The Credentialing and Privileging Toolbox

Field-Tested Documents for Compliance, Management, and Process Improvement

Merella Schandl, BS, CPMSM, CPCS

Credentialing Resource Center

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HCPro
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About the Author

Merella Schandl, BS, CPMSM, CPCS

Merella Schandl, BS, CPMSM, CPCS, is a professional speaker, author, and independent consultant with 25 years of healthcare experience. Schandl entered the industry in 1993 while working to achieve an associate of science degree. While serving in healthcare management positions, she earned a Bachelor of Science degree in workforce education and development from Southern Illinois University Carbondale (SIU-C). After graduating SIU-C, Schandl maintained her role as director while growing the medical affairs department into an integrated healthcare environment. She went on to assist in the building of a new hospital in Shiloh, Illinois.

A current instructor for the National Association Medical Staff Services (NAMSS), Schandl contributed to the development of the NAMSS Leadership Certificate Program and was the 2015 recipient of the NAMSS Golden Key Award. She has held several leadership positions in the Missouri Association of Medical Staff Services (MoAMSS) and in MoAMSS' Greater St. Louis Area chapter. She is also the 2017 recipient of the Graduate Healthcare Management award from the Mid-America Healthcare Executives Forum.

Schandl has had articles published in *Synergy*. She is currently completing a Master of Healthcare Administration degree at Lindenwood University in Belleville, Illinois.

About the Contributors

Canyon Vista Medical Center

Canyon Vista Medical Center is a 100-bed, Joint Commission–accredited acute care hospital and Level III trauma center in Sierra Vista, Arizona. Roughly 85% of the facility's more than 200 credentialed practitioners are licensed independent practitioners, while the rest are independent and dependent allied health professionals.

The hospital, which employs 1.5 full-time medical staff professionals (MSP), organizes its medical staff into three departments and eight service lines. Its governance groups include a medical executive committee, a credentialing committee, a peer review committee, and a code of conduct committee. Canyon Vista is a member hospital of RCCH HealthCare Partners, which has 17 regional health systems in 12 states and 2,000 affiliated practitioners.

Special thanks to Joyce L. Moore, MPA, CPCS, CPMSM, Canyon Vista's medical staff director, for sharing the facility's form featured in this toolbox.

Ellis Medicine

Ellis Medicine is a 438-bed community and teaching healthcare system serving New York's Capital Region. The system has four campuses—Ellis Hospital, Ellis Health Center, Bellevue Woman's Center, and Medical Center of Clifton Park—five additional service locations, more than 3,300 employees, and more than 700 medical staff members. Ellis offers an array of inpatient and outpatient services, including cardiac, cancer, emergency, neuroscience, and women's services. Its medical staff services team consists of two credentialing specialists and one manager.

Special thanks to Kathy Tafel, credentialing and privileging consultant and Ellis' former medical dental staff services manager, for sharing the facility's forms featured in this toolbox with the organization's permission.

Flagler Hospital

Flagler Hospital is a 335-bed, Joint Commission–accredited acute care facility in St. Augustine, Florida. Its 480 credentialed practitioners include 40 telemedicine providers, 43 nurse practitioners, 25 physician assistants, and 36 certified registered nurse anesthetists.

Flagler's affiliated practitioners are organized into nine departments and three department divisions, each of which is overseen by a chief. Its governance structure features 16 committees and subcommittees, including bylaws, cancer, cardiovascular, clinical quality review, continuing education, credentials, and critical care. The medical staff services department consists of one director, one lead credentialing specialist, one credentialing specialist, and one special-projects coordinator.

Special thanks to Terry Wilson, BS, CPMSM, CPCS, Flagler's director of medical staff services, for sharing the facility's forms featured in this toolbox.

Hennepin County Medical Center

Hennepin County Medical Center, operated by Hennepin Healthcare System, Inc., is a 484-bed, Joint Commission–accredited teaching hospital in Minneapolis, Minnesota, that provides acute care and psychiatric care. The facility, which serves as a Level 1 adult trauma center and Level 1 pediatric trauma center, also includes a system of primary care and retail clinics throughout the county. Hennepin's five-person credentialing staff processes applications for approximately 1,000 practitioners (roughly 600 physicians and 400 non-MD independent practice providers). The medical staff is organized into 17 departments.

Special thanks to Gerry Valeri, CPCS, senior credentialing specialist at Hennepin, for sharing the facility's form featured in this toolbox.

HighPoint Health System

Headquartered in Gallatin, Tennessee, HighPoint Health System has four member facilities throughout the state: Sumner Regional Medical Center, the 155-bed flagship hospital; Riverview Regional Medical Center, a 25-bed critical access hospital; Trousdale Medical Center, a 10-bed critical access hospital; and Livingston Regional Hospital, a 114-bed acute care hospital. Other affiliates include homecare, hospice, and several physician practices. HighPoint credentials approximately 459 practitioners, including 73 advanced practice professionals.

Special thanks to Kelly Anderson, credentialing specialist at Sumner, for sharing the facility's form featured in this toolbox, which is under consideration for implementation at the three other hospitals in the HighPoint system.

Hugh Chatham Memorial Hospital

Hugh Chatham Memorial Hospital is an 80-bed, Joint Commission–accredited facility and primary stroke center. In addition to its main campus in Elkin, North Carolina, the hospital has more than 20 clinical centers providing services across the care continuum. Hugh Chatham's one full-time MSP credentials 265 affiliated practitioners, including 65 active physicians, 60 allied health professionals, four locum tenens practitioners, and 61 telemedicine practitioners. The facility's medical staff is organized into five clinical departments (family practice/medicine, surgery, ED, OB/GYN, and radiology) and is governed by the medical executive committee, the credentials committee, and the board of trustees.

Special thanks to Tracey Russell, CPCS, medical staff coordinator at Hugh Chatham, for sharing the facility's form featured in this toolbox.

Kansas Heart Hospital

Kansas Heart Hospital is a 54-bed acute care facility in Wichita, Kansas, that provides specialized cardiovascular, surgical, and vascular services. The hospital, which undergoes CMS surveys and employs one full-time MSP, credentials 250 practitioners, about 40 of whom are advanced practitioner professionals (physician assistants and advanced practice registered nurses). Special thanks to Taylor Diefenderfer, BA, BS, former medical staff coordinator at Kansas Heart, for sharing the facility's form featured in this toolbox.

Kathy Matzka, CPMSM, CPCS, FMSP

Kathy Matzka, CPMSM, CPCS, FMSP, is a speaker, consultant, and writer with 30 years of experience in credentialing, privileging, and medical staff services. Matzka worked for 13 years as a hospital medical staff coordinator before venturing out on her own as a consultant, writer, and speaker. She holds

certification from the National Association Medical Staff Services (NAMSS) in both medical staff management and provider credentialing. She is one of the first recipients of the NAMSS Fellow Designation.

Matzka is author of HCPro's *The Clinician's Quick Guide to Credentialing and Privileging* and coauthor of HCPro's *Verify and Comply, Sixth Edition*. She's written and edited a number of additional books related to medical staff services. Matzka has performed extensive work with NAMSS' education committee developing and editing educational materials related to the field, including CPCS and CPMSM Certification Exam Preparatory Courses. She also serves as an instructor for NAMSS.

Mercy

Mercy is the fifth largest Catholic healthcare system in the United States, operating 43 acute care and specialty hospitals and more than 700 physician practices and outpatient facilities throughout Arkansas, Kansas, Missouri, and Oklahoma. Most, but not all, Mercy hospitals are accredited by The Joint Commission.

The Credentialing and Privileging Toolbox features resources from two specific Mercy affiliates.

Mercy Hospital St. Louis

Mercy Hospital St. Louis is an 859-bed facility and Level I trauma center in Creve Coeur, Missouri. The facility's 1,749 credentialed practitioners are organized into 13 departments and 34 divisions. Medical staff governance groups include department committees, a credentials subcommittee, a medical executive committee, and a board of trustees. The hospital has five full-time MSPs.

Special thanks to Tracy Brooks, CPMSM, CPCS, Mercy Hospital St. Louis' manager of medical staff services, for sharing the facility's forms featured in this toolbox.

Mercy Credentialing and Data Center

Mercy Credentialing and Data Center is the Springfield, Missouri–based centralized credentialing organization (CVO) for 40 Mercy facilities spanning the care continuum. Internal customers include acute care hospitals, critical access hospitals, ambulatory surgery centers, specialty hospitals, and clinics. Between internal clients and delegated credentialing agreements, the 36-person CVO credentials roughly 12,000 practitioners.

Special thanks to Diane Meldi, MBA, CPCS, CPMSM, executive director of medical staff services for Mercy Quality & Safety Center, and Allison Rhodes, CPMSM, CPCS, director of Mercy's Credentialing and Data Center, for sharing the CVO's forms featured in this toolbox.

