UCSF Medical Center
UCSF Benioff Children's Hospital

Office of Medical Affairs and Governance

UCSF Medical Staff

Advanced Health Practitioners (AHPs)
Credentialing Policy & Procedure

Office of Origin: Office of Medical Affairs and Governance (415) 885-7268

I. PURPOSE:

UCSF Medical Staff (UCSF) and Langley Porter Psychiatric Institute (LPPI) Medical Staff ensure that licensed health care providers meet the minimum credentials standards for Advanced Health Practitioners membership.

II. REFERENCES:

- Medical Staff Bylaws, Rules and Regulations
- UCSF Credentialing Policy and Procedures
- JCAHO Medical Staff Standards
- NCQA Credentialing Standards

III. DEFINITIONS:

Advanced Health Practitioner ("AHP") means an advanced practice registered nurse: Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA), Physician Assistant (PA), Optometrist (OD), Clinical Pharmacist (PHARMD) practicing in an expanded role, Acupuncturist (LAc), Genetic Counselor (GC), Marriage & Family Therapist (MFT), and Licensed Clinical Social Worker (LCSW), or any other professional group approved by the Committee on Interdisciplinary Practice.

IV. PROCEDURE:

A. Human Resources

1. **New Hires** – All new AHPs entering into the UCSF system are required to complete a credentials application, privilege request form/advanced procedures and sign in collaboration with a supervising physician. This also includes AHP's employed by the Medical and Nursing Schools and providing care for patients in the Medical Center.

2. **Transfers** – All AHPs transferring from any medical center department to another are required to request additional privileges/procedures for that service and sign in collaboration with supervising physician.

NOTE: As required by CA state regulations, a supervising physician with approved privileges as an Attending can only supervise four Advanced Health Practitioners on site and any given time.

B. Credentialing Process:

B. Credentialing Process: The Office of Medical Affairs and Governance Office of Medical Affairs and Governance (MSO) is responsible for verifying all credentials via primary source at initial application and at a two- year reappointment. (See: Credentialing Policy & Procedures)

1. **Initial Appointments**

a. Providers must complete the following items:
   - Application for AHP Staff appointment
   - Confidentiality Statement
   - Consent to Release Information,
   - Privilege Form/Standardized Procedures.

b. In addition to returning the above documents, providers must also submit any relevant licensure/certificates as applicable to the requested privileges or clinical activity, including but not limited to:
   - Copy of California License(s) (an on-line query is acceptable)
   - Copy of DEA Certificate and/or Furnishing certificate as appropriate; if provider does not have a DEA and/or Furnishing Certificate, they must sign and submit an attestation of “Non-Use” where they cannot prescribe any type of medication.
   - Copy of National Certification (certifying body must be approved and recognized by the Center for Medicaid/Medicare Services (CMS)). All NPs, PAs, CRNAs and CNMs hired after 1992 must maintain national certification within their respective profession.
   - Evidence of Current Malpractice Coverage
   - Sedation Competency as appropriate
   - Provider Performed Microscopy Competency as appropriate
   - CA Driver’s License or Identification Card, or Passport
   - CPR, BLS/ACLS, PALS, NPR as appropriate

c. **Quality/Performance Assessment**: All AHP’s granted new privileges will undergo focused professional practice evaluation or proctoring by their supervising physician pursuant to applicable privilege and standardized procedure criteria for competency assessment as well as the Medical Staff Bylaws: FPPE Process

2. Reappointments

At least four (4) months prior to the end of the two (2) year appointment period, the provider is mailed an application for reappointment. Previously submitted information is populated on the reappointment application.

a. Providers must complete the following items:
   - Prepopulated e-Reappointment Application
   - Copy of current clinical privileges/standard procedures
   - Consent to Release information

b. The provider is required to return the application and any supporting documents within thirty (30) days, including but not limited to:
   - Evidence of Current Malpractice Coverage
   - CPR, BLS/ACLS, PALS, NPR as appropriate
   - Provider Performed Microscopy Competency as appropriate
   - CA Driver’s License or government-issue photo Identification Card, Passport, hospital-issued identification badge.

c. **Quality/Performance Assessment**: Providers are required to utilize the electronic procedure log (eLog) and maintain a list of procedures performed in the prior two (2) year period which includes any adverse outcomes of those procedures. Other sources for assessments are annual performance evaluations by clinical managers and/or supervising physicians, as well as data available via performance improvement resources (e.g. medical records, patient relations, risk management, etc.) (see UCSF Credentialing Policy, Appendix D).

