

PROFESSIONAL STANDARDS BOARD POLICY

Community Health Services

Tennessee Department of Health

Credentialing and Privileging of Health Care Professionals

January 1, 2014 (rev. July 1, 2016)

TABLE OF CONTENTS

I.	PURPOSE	
II.	SCOPE	
III.	DEFINITIONS	
	A. Council for Affordable Quality Healthcare, Universal Provider Datasource (CAQH)	3
	B. Credentialing	3
	C. Initial Professional Practice Evaluation (IPPE)	3
	D. Licensure	3
	E. Medical Leadership Team (MLT)	4
	F. National Practitioner Data Bank (NPDB)	4
	G. Ongoing Professional Practice Evaluation (OPPE)	4
	H. Primary Source Verification	4
	I. Privileging	4
	J. Proactive Disclosure System (PDS)	4
	K. Professional Standards Board (PSB)	4
	L. Regional Credentialing Coordinator	4
	M. Regional Medical Director	5
	N. Registration or Certification	5
IV.	PROCESS STEPS AND ASSIGNMENTS	
	A. Responsibility	5
	B. Establishment of Initial Application and Credentials	6
	C. Re-privileging	8
	D. Revision/Addition/Deletion of Clinical Privileges	10
	E. Monitoring of compliance with Clinical Privileges	10
	F. Disaster/Emergency Privileging	10
	G. Monitoring Programs	11
	1. Initial Professional Practice Evaluation (IPPE)	11
	2. Ongoing Professional Practice Evaluation (OPPE)	12
V.	REGIONAL MEDICAL DIRECTOR RESPONSIBILITIES	14

VI.	REGIONAL CREDENTIALING COMMITTEE RESPONSIBILITIES	14
VII.	PROFESSIONAL STANDARDS BOARD RESPONSIBILITIES	14
VIII.	DOCUMENTATION TOOLS	
	Credentialing and Privileging Process Steps	16
	Initial Credentialing and Privileging Checklist	19
	Clinical Privileges Request Form	22
	Dental Privileges Request Form	25
	TDH Professional Reference Request Form	28
	Declaration of Health and Continuing Education Form	29
	Claims Status Report	30
	Credentialing Release of Information Authorization	32
	IPPE Physician/ Advanced Practice Nurse/Dentist	
	Orientation Check List	33
	IPPE Physician/Advanced Practice Nurse Orientation Evaluation	36
	IPPE Dentist Orientation Evaluation	40
	IPPE Summary Evaluation of the Provider's Practice	43
	Ongoing Credentialing and Privileging Checklist	46
	OPPE Physician/Advanced Practice Nurse Peer Review Forms	48
	1. Observed Examinations and Lab Procedures	
	2. Observed Procedures	
	3. Outcome Focused Chart Review	
	OPPE Dental Peer Review Form	55
	Fair Hearing Process for PSB	56
	Notice of Proposed Professional Review Action	58

PROFESSIONAL STANDARDS BOARD POLICY
COMMUNITY HEALTH SERVICES
TENNESSEE DEPARTMENT OF HEALTH

January 1, 2014 (rev. July 1, 2016)

CREDENTIALING AND PRIVILEGING
OF HEALTH CARE PROFESSIONALS

I. **PURPOSE:** It is the policy of the Tennessee Department of Health (TDH) to ensure that all physicians, dentists, and Advanced Practice Nurses (APN) are properly credentialed and privileged in accordance with applicable public health standards. This document establishes policies, procedures and responsibilities for completion of all credentialing and privileging functions relating to these health care professionals employed by or who provide services for Community Health Services, TDH.

II. **SCOPE:** This policy shall apply to all physicians and dentists who are appointed or utilized on a full-time or part-time basis. All APNs will be credentialed in accordance with the Council for Affordable Quality Healthcare, Universal Provider Datasource (CAQH) following the same criteria for the Medical and Dental Staff, but will function under a Scope of Practice.

