Satisfactory completion of observation requirements; recommend advancement to a non-provisional staff category.
2. Observation requirements not fulfilled; recommend additional time period to complete observation.
3. Observation reports indicate that patient care does not meet standards; recommend staff membership be suspended or dropped.

Psychologist (PhD, EdD, PsyD)

Psychologists deal with the study of human and animal behavior (normal and abnormal) and the psychological, social, and biological processes related to the behavior. Licensure or certification by a state board is required in all states that allow psychologists to practice independently and unsupervised. Psychologists are normally offered membership to hospital medical staffs.

Reappointment

Reappointment and delineation of privileges normally occur every year or every two years. In making these decisions, the governing board relies on recommendations from the organized medical staff. Reappointment decisions are based on the practitioner's demonstrated performance. Reappointment should take into consideration patterns of care, utilization of the hospital, compliance with medical staff bylaws, rules and regulations, and information from QA activities of the hospital and medical staff.

References

Professional references are other members of the applicant's profession:

1. who have worked with or observed the applicant;
2. who are knowledgeable about the applicant's competence, ethnical character, and other qualifications;
3. who are willing to act as references for the applicant and to comment on the applicant's qualifications and competence for specific privileges requested; and
4. upon whose opinions the hospital shall be entitled to rely.

Release of Information Waiver

The applicant signs and dates a written release which:

1. authorizes and requests the release to the Chief Executive Officer for use by the medical staff and hospital of all information relevant to the application;
2. releases from liability any person, institution, or organization conveying the information to the CEO, and;
3. agrees to abide by all applicable provisions with respect to confidentiality, immunity, and releases.

Residency

Residency is specialty training following an internship or PGY-1. The term resident is used to refer to persons at all levels of graduate medical education.

Resident—see PGY and Housestaff

Secondary Source Verification

Secondary source verification is a written verification sent to the entity which has second-hand knowledge of the information that needs to be verified. It is used when primary source verification is not available.

Tickler System

A system (electronic or manual card file system) in which items or documents such as licensure, clinical privileges, medical staff membership, etc. are monitored for expiration dates.

Training Program

A training program is the post-graduate education required for physicians after the completion of medical school and prior to licensure. Internship, residency, and fellowship are post-graduate training programs.

Transitional Year

A transitional year program is sponsored by accredited residency programs. The objective of the 12-month curriculum is to provide a balanced medical education in multiple clinical disciplines. Transitional year programs were designed to give a broad clinical experience for physicians who feel that such experience will be best serve the purpose of subsequent graduate education in their fields and for physicians who have not yet decided on their specialty but may wish to choose among several fields.