Credentialing and Privileging: What physician leaders and credentialing professional must know today!

Presented by
Carol Cairns, CPMSM, CPCS
Albert L. Fritz, MHA
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III. Discussion of relevant JCAHO Standards
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VI. Principles of credentialing

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   Step 2: Collect and summarize information
   Step 3: Evaluate and recommend
   Step 4: Review, grant, deny or approve

VI. Boards role in credentialing and privileging

VII. Clinical Privileges

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XI Wrap up
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About your sponsors

About The Greeley Company

The Greeley Company's consultants and educators are physician leaders and senior healthcare professionals with hands-on experience in hospital, ambulatory, physician practice, and managed care settings. Our approach is to provide consultation, education, and training that is timely and cost-effective and to partner with our clients to produce high-impact results that serve the best interests of your organization, your patients, and the communities you serve.

We're dedicated to helping healthcare leaders succeed in the face of today's toughest challenges. We know how hard your job is. We have years of experience doing your job and helping others across the country do their jobs. From that experience we know you don't always have all the talent, resources, or time available within your organization to tackle the issues most important for your success and sometimes even for your organization's survival. So when you need help, we'll be there with just the customized, effective solution you need.

Contact us at
Consulting: 888/749-3054  781/639-0085 (fax)
Seminars: 800/801-6661   800/738-1553 (fax)

About The Greeley Medical Staff Institute

The Greeley Medical Staff Institute is a unique membership organization dedicated to serving the needs of hospital and medical staff leaders who recognize the importance of effective physician relationships to their hospital's success. Members of the institute receive exclusive access to high-level, nationally renowned consulting experts—all physicians and former hospital leaders—who work closely with you and members of your staff to develop and implement a multifaceted relationship-building program. Each customized program is designed to reduce hospital costs, build effective medical staff leadership, develop a succession strategy, comply with regulatory requirements, meet public accountability for quality, and train staff to practice safe and effective medicine.
Speaker profiles

Carol Cairns, CPMSM, CPCS

Carol Cairns has been in the unique position of overseeing and participating in the development of the medical staff services profession for more than 30 years. She is a senior consultant with The Greeley Company as well as the president of Plainfield, IL-based PRO-CON, a consulting firm specializing in credentialing, privileging, medical organization operations, and survey preparation.

In 1998, Carol began consulting and presenting with The Greeley Company. She recently joined the company as a senior consultant in Credentialing and Privileging. She also serves as an information resource for The Greeley Company’s parent, healthcare media specialist HCPro, Inc. She wrote Verify and Comply: A Quick Reference Guide to the JCAHO and NCQA Standards for Credentialing, Third Edition - a very popular resource. She also coauthored A Guide to AHP Credentialing, a comprehensive how-to resource for credentialing allied health practitioners (AHP), now available in its second edition, as well as the third edition of Core Privileges: A Practical Approach to Development and Implementation. All three books are published by HCPro.

Albert L. Fritz, MHA

Albert L. Fritz currently serves as Vice President at The Greeley Company, a division of HCPro, Inc. specializing in Medical Staff and hospital management activities. Mr. Fritz has extensive experience as a hospital executive with responsibility for Medical Staff and board initiatives, including Medical Staff Leadership/Development, Quality Improvement, Medical Staff Merger/Redesign, and Operations Management. He consults and lectures on Medical Staff Leadership, Reorganization, Medical Staff Integration and Mergers, Credentialing, and Bylaws Development. Mr. Fritz works extensively with hospitals, ambulatory group practices, managed care entities, and medical staffs in enhancing effectiveness and efficiency. Over the past several years Mr. Fritz has been a lead consultant on numerous Hospital System Mergers and has worked with medical staff leaders to enhance the effectiveness of the Medical Staff structure and functions.

Prior to joining The Greeley Company, Mr. Fritz served as administrator of The Millard Fillmore Suburban Hospital in Amherst, New York. He served as an assistant administrator of The Millard Fillmore Gates Circle Hospital in Buffalo, New York, and as an assistant administrator of The Kenosha Hospital and Medical Center in Kenosha, Wisconsin. He is a member of The American College of Healthcare Executives and The American Healthcare Association. He served as a member of The New York State Health Services Committee and The New York State Rehabilitation Licensure Board. Mr. Fritz currently serves as a faculty member for The American College of Physician Executives (ACPE), Tampa, Florida.

Mr. Fritz holds a BA degree in Healthcare Administration from The University of Maryland and a Master’s degree in Healthcare Administration from Xavier University in Cincinnati, Ohio. He is a recipient of The Foster G. McGaw Scholarship sponsored by The American College of Healthcare Executives.
Exhibit A

presentation by
Carol Cairns, CPMSM, CPCS,
and Albert L. Fritz, MHA
History and Perspective

- Discussion of the three reasons credentialing exists
  - Patient safety
  - Physician practice facilitation
  - Institutional protection
The Evolving Credentialing Standard

1. **Credentialing and Privileging**: What physician leaders and credentialing professionals must know today.

EXHIBIT A

About the JCAHO

- CMS
- JCAHO
- NCQA
- AOA HFAP
- State licensing agencies

Credentialing and Privileging: What physician leaders and credentialing professionals must know today!
Discussion of relevant JCAHO Standards

- Standards and elements of performance
  - MS.4.110
  - MS.4.130

- Problematic standards
  - Telemedicine requirements

Principles of Credentialing
## Principles and Guidelines

**Guiding PRINCIPLES for credentialing**

1. Credentialing exists to protect patients
2. Follow the 5Ps*
3. No one works without a ticket!
4. Be consistent and methodical
5. Place the burden on the applicant
6. Don’t be blinded by past practice/success
7. Collect clinical data and obtain accurate references
8. Excellent credentialing requires consistently applied clear criteria
9. Never deny membership or privileges except for demonstrated incompetence
10. Just because “there is no reason to deny” is not a good enough reason to grant
*Our Policy is to follow our Policy. In the absence of a Policy, our Policy is to create a Policy.

**Basic STEPS to credentialing**

1. Establish policies and rules (medical staff, governing board)
2. Collect, verify, and summarize information (management)
3. Evaluate and recommend (medical staff)
4. Review, grant, deny, or approve (governing board)

**Clinical privileges: MYTHS**

1. Clinical privileges are “owned” by physicians
2. Clinical privileges are defined, determined, and granted by the clinical departments
3. A physician is entitled to all clinical privileges requested unless not sufficiently trained or qualified
4. There are “text book” criteria available for delineating privileges

**GUIDELINES to developing criteria for clinical privileges**

1. Establish a consistent method for delineating clinical privileges
2. Don’t be pressured into granting privileges without first developing criteria
3. Distinguish between criteria for medical staff membership and criteria to be eligible to request clinical privileges
4. Criteria should be specialty or procedure-specific, NOT department specific
5. Put the burden on the interested applicant to provide information about required education, training, experience, indications for the procedure, etc.
6. Develop and follow the process to determine cross-specialty criteria

---

### Summary points of learning

- List two opportunities to improve within your organization
The Four Essential Steps to Credentialing

Summary points of learning

- **Step 1**: Establish policies and rules
- **Step 2**: Collect and summarize information
- **Step 3**: Evaluate and recommend
- **Step 4**: Review, grant, deny or approve
Process failures

- Lack of relevant information
  - Background checks
  - Precise references
  - Difficulty obtaining disciplinary action
  - Clinical experience verification

Decision failures

- Pressured to make decisions too quickly
- The information is available, with poor analysis or poor decision
Boards role in credentialing and privileging

Clinical Privileges
Let history be our guide…

“There is no more controversial question in medical practice than who may be granted hospital privileges and to what extent”

Kenneth Babcock, MD
Director of JCAH, 1962

Clinical privileges

- THE most effective quality control mechanism in hospitals
- The goal of privileging: To match privileges granted with demonstrated provider competence
Clinical privileges:

- System of classification of major diagnostic and treatment procedures

- Setting specific
  - Considers procedures and types of care, treatment, and services that can be performed or provided within the proposed setting

- Criteria based

Privileges

The old way  Laundry list

The new way  Core privileges plus criteria
Clinical privileges

- Minimal qualifications necessary to apply

- Criteria:
  - Education
  - Training
  - Experience
  - Evidence of current competence
  - Peer recommendation (PRN)
  - Board certification
  - CME
  - Ability to perform

Establishing core privileging...