OrthoIllinois

OrthoIllinois is a 33-physician subspecialized bone and joint practice with more than a dozen facilities throughout northern Illinois, including four clinics, seven rehabilitation facilities, an urgent care facility, a surgery center, and an orthotic and prosthetic lab. OrthoIllinois' four-person medical staff services workforce credentials the facility's physicians, as well as 20 physician assistants and five nurse practitioners.

Special thanks to Leslie Elmer, CPCS, a credentialing coordinator at one of OrthoIllinois' Rockford, Illinois, clinics, for sharing the facility's form featured in this toolbox.

Saint Luke's Health System

Headquartered in Kansas City, Missouri, Saint Luke's Health System has 10 hospitals and campuses, as well as homecare and hospice agencies, behavioral healthcare facilities, and dozens of physician practices. All system hospitals are Joint Commission accredited, save for the two critical access hospitals. St. Luke's credentialing team includes five MSPs based in a central credentials resource department, a medical staff coordinator at each hospital, and several professionals heading up a centralized payer enrollment department.

St. Luke's has about 2,000 credentialed licensed independent practitioners, including roughly 400 allied health professionals. Each hospital has a medical executive committee, but specific department breakdowns vary by individual facility circumstances.

Special thanks to Jennifer Svetlecic, MD, St. Luke's system director of medical staff development, for sharing the organization's form featured in this toolbox.

St. Clair Hospital

St. Clair Hospital is an independent, 328-bed acute care medical center in Pittsburgh, Pennsylvania. Beyond its main campus in Mt. Lebanon, the hospital offers healthcare services at five outpatient centers. St. Clair is also a member of the Mayo Clinic Care Network. This clinical collaboration—unique in western Pennsylvania—provides St. Clair's physicians with direct access to the renowned expertise of Mayo Clinic. St. Clair's medical staff services department, which credentials 622 affiliated physicians, has a manager, a credentialing specialist, and a secretary.

Special thanks to Kathy Tafel, credentialing and privileging consultant, and St. Clair's former manager of medical affairs and professional credentialing, for sharing the facility's forms featured in this toolbox with the organization's permission.

St. Jude Medical Center

St. Jude Medical Center is a faith-based, nonprofit, 320-bed, acute care hospital in Fullerton, California. The Joint Commission–accredited facility, which provides an array of medical services and programs, is a member of St. Joseph Health, an Irvine, California–based Catholic healthcare delivery system with 16 facilities spanning the care continuum and 10 communities throughout California, Texas, and New Mexico.

St. Jude has 684 affiliated practitioners (609 physicians and 74 allied health professionals) organized into four departments, four clinical service lines, and 11 committees. The hospital's medical staff services team consists of five full-time MSPs.

Special thanks to Cindy Radcliffe, CPMSM, St. Jude's director of medical staff services, for sharing the facility's forms featured in this toolbox.

Union Hospital

Union Hospital is a 154-bed, DNV GL–accredited hospital providing the Dover, Ohio, community with acute care and inpatient rehabilitation services. The independent facility is part of a 25-acre medical campus featuring physician office buildings, an outpatient rehabilitation and sports medicine center, and a mental healthcare agency.

Union's nearly 300 credentialed practitioners include 50 allied health professionals and 35 telemedicine providers. The hospital's medical staff is organized into seven departments and governed through the typical spread of committees, including credentials, peer review, quality, utilization management, infection control, and health information. The hospital employs one full-time MSP.

Special thanks to Todd Meyerhoefer, MD, MBA, CPE, FACS, Union's chief medical officer, for sharing the facility's forms featured in this toolbox.

Introduction

In today's variable healthcare climate, credentialing and privileging best practices can seem like a moving target. Current medical staff professionals (MSP) and medical staff leaders are vetting practitioners who occupy diverse clinical disciplines, practice across a patchwork of settings, and work under disparate regulations. As healthcare reform, shifting patient demographics, and physician shortages drive continual change across the continuum, approaches to credentialing and privileging must likewise evolve.

Regulatory agencies establish frameworks, standards, and checkpoints that promote patient safety and quality care. In this way, these authorities provide the *what* and the *why* of credentialing and privileging but often stop short of revealing the *how*.

That's where *The Credentialing and Privileging Toolbox* comes in. With more than 50 field-tested, peer-vetted materials, this book provides insight into how MSPs and medical staff leaders are tackling modern practitioner vetting challenges from the trenches and offers targeted guidance on how to adapt these materials to meet your organization's specific needs.

The toolbox features checklists, forms, case studies, bylaws, policies, dashboards, job descriptions, practitioner-facing letters, audit tools, and other resources that underpin successful practitioner vetting processes in environments spanning operational circumstances, the care continuum, and the country.

Learn More

See the "About the Contributors" section for more information on the organizations represented in this publication.

While specific credentialing and privileging approaches may vary from organization to organization, successful processes often have the following features in common:

- A team with strong foundational knowledge of industry best practices and key requirements levied by healthcare authorities
- Leaders who cultivate a happy, high-achieving workforce
- A culture of continual improvement and innovation

The following sections reveal why MSPs, medical staff leaders, and other credentialing stakeholders should focus on these domains—and how the toolbox can help.

Strong Foundational Knowledge

Healthcare institutions have an ethical and legal obligation to evaluate the clinical competence of practitioners seeking to provide care to their patients. When it comes to licensed independent practitioners (LIP) who must undergo medical staff review to receive practice authorization, MSPs and medical staff leaders head up the vetting process. These individuals must therefore have a solid grasp of credentialing and privileging.

Credentialing involves capturing, verifying, and assessing the qualifications and competence of LIPs, while privileging is the act of granting qualified practitioners authorization to provide care, treatment, and services. If a LIP is not privileged, he or she cannot practice.

Beyond the mechanics of credentialing and privileging, MSPs and medical staff leaders must understand the requirements set by accrediting bodies, regulatory agencies, and state lawmakers. Many of these authorities establish specific vetting standards, including time frames for reevaluating practitioners' qualifications and renewing their privileges. For example, the Centers for Medicare & Medicaid Services (CMS) requires a hospital's medical staff to appraise affiliated practitioners at least every 24 months.

In order to comply with such requirements, an organization must maintain an effective process for granting initial, renewed, or revised privileges according to the mandated schedule and activities. Key steps and best practices that the toolbox supports include the following:

- Be organized, detail-oriented, and committed to process improvement. Maintaining standardized processes and meticulous records of key credentialing functions (e.g., credentialing and peer review) is especially important in environments without credentialing software that automatically tracks progress. This diligence allows all authorized stakeholders to check on a file's progress and facilitates a smooth transition of work in the event of a contributor's absence or abrupt departure. See Chapter 1 for a collection of tools that support process development and improvement.
- Establish, adhere to, and regularly update well-written governance documents (e.g., bylaws, rules and regulations, and policies and procedures), like those found in Chapter 2.
- Communicate effectively regarding credentialing activities and outcomes. Clear, regular communication with peers and practitioners requesting privileges is key to forging productive interdisciplinary relationships, fortifying practitioners' trust in the organization, and upholding patient safety. See Chapter 3 for a bevy of letters, memos, and other practitioner-facing documents with which to broach important conversations.
- Ensure staff are fully trained, with the necessary tools to complete tasks efficiently and effectively. See Chapter 4 for MSP and medical staff leader job descriptions and performance evaluation tools that support competence and professional development.
- Develop robust solutions for systemic issues. Chapter 5's tools provide a jumping-off point for alleviating some of today's top credentialing and privileging challenges, including vetting advanced practice professionals, addressing adverse issues, and conducting meaningful professional practice evaluation.

- Conduct routine audits of the processes surrounding credentials verification and privileges delineation—a practice that supports patient safety, fewer medical errors, and the provision of high-quality healthcare services. See Chapter 6 for a collection of auditing tools addressing key components of the vetting process.

Effective Leadership

Strong leadership can bring direct benefits for credentialing and privileging, including the following:

- Build strong working relationships with credentialing stakeholders across the organization, including health information management, quality improvement, IT, and HR.
- Develop a comprehensive practitioner onboarding process that encompasses tasks and stakeholders from departments across the organization; cultivates practitioner satisfaction from the get-go; minimizes redundancies; and promotes compliance with all relevant legal, regulatory, and accreditation requirements.
- Demonstrate leadership's devotion to their staff and the community they serve, and fortify the team's commitment to achieving overarching goals and visions.
- Promote critical thinking and problem solving. A typical credentialing team encounters a multitude of issues that demand deep expertise and creative problem solving. Teams with strong leaders, patient-centered cultures, and sufficient training are well positioned to identify and address warning signs before they intensify into full-blown problems (e.g., red flags in medical staff applications, negligent credentialing claims, staffing deficiencies, duplicative processes, and file turnaround times).

