

Title:	Credentials Committee		
Department:	Medical Staff Services		
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SECTION 1 – POLICY

1.1 Policy Statement

The Credentials Committee is responsible for reviewing all applications for credentialing and privileging and making recommendations to the Medical Executive Committee for initial appointments, reappointments, and all other credentialing matters.

1.2 Designation

The following standing committees report to the Credentials Committee: Advanced Practice Providers (APP); and Physician Health and Rehabilitation (PH&R).

1.3 Definitions

Category One – an application that is eligible for expedited credentialing. Further defined in Article 3

Category Two – an application that is not eligible for expected credentialing. Further defined in Article 3.

FPPE – focused professional practice evaluation.

OPPE – ongoing professional practice evaluation.

Re-Entry Criteria – requirements for re-entering practice after a gap of more than 12 months.

1.4 Purpose

The Credentials Committee attempts to ensure, by the administration of credentialing processes that providers are qualified for membership and privileges and continuously meet the qualifications to provide patient care and adherence to the ethics of their profession.

SECTION 2 – COMMITTEE

2.1 Composition

The Credentials Committee will be composed of at least six (6) Members of the Active or Honorary Medical Staff. An administrator will be assigned by the President of the Medical Center to the Credentials Committee and may attend meetings as a non-voting member.

2.2 Duties

2.1.1 The duties of the Credentials Committee will be to:

- A. Review the Department Chair's recommendations on applicants for Medical Staff appointment, reappointment, and clinical privileges, make investigations of and interview such applicants as may be necessary, and make a written report of its findings and recommendations to the MEC;
- B. Review the credentials files of applicants who request to practice at the Hospital as Advanced Practice Providers (APPs), to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations;
- C. Review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and of those practicing as APPs and as a result of such review, to make a written report of its findings and recommendations to the MEC;
- D. Review periodically all available information regarding competency (FPPE/OPPE) of Medical Staff Members and APPs and as a result of such reviews make recommendations to the MEC. The MEC has delegated the authority for approval of FPPE indicators and review to the Credentials Committee;
- E. Establish criteria and procedures for privileging and evaluations of Medical Staff members and APPs;
- F. Review and take appropriate action to develop privileges or core privilege checklists, research medical literature and develop "best practices" regarding new and emerging technology and the privileges, credentialing criteria, and/or proctoring necessary to support the same.
- G. Supervise the maintenance of confidential quality files on Medical Staff members and APPs;
- H. Review the policies related to the Credentials Committee at least every three (3) years;
- I. Review periodically and at least annually all available information from the PH&R Committee; and,
- J. Such other duties as outlined in the Medical Staff Bylaws or requested by the MEC.

2.1.2 Credentials Reviews

- A. Should questions or concerns arise pertaining to a specific Medical Staff member, such member will excuse themselves from any meeting in which their credentials, or anything related to their credentialing, privileges, or status, is discussed by a Medical Staff committee.
- B. Credentials reviews involving the Chair of the Credentials Committee will be presented to the Vice Chair of the Credentials Committee who will have the responsibility of ensuring the Chair is excused from the meeting prior to discussion, if any. The Vice Chair will have the responsibility of presenting the findings and recommendations of the Credentials Committee to the MEC if those findings are other than favorable.
- C. The Chair of the MEC will ensure the Credentials Chair is excused from the MEC meeting prior to discussion of the credentials review, if other than favorable.
- D. Credentials reviews involving other members of the Credentials Committee will be presented to the Chair of the Credentials Committee who will have the responsibility of ensuring the involved member is excused from the meeting prior to discussion, if any.

2.3 Meetings

The Credentials Committee will meet at least bi-monthly or more often as needed to accomplish its duties, will maintain a permanent record of its proceedings and actions, and will report its recommendations to the MEC.

Each Member of the Credentials Committee will attend at least fifty percent (50%) of the meetings held each calendar year. Members not meeting the attendance requirement may be removed and replaced by the Chief of Staff.

SECTION 3 – PROCEDURE

3.1 Procedure for Processing Initial Appointments

3.1.1 Application Categories

When all items required for credentialing have been obtained and verified, the file will then be summarized on an administrative review and presented to the appropriate Department Chair and the Credentials Committee Chair. The Neonatal Medical Director will examine qualifications of applicants requesting neonatal privileges and make recommendations to the Department Chair for such privileges.

Applications will be categorized by the complexity of the information received. Applications will be categorized initially by the Department Chair with support from the appropriate Section Chair

in instances where the Department Chair is unfamiliar with the applicant's specialty.