- Identify diagnostic groups/procedures whose training, experience, and outcome requirements are the same

- Combine into a core privilege

- Identify/list separately those privileges requiring additional training/experience

- Assure clear understanding of content of core by medical and nursing staff
Example of core language

Orthopedic surgery

- Admit, evaluate, diagnose, provide consultation and care to patients of all ages...to correct or treat various conditions, illnesses and injuries of the extremities, spine, and associated structures by medical, surgical, and physical means including but not limited to congenital deformities, trauma, infections, tumors, metabolic disturbances of the musculoskeletal system, deformities, injuries, and degenerative diseases of the spine, hands, feet, knee, hip, shoulder, and elbow including primary and secondary muscular problems and the effects of central or peripheral nervous system lesions of the musculoskeletal system. 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.

Example of criteria

Core privileges in orthopedic surgery

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited postgraduate training program in orthopedic surgery

- Current certification or active participation in the examination process leading to certification in orthopedic surgery by the American Board of Orthopedic Surgery or the American Osteopathic Board of Orthopedic Surgery. Certification must be achieved within five (5) years of initial medical staff appointment.
Example of criteria

Core privileges in orthopedic surgery

- Applicant must be able to demonstrate the performance of at least 100 orthopedic procedures (reflective of the scope of the procedure list) during the last 12 months with acceptable outcome.

Example of maintenance criteria

Core privileges in orthopedic surgery

- Current demonstrated competence and an adequate volume (# ?) of current experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/ improvement activities and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.
Is it core or special???

- Knowledge
- Skill
- Judgment
- Risk
- Ability to manage complications
- Technique
- Equipment

2 or more questioned by 2 credentialing committee members—It’s special

Sources for clinical criteria:

- Postgraduate education programs
- Requirements for specialty boards
- Position statements from specialty societies
- Journals/articles/literature search
- CME programs
- Equipment manufacturers with physician leadership/consultation
- Hospitals/ambulatory sites
- Networking among MSLS and credentialing specialists
Examples of criteria for specific procedures

- **EGD**: Initially 100 cases successfully performed. Minimum of ?? per year with acceptable QI outcome.

- **Stereotactic Breast Biopsy**: Surgeon—successful completion of at least 15 hours hands-on CME OR performance of >36 stereotactic breast biopsies in past 3 years

- **TEE**: Completion of residency or specialty training to include 20 TEE procedures. Thereafter, 20 procedures/year.

Performance improvement criteria:

- **Clinical Indicators**
  - Blood use
  - Medication use
  - Operative and other procedures evaluations
  - Morbidity, mortality, utilization data
  - Adherence to clinical pathways
  - Departures from clinical practice standards/outcome of peer review, etc.

- **Relevant practitioner-specific information compared to aggregate information**
CMS clarification regarding hospital medical staff privileging

Guidance to state survey agency directors and CMS regional offices


Resolving credentialing specialty dispute

Evolving best practices in credentialing and privileging

See Exhibit B page 30
Reappointment

What a mess!

- Time consuming
- Misunderstood
- Confusing
- Paper/labor intensive
- Little positive outcome
- Antagonistic
Physicians are mutually accountable to each other for determining competency at appointment, reappointment and when setting and following privileging criteria.

Remember: Competency is a combination of actual performance + results.
Opportunities

- To reconfirm excellence
- To adjust category based on activity/interest
- To realign privileges
- To determine interest and commitment
- To meet requirements
- To make it sensible

Which requires...

Rethinking

- It occurs at an arbitrary point in time
- It should never be the time at which an incompetent or unqualified physician is identified
- It should rarely result in a denial
- Guidelines must be better developed by MEC and board
- There should rarely be a “surprise”
Consider the parallel:
Employment

- We hire
- We evaluate annually and provide feedback
- We promote, alter job description, supervise more intently and occasionally require retraining
- We don’t fire on the anniversary date
  - In fact, we never fire “out of the blue” (exceptions: loss of license, theft, assault/battery, gross dereliction of duty, murder, etc.)

Physician performance feedback report

- Objective/feedback report – data driven

See Exhibit B page 32
Pulling it All Together
The 12 step process for improving your credentialing and privileging process

Step 1
- Education board, medical staff and management leadership
  - To understand the medical/legal importance of, and their own role in, credentialing and privileging
Step 2

- Assess the effectiveness of the credentialing and privileging process annually

See Exhibit C page 48

Step 3

- Improve credentialing and privileging outcomes by revising “troublesome” policies and processes

credentialinfo.com

The Healthcare Credentialing Information Supersite
Step 4

- **Assure membership criteria are current**
  - Verify through background checks
  - Promote quality patient care

Step 5

- **Develop “core” privileging policies and procedures that facilitate the development of objective criteria**
Step 6

- Establish a process for resolving crossover specialty issues

Step 7

- Determine annually the QI/peer review data
  - Ongoing review and communication of performance
Step 8

- Follow consistently the credentialing principles

Step 9

- Assure the credentials policy and procedure manual and fair hearing and appeal plan is up-to-date with regulatory requirements and safe practices
Step 10

- Evaluate and keep current the board policy and procedures regarding allied health practitioners

Step 11

- Design and implement an “intended practice plan” questionnaire
Step 12

- **Reward**
  - Provide feedback and reward the physician leaders and medical staff professionals who perform the credentialing function.

Thank you for joining us!
The following documents were taken from the seminar in March 2005 titled “Credentialing and privileging: What physician leaders and credentialing professionals must know today!”

Credentialing and privileging: Principles and Guidelines
Evolving best practice in credentialing and privileging
Evolving credentialing standard
Evolving best practices in credentialing and privileging
Physician performance report

Hematology/Oncology clinical privileges
Orthopedic surgery clinical privileges

Source: Core privileges: a practical approach to development and implementation, third edition, published by HCPro, Inc.
Principles and Guidelines

Guiding PRINCIPLES for credentialing
1: Credentialing exists to protect patients
2: Follow the 5Ps*
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6: Develop and follow the process to determine cross-specialty criteria
Evolving best practices in Credentialing and Privileging

**Step 1**  
Begin by understanding the four steps in credentialing and privileging:  
1. Establish policies and procedures (e.g. criteria)  
2. Gather information  
3. Assess and recommend  
4. Review and grant

**Step 2**  
Establish a moratorium on processing crossover and new technology privilege requests until a policy is in place to address these

**Step 3**  
Gather information
   - Other hospitals*
   - Specialty societies*
   - Literature search*

   - CRC white papers
   - Use the web (e.g. credentialinfo.com)
   *Put the burden on the applicant

**Step 4**  
Solicit recommendations for privileging criteria from department chairs/subject matter experts
   - If they agree, you’re done. Adopt the criteria.
   - If they disagree, follow your policy.