3. Medical Staff Services Office Review and Verification Process

a. The Office of Medical Affairs and Governance Office of Medical Affairs and Governance reviews the documents as follows:
- All items on application form. This includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanations for any irregularities on certain questions about practice issues, legal matters and health status.
- Applicant's signature is present and dated on all forms. Signatures must be no greater than 180 days prior to CIDP review.
- Privileging forms are completed as appropriate.
- Completed addresses, phone and fax numbers as listed for:
  - Hospitals and affiliations
  - Peer references; and
  - Malpractice insurance company(ies)
- Continuing Medical Education (CME) information documents any courses relevant to specific privileges requested.
- California License(s) and applicable certificates (e.g. DEA, Fluoroscopy, Furnishing Certificate) are current.
- NP, PA, CRNA, CNM, National Certification as appropriate.
- Supervisor's Evaluation and Annual Attestation between Supervising Physician and AHP, that the provider is practicing within the scope of the approved privileges and standardized procedures.

b. Verification of Information
- Verification of information begins as soon as the application appears complete. Verification for some items must be obtained from primary sources and are received in writing from the primary sources.
- Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

c. Temporary Privileges for Initial Appointments:

For Initial Appointments involving clinical urgency, a Division Chief or Department Chair may request temporary privileges up to 60 days (the timeframe allowed pursuant to the NCQA credentialing standards). Files triaged as "green" may be approved by CEO, or designee, President of the Medical Staff and CIDP Chair (or their authorized designees), upon agreement with the Office of Medical Affairs and Governance Office of Medical Affairs and Governance and the Department Chair or designee that the file is correctly triaged as "green." The agenda of the next CIDP meeting will list all "green" files that were approved for temporary privileges.

Actions on temporary privileges are updated in the Office of Medical Affairs and Governance Office of Medical Affairs and Governance database upon approval and appropriate areas are notified. The Office of Medical Affairs and Governance Office of Medical Affairs and Governance database updates interfaced clinical systems within 24 hours and the applicant's status and privileges are displayed on intranet websites for inquiry by the applicant or other Medical Center staff. Notification is forwarded to the applicant within 10 days of the decision on the request for temporary privileges.

4. Committee on Interdisciplinary Practice (CIDP) Process

a. **Committee Description and Charge**: The Committee on Interdisciplinary Practice ("CIDP") exists to provide medical staff oversight to non-medical staff members as well as fulfill State of California requirements related to performance of standardized procedures by Advanced Health Practitioners and privileging of health care professionals who are not members of the medical staff organization of UCSF Medical Center (UCSF) but who are required to be privileged by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). The membership shall be consistent with the requirements set forth by Title 22 Section s70706.

b. **Reporting Relationships**: The CIDP reports its decisions and recommendations to the Executive Medical Board for review. Executive Medical Board reports to the Governance Advisory Council for final approval.

c. **Responsibilities:** The CIDP is responsible for:

- reviewing, assessing and evaluating credentials to ensure current competence of Advanced Health Practitioners providing care in the UCSF Medical Center and Clinics.
- recommending appointments and reappointments of Advanced Health Practitioners, delineation of staff privileges and standardized procedures.
- recommending and administering policies and procedures for interdisciplinary medical practice at UCSF Medical Center. This shall include the assessment, planning, and direction of the diagnostic and therapeutic care of patients at UCSF conducted by Advanced Practice Registered Nurses and other licensed or certified healing arts professionals, defined by the Governing Body, who carry out overlapping practice with physicians.

d. **Development of privileges/procedures:**

1) The CIDP is responsible for defining functions and/or procedures for which the formulation and adoption of privileges/procedures is advisable under Section 2723 of the Business and Professions Code.