- A. **Category One:** A category one application would be one that is classified as such by the Department Chair, which includes all of the following:
1. All information is complete;
 2. The applicant is in good standing at all current and previous affiliations;
 3. The applicant has two (2) current and unrestricted professional licenses or less;
 4. The applicant is a graduate from an ACGME or AOA approved residency/fellowship, an APMA approved podiatry program, or approved ADA/GPR program;
 5. DEA registration is current and unrestricted;
 6. The applicant provides evidence of adequate professional liability coverage;
 7. Training and/or experience support the privileges requested; and
 8. All references contain no suggestion that the applicant is anything other than highly qualified and capable of exercising good clinical judgment.
- B. **Category Two:** A category two application would be one that is classified as such by the Department Chair, which includes one or more of the following:
1. The privileges requested do not match the training and/or experience;
 2. The applicant has three (3) professional licenses or greater (excluding telemedicine providers);
 3. The applicant is currently or was previously under board order with any state licensing agency;
 4. There are events reported to the NPDB or there is knowledge of an event in the process of being reported;
 5. The applicant has poor letters of recommendation;
 6. The applicant has three (3) or more malpractice actions either pending, settled, arbitrated, mediated, or litigated;
 7. There are gaps in application history;
 8. There are any denials, limitations, reductions, revocations, suspensions or other disciplinary actions or proceeding instituted or recommended by any hospital or healthcare institution, Medical Staff Committee or governing body;
 9. The applicant voluntarily surrendered or limited privileges, or did not reapply while under investigation;
 10. There is disclosure of a history of impairment, (alcohol, drug, behavioral, physical or mental);
 11. There is a criminal history;
 12. There is any adverse information not previously outlined.

A change of category can be recommended by either the Credentials Committee or the MEC in the review process.

3.1.2 Procedure for Processing Categories

Category One: The application is reviewed by the Department Chair and classified as a category one which may make the applicant eligible for temporary privileges as outlined in the Bylaws.

Category Two: The application is reviewed by the Department Chair and classified as a category two. The application is forwarded to the Credentials Committee for review. Following receipt of all information required to be submitted by the applicant pursuant to the Medical Staff Bylaws, the Credentials Committee has the option to conduct an in-depth interview with the applicant and, at its discretion, may also require the applicant to be subject to such an interview by the Department Chairman and/or Credentials Chairman. The MEC will review the application at its next regularly scheduled meeting and forward a recommendation to the Board of Trustees.

- 3.1.3 If all information required is not received within forty-five (45) days of receipt of an application, it will be considered void and no further processing will take place. In the event there is undue delay in obtaining required information, assistance will be requested of the applicant. In this case, the time periods for processing will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance will, after thirty (30) days be deemed a voluntary withdrawal from the application process.

3.2 Procedure for Processing Reappointments

3.2.1 Information Collection and Verification

A. The appointee must furnish in writing:

1. Complete information to update his/her file on items listed in his/her original application;
2. Specific requests for the clinical privileges sought on reappointment, with any basis for changes;
3. Requests for changes in staff category or department assignments;
4. Name of an Active Staff member willing to provide coverage;
5. In circumstances where there are insufficient peer review data available at reappointment, two peer references will be required from peers on the Medical Staff with similar privileges as the applicant for reappointment and who have personal knowledge of the applicant's ability to practice.
6. Failure, without good cause, to provide this information is deemed a voluntary resignation from the staff and automatically results in expiration of appointment.

- 3.2.2 **Policy:** Applications will be categorized by the complexity of the information received.

Applications will be categorized initially by the Department Chair with support from the appropriate Section Chair in instances where the Department Chair is unfamiliar with the applicant's specialty.

Category One: A Category One application would be one that is classified as such by the Department Chair, which includes all of the following:

- No adverse information is received from references, if applicable;
- The applicant is well known to the Medical Staff, and has a current and unrestricted license;
- DEA and DPS registrations are current and unrestricted;
- There is evidence of adequate malpractice insurance;
- The applicant does not want a change in privileges;
- The applicant has provided all information requested and completed the application form;
- The applicant has no unusual quality events identified in the profile.

Please refer to Article II, Section 5 C of the Medical Staff Bylaws with respect to the Military Staff.

Category Two: A Category Two application would be one that is classified as such by the Department Chair, which includes one or more of the following:

- The privileges requested do not match the training and/or experience;
- The applicant has three (3) professional licenses or greater;
- The applicant's profile contains questionable quality events;
- There are events reported to the NPDB or there is knowledge of an event in the process of being reported;
- The applicant has poor letters of recommendation;
- The applicant has three (3) or more malpractice actions either pending, settled, arbitrated, mediated or litigated;
- There are gaps in the application history; or
- There are denials from other Medical Staffs

A change of category can be recommended by either the Credentials Committee or the MEC in the review process.