**Step 5**  
The credentials committee should appoint a task force to develop recommendations for privileging criteria

**Step 6**  
The task force gathers additional information, discusses the issue, and makes a recommendation to the credentials committee for privileging criteria (which may include one or more minority opinions)

**Step 7**  
The credentials committee reviews the proposed criteria, votes on them, and refers the issue to the MEC*

   *Members of the credentials committee who practice in any of the specialties involved in the crossover privilege issue should recuse themselves from the vote.

**Step 8**  
The MEC reviews and votes on the proposed criteria*

   *Members of the MEC who practice in any of the specialties involved in the crossover privilege issues should recuse themselves from the vote.

**Step 9**  
Apply the criteria

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The Evolving Credentialing Standard

1. **Lifetime licensure history**
   Verify each physician’s or medical staff applicant’s lifetime licensure history. Check all Licenses currently held by the applicant across all healthcare disciplines (including allied disciplines) and previous licenses no longer held by the applicant.

2. **Lifetime medical education and training history**
   Verify the applicant’s lifetime medical education and training history, including all medical osteopathic, podiatric, dental or other schools attended, as well as all approved or non-approved residency and fellowship programs.

3. **Malpractice insurance and 10-year history**
   Check the applicant’s current malpractice policy and previous 10-year malpractice history, including claims, lawsuits and settlements (include those brought against the physician’s professional corporation or incorporated practice).

4. **Specialty board status**
   Verify the applicant’s specialty board status. Obtain information on admissibility to take the exam, components of the exam currently taken, sections passed or failed, as well as the number of times the applicant took the exam. Confirm either no status or certification.

5. **Sanctions and disciplinary actions**
   Investigate all sanctions or disciplinary actions taken, recommended, or pending against an applicant by a hospital, health system, component of a health system, freestanding ambulatory care facility, any branch of the federal or state government, specialty board, or managed care organization.

6. **Lifetime criminal record**
   Thoroughly check the applicant’s lifetime (or legally obtainable) criminal history.

7. **All healthcare-related employment/appointment history**
   Verify the applicant’s healthcare-related employment, appointment, and/or privilege history, including terminations, challenges, pending investigations or decisions, voluntary resignations, and relinquishments of either medical staff membership, clinical privileges, or panel appointments.

8. **Current professional references from knowledgeable practitioners**
   Obtain current professional references of the applicant via mail, fax, email or telephone.

9. **Clinical activity for the past 6 to 12 months**
   Require a summary report of the applicant’s past 6 to 12 months of clinical activity (including the approximate number, type, and location of patients treated) as part of the application to the medical staff. For applicants who have had little clinical activity, obtain the full 12 month report. For applicants who have had much clinical activity, obtain the past 6 months.

10. **Comparison of applicant-provided information and verified**
    Summarize and compare all of the applicant’s collected and verified information for review by physician leaders, committees and the board.

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Credentialing and Privileging: What physician leaders and credentialing professionals must know today!

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### Physician Performance Report

**Provider:** John Smith, MD  
**Dept:** Medicine  
**Period:** Jan. 2001-Dec. 2002

| Activity Data                       |  
|------------------------------------|-----------------------------------------------|---|
| Admissions                         | 200                                           |   |
| Consults                           | 12                                            |   |
| Procedures                         | 80                                            |   |
| Total encounters                   | 250                                           |   |
| Transfusions (episodes)            | 100                                           |   |

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<td>&gt;50%</td>
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<td>80</td>
<td>1</td>
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<td>&lt;3</td>
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<td></td>
<td>% H&amp;P/OP documentation elements</td>
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<td>Medical Records Suspensions</td>
<td>Rule</td>
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<td>0</td>
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<td>MEC</td>
<td>G</td>
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<td>Meeting Attendance</td>
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<td>&gt;70%</td>
<td>&gt;50%</td>
<td>MEC</td>
<td>G</td>
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</tbody>
</table>

**Physician Profiles:** How to collect, measure, and use data to evaluate physician performance.

---

**Credentialing and Privileging:** What physician leaders and credentialing professionals must know today!
HEMATOLOGY/ONCOLOGY CLINICAL PRIVILEGES

Name: _______________________________________________________    Effective from __/__/__ to __/__/__

To be eligible to apply for core privileges in hematology, the applicant must meet the following criteria:

• Current certification or active participation in the examination process leading to certification in hematology by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.

Or

• Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited post-graduate training program in internal medicine and completion of an accredited training program in hematology.

And

• Applicants for initial appointment must be able to demonstrate that (s)he has provided inpatient or consultative services for at least 24 hematology patients during the past 12 months or demonstrate successful completion of a hospital-affiliated formal fellowship, special clinical fellowship, or research.

• Applicants for initial appointment may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence and other qualifications and for resolving any doubts.

To be eligible to renew core privileges in hematology, the applicant must meet the following Maintenance of Privilege criteria:

• Current demonstrated competence and an adequate volume of experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

HEMATOLOGY CORE PRIVILEGES

- Requested Admit, evaluate, diagnose, treat, and provide consultation to patients of all ages, except as specifically excluded from practice, with diseases and disorders of the blood, spleen, lymph glands, and immunologic system such as anemia, clotting disorders, sickle cell disease, hemophilia, leukemia, and lymphoma. Privileges include, but are not limited to
  • bone marrow aspirations and biopsy
  • diagnostic lumbar puncture
  • administration of chemotherapeutic agents and biological response modifiers through all therapeutic routes
  • management and care of indwelling venous access catheters
  • therapeutic phlebotomy
  • therapeutic thoracentesis and paracentesis
To be eligible to apply for core privileges in oncology, the applicant must meet the following criteria:

- Current certification or active participation in the examination process leading to certification in oncology by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.

Or

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited post-graduate training program in internal medicine and completion of an accredited program in oncology.

And

- Applicants for initial appointment must be able to demonstrate that (s)he has provided inpatient or consultative services for at least 24 oncology patients during the past 12 months, or demonstrate successful completion of a hospital-affiliated formal fellowship, special clinical fellowship, or research.

- Applicants for initial appointment may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence and other qualifications and for resolving any doubts.

To be eligible to renew core privileges in medical oncology, the applicant must meet the following Maintenance of Privilege criteria:

- Current demonstrated competence and an adequate volume of experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

**MEDICAL ONCOLOGY CORE PRIVILEGES**

- **Requested** Admit, evaluate, diagnose, treat, and provide consultation to patients of all ages, except as specifically excluded from practice, with all types of cancer and other benign and malignant tumors. Privileges include but are not limited to:
  - bone marrow biopsy and interpretation
  - diagnostic lumbar puncture
  - administration of chemotherapeutic agents and biological response modifiers through all therapeutic routes
  - management and maintenance of indwelling venous access catheters
  - therapeutic thoracentesis and paracentesis

**SPECIAL NON-CORE PRIVILEGES (See Qualifications and/or Specific Criteria)**

To be eligible to apply for the special non-core privileges listed below, the applicant must demonstrate successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship, or other acceptable experience, and must provide documentation of competence in performing the requested procedure consistent with criteria set forth in medical staff policies governing the exercise of specific privileges.
### BONE MARROW TRANSPLANTATION

<table>
<thead>
<tr>
<th>Requested</th>
<th>High dose chemotherapy with autologous peripheral blood stem cell and/or bone marrow transplantation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requested</td>
<td>Allogeneic bone marrow transplantation</td>
</tr>
<tr>
<td>Requested</td>
<td>Stem cell harvest</td>
</tr>
</tbody>
</table>
HEMATOLOGY/ONCOLOGY CLINICAL PRIVILEGES

Name: _______________________________________________________    Effective from __/__/__ to __/__/__

Acknowledgement 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 [HOSPITAL NAME], 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.