2) CIDP shall prepare written privileges/procedures in collaboration with those physicians who are members of the medical staff in the medical specialty of the designated clinical field of practice and/or in collaboration with persons in the non-medical category who practice in the designated clinical field or specialty. The written clinical privileges/procedures shall be completed using the privilege/procedure template developed by the CIDP. The privileges/procedures must comply with all applicable provisions of Title 22 and the Business and Professions Code. The completed privilege/procedures forms shall be signed off by the supervising physician who is also a physician member of the medical staff in the medical specialty or designated clinical field of practice and the Advanced Health Practitioner who request to perform them.

3) All initial privileges/procedures will be reviewed and approved by CIDP prior to recommendation to the Executive Medical Board. Any changes or deviations from the privileges/procedure forms shall be reviewed and approved by CIDP.

4) Once the privilege/procedure form is approved, it will be forwarded on for approval to the Executive Medical Board and Governing Body for final approval.

5) In an effort to ensure that the patients receive the same standard of care, once the privilege/procedure form is approved, it will be used for any AHPs requesting privileges to a specific service.

6) Once the privileges/procedure form is approved by the Governing Body, it will be placed on the MSO website and available for any AHP requesting privileges/procedures based on the department or service. The AHP and supervising physician must print and sign privilege/procedure form and attest to follow the guidelines and criteria when performing any requested privileges/procedures.

e. **Title 22 Requirements**

(§70706. Interdisciplinary Practice and Responsibility for Patient Care): In any facility where registered nurses will perform functions requiring standardized procedures pursuant to Section 2725 of the Business and Professions Code, or in which licensed or certified healing arts professionals who are not members of the medical staff will be granted privileges pursuant to Section 70706.1, there shall be a Committee on Interdisciplinary Practice established by and accountable to the Governing Body, for establishing policies and procedures for interdisciplinary medical practice

5. **Executive Medical Board (EMB):** The Executive Medical Board and Governing Body Evaluation Process includes the CIDP Committee Report where a full review is completed.

6. **Governance Advisory Council (GAC)**

a. Final Governing Body Approval: The CIDP Committee Report is reviewed by the Chancellor of UCSF, as the delegated Governing Body of the UC Regents. The Chancellor's decision is considered the final decision of the UC Regents.

b. Actions on appointments/reappointments are updated in the Office of Medical Affairs and Governance's credentialing database within 15 days of Governing Body approval. The Office of Medical Affairs and Governance credentialing database updates interfaced clinical systems within 24 hours and the applicant's status and privileges are displayed on intranet websites for inquiry by the applicant or other Medical Center staff. Notification of the Governing Body decision is forwarded to the applicant within 60 days.

V. RESPONSIBILITY

A. This policy resides in the Medical Staff Organization Policy and Procedure Manual. Copies are located in the Medical Staff Services Department.

B. Review and Renewal Requirements: This policy will be reviewed annually and as required by change of law or practice, by the Committee on Interdisciplinary Practice (CIDP). The review is facilitated by the Director of Medical Staff Services. Any changes must be approved by the CIDP, the Executive Medical Board and the Governing Body.

VI. HISTORY OF POLICY:

A. Revisions: 12/07, 04/08, 12/09, 12/10, 01/11, 05/13, 08/13, 7/17, 9/18
B. Approvals:
- CIDP: 12/07, 12/09, 01/11, 05/13, 08/13, 8/17, 9/18
- Executive Medical Board: 12/07, 12/09, 01/11, 05/13, 8/17, 9/18
- Governing Body: 12/07, 12/09, 01/11, 05/13, 8/17, 9/18

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VIII. APPENDIX A - CREDENTIALS FILES

The following documents are kept current and maintained in the Credentials file (as applicable):