3.2.3 Procedure for Processing Categories

Category One: The application is reviewed by the Department Chair and classified as a Category One. The application is then forwarded to the Credentials Chair for review on behalf of the Credentials Committee. The application is forwarded to the MEC for review and recommendation to the Board of Trustees.

Following a positive recommendation from the MEC, the Board of Trustees reviews and evaluates the qualifications and competence of the applicant applying for appointment,

reappointment, or renewal or modification of clinical privileges and renders its decision. A positive decision by the Board of Trustees results in the status or privileges requested.

An informational report to the Board of Trustees will be made at the next regularly scheduled meeting where the approvals will be ratified. If any of the above credentialing representatives feel uncomfortable signing for approval, the application will automatically advance to a Category Two.

If the decision of the Board of Trustees is adverse to an applicant, the matter is referred back to the MEC for further evaluation.

An applicant is usually ineligible for the expedited process related to a Category One application, if any of the following has occurred since the time of reappointment:

- The applicant submits an incomplete application;
- The MEC makes a final recommendation that is adverse or with limitations;
- There is a current challenge or a previously successful challenge to licensure or registration;
- The applicant has received an involuntary termination of Medical Staff membership at another organization;
- The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges; or
- There has been a final judgment adverse to the applicant in a professional liability action.

Category Two: The application is reviewed by the Department Chair and classified as a Category Two. The application is forwarded to the Credentials Committee for review. The MEC will review the application at its next regular meeting and forward a recommendation to the Board of Trustees.

3.3 Focused Professional Practice Evaluation

All initially requested privileges and privileges requested for re-entering practice will be subject to focused professional practice evaluation (FPPE). FPPE will occur (i) in all requests for new privileges, (ii) in all requests for re-entering practice, and (iii) when there are concerns regarding the provision of safe, high quality care by a current Medical Staff Member. The Department Chair will be responsible for overseeing the evaluation process for all applicants or Medical Staff Members assigned to their department. All FPPE is to be completed within a six (6) month timeframe. If not completed within (six) months, the Credentials Committee will provide further direction. All FPPE requires a minimum of five (5) cases, unless otherwise specified on the privilege form or by the Credentials Committee and/or Medical Executive Committee.

3.3.1 Information for this evaluation may be derived from the following:

- A. Discussion with other individuals involved in the care of each patient (e.g., consulting physician, assistants in surgery, nursing or administrative personnel);

- B. Chart review;
 - C. Monitoring clinical practice patterns;
 - D. Proctoring;
 - E. Simulation;
 - F. External peer review.
- 3.3.2 The Credentials Committee will be responsible for: (i) monitoring compliance with FPPE; and (ii) establishing the duration for such FPPE as well as the triggers that indicate the need for performance monitoring.
- 3.3.3 FPPE for applicants seeking to re-enter practice will include a case review by the Quality Department as required in Article I of the Bylaws. The Quality Department will review all required cases within seventy-two (72) hours of any patient care activity by the applicant.
- 3.3.4 A re-entering applicant who has not provided acute inpatient care within the past two (2) years who requests clinical privileges at the Hospital will arrange proctoring with a current Member in good standing of the Medical Staff who practices in the same or like specialty, subject to approval by the Credentials Committee. The applicant will assume responsibility for any financial costs required to fulfill the requirements. The Performance Improvement, Performance Review Policy and Procedure Manual will apply to the FPPE by the proctor.
- 3.3.5 A proctoring physician selected pursuant to Article I, Table A, of the Bylaws will be required to review all cases required in Table A. The Quality Department will notify the proctoring physician when it identifies any patient concerns. The proctoring physician will immediately notify the Chair of Department or his/her designee in the event the proctoring physician observes or identifies patient care that adversely affects or could adversely affect the patient. Patient care activity as defined in the Medical Staff Bylaws does not include referrals for outpatient diagnostic procedures.
- 3.3.6 The scope and intensity of proctoring activities required, and the requirement for submission of a written report from the proctor to the Department Chair for the Credentials Committee prior to termination of the proctored period, will assess, at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, professional ethics and conduct. The proctor's written report will be reviewed by the Department Chair and the Credentials Committee and approved by the Medical Executive Committee before the re-entering applicant is approved to practice independently.

3.4 Ongoing Professional Practice Evaluation

The Medical Staff will also engage in ongoing professional practice evaluation (OPPE) to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to allow Practitioners to maintain existing privileges, revise existing privileges, or revoke existing privileges prior to or at the time of reappointment.

OPPE will be undertaken as part of the Medical Staff's evaluation, measurement and improvement of Practitioners' current clinical competency. In addition, each Practitioner may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified during the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior and ability to perform a specific privilege.