Signed: ______________________________________________  Date: _______________________________

Department Chair’s Recommendation
I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges
☐ Recommend privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

<table>
<thead>
<tr>
<th>Privilege</th>
<th>Condition/Modification/Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
<td></td>
</tr>
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<td>4.</td>
<td></td>
</tr>
</tbody>
</table>

Notes:

Department Chair Signature: _______________________________ Date: _______________________________

**********For Medical Staff Office Use Only **********

Credentials Committee Action: _______________________________ Date: _______________________________

Medical Executive Committee Action: _________________________ Date: _______________________________

Board of Trustees Action: _________________________________ Date: _______________________________
ORTHOPEDIC SURGERY CLINICAL PRIVILEGES

Name: _______________________________________________________    Effective from __/__/__ to __/__/__

To be eligible to apply for core privileges in orthopedic surgery, the applicant must meet the following criteria:

- Current certification or active participation in the examination process leading to certification in orthopedic surgery by the American board of Orthopedic Surgery or the American Osteopathic Board of Orthopedic Surgery

Or

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited post-graduate training program in orthopedic surgery

And

- Applicants for initial appointment must be able to demonstrate the performance of at least 100 orthopedic procedures during the past 12 months or demonstrate successful completion of a hospital-affiliated accredited residency, special clinical fellowship or research.

- Applicants for initial appointment may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence and other qualifications and for resolving any doubts.

And

To be eligible to renew core privileges in orthopedic surgery, the applicant must meet the following Maintenance of Privilege criteria:

- Current demonstrated competence and an adequate volume of experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

ORTHOPEDIC SURGERY CORE PRIVILEGES

- Requested

Admit, evaluate, diagnose, treat, and provide consultation to patients of all ages, except as specifically excluded from practice, to correct or treat various conditions, illnesses, and injuries of the extremities, spine, and associated structures by medical, surgical, and physical means including but not limited to congenital deformities, trauma, infections, tumors, metabolic disturbances of the musculoskeletal system, deformities, injuries, and degenerative diseases of the spine, hands, feet, knee, hip, shoulder, and elbow, including primary and secondary muscular problems and the effects of central or peripheral nervous system lesions of the musculoskeletal system. 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.
To be eligible to apply for core privileges in the subspecialty of hand surgery, the applicant must meet the following criteria:

- Current certification in surgery, plastic surgery or orthopedic surgery and post graduate training in hand surgery or subspecialty certification in hand surgery by the American Board of Surgery, Plastic Surgery or Orthopedic Surgery or the American Osteopathic Board of Surgery.

Or

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited post-graduate training program in surgery, orthopedic surgery, or plastic surgery that included training in surgery of the hand.

And

- Applicants for initial appointment must be able to demonstrate performance of surgery on the internal structures of the hand and related structures at least 20 times during the past 12 months, or demonstrate successful completion of a hospital-affiliated accredited residency, special clinical fellowship or research.

- Applicants for initial appointment may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

And

To be eligible to renew core privileges in hand surgery, the applicant must meet the following Maintenance of Privilege criteria:

- Current demonstrated competence and an adequate volume of experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

**HAND SURGERY CORE PRIVILEGES**

- Admit, evaluate, diagnose, treat, and provide consultation to patients of all ages, except as specifically excluded from practice, presenting with injuries and disorders of all structures of the upper extremity directly affecting the form and function of the hand and wrist by medical, surgical, and rehabilitative means. 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.

To be eligible to apply for core privileges in orthopedic surgery of the spine, the applicant must meet the following criteria:

- As for Orthopedic Surgery plus postgraduate training in orthopedic surgery of the spine.

And

- Applicants for initial appointment must be able to demonstrate performance of surgery of the spine at least 20 times during the last 12 months, or demonstrate successful completion of a hospital-affiliated accredited residency, special clinical fellowship or research.
• Applicants for initial appointment may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

And

**To be eligible to renew core privileges in orthopedic surgery of the spine, the applicant must meet the following Maintenance of Privilege criteria:**

• Current demonstrated competence and an adequate volume of experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

**ORTHOPEDIC SPINE SURGERY CORE PRIVILEGES**

| Requested | Admit, evaluate, diagnose, treat, and provide consultation to patients of all ages, except as specifically excluded from practice, with spinal column diseases, disorders, and injuries by medical, physical, and surgical methods including the provision of consultation. 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. |

**To be eligible to apply for core privileges in pediatric orthopedic surgery, the applicant must meet the following criteria:**

• As for Orthopedic Surgery plus postgraduate training in pediatric orthopedic surgery.

And

• Applicants for initial appointment must be able to demonstrate performance of pediatric surgery at least 50 times during the past 12 months, or demonstrate successful completion of a hospital-affiliated accredited residency, special clinical fellowship or research.

• Applicants for initial appointment may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

And

**To be eligible to renew core privileges in pediatric orthopedic surgery, the applicant must meet the following Maintenance of Privilege criteria:**

• Current demonstrated competence and an adequate volume of experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.
PEDIATRIC ORTHOPEDIC SURGERY CORE PRIVILEGES

- **Requested**
  Admit, evaluate, diagnose, consult, and provide medical and surgical care to children under the age of 18 years of age, with disorders, diseases, and injuries of the extremities, pelvis, shoulder, girdle, and spine. Privileges include but are not limited to treatment of fractures, dislocations, arthritis, and other diseases of joints; infections, tumors, tumor-like lesions, and metabolic diseases of the bone, joint, tendon, tendon sheath, fascia, bursa, and nerves; congenital, traumatic, infectious, postural, developmental, neurogenic, and metabolic deformities and diseases including reconstructive surgery in children to correct traumatic, postural, congenital, neurogenic, arthritic, and idiopathic deformity or diseases of the extremities, spine, or pelvis; and operative and non-operative treatment of abrasions, contusions, hematomas, and lacerations (both superficial and deep) anywhere about the body. 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.

SPECIAL NON-CORE PRIVILEGES (See Qualifications and/or Specific Criteria)

To be eligible to apply for the special non-core privileges listed below, the applicant must demonstrate successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship, or other acceptable experience, and provide documentation of competence in performing the requested procedure consistent with criteria set forth in medical staff policies governing the exercise of specific privileges.

USE OF LASER

- **Requested**
  [Criteria: Completion of an approved eight hour minimum CME course which includes training in laser principles and safety, basic laser physics, laser tissue interaction, discussions of the clinical specialty field and hands-on experience with lasers. A letter outlining the content and successful completion of course must be submitted, or documentation of successful completion of an approved residency in a specialty or subspecialty that included training in laser principles and safety, basic laser physics, laser tissue interaction, discussions of the clinical specialty field and a minimum of six hours observation and hands-on experience with lasers.]