1. Application for membership.
2. Delineation of privileges, including FPPE reports, recommended by the Department Chair or designee in the service which privileges are being requested.
3. Current California State Medical (or other professional) License
4. Valid DEA certification, as applicable
5. Verification of graduation from professional/graduate school and completion of residencies and fellowships, if applicable
6. Verification of previous affiliations prior to UCSF Medical Staff appointment
7. Verification of clinical privileges in good standing from the applicant's primary admitting facility (when this facility is not UCSF Medical Center or LPPI.)
8. Curriculum Vitae that includes a comprehensive work history
9. Evidence of current, adequate malpractice insurance
10. Professional liability claims history
11. Verification of national board certification or candidacy, as applicable
12. National Practitioner Data Bank Query Report (which includes Medicare and Medicaid Sanctions activity)
13. California Professional Licensing Board Status check for validation of license and sanction activity
14. Letters of Reference (including Service Chief Review) that attests to clinical competence and ethical character of the applicant.
15. Continuing Medical Education information
16. Consent to release relevant information to contract health plans.
17. Copies of the Governing Body Approval letters confirming AHP Staff appointment and/or approved privileges
18. Quality and Peer Review documents, such as:
    a. Any action taken as a result of a malpractice claim.
    b. Reports of disciplinary actions taken by hospitals and managed care organizations and the outcome of those actions.
    c. Results of peer reviews and health plan quality management reviews
    d. State Professional Licensing Board reports on any state sanction activity (e.g. 805 reports).
    e. Any supplemental information or documentation regarding quality of care.

19. Medicare Opt-Out Report
20. Office of Inspector General (OIG) Sanctions Report
21. Excluded Parties List System (EPLS) Sanctions Report

IX. APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event				
			Initial Appointment	New Privileges	Reappointment	Update as Expires	Visiting Privileges
1.	***License/Certificate(s) to Practice in California*** Includes information related to licensure sanctions monitored monthly	**Website query as available for the type of provider. If website that is considered primary source verification is not available, confirm in writing.**	X	X	X	X	X
2.	***DEA Registration*** Provider attests if DEA is not applicable to scope of practice.	NTIS/DEA Website query (if applicable to Provider's scope of privileges) For pending DEAs, the practitioner signs an attestation agreeing not to prescribe controlled substances until a DEA certificate has been obtained.	X	X	X	X	X

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			Initial Appointment	New Privileges	Reappointment	Update as Expires	Visiting Privileges
3.	**Professional/Graduate School (Domestic Graduates)**	May be obtained (in writing or orally) from the institution(s) where professional/graduate school/other professional school completed or the AMA or AOA profile service, as applicable.	**X**				**X**
4.	***Internship/other professional training (if applicable)***	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	**X**				
5.	***Residency/other professional training (if applicable)***	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	**X**		**X** If any new training during the previous appointment period		

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			Initial Appointment	New Privileges	Reappointment	Update as Expires	Visiting Privileges
6.	***Fellowship/other professional training (if applicable)***	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	**X**		**X** If any new training during the previous appointment period		
7.	**National Board Certification (recognized by CMS) or other professional certification or registration**	Query of national certification organization, AMA or AOA profile or confirmation (orally or in writing) directly from the certifying organization. AHP national certification queried.	**X**	**X**	**X**	**X**	**X**

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Number	Credentialing Item	Method of Verification	Credentialing Event				
			Initial Appointment	New Privileges	Reappointment	Update as Expires	Visiting Privileges
8.	**Healthcare Organization Affiliations**	Confirm in writing via website or by telephone with affiliation. Confirm dates of affiliation, scope of privileges, restrictions and any disciplinary actions taken during the affiliation. If verification of an affiliation is not obtained after three requests (including a phone call to the facility), this will be noted in the file and the file may then move through the evaluation process without verification of the affiliation.	**X** Verify all affiliations for past 10 years.	**X** Verify as necessary to obtain information related to competency	**X** Verify current active affiliations		**X** Verify at least one current affiliation
9.	**Work History (Looking for gaps in training and work history)**	Applicant provides information on application form or curriculum vitae. Additional investigation occurs for 3 month gaps in work history. Gaps over 12 months will be documented in the file.	**X**				**X**