Provide development opportunities

Leaders create and transform the climate within their organizations. Providing regular continuing education opportunities is a great way to break entrenched bad habits and instill modern vetting philosophies. To accommodate different learning styles and promote ongoing engagement, consider a mix of training mediums, such as webinars, books, guest speakers, and live events. Allocating time and funds toward continuing education for MSPs and medical staff leaders supports successful credentialing and privileging by:

- Ensuring these stakeholders keep current on vetting best practices.
- Promoting staff retention. Regular education fuels skill growth, morale, and, by extension, job loyalty.
- Overcoming the "we've always done it this way" mentality. This is particularly true of live events, where the confluence of contemporary thought leadership, face-to-face networking opportunities, and success stories from the field demonstrate the power of productive change.

Align individual and organizational goals

To enhance overall performance and outcomes, leaders must inspire their team to work toward the organization's overarching goals. Understanding staffs' preferences fosters professional growth, job satisfaction, and an engaged workforce.

Leaders must leverage their knowledge and experiences to guide their team while allowing members to apply their direct expertise in problem solving and process improvement. The case studies in Chapter 5 exemplify the measurable gains that are achievable through effective leadership, committed staff, and a collaborative spirit.

A Culture of Innovation

Successful credentialing and privileging require a leader with a vision for the future and a team that embraces change.

In today's fast-paced credentialing arena, "automation" has become synonymous with innovation. Continual advances in credentialing technology allow healthcare institutions to onboard practitioners faster, invigorate revenue, and fortify quality patient care. There's a variety of software options for automating medical staff processes. Helpful features available in products on the market today include:

- Reducing redundant data entry
- Automating tasks that were once time-consuming manual activities, such as identifying red flags based on rules built into the system
- Housing scrubbed data on across-the-board and facility-specific quality indicators
- Analyzing and producing individualized reports on practitioners' performance
- Providing performance comparisons in relation to determined peer groups and national benchmarks

Tools throughout this publication emphasize the important and expansive roles of technology in the modern credentialing and privileging sphere, which range from informing peer review findings and providing fodder for leadership-facing reports to generating historic and comparative data that help credentialing teams keep track of progress toward major goals.

In organizations without the funding or buy-in necessary to implement credentialing software, streamlining manual processes and implementing safeguards to promote ongoing compliance can drive meaningful change. Define your processes using spreadsheets, graphs, and flow charts, such as those throughout this book. To advance the conversation on technology adoption, collaborate with quality and risk management. Determine across-the-board software needs, conduct research on programs that can accommodate these collective demands, and develop a proposal for purchasing the desired solution.

Takeaways

With consolidation and value-based reimbursement models on the rise, healthcare institutions are increasingly asked to improve quality while reducing cost. A lean, rigorous practitioner vetting process supports this initiative. *The Credentialing and Privileging Toolbox* cuts down the time-consuming, often tedious tasks of soliciting examples from disparate sources and developing credentialing, privileging, and governance forms from scratch. With time and energy restored, MSPs and medical staff leaders can focus on their urgent work championing compliance and upholding patient safety.

Chapter 1

Workflow Management

Effective credentialing and privileging are at the junction of quality, compliance, and efficiency. The process management tools featured in this chapter emphasize successful development, deployment, and ongoing maintenance of essential vetting activities, including those outlined in the following sections.

Validating Competency

Regulatory and accreditation bodies require healthcare institutions to obtain peer references during the credentialing process to validate applicants' current clinical competence. For example, The Joint Commission specifies that these recommendations can factor into the privileging process when there are insufficient peer review data available (e.g., at initial appointment or for low/no-volume practitioners).

Beyond satisfying relevant authorities' criteria for a peer, colleagues who provide references must be familiar with the applicant's actual performance. Tool 1.5 is a confidential peer review reference form that captures the reference's relationship with the practitioner undergoing credentialing, as well as his or her knowledge of the applicant's skills.

Approving Privileging Requests

After completely preparing an applicant's file, the medical staff professional (MSP) should schedule time to thoroughly review the file with the relevant department chair, division head, or equivalent leader. Prior to the meeting, the MSP should highlight potential concerns or red flags that warrant deeper discussion.

During the meeting, the MSP and department chair should review the credentialing file's contents, addressing lingering red flags according to established policies and procedures.

Afterward, the chair or division head should complete an approval form attesting that he or she has reviewed the practitioner's credentials file and providing a recommendation regarding the requested privileges. This report will inform subsequent medical staff reviews, as well as the governing board's final decision regarding practice authorization. Tools 1.3 and 1.4 can be used to capture feedback from a range of stakeholders who contribute to medical staff appointment and privileging decision-making, beginning with the department chair.

Given their bearing on quality care delivery, these recommendations should be based on a thorough evaluation and understanding of the applicant's documented licensure, training, experience, current clinical competency, character, and judgment.

Processing requests to perform new, special, or otherwise noteworthy privileges

Beyond the routine vetting protocol, organizations should deploy compliant policies, efficient processes, and robust supporting materials for processing requests that may fall outside the typical scope of practice authorization, such as privileges for telemedicine (Tool 1.6) or new procedures (Tool 1.7).

Onboarding and Orienting New Affiliates

The United States could experience a shortage of 61,700–94,700 physicians by 2025, according to a 2016 report from the Association of American Medical Colleges. Faced with this systemic deficit, many organizations are bumping up their recruitment budgets to attract qualified affiliates amid shrinking candidate pools and fiercer competition. Developing an effective practitioner onboarding process equips new affiliates with the tools and knowledge they need to be successful from day one (or even earlier), supporting professional satisfaction, high retention, and a culture of clinical excellence.

Structure

Most onboarding teams feature professionals with interdisciplinary expertise, including recruitment, credentialing and payer enrollment, employment, staff integration, retention, health information management, and information technology.

The process should provide each new affiliate with access to all necessary paperwork in one convenient location, such as an online physician portal, to eliminate confusion and fragmented materials distribution during orientation. For the same reason, new practitioners should be assigned the following:

- A point of contact
- A reliable method for sending and retrieving feedback
- A mentor (a dedicated mentor program is an onboarding must-have)

Purpose and planning

The key to successful onboarding is global understanding among program administrators about why the process exists and what effects it has on the practitioner and the organization. In addition, the program's end users (new practitioners) must learn how to be successful in providing care for patients within the organization—and what happens if they fall short of initial training requirements.

Before receiving official privileges, every new practitioner at Flagler Hospital in St. Augustine, Florida, must complete orientation, which includes electronic medical record training. Practitioners who fail to complete the required orientation within 90 days of the board's approval are removed from the privileging docket. Flagler's medical executive committee approved this practice—a testament to its understanding of the impact a timely, robust onboarding process can have on new affiliates' long-term success. See Tool 1.9 for Flagler's physician orientation policy.

Tip

Fill new practitioners in on orientation logistics (e.g., the scheduling process and timeline), as well as any penalties for noncompliance. Spell this information out in a letter or other written communication so they have a reference on hand throughout the process (and fewer excuses for falling short of expectations). See Tool 3.2 for a sample onboarding letter featuring these details.

Evaluation

Assessing existing approaches is key to maintaining an effective orientation process. Implement a monitoring process to ensure all aspects of orientation meet the needs of new practitioners, the medical staff, and the organization. To determine whether execution aligns with intent—a requirement when continuing medical education is in play—organizations should offer an outlet for practitioners to provide feedback on their onboarding and orientation experience, such as a survey.

Despite all this behind-the-scenes work, the orientation process should appear seamless to the new practitioner. Tools 1.8–1.10 provide frameworks for developing and executing successful onboarding and orientation processes.

Vetting Student Observers and Shadowers

Healthcare organizations that allow residents, medical and pre-medical students, and other individuals considering or actively pursuing a clinical career (e.g., physician assistant students) to rotate with various specialties through their facility should have a documented process for administering these programs. Failure to develop and enforce a strong policy regarding observation, shadowing, and student participation in care delivery can have serious consequences. For example, legal issues can surface if a poor care outcome occurs and there's insufficient documentation on a student observer who was present during the relevant procedure.

Residents and medical students

Policies for residents and medical students, who may participate in patient care, should address major requirements governing their work with the organization, such as the following:

- Purpose
- Implicated parties—for example, physicians, residents, fellows, and medical students
- Key definitions—for example, "accredited program" may be defined as a medical school or osteopathic program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA)
- The permissible scope of practice—for example:
  - Performing the history and physical examination
  - Writing orders (individual healthcare organizations determine whether medical students may enter orders into medical records)
  - Writing progress notes and proposing treatment plans
  - Performing diagnostic evaluations
  - Diagnosing surgical problems and diseases; providing pre- and postoperative care
  - Assisting in surgery
  - Writing discharge summaries

- Physician preceptor supervision responsibilities
- HIPAA requirements
- Rotation schedule
- Information the student/resident and sponsor must provide in order to participate in designated activities at the organization
- Medical record completion process
- Patient authorization requirements

For their part, MSPs may be charged with managing and monitoring affiliation agreements, schedules, and preceptor assignments for residents, medical students, and students in non-physician clinical programs. To promote an organized approach, MSPs should have a structured process for obtaining and gathering pertinent information, as defined in the relevant policy.