MINIMALLY INVASIVE TOTAL HIP ARTHROPLASTY (THA)

- **Requested**
  [Criteria: Applicants must have completed an ACGME- or AOA-accredited training program in orthopedic surgery followed by completion of specialized training in minimally invasive THA. It is recommended that surgeon experienced in minimally invasive THA procedures should proctor an applicant’s initial cases. Required Previous Experience: Applicants must be able to demonstrate the performance of at least 25 minimally invasive THAs in the past 12 months. Maintenance of Privilege: Applicants must be able to demonstrate that they have maintained competence by showing evidence of the performance of at least 25 minimally invasive THAs annually over the reappointment cycle. In addition, continuing education related to minimally invasive THAs should be required.] Source: Clinical Privilege White Paper # 217
PERCUTANEOUS LUMBAR DISCECTOMY (PLD)

- **Requested**

  **Criteria**: Successful completion of an ACGME or AOA residency or fellowship training program in orthopedic surgery, neurological surgery, neurology, physical medicine and rehabilitation, anesthesiology, interventional radiology, or pain medicine. Applicants must provide evidence that the training program included fluoroscopy and discography. In addition, applicants should have completed a training course in the PLD method for which privileges are requested. **Requires Previous Experience**: Applicant must be able to demonstrate that s/he has performed in the past 12 months at least five procedures in the PLD method for which privileges are requested. **Maintenance of Privilege**: Applicant must be able to demonstrate s/he has maintained competence by showing evidence of the performance of at least five procedures in the PLD method for which privileges are requested annually over the reappointment cycle. In addition, CME related to the discography and PLD should be required.

  Source: Clinical Privilege White Paper # 218

PERCUTANEOUS VERTEBROPLASTY OR BALLOON KYPHOPLASTY

- **Requested**

  **Criteria**: Successful completion of an ACGME- or AOA-accredited residency program in orthopedic surgery or neurosurgery, followed by a fellowship in spine surgery. Applicants must also have completed an approved training course in the use of the inflatable bone tamp and have been proctored in their initial cases by a Kyphon company representative. **Required Previous Experience**: Applicants must be able to demonstrate that they have performed at least 10 balloon kyphoplasty procedures in the past 12 months. Applicants must also have completed training in radiation safety. **Maintenance of Privilege**: Applicant must be able to demonstrate maintenance of competence by evidence of the performance of at least 10 balloon kyphoplasty procedures annually over the reappointment cycle.

  Source: Clinical Privilege White Paper # 30 and Source: Clinical Privilege White Paper # 201

ENDOSCOPIC LASER FORAMINOPLASTY (ELF)

- **Requested**

  **Criteria**: Successful completion of an ACGME- or AOA-accredited residency training program in orthopedic surgery or neurosurgery followed by formal training in endoscopy for the spine and laser surgery for the spine. In addition, attendance at an ELF training workshop and proctored in initial cases by a physician experienced in the ELF procedure. **Required Previous Experience**: Demonstration of the performance of at least 25 ELF procedures in the past 12 months. **Maintenance of Privilege**: Applicant must be able to show maintenance of competence with evidence of the performance of at least 50 ELF procedures in the past 24 months.

  Source: Clinical Privilege White Paper # 60

ORTHOTRIPSY

- **Requested**

  **Criteria**: Successful completion of an ACGME- or AOA-accredited residency training program in orthopedic surgery or CPME accredited training program in podiatric surgery. Applicants must have also completed an orthotripsy course that included shock wave machine training and observed cases. **Required Previous Experience**: Applicants must be able to demonstrate that they have performed at least five orthotripsy procedures in the past 12 months. **Maintenance of Privilege**: Applicant must be able to show maintenance of competence with evidence of the performance of at least five orthotripsy procedures in the past 24 months.

  Source: Clinical Privilege White Paper # 211
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<th>Requested</th>
<th>Criteria: Successful completion of an ACGME- or AOA-accredited residency training program in orthopedic surgery as well as a relevant fellowship program. In addition, the applicant must have completed an advanced course in ACI that included proctored cases. <strong>Required Previous Experience:</strong> Demonstration of the performance of at least five ACI procedures as the primary surgeon in the past 12 months. <strong>Maintenance of Privilege:</strong> Demonstration of the maintenance of competence by evidence of the performance of at least 20 ACI procedures as the primary surgeon in the past 24 months.</th>
<th>Source: Clinical Privilege White Paper # 62</th>
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</thead>
<tbody>
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<td>AUTOLOGOUS CHONDROCYTE IMPLANTATION (ACI)</td>
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<td>INTRADISCAL ELECTROTHERMAL THERAPY (IDET)</td>
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<td>ADMINISTRATION OF SEDATION AND ANALGESIA</td>
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<td>See Hospital Policy for Sedation and Analgesia by Non-Anesthesiologists</td>
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</table>
ORTHOPEDIC SURGERY CLINICAL PRIVILEGES

Name: _______________________________________________________ Effective from __/__/__ to __/__/__

Note: This list is a sampling of procedures included in the core. It is not intended to be an all-encompassing list but rather to reflect the categories/types of procedures included in the core.

Orthopedic Surgery Core Procedure List:

- Amputation surgery including immediate prosthetic fitting in the operating room
- Arthrocentesis, diagnostic
- Arthrodesis, osteotomy and ligament reconstruction of the major peripheral joints, excluding total replacement of joint
- Arthrography
- Arthroscopic surgery
- Biopsy and excision of tumors involving bone and adjacent soft tissues
- Bone grafts and allografts
- Carpal tunnel decompression
- Closed reduction of fractures and dislocations of the skeleton
- Debridement of soft tissue
- Excision of soft tissue/bony masses
- Fasciotomy and fasciectomy
- Fracture fixation
- Growth disturbances such as injuries involving growth plates with a high percentage of growth arrest, growth inequality, epiphysiodesis, stapling, bone shortening or lengthening procedures
- Ligament reconstruction
- Major arthroplasty, including total replacement of knee joint, hip joint, shoulder
- Major cancer procedures involving major proximal amputation (i.e., forequarter, hindquarter) or extensive segmental tumor resections
- Management of infectious and inflammations of bones, joints and tendon sheaths
- Muscle and tendon repair, excluding hand
- Open and closed reduction of fractures
- Open reduction and internal/external fixation of fractures and dislocations of the skeleton
- Reconstruction of nonspinal congenital musculoskeletal anomalies
- Removal of ganglion (palm or wrist; flexor sheath)
- Total joint replacement revision
- Total joint surgery
- Treatment of extensive trauma, excluding pelvis or spine
Hand Surgery (As part of Orthopedic Surgery Scope of Practice)

- Arthroplasty of large and small joints, wrist, or hand, including implants
- Bone graft pertaining to the hand
- Carpal tunnel decompression
- Fasciotomy and fasciectomy
- Fracture fixation
- Laceration repair
- Nerve graft
- Neurorrhaphy
- Microvascular surgery
- Open and closed reductions of fractures
- Removal of soft tissue mass, ganglion palm or wrist, flexor sheath, etc.
- Skin and bone grafts
- Tendon reconstruction (free graft, staged)
- Tendon release, repair, and fixation
- Tendon transfers
- Treatment of infections

Orthopedic Surgery of the Spine

- Assessment of the neurologic function of the spinal cord and nerve roots
- Interpretation of imaging studies of the spine
- Management of traumatic, congenital, developmental, infectious, metabolic, degenerative, and rheumatologic disorders of the spine
- Treatment of extensive trauma including spine
- Laminectomies, laminotomies, and fixation and reconstructive procedures of the spine and its contents including instrumentation
- Lumbar puncture
- Scoliosis and kyphosis instrumentation
- Spinal cord surgery for decompression of spinal cord or spinal canal, rhizotomy, cordotomy, dorsal root entry zone lesion, tethered spinal cord, or other congenital anomalies

