SUBJECT: CREDENTIALING AND PEER REVIEW PROGRAM

EFFECTIVE DATE: 10/08/14

I. PURPOSE:

The purpose of the credentialing and peer review program is to ensure that all health care practitioners serving the Florida Department of Corrections (DC) have the proper credentials to practice within their field and that they perform their duties in a manner commensurate with their training and clinical competence, and in accordance with DC policies and procedures.

These standards and responsibilities apply to both Department staff and Comprehensive Health Care Contractor (CHCC) staff. Prior approval by the Assistant Secretary of Health Services is required before any modifications to this program are instituted by the CHCC.

II. RELEVANT REGULATIONS/REFERENCE DOCUMENTS:

A. Sections 286.011, 395.0191, 395.0193, 456.073, 458, 459, 466, 490, 491, 766.101, 766.1015, 945.6032 and 945.6034, Florida Statutes (FS)
B. Chapter 45 Code of Federal Regulations (CFR) Part 60
C. Florida Administrative Code (FAC) 60L-36
D. American Correctional Association 4-4411
E. DH-MQA– On-line Department of Health (DH) form required of all Clinical Associates/Physician Assistants (PA)

III. DC CREDENTIALS FORMS:

1. DC4-513, *Renewal of Credentials for Health Services Assignment*
2. DC4-513H, *Cover Letter for Professional Reference Questionnaire*
3. DC4-513I, *Professional Reference Questionnaire*
4. DC4-514, *Health Care Professional Credentialing Documents Checklist*
5. DC4-515, *Credentialed Staff Status Change Form*
6. DC4-515A, *Credentialing Committee Approval/Disapproval*
7. DC4-517A, Terms of Agreement & *Release of Immunity*
8. DC4-517B, *Health Care Professional Appointments & Training History*
9. DC4-518A, *Credentialing & Essential Functions –Physical Health Physicians & Psychiatrist*
10. DC4-518B, *Credentialing & Essential Functions -Physician's Assistant & Advanced Registered Nurse Practitioner*
11. DC4-518C, *Credentialing & Essential Functions - Dentist*
12. DC4-518D, *Credentialing & Essential Functions- Psychologists & Senior Behavioral Analysts*
13. DC4-518E, *Credentialing & Essential Functions -Behavioral Health Specialists*
14. DC4-518F, *Credentialing & RMC Hospital Privileging - Physicians*
15. DC4-519A, *Advanced Registered Nurse Practitioner (ARNP) Protocol-Mental Health*
16. DC4-519B, *Advanced Registered Nurse Practitioner (ARNP) Protocol-OB/GYN*
17. DC4-519C, *Advanced Registered Nurse Practitioner (ARNP) Protocol-General Medicine*

IV. DEFINITIONS AND ABBREVIATIONS:

A. Credentials Review Process – a process that reviews and verifies qualifications of a practitioner to deliver health care services.

B. Credentials Review Coordinator (CRC) – the individual that manages the statewide credentialing review program for the Department.

C. Credentials & Peer Review Committees – committees established by the Assistant Secretary of Health Services to evaluate qualifications and identify any concerns regarding a practitioner's qualifications and clinical performance in the delivery of health care.

D. Contracted Credentialed Health Services Practitioners – an entity that is qualified to provide health care services on a contractual basis.

E. Federation of State Medical Boards (FSMB) – a federation that keeps pertinent information on the practices of physicians, psychiatrists and other providers throughout the United States.

F. National Practitioner Data Bank (NPDB) – a national organization that keeps information regarding the practices of all licensed physicians, psychiatrists and dentists in the United States.

V. CREDENTIALS REVIEW COMMITTEE:

A. The Credentials Review Committee is a component of the Department of Corrections' Quality Management Program and will meet once a calendar quarter or more frequently as needed. Voting Members:

1. Assistant Secretary of Health Services
2. Director of Medical Services
3. Dental Services Director
4. Mental Health Services Director
5. Psychiatric Consultant
6. RMC Hospital Medical Director
7. Each Regional Medical Director

B. Committee Functions: review and make recommendations to the Assistant Secretary of Health Services regarding credentials for all new hires and staff requiring renewal to include any peer review findings. Develop, approve, and periodically update all policies, procedures, technical instructions and forms regarding the Office of Health Services (OHS) credentialing and peer review programs.