Learning expectations for medical and non-physician students must be outlined in the affiliation agreement between the academic center and the accepting healthcare facility. Residents are generally considered house staff and function according to their training program's specific requirements.

High school and undergraduate student observers

Beyond programs for individuals who are actively engaged in clinical education and training, many healthcare organizations provide observation/shadowing opportunities for high school and college students who are considering a career in the medical field. Relevant policies should address the structure for requesting an application to observe a member of an organization's healthcare staff performing duties.

In these situations, students should only be permitted to observe how relevant disciplines and departments function individually and within the greater context of the healthcare organization. The hosting facility should specify acceptable observation thresholds. For example, "student observers may request up to 50 hours of observation in a period of no more than 16 weeks." The organization should also consider requiring a letter from the student's academic advisor, immunization records, and completion of some form of orientation (e.g., HIPAA compliance video, facility orientation demonstrating the entry and exit points in the building, and review of the facility codes).

Tools 1.11 and 1.12 are checklists for executing consistent, compliant observing and shadowing processes.

Bonus Tools

Visit the book's downloadable materials website (*www.hcpro.com/downloads/12581*) to access a sample resident and postgraduate clinical student policy and an application for clinical rotation.

Confirming Compliance

Whether electronic or paper, checklists can be used to ensure various medical staff applications (e.g., for initial privileges and renewal of privileges) are processed in accordance with all applicable requirements.

For MSPs, these tools provide a systematic means of recording and tracking all documents necessary for complete, compliant credentials files. For stakeholders less intimately involved in the credentialing process (e.g., chief medical officer, administrative assistant, chief nursing officer, or vice president of risk management), checklists can provide quick-reference information about the application's status when an MSP isn't available to shed light.

In the hospital setting, a completed checklist prefacing a credentials file can demonstrate to department chairs, the credentials committee, the medical executive committee, and the governing board that an application has been thoroughly vetted and properly prepared.

Credentialing checklists can serve similar functions in ambulatory care facilities, surgery centers, private physician practices, and managed care environments. For OrthoIllinois, a subspecialized orthopedic care–focused heath system headquartered in Rockford, Illinois, developing a robust, organizationwide new practitioner checklist has standardized the onboarding process across all member facilities and allowed new MSPs to get up to speed quickly on the credentialing process (Tool 1.8).

When developing circumstance-specific application checklists (e.g., for initial appointment and reappointment), account for all relevant state laws, regulations, accreditation standards, and industry best practices, as well as any additional facility-specific requirements, such as medical staff bylaws, policies and procedures, and/or practitioner scopes of practice. At minimum, initial and recredentialing checklists should reference education and training, licensure, DEA registration, certification, experience, medical malpractice claims, liability insurance, negative clinical occurrences, work history gaps, peer references, and health status.

Review checklists regularly to ensure they align with all relevant expectations and current practices. Failure to adhere to internal and/or external requirements can put your organization at risk for noncompliance with accreditation standards and negligent credentialing allegations.

Tools 1.1, 1.2, 1.8, 1.11, and 1.12 are checklists addressing various stages of the credentialing and privileging processes.

Takeaways

A consistent, comprehensive approach to credentialing and privileging fortifies a number of healthcare pillars, including patient safety, quality care, regulatory compliance, legal standing, and operational efficiency. Strong processes and supportive materials (e.g., checklists, applications, and policies) allow MSPs and medical staff leaders to address concerns in a practitioner's application early, promoting timely, well-reasoned practice authorization.

Tool 1.1 Application Checklist for Initial Appointments and Reappointments

	Initial appointment	Reappointment
Application fee		
Contact information up to date		
Copies of the following documents attached		
Current unrestricted license to practice medicine in Ohio		
Current DEA registration		
Current certificate of professional liability coverage		
ECFMG certificate (if foreign medical graduate)		N/A
Evidence of board certification: Union Hospital requires board certification within five years of training completion		
Government-issued photo identification (passport, driver's license)		N/A
Current curriculum vitae		N/A
Current clinical competence documentation included		
Training just completed and no prior medical staff membership at any hospital? Attach residency log (and fellowship log if applicable).		
Completed residency and/or fellowship within past five years? Attach residency log (and fellowship log if applicable) and your quality profile (or similar documentation) from the hospital(s) where you have practiced.		
Completed residency and/or fellowship more than five years ago? Attach your quality profile (or similar documentation) from the hospital(s) where you have practiced in the past 24 months.		
Application form COMPLETE		
All questions in Sections III, V, VI, and VIII answered. Explanations accompany "yes" answers.		
All questions in Section IV answered. Explanations accompany "no" answers.		
Professional liability data completely filled out and explained as necessary		
Signatures present		
Application form		
Medicare payment notice		
Statement of release		
Complete contact information provided for three professional references		
CME attestation form signed		
Core privileging form completed		

Source: Union Hospital in Dover, Ohio. Published with permission.

This tool offers new medical staff services personnel a comprehensive rundown of the items essential to processing medical staff applications.

This application checklist is used at initial appointment and reappointment. The "N/A" notations in the reappointment column clearly indicate which elements are only required at initial appointment.

Applicants who are fresh out of training sometimes forget to attach residency/fellowship logs. This box provides a helpful reminder and encourages submission of a complete application on the first try.

Calling out key components of the application—including required explanations and signatures—encourages practitioners to submit a complete application.

Tool 1.1 Application Checklist for Initial Appointments and Reappointments (cont.)

Application fee included		
Background check form completed		N/A
I.S. access form completed		N/A
Delineation of privileges form completed		
Delineation of privileges checklist completed		

Source: Union Hospital in Dover, Ohio. Published with permission.

Union Hospital uses color coding in the lefthand margin to indicate which checklist items correspond to which applicant categories (i.e., locum tenens, active staff, courtesy staff, and allied health professionals). Access the downloadable version of this tool (*www.hcpro.com/downloads/12581*) to view this feature.

Tool 1.2 Physician and APP Application Checklist

Highlighted information should be examined by committee.

Name:
Service:
Specialty:
Staff Category:

Application fee received?	Yes ☐ No ☐
CME attestation complete?	Yes ☐ No ☐
Current licensure verified?	Yes ☐ No ☐
National Practitioner Data Bank queried?	Yes ☐ No ☐
Current DEA on file?	Yes ☐ No ☐
AMA profile received with no comparative discrepancies? (Only on initial appointment)	Yes ☐ No ☐
Background check? (Only on initial appointment)	Yes ☐ No ☐
Medicaid/Medicare section review: Adverse information found?	Yes ☐ No ☐
Possesses professional liability insurance?	Yes ☐ No ☐
Has professional liability suits?	Yes ☐ No ☐
Certifications:	Yes ☐ No ☐
Peer references received with no adverse information?	Yes ☐ No ☐
Comments:	
Current hospital affiliation received with no adverse information?	Yes ☐ No ☐
Hospital affiliations verified?	Yes ☐ No ☐
Case logs/Statit report received?	Yes ☐ No ☐
Health screen required? (For applicants aged 59 +)	Yes ☐ No ☐
Up-to-date PPD (Two-step TST for initial applicants)?	Yes ☐ No ☐
Orientation information sent and received?	Yes ☐ No ☐

Source: Union Hospital in Dover, Ohio. Published with permission.

Tip: Make sure to account for all application elements that are required at your facility, says Meyerhoefer. It helps to diagram your current process to see whether it aligns with the one outlined in your medical staff documents.

This tool was created to ensure the various practitioner applications Union Hospital receives (e.g., physician and APP initial appointments and reappointments) contain all the elements necessary for processing, says Todd A. Meyerhoefer, MD, MBA, CPE, FACS, chief medical officer at Union Hospital.

Tip: Ensure your checklist includes any department-specific processes (e.g., orientation, health screening, two-step PPD) and relevant deadlines/turnaround times. Timely communication between the medical staff services department and new practitioners must occur until the practitioner submits documentation of completion. The burden of proof is on the applicant, but a paper trail demonstrating MSPs have exhausted all methods of assistance can prevent pushback from noncompliant practitioners.

This form can be used to capture key medical staff leaders' recommendations regarding initial or renewed privileges for physicians and advanced practice professionals. It should only be circulated once the medical staff services department has sufficiently credentialed the applicant's file.

Tool 1.3 Initial Appointment/Reappointment Recommendation Form

Please check the following boxes as appropriate:

☐ Medical staff ☐ Advance practice allied health staff ☐ Initial appointment ☐ Reappointment

Name of applicant:	
Department assignment:	
Specialty:	

To be filled out for initial appointment only:

I have reviewed the subject practitioner's credentials files with specific attention given to either the privileges or practice privileges requested. Based upon the applicant's documented licensure, training, experience, and current clinical competency as determined by peer and affiliation references, and health status, it is my recommendation that the applicant be granted the privileges or practice privileges as requested. Exceptions are noted as follows:

☐ Scheduled for an interview with Clinical Service Chair, if applicable, and Department Chair for the purpose of securing Temporary Privileges or Practice Privileges

☐ Scheduled for an interview with Credentials Committee

☐ Not scheduled for an interview with Credentials Committee, as the interview is not warranted at this time

Notice how this particular form charges the chair with attesting that the applicant meets the qualifications for initial appointment or reappointment, as defined in the medical staff bylaws. This responsibility reflects the chair's accountability for his or her department.