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Number	Credentialing Item	Method of Verification	Credentialing Event				
			Initial Appointment	New Privileges	Reappointment	Update as Expires	Visiting Privileges
10.	**Professional Liability Insurance**	Obtain information related to coverage and amounts of coverage directly with carrier. Minimum insurance: \$1/million per claim and \$3/million annual aggregate coverage.	**X**		**X**	**X**	**X**
11.	**Professional Liability Claims History:**	Applicant provides information about current and past claims, settlements and judgments; AND write to current carrier; AND request NPDB report.	**X**		**X** For past 3 years		**X** Do not write to current carrier
12.	**Continuing Medical Education**	Applicant provides information pursuant to licensing agency requirements	**X**		**X**		
13.	**National Practitioner Data Bank (NPDB)**	Query	**X**	**X**	**X**		**X**

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Number	Credentialing Item	Method of Verification	Credentialing Event				
			Initial Appointment	New Privileges	Reappointment	Update as Expires	Visiting Privileges
14.	**OIG Sanctions, and Excluded Parties List System (EPLS)**	OIG Sanction Report, GSA List	**X**	**X**	**X**	**Monthly**	**X**
15.	**Medicare Opt-Out Report**	On a monthly basis, verify that the latest Medicare Opt-Out report for both Northern and Southern California are available for review and monitoring. The report is available through the Palmetto GBA website. The file is downloaded, reviewed and saved in the department shared drive. At the time of initial and reappointment credentialing, Credentialers are responsible to include a verification of the Medicare Opt Out report for each credentialed provider.	**x**	**x**	**x**		**x**

IX. APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event				
			Initial Appointment	New Privileges	Reappointment	Update as Expires	Visiting Privileges
16.	**Peer/Professional References/ Recommendations** Peer means an individual in the same professional discipline (same type of license).	Peer references must be from individuals who have recently worked with the applicant, have directly observed his or her professional performance over a reasonable period of time, and who can and will provide reliable information regarding current clinical ability, ethical character, health status and ability to work with others. If the applicant has recently completed professional training (resident, fellowship, etc.), a reference from the program director must be requested.	**X** Obtain at least 2 Peer References	**X** As necessary to obtain confirmation of clinical competency	**X** Obtain at least 1 Peer Reference		**X** One peer reference

X. APPENDIX C – FILE TRIAGING CATEGORIES

File Category	Initial Appointment	Reappointment
Green	No issues have been identified with the provider's application, and the file meets the following criteria: • Satisfactory References • No record of malpractice payment or current pending claims • No disciplinary actions • No licensure restrictions • No unexplained time gaps in work history • Current licensure • No problems verifying information • No indication of investigations or potential problems • Information is returned in a timely manner and contains nothing that suggests the practitioner is anything but highly qualified	No issues have been identified with the provider's reappointment, and the file meets the following criteria: • Satisfactory References • No record of malpractice payments since the last appointment or current pending claims • No disciplinary actions • No licensure restrictions • Current licenses • No problems verifying information • No indications of investigations or potential problems • Information is returned in a timely manner and contains nothing that suggests the practitioner is anything by highly qualified • Applicant is not requesting new privileges • Applicant is not requesting a status change • Applicant meets all criteria for privileges requested • Activity levels are appropriate • CME relates to privilege requests • QA data includes no Peer Review or Quality of Care issues • No health problems identified

X. APPENDIX C – FILE TRIAGING CATEGORIES

File Category	Initial Appointment	Reappointment
Yellow	The provider's file may include questionable information, such as: • Peer references and prior affiliations indicate potential or minor problems • One malpractice claim • Privileges vary from those typically requested by other practitioners in the same specialty	The provider's file may include questionable information, such as: • Peer references and prior affiliations indicate potential or minor problems • One malpractice claim in past 3 years • Additional Privileges requested • Change in status requested • Low Clinical Activity • Minor Health problem identified which will likely have no impact on exercise of clinical privileges • Difficulty in obtaining monitoring reports
Red	The provider's file shows potentially adverse information, including: • Unsatisfactory peer references or prior affiliations • Disciplinary actions or reports filed by any verification organization (NPDB, State Professional Licensing Board, Medicare Sanctions, AMA) • Clinical privileges revoked, diminished or altered by another Healthcare organization • 2 or more malpractice claims • Multiple Healthcare organization affiliations during the past 5 years • Substantial number of state medical licenses • Any existing QA information shows a quality of care issue • Any existing monitoring reports question competency	The provider's file shows potentially adverse information, including: • Unsatisfactory peer references or prior affiliations • Disciplinary actions or reports filed by any verification organization (NPDB, State Professional Licensing Board, Medicare Sanctions, AMA) • Clinical privileges revoked, diminished or altered by another Healthcare organization • 2 or more malpractice claims in past 3 years • QA information shows a quality of care issue • Monitoring reports question competency • Major Health Problems identified • New privileges requested outside of normal scope of specialty • Substantial # of professional licenses (greater than 3)