VI. CREDENTIALING PROCESS:

A. Credentialing responsibilities are part of the hiring process. The following occupational groups are credentialed:

1. Physician, all levels and specialties including psychiatry
2. Advanced Registered Nurse Practitioner (ARNP)
3. Clinical Associate/Physician's Assistant
4. Dentist, all levels and specialties
5. Psychologist, Senior Behavioral Analyst/Senior Mental Health Clinician
6. Behavioral Specialist/Mental Health Specialist

B. The hiring officials and/or personnel staff will be aware of the specific educational requirements for each discipline and proof of these requirements must be obtained.

C. It is the responsibility of the hiring supervisor to explain the credentialing process to the practitioner.

1. All newly hired practitioners must receive and acknowledge receipt and understanding of essential functions as dictated by the Department's policies, procedures and rules generally applicable to all situations prior to providing health care to our inmate/patient population.
2. All practitioners must complete all applicable documents listed in Section III for presentation to the Credentials Review Committee within 180 days of official hire date and every two (2) years for continuation of employment. The credentialing Review Coordinator on behalf of the committee may request other items not listed. Only the Credentialing Review Coordinator, upon approval by the Assistant Secretary of Health Services, can grant extensions.
3. Committee reviews credentials every two (2) years to ensure practitioners have maintained licensure, specialty qualifications and clinical competence. The committee meets once a calendar quarter or more frequently as needed.

D. Basic Life Support (BLS)/ Cardio-Pulmonary Resuscitation (CPR) compliance is a critical component of credentialing. The following BLS cards will be accepted: (1) An American Heart Association (AHA) approved CPR-Pro or Healthcare Provider card; (2) The American Safety & Health Institute (ASHI) Healthcare Provider card bearing the AHA endorsement; or, (3) The American Red Cross CPR/AED card for Professional Rescuer & Healthcare Provider. In addition to the BLS card, an American Heart Association approved Advanced Cardiac Life Support (ACLS) card may also be required depending upon discipline requirements.

E. Rehire – Previous information submitted on the DC4-517B, *Health Care Professional Appointment & Training History* form will be accepted as current for credentialed practitioners with breaks in service of six (6) months or less. DC4-515, *Credentialed Staff Status Change* form must be completed by the practitioner noting no change or

any changes pertinent to employment as a health care provider. Practitioner credentials packets may be in State Archives with breaks longer than two (2) years.

F. Contracted health services providers must maintain a credentialing and privileging program for all credentialed positions in their employ. This program must meet the requirements of the Department's policies, procedures, Florida State statute laws and rules.

G. The credentialing process requires the following documentation for determination of credentialing:

1. A copy of a current Florida license and all board certification (if applicable)
2. A copy of a current DEA certificate (if applicable)
3. At least two (2) professional references (optional if personal and professional background queries are clear)
4. Copy of current liability coverage (if new hire, rehire or contract), if applicable
5. Copy of query to the NPDB and FSMB (queries are done by CRC for employees; vendors must submit contract employee findings to CRC)
6. Practitioner's curriculum vitae
7. Copy of query to Florida Crime Information Center (FCIC) and National Crime Information Center (NCIC) (queries are done at institution for new hires; findings will be submitted to OHS and institutional Warden for approval)
8. CPR (DC mandated compliance)

H. Routine and random credentials inspections will occur on contracted health services practitioners providing care at any facility housing inmates as disclosed in the contract agreement.

VII. INSTITUTIONAL RESPONSIBILITIES:

A. The Health Services Administrator (HSA) or Senior Health Services Administrator (SHSA) will manage the credentialing program with the assistance of the health discipline supervisor for their facility.

B. The health discipline supervisor or CHO/ Institutional Medical Director has the option to request professional references at the time of hire (if all personal and professional queries are clear).

C. Current credentialing forms must be maintained and made available for practitioners in time to meet all deadlines.

D. Credentialing files are confidential and shall be maintained in a locked/secured cabinet/area at all times. Per Florida Statute 945.6032, credentialed staff will not have access to their credentials file.

E. The administrator will ensure that the DC4-515, *Credentialed Staff Status Change* form is completed (placed in file) and submitted to the CRC with a copy going to the RHSM credentials manager. If status change involves transfer of employee the credential file is to be forwarded to the institution in which the employee is transferring. If status change is due to employment separation then the inactive file should be kept in house for a period of 2 years unless approval to destroy file is given by the Central Office CRC.

F. The administrator will track BLS/CPR compliance and ensure all credentialed staff are notified and scheduled for a class well in advance of expiration.

VIII. REGIONAL HEALTH SERVICES MANAGER (RHSM) AND REGIONAL MEDICAL DIRECTOR (RMD) RESPONSIBILITIES:

A. Each discipline director will provide guidance to the hiring staff to ensure applicants meet specific educational and experience levels required for a position and that the applicant has the proper degree and qualifications prior to hire.