CHAIR'S RECOMMENDATION FOR INITIAL APPOINTMENT OR REAPPOINTMENT:

To the best of my knowledge, the above applicant has met the qualifications as noted in the Medical Staff Bylaws, has carried out the responsibilities specified in the Medical Staff Bylaws, and has met all of the standards and requirements set forth in all sections of these Bylaws and in the Allied Health Professional Rules and Regulations if applicable. The applicant has complied with legal requirements applicable to the practice of his or her profession, with the Medical Staff Bylaws, and Rules and Regulations and hospital policies and AHP Rules & Regulations if applicable. The applicant has rendered quality services to his or her patients and has no physical or mental impairment which might interfere with his or her ability to practice medicine with reasonable skill and safety. He or she has provided accurate and adequate information to allow the Medical Staff to evaluate his or her competency and qualifications. The applicant's activity is adequate in accordance with his or her staff status, and favorable reports have been received from utilization review, quality assurance, medical records, and infection control.

It is my recommendation that the above applicant be appointed or reappointed with the staff status and department as noted above.

CHAIR'S RECOMMENDATION FOR PRIVILEGES OR PRACTICE PRIVILEGES:

To the best of my ability, I have reviewed the above applicant's request for privileges and/or practice privileges and have evaluated that request on the basis of his or her education, training, experience, demonstrated ability, judgment, and physical and mental health status. His or her performance is within the acceptable standards of this Medical Staff or Advance Practice AHP Staff as documented by results of patient care audit and other quality review, evaluation, and monitoring activities required by the Medical Staff Bylaws and the Hospital Corporate Bylaws.

It is my recommendation that the above applicant be granted the following privileges or practice privileges as noted on the attached privilege or practice privilege requested list.

☐ Privileges or Practice Privileges recommended as requested

☐ Privileges or Practice Privileges recommended as modified (see Privileges Requested List)

"We have the respective chair come to the medical staff office and sit with the medical staff coordinator to review files and fill out the form as appropriate," says Cindy Radcliffe, CPMSM, director of St. Jude Medical Center's medical staff services department. The form also demonstrates to surveyors that medical staff leaders are actively engaged in the privileging process, she adds.

Source: St. Jude Medical Center in Fullerton, California. Published with permission.

Tool 1.3 Initial Appointment/Reappointment Recommendation Form (cont.)

DEPARTMENT CHAIR COMMENTS:

_____

Signature: _____ Date: _____

_____

CREDENTIALS CHAIR COMMENTS: (FOR INITIAL APPLICATIONS ONLY)

_____

Signature: _____ Date: _____

Medical staff office to complete:
Credentials committee date: _____ Medical executive committee date: _____
Board of Trustees date: _____

Source: St. Jude Medical Center in Fullerton, California. Published with permission.

Capturing key privileging perspectives in one form streamlines the process for reviewers. This tool must be reviewed by the department chair and then presented with the credentialing file to the credentials committee (or equivalent body) for review and recommendation. Both authorities must sign off on the form before it's presented to the medical executive committee and the board for final approval. Tip: Review your bylaws and policies and procedures to ensure they mirror the process outlined in your department chair recommendation form.

Tool 1.4 Recommendation and Approval Form for Medical Staff Appointment and Clinical Privileges

This form can be used to capture feedback from the full range of stakeholders who contribute to medical staff appointment and privileging decision-making, from the department chair's initial recommendation through the governing body's official authorization.

Practitioner name: _____

Staff status: _____ Department: _____ Specialty: _____

Departmental Recommendation

Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment of the applicant, the following recommendations are made:

- ☐ Privileges be granted/renewed
- ☐ Medical staff membership be granted/renewed
- ☐ Additional privileges requested be granted
- ☐ Privileges be modified as follows: _____

_____

- ☐ Privileges not be granted/renewed
- ☐ Medical staff membership not be granted/renewed (comment below)
- ☐ Additional privileges requested be denied (comment below)

This form is maintained at the front of the credentialing file throughout the review process.

Comments: _____

_____ _____

Department Chair Date

Credentials Committee Recommendation

Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment of the applicant, and on the evaluations and recommendations of the Department Chair, the following recommendations are made:

- ☐ Concur with recommendation(s) of the Department Chair and forward these recommendations to the Medical Executive Committee for consideration.
- ☐ Do not concur with the recommendations of the Department Chair, and instead make the following recommendations:

_____

_____

_____ _____

Credentials Committee Representative Date

Source: Kathy Matzka, CPMSM, CPCS, FMSP. Published with permission.

Tool 1.4 Recommendation and Approval Form for Medical Staff Appointment and Clinical Privileges (cont.)

Medical Staff Executive Committee Recommendation

Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment of the applicant, and on the evaluations and recommendations of the Department Chair and Credentials Committee, the following recommendations are made:

- ☐ Concur with recommendation(s) of the Department Chair and Credentials Committee and forward these recommendations to the governing body for consideration.
- ☐ Do not agree with the recommendations of the Department Chair and Credentials Committee, and instead make the following recommendations:

_____

_____

_____ _____

Medical Staff Executive Committee Representative Date

Governing Body Approvals/Action Taken

Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment data and information, and on the recommendations of the Medical Staff, the following action is taken:

- ☐ Concur with and approve the recommendation(s) of the Medical Staff.
- ☐ Do not concur with the recommendations of the Medical Staff. Action taken is documented in Board minutes of _____. (date)

_____ _____

Board of Trustees Representative Date

Source: Kathy Matzka, CPMSM, CPCS, FMSP. Published with permission.

Tip: Given its summary of key steps in the privileging process, this form can be a valuable educational tool and reference sheet for credentialing staff. Provide a copy to team members who are new to the field or who simply need a refresher.

This document clearly indicates the outcome of each major privileging stage, allowing surveyors and internal auditors alike to ensure the review, recommendation, and approval process aligns with the process outlined in the medical staff bylaws.

Tool 1.5 Confidential Professional Peer Review Reference and Competence Validation Form

Name:	Department or Section Speciality Name:
Affiliation of Peer Reference: Hospital Medical Staff Services Avenue, City, State, Zip	
Affiliation date:	From: To:
Affiliation type:	Medical Staff Staff category:

How well do you know the applicant?

☐ Very well ☐ Professional acquaintance ☐ Casual personal acquaintance ☐ Not well

Do you refer patients to the applicant? ☐ Yes ☐ No

If you do not refer patients, why?

CONFIDENTIAL: Professional Peer Reference Competency Evaluation

Please rate the practitioner in the following areas:

Competency Review	Superior	Good	Fair	Poor	Unable to Evaluate
Medical Knowledge: Practitioner should have a good knowledge of established and evolving biomedical, clinical, and cognate sciences, and how to apply this knowledge to patient care. This is evidenced by completion of educational and training requirements, as well as on-the-job experience, in-service training, and continuing education.					
Technical and Clinical Skills: Skill involves the capacity to perform specific privileges/procedures. It is based on both knowledge and the ability to apply the knowledge.					
Clinical Judgment: Clinical judgment refers to the observations, perceptions, impressions, recollections, intuitions, beliefs, feelings, and inferences of providers. These clinical judgments are used to reach decisions, individually or collectively with other providers, about a patient's diagnosis and treatment.					
Communication Skills: The provider should create and sustain a therapeutic and ethically sound relationship with other caregivers, patients, and their families. He or she should be able to communicate effectively and should demonstrate caring, compassionate, and respectful behavior. This includes effective listening skills, effective nonverbal communication, eliciting/providing information, and good writing skills.					
Interpersonal Skills: Areas of evaluation include how the provider works effectively with professional associates, including those from other disciplines, to provide patient-focused care as a member of a healthcare team.					

Source: Kathy Tafel. Published with permission from Ellis Hospital in Schenectady, New York.

Use this tool to obtain a professional peer reference for applicants.

This question is especially pertinent when the reference is a referring physician providing feedback about a specialist to whom he or she could potentially refer. In such cases, a "no" answer could be a red flag, even if the rest of the feedback is positive. Dig deeper to find out why the respondent does not refer to the applicant.

This form was created to comply with Joint Commission standards.

Tool 1.5 Confidential Professional Peer Review Reference and Competence Validation Form (cont.)

Professionalism: Professionalism is demonstrated by respect, compassion, and integrity. It means being responsive and accountable to the needs of the patient, society, and the profession. It also means being committed to providing high-quality patient care and to continuous professional development, as well as being ethical in issues related to clinical care, patient confidentiality, informed consent, and business practices.					

This form's clean formatting and clearly defined competency criteria promote the receipt of accurate, complete responses from references.