III. **DEFINITIONS:**

- A. Council for Affordable Quality Healthcare, Universal Provider Datasource (CAQH). This is a universal credentialing database system. The CAQH Universal Credentialing DataSource simplifies the credentialing process for providers and plans across the United States. For more information, see www.CAQH.org or call 1-888-599-1771.
- B. Credentialing. The term “credentialing” refers to the systematic process of screening and evaluating qualifications and other credentials, including licensure, registration, certification, required education, relevant training and experience, and current competence.
- C. Initial Professional Practice Evaluation (IPPE). This is a process to consistently evaluate the privilege-specific competency of a provider who is newly hired or who is requesting privileges for new procedures.
- D. Licensure. The term “licensure” refers to the official or legal permission to practice in an occupation in Tennessee, as evidenced by documentation issued by the appropriate licensing board.

- E. Medical Leadership Team (MLT) – The Medical Leadership Team is a tactical decision making body maintained to conduct on-going evaluations of the appropriateness of health services provided in all state and local health department clinic sites.
- F. National Practitioner Data Bank (NPDB) - The National Practitioner Data Bank (NPDB), or "the Data Bank," is a confidential information clearinghouse created by Congress with the primary goals of improving health care quality, protecting the public, and reducing health care fraud and abuse in the U.S. For more information, see www.npdb.hrsa.gov or call 1-800-767-6732.
- G. Ongoing Professional Practice Evaluation (OPPE)- This is a process for ongoing evaluation of providers' competence to ensure they continue to provide safe and effective patient care.
- H. Primary Source Verification. "Primary source verification" is documentation from the original source of a specific credential that verified the accuracy of a qualification reported by an individual health care practitioner. This can be documented in the form of a letter, telephone contact, or appropriate electronic communication with the original source. A photo of the applicant should be sent to the primary source.
- I. Privileging. The term "privileging" refers to the systematic process of evaluating a health care professional's competence to furnish particular health care functions.
- J. Proactive Disclosure System (PDS) – PDS (Continuous Query) is an alternative to the traditional querying of the NPDB and allows for on-going monitoring of a practitioner's credentials.
- K. Professional Standards Board (PSB)- The Professional Standards Board establishes policies, procedures and responsibilities for completion of all credentialing and privileging functions related to health care professionals (physicians, dentists, advanced practice nurses) employed by or who provide services for the Community Health Services Division of the Tennessee Department of Health. Board membership reflects that of the Medical Leadership Team.
- L. Regional Credentialing Coordinator - Regional Credentialing Coordinators evaluate adherence to state regulations governing physicians, dentists and advanced practice nurses, verify certifications and licenses, and perform Primary Source verification of medical/dental/nursing degrees and job experience. They hold primary responsibility for managing credentialing files for each provider in their region.

- M. Regional Medical Director - This is a licensed physician who serves as a medical director for a geographical region of the Tennessee Department of Health and as chairperson of the Regional Credentialing Committee.
- N. Registration or Certification - The terms “registration or certification” refer to the official confirmation by a professional organization or licensing board or agency that one has fulfilled the requirements or met a standard or skill to practice the profession or assume certain professional responsibilities, such as prescribing drugs.

IV. PROCESS STEPS AND ASSIGNMENTS:

A. Responsibility

1. The office of the Medical Director, Community Health Services (CHS), in coordination with Billing and Operations Unit, Community Health Services (CHS) and Regional Credentialing Coordinators, will hold responsibility for the development, issuance and enforcement of the requirements relating to credentialing and privileging.
2. A Regional Credentialing Committee will be established for each region which will utilize the processes of the PSB to credential and privilege all appropriate personnel employed in said region. The Regional Credentialing Committee membership will consist of Regional Medical Director, Regional Nursing Director, Regional Dental Director, and Regional Credentialing Coordinator. Other members may be appointed at the discretion of the Regional Medical Director, who serves as chairperson of the committee. The Regional Director, while not a member of the Regional Credentialing Committee, will be informed and concur with decisions on the credentialing and privileging process.
3. Regional Medical Directors will be responsible for ensuring that all regional personnel who are within the scope of this policy are appropriately credentialed and privileged and perform only those procedures for which they have been privileged. Regional Medical Directors will ensure that credentialing and privileging including the preparation of documentation are performed in a timely manner. The Regional Credentialing Coordinator will assist Regional Medical Director and will notify Regional Medical Director when members of their service(s) fail to provide required information. The Credentialing and Privileging process of this board will establish pre-hire and post-hire steps. It is expected that four to eight weeks will be required for completion of the Credentialing and Privileging Checklist, which will be

consistent with new employee orientation timeframe.