Pediatric Orthopedic Surgery

- Amputation surgery including immediate prosthetic fitting in the operating room
- Amputations/simple polydactyly/digital tip injuries
- Arthrocentesis
- Arthrodesis, osteotomy and ligament reconstruction of the major peripheral joints, excluding total replacement of joint
• Arthroscopy
• Arthrography
• Biopsy and excision of tumors involving bone and adjacent soft tissues
• Bone grafts
• Carpal tunnel decompression
• Closed reduction of fractures and dislocations of the peripheral skeleton
• Closed treatment of congenital foot deformity
• Debridement of soft tissue
• Excision of soft tissue/bony masses
• Fasciotomy and fasciectomy
• Fracture fixation with mini compression plates
• Growth disturbances such as injuries involving growth plates with a high percentage of growth arrest, growth inequality, epiphysiodesis, stapling, bone shortening or lengthening procedures
• Major arthroplasty, including total replacement of knee joint, hip joint, shoulder
• Major cancer procedures involving major proximal amputation (i.e., forequarter, hindquarter) or extensive segmental tumor resections
• Management of infectious and inflammations of bones, joints and tendon sheaths
• Muscle and tendon repair, excluding hand
• Non-operative treatment of congenital bone malformation or deformations, or acquired bone deformities
• Open and closed reduction of fractures
• Open reduction and internal fixation of fractures and dislocations of the peripheral skeleton
• Reconstruction of nonspinal congenital musculoskeletal anomalies
• Removal of ganglion (palm or wrist; flexor sheath)
• Treatment of extensive trauma, excluding pelvis or spine
ORTHOPEDIC SURGERY CLINICAL PRIVILEGES

Name: _______________________________________________________    Effective from __/__/__ to __/__/__

Acknowledgement 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 [ HOSPITAL NAME ], 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.

Signed: ______________________________________________  Date: _______________________________

Department Chair’s Recommendation
I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

- Recommend all requested privileges
- Recommend privileges with the following conditions/modifications:
- Do not recommend the following requested privileges:

<table>
<thead>
<tr>
<th>Privilege</th>
<th>Condition/Modification/Explanation</th>
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<tbody>
<tr>
<td>1.</td>
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</table>

Notes:

Department Chair Signature: _______________________________ Date: _______________________________

**********For Medical Staff Office Use Only **********

Credentials Committee Action: __________________________________ Date: ____________________________

Medical Executive Committee Action: ___________________________ Date: _____________________________

Board of Trustees Action: ____________________________________ Date: _____________________________
Exhibit C

The following documents were taken from the seminar in March 2005 titled “Credentialing and privileging: What physician leaders and credentialing professionals must know today!”

Credentialing self-assessment tool by Hugh Greeley
CREDENTIALING SELF-ASSESSMENT TOOL

PREPARED BY

HUGH P. GREELEY

THE GREELEY COMPANY
INTRODUCTION

Active, effective, and committed credentials committees have never been more important to hospitals, managed care organizations, and other health care organizations than now. Because of this, credentials committees need to strengthen their abilities to carry out their functions and assist the organizations they serve.

Critical and detailed self-evaluation can be an important tool in today’s complex environment. When used appropriately, the self-evaluation process will undoubtedly improve the effectiveness of the credentials committee. With the assistance of medical staff presidents, chiefs of staff, and vice presidents for medical affairs across the United States, Opus Communications has developed this manual for hospital and other health care organization credentials committees to evaluate their performance and contribute more to their organizations.

WHY SELF-ASSESSMENT?

In the past, medical staffs operated in relative tranquility. But that smooth ride has now become one of greater strife, competitiveness, discord, and general unease. This change is due, largely, to external forces now acting on hospitals and medical staffs. Hospital management and governance now ask that medical staffs help with legal, regulatory, accreditation, financial, societal, and professional issues.

Physician leaders must realize that internal self-management is necessary to extend the help that hospital management and governance need to survive. One tool medical staff leaders need to learn is self-assessment. This method has hospital medical staff leaders, such as the members of the credentials committee, asking themselves how prepared they are to meet future challenges.

Such a performance appraisal may help the credentials committee members identify both their strengths and their weaknesses. In all, it is a vital function that the credentials committee should conduct annually.

Opus Communications has designed the following self-assessment manual to assist credentials committees and their members in identifying their strengths and weaknesses in the three specific medical staff areas: structure, process, and outcomes.

The credentials committee must understand that an evaluation of structure and process alone will not result in effective change (if necessary). Only through critical evaluation of the results or outcomes of deliberations and discussions will true performance appraisal result.

STRUCTURE: COMPOSITION

Ideally, a credentials committee of an acute care hospital, managed care organization, or other health care organization with significant credentialing responsibilities should be composed of between five and seven seasoned expert credentialers. These individuals should serve for staggered three- to five-year terms. In general, this responsibility for the credentials committee members should be their only responsibility within the staff structure, thus allowing them to spend the time and devote the effort to this issue that is appropriate.

Frequently, excellent candidates for the credentials committee are former medical staff leaders. After all, these individuals have served as chief-elect and chief of staff. They have achieved these positions through popular vote of the medical staff but have probably learned a great deal about the credentialing issues extant within their organization. It is likely that during their two to four years as chief-elect and chief they have experienced turf battles, fair hearings, disciplinary actions, and a myriad of other related credentialing issues. These individuals make excellent credentials committee members, as they understand the enormous importance of this activity, while also understanding that most physicians are of extremely high caliber and could be ushered onto the medical staff with little difficulty.

It is also important to recognize that many hospitals have placed the chief-elect in the position of chair of the credentials committee, thinking that this will prepare the individual for his or her responsibilities as president or
chief of staff. Hospitals should recognize that this is often placing the individual with the least amount of experience as the chair of one of the most important medical staff committees. Our suggestion is that hospitals consider a revision of this bylaws policy and make an immediate past chief of staff the chair of the credentials committee, or that the credentials committee be a standing appointment of an individual who is thoroughly experienced, knowledgeable, and dedicated to the credentialing activity.

As for the role of the vice president for medical affairs (VPMA) on the credentials committee, it is our recommendation that hospitals with a VPMA strongly consider having this person serve not only as a member of the credentials committee, but also as its chair. It should also be recognized that the chair of this committee does not hold any more power or authority than any other member. The VPMA is, however, constantly in residence, knowledgeable of all of the issues, and is in the best position to assure that the credentialing program in the hospital operates appropriately. There is probably no greater role for a VPMA than ensuring that patients receive the highest quality of care. One of the major factors in this outcome is the availability of high-quality physicians dedicated to the institution. Clearly, a VPMA is ideal in this position.

A word about tenure: Many credentials committees are appointed by the incoming chief of staff. We do not believe that this will necessarily result in an ideally composed credentials committee. Members should understand that when they agree to accept this responsibility that they are signing on for the duration. Three- to five-year terms that may be repeated at the request of the chief of staff with the acquiescence of the credentials committee member should now become standard within this industry.