	Yes	No	Unable to Evaluate
Relevant Training and Experience Do you feel the applicant is qualified and competent to perform the duties in his or her specialty?			
If no, provide detail:			
Current Competence Are there clinical areas, procedures, or patient severity levels for which you have concerns about this applicant's ability?			
If yes, provide detail:			
Current Competence In reviewing the attached clinical privilege form(s), do you feel that the applicant is currently competent to carry out these procedures?			
If no, provide detail:			
Health Status To the best of your knowledge, are there any physical, mental, or chemical dependency conditions that would affect this practitioner's competence to practice in his/her field or that would require an accommodation to exercise those privileges safely and competently?			
If yes, provide detail:			
Corrective Action To the best of your knowledge, has the applicant's license, clinical privileges, hospital appointment, affiliation with any healthcare organization, or other professional status ever been denied, challenged, investigated, terminated, reduced, not renewed, limited, withdrawn, suspended, revoked, modified, placed on probation, relinquished, or voluntarily surrendered, or do you have any knowledge of any such actions that are pending?			
If yes, provide detail:			
Corrective Action Do you know of any malpractice action instituted or in process against the applicant?			

Source: Kathy Tafel. Published with permission from Ellis Hospital in Schenectady, New York.

Tool 1.5 Confidential Professional Peer Review Reference and Competence Validation Form (cont.)

Identification The picture of the applicant submitted (copy enclosed) is the person named and known to me.			

Recommendations

☐ Recommend without reservation

☐ Recommend with reservation (provide detail):

☐ Do not recommend (provide detail):

Please use a separate sheet if you have any additional comments, information, or recommendations that may be relevant to our decision to grant clinical privileges to the applicant.

Name (Print):	Position or Title:	Name of Affiliated Entity:
Signature:		Date:
Field of Practice:		Phone Number:

Failure to receive a prompt response will delay consideration of the applicant's request for privileges.

Image of: [Doctor, Credentials]	You may fax, scan, and email the form or send a hard copy to: Hospital Medical Affairs Street City, State, ZIP code Fax: Email: Phone:

Source: Kathy Tafel. Published with permission from Ellis Hospital in Schenectady, New York.

Tip: Ensure your peer review form includes a place for the respondent to provide his or her contact information so credentialing personnel can reach out with any requests for clarification or elaboration, says Kathy Tafel, this tool's creator.

Tip: Attach a high-quality copy of the applicant's photo.

Tool 1.6 Teleradiology Core Privileges

DEPARTMENT OF MEDICINE RADIOLOGY: CLINICAL PRIVILEGE DELINEATION FORM (Excerpt)

Criteria-based core privileging is flexible, efficient, and consistent. Core privileges define the scope of the procedures and activities within a specialty that practitioners typically have the education, experience, and competence to perform.

QUALIFICATIONS FOR RADIOLOGY

At the time of this application, Radiology privileges are subject to an exclusive contract. In order to be eligible to apply for Diagnostic Radiology Cognitive Core Privileges, Diagnostic Radiology General Core Procedures Privileges, Vascular and Interventional Radiology Cognitive Core Privileges, Vascular and Interventional Radiology General Core Procedures, Teleradiology Cognitive Core Privileges, or Teleradiology General Core Procedures Privileges, the practitioner must be recommended in writing for privileges by the Medical Director of the group holding the Radiology Services exclusive contract. Other required qualifications are as follows:

All new applicants must meet the following requirements as approved by the Board of Trustees.

Privileges in Radiology are granted in clinical cognitive areas and for specific procedures. Physicians applying for Medical Staff membership and privileges in the Department must submit documentation of the following:

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)– or American Osteopathic Association (AOA)–accredited residency in diagnostic radiology.
AND
Current certification or active participation in the examination process with achievement of certification within 5 years leading to certification in radiology by the American Board of Radiology or the American Osteopathic Board of Radiology.

Rather than tucking telemedicine tasks into the standard privilege delineation form for radiology, St. Jude Medical Center has devoted a separate category to teleradiology on its radiology-focused clinical privilege delineation form (excerpted here). This decision speaks to the significant difference in feasible practice between teleradiologists and on-site radiologists. "We decided to have a specific privilege set just for them," says Cindy Radcliffe, CPMSM, director of medical staff services at St. Jude.

APPLICANT: Check off the "requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications, and for resolving any doubts related to qualifications for requested privileges.

CURRENT CLINICAL COMPETENCY REQUIREMENTS: Practitioners must also demonstrate appropriate training, experience, current competence, and recent clinical experience for all privileges requested. Recent clinical experience for initial appointment and reappointment is defined as having performed the minimum number of procedures or current clinical activity performed as defined under each core group in the last 24 months. The variety and type of current clinical activity performed within the last 24 months must be reflective of the scope of privileges requested. Additional criteria for advanced privileges are defined in the privilege criteria noted under each special non-core privilege. If a physician is not able to meet the minimum number of procedures or clinical activity as required under each core or non-core privilege(s), he/she will automatically be required to fulfill proctoring/Focused Professional Practice Evaluation (FPPE) requirements as noted for new applicants. If a physician is not able to meet the requisite number of procedures or clinical activity as defined in order to fulfill the proctoring/FPPE requirements within their next 24-month cycle, those privileges will automatically be relinquished.

Source: St. Jude Medical Center in Fullerton, California. Published with permission.

Tool 1.6 Teleradiology Core Privileges (cont.)

RECIPROCAL ACTIVITY: Practitioners who cannot demonstrate the number of procedures or current clinical activity performed at St. Jude Medical Center as required under each core and non-core privilege(s) within the last 24 months will be required to list and attach their clinical activity and procedural reports and the name of the Hospital that can document these procedures and clinical activities were performed.

PROCTORING/FPPE: New practitioners in the Department will be proctored using FPPE as defined in this document. Proctoring requirements are listed under the core and non-core privilege criteria for each bundle. Proctoring requirements will also apply to existing Medical Staff Members requesting new or additional privileges within the Department.

OTHER REQUIREMENTS: ***Note that granted privileges may only be exercised at the site(s) and setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document.*** This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

St. Jude, which credentials its telemedicine practitioners in house, developed these core privileges when a teleradiologist joined its ranks nearly a decade ago, says Radcliffe, noting the facility's use of HCPro's *Core Privileges* books during the development process.

TELERADIOLOGY COGNITIVE CORE PRIVILEGES

R = REQUESTED G = GRANTED D = DEFERRED
Please check "R" for privileges you are requesting.

R	G	D	
☐	☐	☐	Perform general diagnostic radiology to diagnose diseases of patients of all ages via a teleradiography link. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

Initial criteria: Meet criteria for Diagnostic Radiology Core.

Required previous experience: Applicants for initial appointment must be able to demonstrate performance and interpretation of at least 200 radiologic tests or procedures, reflective of the scope of privileges requested, or demonstrate successful completion of an ACGME– or AOA–accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months.

Proctoring/FPPE: Completion of proctoring from the acceptable teleradiology core procedure

Reappointment criteria: To be eligible to renew core privileges in diagnostic radiology, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience (**100** radiologic tests or procedures) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

The inclusion of reappointment criteria on the form used to request and grant initial privileges lets practitioners know right away of the requirements for maintaining desired privileges.

Source: St. Jude Medical Center in Fullerton, California. Published with permission.

Tool 1.6 Teleradiology Core Privileges (cont.)

TELERADIOLOGY GENERAL CORE PROCEDURES PRIVILEGES

Please check "R" for privileges you are requesting.

R	G	D	
☐	☐	☐	***To the applicant: If you wish to exclude any procedures, please strike through those procedures that you do not wish to request, initial, and date.*** • Computed tomography of the head, neck, spine, and chest including the heart, abdomen, and pelvis, extremity, and their associated vasculatures • Diagnostic nuclear medicine of the head, neck, spine, and chest including the heart, abdomen, and pelvis, extremity, and their associated vasculatures, and associated procedures • MRI of the head, neck, spine, and chest including the heart, abdomen, and pelvis, extremity, and their associated vasculatures, and muscular skeletal structures, etc. • Routine imaging (e.g., interpretation of plain films and ultrasounds)

Initial criteria: Meet criteria for Diagnostic Radiology Core.

Required previous experience: Applicants for initial appointment must be able to demonstrate performance and interpretation of at least 200 radiologic tests or procedures, reflective of the scope of privileges requested, or demonstrate successful completion of an ACGME– or AOA–accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months.

Proctoring/FPPE: 4 cases representative of the core. 4 advanced cases will be accepted if all privileges are requested to meet the FPPE requirement for this core bundle.

Reappointment criteria: To be eligible to renew core privileges in diagnostic radiology, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience (200 radiologic tests or procedures) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and that I wish to exercise at St. Jude Medical Center, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signature:_____ Date:_____

Print Name:_____

Source: St. Jude Medical Center in Fullerton, California. Published with permission.