4. Each staff member who is within the scope of this policy is responsible for providing the required information in a timely manner, when requested by the Regional Medical Director, Regional Dental Director, or the Regional Credentialing Coordinator. All Credentialing and Privileging pre-hire steps must be successfully completed prior to extension of an employment offer from the TDH.
5. The Regional Credentialing Coordinator will be responsible for the maintenance of all records necessary for a complete credentialing and privileging folder on every applicable staff member. The Regional Credentialing Coordinator serves as facilitator for CAQH. In addition, the Regional Credentialing Coordinator shall:
 - (a) ensure that providers are initially registered with Medicaid using the TennCare Registration Portal and are informed to enter and submit their credentialing information in CAQH; the coordinator shall provide assistance and training as needed.
 - (b) notify providers at the time of reappraisal to update credentialing data in CAQH and re-attest.
 - (c) performs complete credentialing process in CAQH of all credentialed and privileged providers.
 - (d) assist with any problems that occur with staff during the appointment process.
 - (e) ensures that primary source verification is completed whenever possible. Attempts to obtain primary source verification that will be documented in the practitioner's credentialing and privileging ("C&P") folder.

B. Establishment of Initial Application and Credentials

1. Regional Medical Director will ensure that the documents listed below are submitted to the Regional Credentialing Coordinator for every individual requesting credentialing or privileges in their services. Privileges are provider specific. These forms are available from the Regional Credentialing Coordinator and they should be completed and returned to the credentialing coordinator.

- (a) completed State of Tennessee employment application.
- (b) completed and signed Release of Information.
- (c) completed and signed Clinical Privilege Request Form or Scope of Practice.
- (d) list of all professional licenses ever held.
- (e) copy of all Board Certifications, Certificates of Residency/Fellowship training, Drug Enforcement Administration (DEA) certification, copy of all life support cards - Basic, Advanced, and/or Trauma, if applicable.
- (f) copy of Educational Commission for Foreign Medical Graduates (ECFMG), if applicable.
- (g) copy of current privileges and data from professional practice review from other facilities where currently privileged, if available.
- (h) a completed Declaration of Health form stating that no health problems exist that could affect the ability of the practitioner to safely perform the privileges requested.

2. After the above documents have been received, the Regional Credentialing Coordinator will:

- (a) establish a Credentialing and Privileging folder (C&P Folder).
- (b) conduct primary source verification of the qualifying degree (MD, DDS, etc.), board certification, all medical licenses ever held, ECFMG if applicable, all residencies, fellowships, and any advanced education or professional training. All licenses and certifications will be tracked and verified before the expiration date. The status of the license or certification at expiration will be documented and any negative information will be brought to the attention of the Regional Medical Director.
- (c) complete documentation form concerning professional references checked via telephone or send reference requests letters to all references listed. Three (3) references are recommended and must be documented/received as part of pre-hire process.

(d) submit information to central office contact and ensure provider is enrolled in the National Practitioner Data Bank (NPDB)-Proactive Disclosure System (PDS). Submit the Federation of State Medical Boards (FSMB) and Office of the Inspector General (OIG) queries.

(e) obtain information regarding each lawsuit, civil action, or other claim brought against the practitioner for malpractice or negligence. This information may be forwarded to central office contact for confirmation from an objective attorney, insurance company or court if additional information is requested by the Regional Credentialing Committee.

(f) verify liability insurance on all contracted providers. All contracted providers shall maintain Professional Malpractice Liability with a limit of not less than one million dollars (\$1,000,000) per claim and two million dollars (\$2,000,000) aggregate.

(g) ensure that the applicant completes and signs the Declaration of Health form to attest to the applicant's physical and mental ability to carry out the duties of the position for which application is made.

(h) ensure presence of a positive identification attestation (a valid photo ID issued by a state or federal agency, such as a driver's license or passport).

3. When all of the above information is received and verified by the Regional Credentialing Coordinator, the file will be reviewed by the Regional Medical Director. The Regional Medical Director then establishes an appropriate Initial Professional Practice Evaluation (IPPE).