**STRUCTURE: ORIENTATION**

All credentials committee members should receive significant orientation to their duties and responsibilities. Any individual who is contemplating service on a credentials committee should first receive detailed information concerning the expected duties, responsibilities, and time commitments for committee members. Additional information should be provided to the prospective credentials committee member concerning the complexities of credentialing, as well as the degree to which the institution will "stand behind" that individual when he or she serves as a member of this committee. If the individual indicates an interest and willingness to devote significant time and attention to the credentials matters of the institution, a full function description should be provided to the institution, along with a fairly significant verbal, audio, or audiovisual orientation. A brief discussion with someone knowledgeable about regulatory, legal, and accreditation issues as they pertain to credentialing is also in order.

Further orientation of credentials committee members should include a review of the past year's worth of credentials activities within the institution. Specific attention should be paid to major and complicated issues that the credentials committee handled, as well as any "carry over" issues from the previous year.

Every credentials committee member should receive subscriptions to various journals and newsletters concerning their credentialing responsibilities. They should also receive, at their request, the ability to participate in basic and advanced training in the area of hospital/medical staff credentialing, legal issues, regulatory issues, and privileging.

**STRUCTURE: HOSPITAL SUPPORT**

Ideally, the credentials committee should meet in the same place within the organization. The room should be prepared in a manner that allows the credentials committee to recognize its ongoing and continuing responsibilities. Credentialing points, procedures, posters, and accomplishments should be prominently displayed on the wall or bulletin board for reference by the chair. Furthermore, members of the credentials committee should receive significant clerical, research, and other support for any credentialing issue that arises. Rarely should credentials committee members be asked to review an issue, make a recommendation, or determine the outcome of an issue without clearly organized written materials available to them in advance of the meeting.
**PROCESS: MEETINGS AND BUSINESS**

Ideally, the credentials documents of acute care as well as sub-acute and managed care organizations should exist separately from documents often referred to as bylaws. The credentials policies and procedures of an organization should be designed so as to maximize the ability of the credentials committee and other authorities within the organization to operate this program in the most effective manner possible. Placing complex provisions concerning applications, processing applications, streamlining credentialing, or delineating clinical privileges, in a set of bylaws unnecessarily complicates the bylaws, eliminates the flexibility needed by a credentials committee to make changes, and does not provide the credentials committee with clear guidelines concerning its responsibilities.
**CREDENTIALING SELF-ASSESSMENT TOOL**

**STRUCTURE**

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Is your credentials committee composed of a reasonable number of practitioners? (Ideally 5-7 with assistance from the MSSP)</td>
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<td>2.</td>
<td>Are the members of the credentials committee &quot;expert credentialers&quot;? (i.e.: individuals who have served in MS leadership positions into the past and know the problems associated with poor credentialing practices)</td>
<td>Yes</td>
<td>No</td>
<td>Action Plan</td>
</tr>
<tr>
<td>3.</td>
<td>Is the CEO or designee a member of the committee (with or without vote)?</td>
<td>Yes</td>
<td>No</td>
<td>Action Plan</td>
</tr>
<tr>
<td>4.</td>
<td>Do the members of the credentials committee serve for at least three years with staggered terms?</td>
<td>Yes</td>
<td>No</td>
<td>Action Plan</td>
</tr>
<tr>
<td>5.</td>
<td>If your facility has a VPMA is this person either the chair or vice chair of the committee?</td>
<td>Yes</td>
<td>No</td>
<td>Action Plan</td>
</tr>
<tr>
<td>6.</td>
<td>Does each member receive a job or position description prior to accepting the assignment to the committee?</td>
<td>Yes</td>
<td>No</td>
<td>Action Plan</td>
</tr>
<tr>
<td>7.</td>
<td>Are all members indemnified by the hospital?</td>
<td>Yes</td>
<td>No</td>
<td>Action Plan</td>
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<tr>
<td>8.</td>
<td>Do all members receive both basic and ongoing education regarding the credentials function?</td>
<td>Yes</td>
<td>No</td>
<td>Action Plan</td>
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**PROCESS:**

**INITIAL APPOINTMENT PROCESS**

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<tr>
<th>Number</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Do you have written policies and procedures for the initial appointment process?</td>
<td>Yes</td>
<td>No</td>
<td>Action Plan</td>
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<tr>
<td>2.</td>
<td>Does the governing body approve all credentialing policies and procedures?</td>
<td>Yes</td>
<td>No</td>
<td>Action Plan</td>
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<tr>
<td>3. Do current medical staff bylaws, hospital corporate bylaws, or a separate document describe the roles, responsibilities, functions, relationships, and authorities of the following:</td>
<td>Yes</td>
<td>No</td>
<td>Action Plan</td>
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<td>• Governing board</td>
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<tr>
<td>• Chief executive officer</td>
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<tr>
<td>• Medical executive committee (MEC)</td>
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<tr>
<td>• Credentials committee</td>
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<tr>
<td>• Department chair</td>
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<tr>
<td>• Vice president of medical affairs, if applicable</td>
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</table>

| 4. Do you consistently apply credentialing criteria?          | Yes | No | Action Plan |
|                                                            |     |    |             |

| 5. Do you follow the same credentialing procedures for all practitioners? | Yes | No | Action Plan |
|                                                                         |     |    |             |

| 6. Are your credentialing criteria objective and rational with respect to the hospital's business and quality-of-care concerns? | Yes | No | Action Plan |
|                                                                                                                                  |     |    |             |

| 7. Do you process applications within the time frame specified in the medical staff bylaws? | Yes | No | Action Plan |
|                                                                                                                                 |     |    |             |

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<th>8. Does each applicant to the medical staff submit</th>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
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<tr>
<td>• A formal application for appointment?</td>
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<td>• A statement regarding his or her:</td>
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<td></td>
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<tr>
<td>- Physician and mental status</td>
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<tr>
<td>- Lack of impairment due to chemical dependency/substance abuse</td>
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<tr>
<td>- History of loss of license and/or felony convictions?</td>
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<tr>
<td>- History of loss or limitation of privileges or disciplinary activity?</td>
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<tr>
<td>- Medicare/Medicaid sanctions?</td>
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<td>- An attestation to the correctness and completeness of his or her application?</td>
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<tr>
<th>9. For each applicant, do you obtain and verify from primary sources</th>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
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<tr>
<td>• A current, valid license</td>
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<tr>
<td>• Clinical privileges in good standing</td>
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<tr>
<td>• A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate</td>
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</tbody>
</table>
- Board certification status
- Graduation from medical school and completion of residency, or board certification (if applicable)
- Clinical practice history
- Current professional liability insurance coverage including coverage for the privileges requested (according to hospital policy)?
- Professional liability claims history

**10. Do you request information from the following sources for each applicant:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
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</table>

- The National Practitioner Data Bank (NPDB)?
- The State Board of Medical Examiners or Department of Professional Regulations
- The American Medical Association (AMA) Physician Masterfile
- The American Board of Specialties (ABMS)
- The American Osteopathic Physician Profile
- The Board Action Data Bank of the Federation of State Medical Boards (FSMB)
- The Chiropractic Information Network/Board Action Databank (CINBAD), when appropriate
- The National Register of Health Service Providers in Psychology, if applicable
- The Office of the Inspector General (OIG) for a list of excluded individuals and entities
- Appropriate individuals at the practitioner's previous practice settings/hospital affiliations

**11. Do you have written procedures for:**

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<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
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</table>

- Obtaining any missing or additionally required information from the applicant?
- Closing the applicant’s file if he or she does not respond to requests for additional information in a timely manner?