Here's how the credentialing process works for St. Jude's teleradiologists:

- **The teleradiologist requests privileges outlined in this form.**
- **The medical staff service team ensures the applicant satisfies the criteria as established by supporting documentation.**
- **The radiology clinical service chair reviews the file and checks the appropriate box to indicate whether the applicant meets the criteria to grant the privileges as requested.**

Once applicants receive teleradiology privileges, they must undergo proctoring on their first four procedures. The radiology clinical service chair accomplishes this through retrospective review.

Tip: Ensure the applicant's file contains documentation supporting the volume indicators and make every effort to complete proctoring as soon as possible, says Radcliffe.

Tool 1.6 Teleradiology Core Privileges (cont.)

Use of the dedicated teleradiology privileges has been smooth sailing, says Radcliffe. "It's been great—we haven't had any issues with it."

DEPARTMENT CHAIR RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the previously named applicant and make the following recommendation(s):

☐ Recommend all requested privileges

☐ Recommend privileges with the following conditions/modifications/deferred:

☐ Do not recommend the following privileges:

Privilege	**Condition/Modification/Deferred/Explanation**
_____	_____
_____	_____
_____	_____
_____	_____

Notes/Comments

_____

_____

_____

Clinical Service Chair Signature:_____ Date: _____

Department Chair Signature:_____ Date: _____

FOR MEDICAL STAFF OFFICE USE ONLY

Credentials Committee action: ***Date:*** _____

Medical Executive Committee action: ***Date:*** _____

Board of Trustee action: ***Date:*** _____

Approved on:

Source: St. Jude Medical Center in Fullerton, California. Published with permission.

This type of form may be used to capture and evaluate an affiliated practitioner's request to use new technology, perform new procedures, or receive new or additional privileges. The medical staff must specify the eligibility criteria and any monitoring/evaluation required for maintenance of privileges.

Tool 1.7 Worksheet for Consideration of New Procedure/Privilege

Name of procedure/privilege:

Education required to request privilege (check all that apply):

☐ MD—Medical Doctor
☐ DO—Osteopathic Physician
☐ DDS—Oral and Maxillofacial Surgeon
☐ DMD—Dentist
☐ DPM—Podiatrist
☐ APN—Advance Practice Nurse (specify specialty):
☐ PA—Physician Assistant (specify specialty):
☐ DC—Chiropractic
☐ Other (specify):

Training required:

_____

_____

Experience required:

_____

_____

Is there a transference of skill from another procedure? ☐ No ☐ Yes
If "yes," which procedure? _____

Additional requirements:

☐ CME
☐ Manufacturer's training course/Certificate
☐ Board certification
☐ Peer recommendations

Is monitoring or proctoring required?

☐ No ☐ Yes

If "yes," specify the following:

☐ Number of procedures: ☐ Length of time:
☐ In order to complete proctorship/monitoring requirements, the applicant must perform:
_____ (number) procedures within _____ (time frame).

What type of review or follow-up will be conducted?

_____

_____

Source: Kathy Matzka, CPMSM, CPCS, FMSP. Published with permission.

This form triggers the medical staff to review its policies and procedures to determine what, if any, special eligibility criteria an applicant must meet to perform the requested privilege. This will also ensure MSPs are aware of any materials they must capture and credential. For example, the medical staff may have special privileging criteria for robotic surgery that require the applicant to undergo proctoring for a specified number of cases and/or to take a training course.

Indicate the type and duration of the designated FPPE activity (e.g., three proctored cases, plus retrospective chart review). These specifications must suit the requested privileges and align with requirements outlined in the medical staff bylaws.

Tool 1.8 New Practitioner Onboarding Checklist

This checklist outlines key tasks in the credentialing process at ambulatory care/surgery centers and physician practices. OrthoIllinois uses the checklist when onboarding new providers for its clinic and surgery center.

Indicating the applicant's anticipated start date at the top of the checklist provides the credentialing professional with a visible reminder of the time frame for vetting the practitioner's file.

Practitioner: **Anticipated start date:**

Task	Requested	Rec'd	Drafted	Sent to prov.	Rec'd from prov.	Sent to org.	Rec'd approval
License(s)							
• Illinois License App./ Change of Address							
• Illinois Controlled Substance App.							
• Federal DEA Application (Change Address Online)							
• State of IL Employment Notification Form (PA Only)							
• Ltr for Permission to ✔ Status on IL Lic. App.							
Malpractice							
• ISMIE Application (Min. 30 Days Prior)							
• Previous Malpractice Information							
• Previous Malpractice Information							
Hospitals/Surgery Centers							
• Rockford Memorial Hospital							
Orientation							
• SwedishAmerican Hospital							
Orientation							
• OSF Saint Anthony Medical Center							
Orientation							
• Centegra Woodstock							
Orientation							
• Centegra McHenry							
Orientation							
• Sherman							
Orientation							
• Rockford Ambulatory Surgery Center							
• Algonquin Road Surgery Center							

Tip: Add an entry for the third-party request letter to the license section. This letter allows the credentialing professional to contact the state licensing agent on the practitioner's behalf to inquire about the status of a pending license.

All OrthoIllinois hospitals and surgery centers where practitioners may seek privileges are listed here as a reminder to account for their facility-specific orientation processes and requirements.

Source: OrthoIllinois in Rockford. Published with permission.

Tool 1.8 New Practitioner Onboarding Checklist (cont.)

• Rockford Orthopedic Surgery Center							
• VanMatre HealthSouth Rehab Hosp.							
Unique Identifiers							
• NPI							
• NPPES Website							
CAQH							
Health Plans							
• Aetna/Personal Care/ Coventry							
• Blue Cross Blue Shield							
• Centegra Health and Wellness							
• Cigna							
• Corvel							
• Community Care Alliance of IL							
• Stratose (HFN and ECOH)							
• First Choice							
• Health Alliance							
• Humana							
• MercyCare Health Plans							
• OSF Health Plans							
• Physicians Care Network							
• The Alliance							
• United HealthCare							
Medicare (30 days prior)							
Medicaid							
• IL Medicaid							
• WI Medicaid							
Health and Wellness							
• N-95 Fit Testing/CAPR (SWEDES)							
• Drug Screen (SWEDES) w/in 90 Days of Start							
Signed Copy of Job Description and Scope of Service (PAs Only)							
Copy of Diplomas							
Copy of Certification							

Tip: Add entries for creating any applicable usernames, passwords, and the CAQH ID #.

List partnering health plans to remind credentialing staff to verify that the applicant has submitted complete payer applications for provider enrollment.

Source: Orthollinois in Rockford. Published with permission.

Tool 1.8 New Practitioner Onboarding Checklist (cont.)

Clinical Activity w/in Past 12 Months							
Check With HR to be Sure Internal Orientation is Scheduled							
Lab Coats Ordered							
Immunizations							
• Hepatitis B							
• Rubella							
• Rubeola							
• Tdap							
• TB (Two Step) w/in the Last 12 Months							
• Varicella							
• Flu (October–March)							
Physicians Only							
• Tail Coverage Proof							
• Winnebago County Medical Society							
• UICOM Application							
• IDFPR Physician Profile							
• AMA Profile (Confirm Profile Exists)							
Physician Assistants							
• AMA Profile (Request)							

Identify the time frame for testing/ results to ensure practitioners know when they'll need new immunization(s).

Tip: Modify these final two sections to include any facility- and discipline-specific requirements for submitting and processing physician and PA applications.

Source: OrthoIllinois in Rockford. Published with permission.

Tool 1.9 Physician Orientation Policy

MEDICAL STAFF SERVICES DEPARTMENT	
Policy: Orientation of Physicians	
[Medical Staff Services Contact]	Signature:
Original Issue Date:	
Current Revision Date:	
Last Review Date:	

Flagler Hospital's clinical departments and medical staff recognized the need for new practitioners to undergo orientation. Given the process' evolution over the years, the medical staff services department developed a formal policy to reflect the current approach, says Terry Wilson, BS, CPMSM, CPCS, the department's director.

OBJECTIVE:
New Active and Consulting and Dental/Podiatry (Psychology Staff) physicians to the Medical Staff will be oriented to the policies, procedures, and administrative and clinical requirements pertaining to Medical Staff members. They will also be provided a facility tour, if requested.

PROCEDURE:
When a physician is recommended for Medical Staff membership by the Credentials Committee, temporary privileges may be granted, if requested. At this time, the physician is notified either by telephone or email that before privileges can be granted, an orientation of Flagler Hospital must be completed. NOTE: The orientation cannot be scheduled prior to the applicant's application being submitted and recommended for approval by the Credentials Committee. Some contracted services (e.g., Emergency Medicine) may conduct their own orientation.

Tip: Providing dates, times, locations, and contacts for orientation activities lessens anxiety and frustration for new practitioners.

All orientations are scheduled to begin at either 9:00 a.m. or at 1:00 p.m. on the weekday that the physician chooses. Once the date is confirmed, a notice is sent out to the appropriate departments with the schedule. Each affected department director is given a tentative time that the physician will be in his or her area and that the director or designee should be available to meet with the physician to give him or her any appropriate information for his or her department. When each department completes its portion of the orientation, the physician should be escorted to the next department on his or her orientation schedule.