B. Each discipline director will ensure compliance with the credentialing and peer review HSB and provide recommendations regarding the qualifications and clinical competence of practitioners within their discipline for review by the credentialing and peer review committees.

C. The RHSM or designee will check all credentialing documents for completeness and legibility.

   1. Ensure the completed packet is given to the appropriate Regional Discipline Director and the RMD for review and approval. Forward credentialing packet to Central Office CRC once reviewed and approved.
   2. Ensure DC4-515, *Credentialed Staff Status Change* forms are properly submitted upon notice of the status change.

D. The RMD will review and make final regional decisions concerning the credentials of all occupational groups under regional authority.

IX. ADVERSE PRACTITIONER INFORMATION:

A. Adverse information includes, but is not limited to, the following: license actions of any sort (revocation, suspension, and modification), sanctions, criminal activity, lawsuit resulting in either settlement or a judgment for plaintiff, or Agency for

Healthcare Administration complaints filed by patients only if such complaints result in discipline.

B. Credentialed practitioners are responsible for reporting any adverse information to their immediate supervisor or the SHSA within fourteen (14) days of discovery. Failure to do so may result in penalties up to and including revocation of privileges.

C. The appropriate clinical services supervisor for determination of appropriate action will review adverse information. All factual information and recommended action shall be submitted to the central office Discipline Directors for final determination. This information is to be included in the practitioner's credentials file.

D. The department governs the effect of a restriction, investigation or suspension of clinical practice of an employee.

E. A contracted physician/consultant or other practitioner is governed by the department's contract agreement. Adverse actions include:

   1. Automatic suspension/revocation of privilege to practice within the Department of Corrections including, but not limited to:
      a) failure to maintain the minimum amount of professional liability insurance as specified in the contract. Request for reinstatement must include certified copy of a current insurance certificate and statement of explanation for previous coverage lack of renewal or cancellation.
      b) Failure to meet and maintain credentialing requirements.

F. Clinical performance issue(s): All recommendations for clinical disciplinary action shall be in writing and address the specific clinical performance issue(s) that constitute the grounds for action in accordance with this policy, FAC 60L-36 and Procedure 208.039, *Employee Counseling & Discipline*, if applicable.

G. Grounds for disciplinary action recommending denial, reduction, or suspension of clinical practice shall include, but not be limited to, the following:

   1. A practitioner's professional performance or competency that adversely affects or could affect the health or welfare of a patient or patients.
   2. Unethical clinical practice.
   3. Reasonable belief of mental or physical impairment that is detrimental to patient safety or quality of patient care.
   4. Does not include administrative termination of select exempt service (SES) employees when terminated in accordance with Chapter 110.604, FS (at-will clause).

H. Grounds for disciplinary action resulting in ***automatic*** suspension/revocation of privilege to practice within the Department of Corrections include, but are not limited to the following:

1. Failure to report immediately upon discovery to the applicable Chief Health Officer/ Institutional Medical Director any of the following actions against clinical license or registration constitutes grounds for automatic and permanent revocation of ability to provide further care to inmates/patients:
    a) Revocation, suspension, or expiration of license to practice in Florida (includes Area of Critical Needs license);
    b) Revocation, suspension, or expiration of Drug Enforcement Administration (DEA) registration;
    c) Restriction/limitation to license or DEA registration.

I. When an adverse recommendation is made the practitioner is notified via certified mail by the Office of Health Services and will be afforded an opportunity to an interview prior to a final decision by the Assistant Secretary of Health Services.

J. The Department will report information to the Board of Medical Examiners and National Practitioner Data Bank pursuant to 45 CFR § 60.

K. Pursuant to section 456.073 (1), F.S. (Disciplinary Proceedings), the Assistant Secretary of Health Services will notify the Department of Health in writing within 15 days after the department disciplines, suspends or allows a resignation for an offense related to the practice of his/her profession. A copy of this notification will be placed in the employee's credentialing file.

X. RECEPTION AND MEDICAL CENTER HOSPITAL (RMCH):

A. As a licensed hospital, the Reception and Medical Center Hospital (RMCH) shall maintain a complete credentialing and privileging program for all credentialed positions in its employ. This program will meet all requirements of sections 395.0191 and 395.0193, F.S., Art. X, § 25, Fla. Const., 45 CFR Part 60, and RMCH Credentialing Policies and Procedures 01-2.