3.5 Confidentiality of Credentials Files

Medical Staff Services will respond to proper requests for access to credentials files. Credentials files will be consistently handed and maintained in a confidential manner.

3.5.1 Responses to Requests from Practitioners

- A. Medical Staff and Advanced Practice Providers (Practitioners) may have copies of any documents in their own credentials files which they submitted to the Medical Staff Services department (i.e., the initial application, reappointment application, addendum to the application, request for privileges, correspondence from the Practitioner, etc.) or documents which were addressed directly to the Practitioner.
- B. Practitioners also have the right to inspect documents regarding meeting attendance, CME, suspensions for failure to complete medical records, and patient care activity reports.
- C. Individual Practitioners may review information in their credentials files in the presence of a Medical Staff leader or Medical Staff Services personnel during normal business hours. Documents may not be removed from the Medical Staff Services department with the exception of copies of documents mentioned above, submitted by or addressed to the Practitioner.

3.5.2 Responses to Requests by Persons Performing Official Facility or Medical Staff Functions

- A. In addition to Medical Staff Services personnel, access to information contained in credentials files to the extent necessary to perform official functions is limited to: hospital CEO and legal counsel; Chief/Vice Chief of Staff, Clinical Department Chairs/Vice Chairs; Credentials Committee Chair or APP chair for APPs; peer review committees; and Board of Trustees members.
- B. Access to information contained in credentials files to the extent necessary to prepare documents, reports, profiles is limited to the personnel of Medical Staff

Services, Quality, Risk Management, and legal counsel.

- C. Any non-routine requests to review files will be routed to the hospital's legal counsel. If approved, such requests will be noted, including date of review, names of Practitioner files reviewed, and purpose of review.

3.5.3 Responses to Requests by Persons or Organizations Outside Hendrick Medical Center

- A. Requests for information from other hospitals/health care entities will receive responses with the most recent data regarding staff status, appointment and/or reappointment dates, specialty area in which privileges have been granted. This information may be provided based on a written or oral request, with or without a release from the Practitioner.
- B. Requests for Practitioner information other than information noted above must be in writing. The request must include the reasons and a statement signed by the Practitioner specifically releasing the hospital from liability and dated within the previous six (6) months.
- C. Requests for information about Practitioners whose files contain adverse information (having negative effect on a Practitioner's membership or privileges) will be addressed according to Section 3.6.

3.6 Responses to Requests for Information from Outside Health Care Facilities

Responses will be provided to requests for information about Medical Staff and Advanced Practice Providers Staff members who have or have had membership and/or clinical privileges.

- 3.6.1 Requests from an outside health care facility for information regarding quality of care issues of a past or present member of the Medical Staff of Hendrick Medical Center will be forwarded to, and handled by, an authorized representative or member of a Medical Peer Review Committee of Hendrick Medical Center, which may include the Credentials Committee and/or Medical Executive Committee. The Medical Staff Services department will be considered an authorized representative of a Medical Peer Review Committee when undertaking such activities on behalf of such Committee. Requests will be reviewed to determine the following:

- A. Whether the request is being made by a Medical Peer Review Committee (as defined by law) or an authorized representative of such a Medical Peer Review Committee; and
- B. Whether the involved physician, about whom such request is being made, has authorized the requesting health care facility to secure the requested information.

- 3.6.2 Providing the request is from a Medical Peer Review Committee and providing the involved physician has authorized the release of the requested information, the proper

Medical Peer Review Committee, or authorized agent thereof, of Hendrick Medical Center, will disclose the requested information, to the extent that it is reasonably available, to the Medical Peer Review Committee of the requesting health care facility, or one acting on its behalf.

3.6.3 If it cannot be determined that the request is from a Medical Peer Review Committee or that the involved physician has authorized the release of the requested information, then no quality of care information will be provided and the requesting party will be contacted, in writing, asking it to confirm that the request is being made by, or on behalf of, a Medical Peer Review Committee.

3.6.4 Upon receipt of written confirmation that the request is being made by a Medical Peer Review Committee, or an authorized agent thereof, and that the involved physician has authorized the release of the requested information, the proper Medical Peer Review Committee, or authorized agent thereof, of Hendrick Medical Center will disclose the requested information, to the extent it is reasonably available, to the Medical Peer Review Committee of the requesting health care facility, or one acting on its behalf.

3.7 Establishing Criteria to Support Requests for New Technology, Procedures and/or Privileges

Refer to Medical Staff policy for establishing criteria to support requests for new technology, new procedures, and/or new privileges.

3.8 Credentialing and/or Privileging for Advanced Practice Providers.

Refer to the APP Policy,