**12. If you delegate any credentialing activities to a credentials verification organization (CVO), do you**

<table>
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<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
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- Oversee and monitor the CVO’s activities
- Maintain written documentation specifying
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<tr>
<th></th>
<th>Any delegated activities</th>
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<tr>
<td></td>
<td>The CVO’s accountability for credentialing functions</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>13.</td>
<td>Do you present only completed files to the department chair for review?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>14.</td>
<td>Does the credentials committee review requests for and make recommendations for temporary privileges?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>15.</td>
<td>Does the credentials committee make all recommendations on medical staff appointment and clinical privileges to the MEC?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>16.</td>
<td>Does the MEC make final recommendations to the board concerning credentialing decisions?</td>
<td>Yes</td>
<td>No</td>
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<td>17.</td>
<td>Does your hospital routinely consider the impact of credentialing decisions on:</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td></td>
<td>- The quality of patient care</td>
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<td></td>
<td>- The medical staff</td>
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<td></td>
<td>- The Hospital</td>
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<tr>
<td>18.</td>
<td>Does your hospital grant medical staff membership and clinical privileges only to qualified individuals?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>19.</td>
<td>Do you have a fair hearing plan that gives practitioners the opportunity to appeal adverse credentialing decisions?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>20.</td>
<td>Has your fair hearing plan been recently reviewed by appropriate legal counsel?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>21.</td>
<td>Do you report all adverse decisions (through the state medical board) to the NPDB?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>22.</td>
<td>Do you orient all new medical staff appointees to their roles and responsibilities?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>23.</td>
<td>Do you have policies and procedures for monitoring the performance of all new medical staff members for a provisional period?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>24.</td>
<td>Do your policies include a provision for fast tracking or expedited processing of requests for privileges or appointment?</td>
<td>Yes</td>
<td>No</td>
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</table>
## Credentialing and Privileging

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
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<tbody>
<tr>
<td>25. Have you eliminated routine granting of temporary privileges?</td>
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<tr>
<td>26. Do you have policies pertaining to granting of emergency or disaster privileges?</td>
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</table>

**RIVILEGING**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
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</thead>
<tbody>
<tr>
<td>1. Do you have written policies and procedures for delineating clinical privileges?</td>
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<tr>
<td>2. Do the written criteria for granting of privileges include:</td>
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<td></td>
<td>The physician’s prior and continuing education and training?</td>
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<td></td>
<td>Prior current experience</td>
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<td></td>
<td>Utilization practice patterns</td>
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<td></td>
<td>Current health status</td>
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<td></td>
<td>Documented current clinical competence and judgment to provide</td>
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<td></td>
<td>High-quality, appropriate services in an efficient manner</td>
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<td></td>
<td>Geographic location</td>
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<td></td>
<td>Patient care needs for the type of privileges being requested</td>
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<td></td>
<td>Current and/or anticipated practice volume</td>
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<td></td>
<td>The hospital facility’s ability to accommodate the requested privilege(s)</td>
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<td></td>
<td>Availability of qualified coverage in the practitioner’s absence</td>
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<td></td>
<td>The adequate level of professional liability insurance the physician must have to perform or provide the requested procedures or treatments</td>
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<tr>
<td>3. Do you query the NPDB</td>
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<tr>
<td></td>
<td>For all requests for temporary privileges</td>
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<td>For initial appointment and reappointment</td>
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<td></td>
<td>For all requests for additional privileges during the interim</td>
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</tbody>
</table>
4. Does your hospital grant clinical privileges only to qualified individuals? | Yes | No | Action Plan

**REAPPOINTMENT PROCESS**

5. Do you have written policies and procedures for the reappointment process? | Yes | No | Action Plan

6. Do you review and reverify the credentials of each practitioner at least every two years? | Yes | No | Action Plan

7. Do you reverify (with primary sources) at least the following information:
   - A current, valid license
   - Clinical privileges in good standing
   - A valid DEA or CDS certificate
   - Board certification (if applicable)
   - Work history
   - Current professional liability insurance coverage including coverage for the privileges granted (according to hospital policy)
   - Professional liability claims history | Yes | No | Action Plan

8. Do you receive from each practitioner a statement regarding his or her:
   - Physical and mental health status
   - Lack of impairment due to chemical dependency or substance abuse | Yes | No | Action Plan

9. Do you request information from the following sources:
   - The National Practitioner Data Bank
   - The State Board of Medical Examiners or Department of Professional Regulations
   - The American Medical Association (AMA) Masterfile | Yes | No | Action Plan

10. Do you review the following information for each practitioner:
    - Physician utilization statistics
    - Continuing medical education | Yes | No | Action Plan
### DISCIPLINARY MATTERS

<table>
<thead>
<tr>
<th>1. Do you have policies and procedures that address</th>
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<tr>
<td>• Impaired physicians</td>
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<td>• Sexual harassment</td>
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<td>• Conflict resolution within the medical staff regarding any aspect of the credentialing and/or privileging process in dispute</td>
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<tr>
<td>• Leave of absence</td>
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<td>• Sharing or exchange of medical staff information</td>
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<tr>
<th>2. Does your hospital:</th>
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<td>Yes</td>
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<tr>
<td>Reduce, suspend, or terminate clinical privileges as necessary</td>
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<tr>
<td>Report disciplinary actions to appropriate authorities</td>
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<tr>
<td>Have an appeal process for practitioners who have been disciplined</td>
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<tr>
<td>Inform practitioners of the procedure by which they may appeal any disciplinary action</td>
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### DOCUMENTATION

<table>
<thead>
<tr>
<th>1. Do you store credentials files in a secure location?</th>
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<td>Yes</td>
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<td>Are credentials files easily accessible?</td>
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<td>Yes</td>
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<tr>
<td>Do you have a policy and/or procedure controlling the confidentiality of credentials information?</td>
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</table>
Credentialing and Privileging: What physician leaders and credentialing professionals must know today!

**EXHIBIT C**

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<thead>
<tr>
<th>4. Do you have a policy and/or procedure regarding access to and release of credentials information?</th>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>5. Do you maintain updated information regarding the following:</th>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physician utilization statistics</td>
<td></td>
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<tr>
<td>• Continuing medical education</td>
<td></td>
<td></td>
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<tr>
<td>• Department, general staff, and committee meeting attendance</td>
<td></td>
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<tr>
<td>• Medical records completion</td>
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<tr>
<td>• Participation in emergency on-call schedule</td>
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<td></td>
<td></td>
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<tr>
<td>• Clinical activity statistics</td>
<td></td>
<td></td>
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<tr>
<td>• Incident reports</td>
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<tr>
<td>• Reports of disciplinary action/sanctions</td>
<td></td>
<td></td>
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<tr>
<td>• Data bank reports</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**OUTCOME**

<table>
<thead>
<tr>
<th>1. During the past year has your facility permitted any practitioner to provide service to patients without verifying all background information?</th>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>2. Has your facility found it necessary to terminate the membership or privileges of a newly appointed practitioner due to &quot;New information&quot; not identified during the initial verification process?</th>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3. Has your facility found it necessary to offer a fair hearing to any provider?</th>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4. Are all members of the credentials committee convinced that the credentials process serves to protect patients at all times?</th>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>5. Has your facility denied privileges for reasons related to lack of education, training or experience?</th>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>6. Does the committee understand the benefit of putting the burden on the applicant?</th>
<th>Yes</th>
<th>No</th>
<th>Action Plan</th>
</tr>
</thead>
</table>
Contacts

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