B. The RMCH governing board will make all credentialing determinations for practitioners at this facility, subject to approval by the credentialing committee and final approval of the Assistant Secretary of Health Services in accordance with this policy. Practitioners approved by the RMCH governing board are authorized to provide services at any facility where comprehensive medical services are delivered by DC-employed health services staff.

XI. PEER REVIEW:

Peer review is an integral part of the credentialing and privileging process, assuring the competence of the providers for the inmate/patients they treat. All credentialed staff, except Behavioral Specialists, must have peer review completed every two (2) years to be presented to the credentials review committee at time of renewal of credentials.

A. Clinical Quality Peer Assessment:

1. Practitioners of the same discipline shall perform another's review. The practitioner performing the review must utilize records of inmates for whom the reviewer has had no direct contact (in the prior ten (10) days). A minimum of ten (10) records shall be reviewed for appropriateness of care, proper diagnosis and treatment, and legibility.
2. A physician can perform peer review for the following positions if a peer of the same class is not available:
    a) Clinical Associate/Physician's Assistant,
    b) Advanced Registered Nurse Practitioner (ARNP), and
    c) Psychiatrist
3. The itemized privilege specific reviews are to be placed in the institutional credentials file and copies forwarded with the credentialing packet every two (2) years at time of credentialing review. This review is considered part of clinical quality management and shall be shared only with those on a need-to-know basis.
    a) This information is to be used for the reappraisal and reappointment process.
    b) This detailed information may not be shared with any organization (ACA, CMA, etc.) as part of an official survey or audit of health care due to confidentiality restrictions. However, as evidence of completion of the peer review process, a summary letter in a standard format identifying satisfactory or unsatisfactory performance shall be provided upon official request.

B. Establishment of Special Peer Review Committees:

1. Upon approval or direction by the Assistant Secretary of Health Services or Director of Medical Services, a special peer review committee will be established when it has been determined by clinical discipline directors, or the Regional Medical Directors, as the best mechanism to address concerns regarding a practitioner's clinical performance.
2. The Assistant Secretary of Health Services or Director of Medical Services will appoint a committee chairperson from a director or manager level annually, subject to reappointment.
3. The Chairperson is responsible for identifying a minimum of three committee members appropriate to peer group under review. Committee appointment is subject to Assistant Secretary of Health Services or Director of Medical Services's approval.

C. Conduct of Special Peer Review Committees:

1. The designated chairperson of the peer review committee will establish the date, time and location of the meeting and provide notification to all committee members and to the practitioner under review.
2. The committee will gather and review sufficient information (e.g., records review, staff interviews, direct observations, etc.) to thoroughly evaluate the identified clinical concern(s).
3. The practitioner who is the subject of the peer review will be afforded an opportunity to present his/her position and to answer questions of the committee members.

D. Outcome of Special Peer Review:

1. Within seven (7) calendar days after the review has been completed, the committee chairperson shall submit a written report of the committee's findings and recommendations to the Director of Medical Services. A copy of the report will be sent to the Credentials Review Coordinator to be placed in the practitioner's credentials file and a copy will be placed in the practitioner's personnel file if appropriate.
2. The Assistant Secretary of Health Services, the appropriate central office clinical discipline director, the Regional Medical Director, and/or the Regional discipline director will review the committee's written report and determine what, if any, actions should be taken.
3. Actions which may be taken based on findings of the special peer review committee include, but are not limited to: required continuing education; increased clinical supervision and reduction, suspension or revocation of clinical services (all or in part, temporary or permanent); reduction, suspension or revocation of clinical services, whether temporary or permanent. The practitioner involved will be notified in writing of any such proposed action before it is taken.
4. The outcome of all peer review activities will be reported to the Credentials Review Committee.

XII. CONFIDENTIALITY:

The confidentiality provided by this section is limited by Florida's public records law. The official personnel file is public record. Credentials files and meeting minutes are maintained in the Office of Health Services as part of the quality management program and, as such, are subject to sections 766.101 and 945.6032(3), F.S. (See DC Procedure 401.006, *Confidentiality of Health Services Medical Review Committees Information*.)

XIII. IMPLEMENTATION DATE:

Each institution will implement this health services bulletin no later than 30 days after signature.

Assistant Secretary of Health Services ______________________ Date ______________________

This Health Services Bulletin Supersedes: Credentialing Procedures Manual dated 2/89
HCS 25.09.02 dated 10/1/89, HSB 15.09.05 dated 6/22/95,
TI 15.09.05 dated 10/3/01, 6/4/04 and 02/21/13.