The schedule of hospital departments for each physician to orient with is determined by specialty and requested Medical Staff status.

MSPs help new practitioners navigate the facility, providing information they need to be successful on day one.

Medical Staff Services Department: The Medical Staff Services Department personnel provide information to the physician, including:

- Maps of the hospital floors
- Contact information for Medical Staff Officers and Medical Staff Department Chiefs
- Contact names and numbers of Administration and Hospital Department Directors
- Meeting attendance requirements
- Dates and times of pertinent meetings, including General Staff and practitioner's specific department
- CME information
- Medical Staff Library contact information
- Medical Staff Bylaws, Rules & Regulations pertaining to Medical Records
- Listing of journals available on our intranet

Source: Flagler Hospital in St. Augustine, Florida. Published with permission.

Tool 1.9 Physician Orientation Policy (cont.)

In addition, the Medical Staff Services personnel take the physician to the Human Resources Department to obtain a picture identification name badge.

The following departments are included in the orientation, as noted above and as determined by their specialty and the Medical Staff Status they have requested. Each area will provide specific information and a tour of their area to the physician orienting.

- Information Systems: Provides computer access and instructs the physician on the specific systems available to him or her at Flagler Hospital.
- Quality Management: Provides quality improvement and quality assurance information.
- Medical Records: Explains patient records system, medical documentation guidelines, dictation methods, medical record regulations, etc.
- Radiology.
- Surgery.
- Cardiac Catheterization.
- ICUs.
- Obstetrics/Pediatrics.
- Cardiopulmonary.
- Cardiac Rehabilitation.
- Emergency Department.
- Psychiatry.
- Physical Rehabilitation.
- Administration: The physician will meet the Hospital President/CEO and other administrative personnel.

After the orientation is complete, if the physician has requested temporary privileges, a notice is sent out to all hospital departments welcoming the new physician to the Flagler Hospital Medical Staff. Otherwise, the welcome notice is sent out after the physician's application is approved by the Governing Board.

At Flagler, every new practitioner must undergo orientation, including EMR training. "Privileges are not officially granted until the orientation/EMR process has been completed," says Wilson. Practitioners who fail to complete the required program within 90 days of the board approving their privileges will be removed from consideration, and must reapply for privileges. The medical executive committee approved this policy, adding weight to the practice of closing a practitioner's file for failing to complete the required orientation, says Wilson.

Source: Flagler Hospital in St. Augustine, Florida. Published with permission.

Tool 1.10 Medical Staff and Non-Physician Practitioner Orientation Agenda

This agenda outlines activities in a formal new practitioner orientation. It's included in the orientation packet provided to the new practitioner.

TABLE OF CONTENTS

Key hospital leaders are asked to create a 5–15-minute PowerPoint presentation highlighting important information new practitioners should know to ensure a smooth transition into the facility.

7:15–7:30 AM **Sign In/Meet and Greet**

7:30–7:40 AM **Organizational Overview: CEO/COO/CMO**
- Welcome/Mission/Vision

7:40–7:55 AM **Hospitalist Program: Director/Mgr of Hospitalist Team**

7:55–8:05 AM **Nursing Administration: CNO**
- Nursing/Physician Partnership
- Magnet Accreditation
- Independent Practitioner/Employed Roles

8:05–8:20 AM **Practitioner Service Excellence**
- Service Excellence
- Press Ganey and HCAHPS

8:20–8:30 AM **Risk Management**

8:30–8:45 AM **Utilization Review**
- Care Management/Social Services
- Utilization Review
- Executive Healthcare Resources
- Clinical Documentation Specialist
- Physician Advisors

8:45–8:55 AM **Quality Management**
- Performance Improvement and the Practitioner's Role in Quality
- CMS Core Measures
- Publicly Reported Data
- MD Statit
- Accreditation Agency Overview

8:55–9:15 AM **Information Technology**
- HIPAA Privacy & Security/Acknowledgment Statement
- Remote Access to Hospital Information
- Electronic Medical Record

9:15–9:30 AM **Laboratory Director/Pathology Chair**
- Computerized Physician Order Enter for Lab Orders
- Blood Utilization
- Reference Lab Testing

Source: Merella Schandl, BS, CPMSM, CPCS. Published with permission.

Tool 1.10 Medical Staff and Non-Physician Practitioner Orientation Agenda (cont.)

9:30–9:45 AM **Safety and Security**
- Badges/Card Reader
- Rescue Alarm Contain Extinguish (RACE)/Pull Aim Squeeze Sweep (PASS) Procedures
- Parking Information
- Disaster Preparedness

9:45–10:00 AM **Infection Prevention**

10:00–10:15 AM **Pharmacy**
- Hospital Formulary
- Antibiotic Stewardship

10:15–10:30 AM **Closing Remarks: Manager/Director or Designee for Medical Staff Services**

EMR Training, Picturing Archiving Communication Systems, and Medical Records Dictation Orientation will be conducted around the time that temporary privileges are issued: [contact, date, times, and location].

Optional Facility Tour provided [*Facilitator*]: To include the Medical Staff Offices, Medical Staff Lounge, Radiology, Pathology, Emergency Department, Library, South Wing, and Human Resources for badge and picture. (If surgeon, tour will also cover OR with OR Administration.)

Source: Merella Schandl, BS, CPMSM, CPCS. Published with permission.

This hospital includes a survey in the orientation packet to gauge new affiliates' satisfaction with the onboarding process. Practitioners complete the form prior to exiting the facility after orientation. This program has been well received by both physicians and non-physician practitioners, according to the survey results.

Tool 1.11 Resident and Postgraduate Clinical Student Rotation Checklist

This tool provides a rundown of documentation required to support a clinical rotation. Facilities may modify this checklist to include other required documentation (e.g., copy of a government-issued photo ID; current CPR/BLS, if applicable).

Name:

Application received?	Yes ☐	No ☐
Sponsoring hospital medical staff member?	Yes ☐	No ☐
Name(s):		
Accredited school?	Yes ☐	No ☐
Affiliation agreement?	Yes ☐	No ☐
Letter of good standing?	Yes ☐	No ☐
Malpractice/liability insurance?	Yes ☐	No ☐
Health record/immunizations?	Yes ☐	No ☐
Hospital orientation?	Yes ☐	No ☐
Fire safety/extinguisher demo? (Educational services)	Yes ☐	No ☐

Address your hospital's notable orientation requirements (e.g., duration, dates, items needed from the resident/student).

Tip: Add the clinical site coordinator's name and contact information to ensure the resident/student knows whom to approach with questions.

Medical staff office completion: _____

Educational services completion: _____

Bonus tools! Access a sample resident and postgraduate clinical student policy and an application for clinical rotation in the downloadable materials for this book: ***www.hcpro.com/downloads/12581***.

Source: Union Hospital in Dover, Ohio. Published with permission.

Tool 1.12 Student Preceptorship Checklist

This tool supports a formal process for allowing students to participate in a preceptorship or to shadow on-staff practitioners.

This form provides detailed contact information for the student's advisor, which can come in handy when issues arise during the preceptorship.

Name of student: _____

Please check type of agreement: ___ PA ___ Medical student ___ Shadowing

Name of affiliated school: _____

Address: _____

Contact telephone: _____ Email: _____

Start date: _____ End date: _____

Name of supervising physician: _____

	Received	Does not have
Affiliation agreement		
Confidentiality agreement		
Immunization records		
Malpractice coverage		
Government issued ID		
Lab coat		
Badge (*if applicable*)		
Current CV or resume		
License (*if applicable*)		
Online orientation/education requirements complete		

Tip: Adapt this checklist as necessary to reflect your facility's specific shadowing requirements. Provide the completed checklist and relevant items to the student, as well as to his or her affiliated school. Also keep a copy in the medical staff services department, if applicable.

Tip: Include pertinent excerpts from your policies and procedures on student observers and shadowing to guide the process.

NOTES:

Preceptor must inform Medical Staff Office of the tasks the student will be performing and the dates of preceptorship.

Refer to the requirements outlined in the affiliation agreement regarding the student's learning expectations (PAs and medical students).

Residents are considered part of a house staff category. Refer to the MS Bylaws and requirements outlined by the training program.

Students undergoing shadowing opportunities are in an observation status only (no hands-on).

Medical Staff Office will manage and monitor medical students, physicians, PAs, and shadowing agreements related to physician preceptors.

Source: Merella Schandl, BS, CPMSM, CPCS. Published with permission.

The Credentialing and Privileging Toolbox

Field-Tested Documents for Compliance, Management, and Process Improvement

Merella Schandl, BS, CPMSM, CPCS

With over 50 field-tested, expert-vetted forms that support regulatory compliance, policy development, and process improvement, ***The Credentialing and Privileging Toolbox*** lightens the research load so MSPs and medical staff leaders have more time for their frontline duties fostering high-quality care and patient safety.

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This book provides:

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