XI. APPENDIX D – SOURCES OF ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) AND OTHER QUALITY/PERFOFRMANCE DATA

When available, information from these sources is integrated into the credentialing process:

1. **Office Site/Medical Record Audits:** UCSF Medical Center clinics accredited by TJC are recognized as compliant with NCQA requirements for office site/medical record reviews. Health plans may submit provider specific audit information for consideration as applicable.

2. **Patient Complaints and Grievances:** All patient inquiries and their resolution are managed by Patient Relations in coordination with the involved provider and Department Chair or designee. For monthly reappointment cycles, Patient Relations forwards a list of providers who have received patient inquiries during the prior two years. The inquiries are triaged by Patient Relations based on volume as well as the severity of the inquiries.

   Between reappointment cycles, all serious inquiries are forwarded to Quality Improvement and/or Risk Management for further analysis with communication to the Department Chair or designee. If the Department Chair or designee determines immediate action is required, the President of the Medical Staff is notified and initiates appropriate resolution.

3. **Clinical Activity Reports:** For monthly reappointment cycles, the Quality Improvement department forwards physician volume statistics and comparative data analysis to the Office of Medical Affairs and Governance. Volume data are gathered from UCSF Medical Center/Medical Group billing systems and compared to the Service as well as UHC clinical databases. For providers with no clinical activity during the previous twelve months and who are requesting privilege(s), he/she must provide clinical activity from their primary hospital/ practice site that will provide supporting information for consideration by the Service Chief to ensure appropriate recommendation of membership/privileges. (Refer to form “Low or No Volume Competency Assessment Form)

4. **Quality Measures:** The Quality Improvement department tracks a variety of quality indicators, such as, sedation and surgical case and hospital mortality review. For monthly reappointment cycles, Quality Improvement forwards physician specific quality data flagged for Credentials Committee review as inappropriate. The Service QI Physician reviews any flagged files prior to further consideration by the Department Chair or designee.

5. **Peer Reviews:** Individualized profiling information or quality audits may also be included as appropriate. For example, a suspected issue may provoke an investigation and these findings will be reported and filed in the provider’s quality file. In addition, the health plans may submit provider specific data for inclusion.

6. **Medical Record Delinquencies**: For monthly reappointment cycles, medical records delinquency reports for the prior two years are queried by the Office of Medical Affairs and Governance and triaged for Credentials Committee review.

7. **Risk Management/Malpractice Claims:** Risk Management reports UC Regents claims history. Providers are obligated to disclose past and pending liability actions and provide further details regarding these actions, including specific discussion with the Department Chair or designee. Claims histories are also requested from external professional liability insurance companies, as applicable. Providers with one or more claims are flagged for review by the Department Chair or designee and the Credentials Committee.

8. **Suspensions/Sanctions**: Physicians may be suspended for non-compliance with policies as outlined in the Medical Staff bylaws, such as delinquent signature on medical records. In addition to citizenry suspensions, a physician may be suspended for more serious infractions, such as a license revocation or other action by the Medical Board or Governing Body (please see the Medical Staff bylaws for further information). These

suspensions are monitored by the Office of Medical Affairs and Governance and flagged for Department Chair or designee and Credentials Committee review.

9. **Service Quality Indicators:** Each clinical service establishes and monitors quality indicators. The Department Chair or designee considers a provider's performance with applicable indicator's when recommending appropriate membership/privileges and indicates any issues for Credentials Committee consideration.