C. Re-privileging

1. Reappraisal for the granting of clinical privileges must be conducted for each practitioner at least every two (2) years. The re-privileging process will be initiated approximately three to four months prior to the date of expiration of current privileges. The provider should complete re-privileging documentation and return within 14 days of issuance to allow time for processing. The Regional Credentialing Coordinator will notify providers that they should update their CAQH account and complete or provide the following documents or information:

(a) evidence of required continuing medical education or continuing education units, any new certifications, and current life support

certification cards as applicable.

- (b) a signed privilege form or for nurse practitioners, a copy of annual protocol signature page.
- (c) an updated signed Declaration of Health
- (d) an updated signed Release of Information form

2. After the information is received, the Regional Credentialing Coordinator will conduct primary source verification and conduct a license verification of all current licenses. After all verifications are complete, the entire credentials file will be sent to the Regional Medical Director for a Regional Medical Director Assessment using the above re-privileging documents and Quality Improvement (QI) data.

3. The Regional Medical Director will consider information concerning professional performance, including clinical and technical skills as well as information from quality improvement activities and the provider's Ongoing Professional Practice Evaluation (OPPE). The Regional Medical Director will perform:

- (a) an assessment of the information provided regarding Declaration of Health, current licensure; any new education and relevant training and experience, ability, and current competence to perform the requested privileges.
- (b) a review of pertinent information such, as malpractice claims; challenges, relinquishment, or revocation of any licenses or registration; termination of medical staff membership; limitation, reduction, or loss of clinical privileges; and derogatory references.

4. The Regional Medical Director will provide an IPPE for any new privileges requested at re-privileging. If a provider has current privileges for a certain procedure but does not routinely provide that procedure, the Regional Medical Director may elect to alter the provider's work assignment. Withdrawal of any privilege resulting from adverse event should be reported to the PSB and if upheld, to the NPDB.

5. After the Regional Medical Director completes the actions set out in paragraphs 3 and 4, the Regional Credentialing Coordinator will send a copy of the signed privileging documents to the applicant and maintain in the provider's Credentialing and Privileging folder. If it is determined that privileges should be

denied, the applicant is informed of the reason by the Regional Medical Director.

D. Revision/Addition/Deletion of Clinical Privileges

1. Because a facility's mission may change over time and clinical techniques are constantly changing, it is anticipated that a provider may need to revise or request additional clinical privileges. To request a revision or additional privileges the provider will:

(a) request the change via the Regional Medical Director, who will inform the Regional Credentialing Coordinator.

(b) provide the appropriate documentation, which supports the practitioner's assertion of competence (i.e. advanced educational or clinical practice program, clinical practice information from other institutions, or references)

2. For an additional privilege, the Regional Credentialing Coordinator , in consultation with the Regional Medical Director, will open the practitioner's file for re-privileging in CAQH and will complete the re-privileging process as outlined above. An IPPE will be required for any newly requested privileges.

E. Monitoring of compliance with clinical privileges

Medical staff members will perform only those procedures and treatments for which they have been granted permission in accordance with the process specified in this policy. The monitoring of compliance with approved clinical privileges is the responsibility of Regional Medical Director.

F. Disaster/Emergency Privileges

Disaster/Emergency Privileges will be addressed through Emergency System for the Advance Registration-Volunteer Health Professional (ESAR-VHP) or Medical Reserve Corp (MRC) registration.

Disaster/emergency privileges are designed for a specified period under which health care professionals may practice under specified disaster privileges. This period may not exceed ten (10) calendar days or the length of the declared disaster, whichever is shorter. The process to be followed is defined by Emergency Preparedness standards.

G. Monitoring Programs

The following monitoring programs are in place:

1. Initial Professional Practice Evaluation (IPPE)

- (a) The IPPE is a process by which the Professional Standards Board consistently evaluates the privilege-specific competency of a provider who is newly hired or who is requesting additional privileges for new procedures. This process encompasses a standardized orientation to Public Health programs, and includes legal responsibilities of Public Health Officers as appropriate for each provider.
- (b) The Physician/Advanced Practice Nurse/ Dentist Orientation Checklist (Appendix G) will be completed during the first four to eight weeks of public health practice for all newly hired clinical providers.
- (c) After a complete evaluation of the provider's competency indicators, the Regional Medical Director will determine the type, extent, and duration of the evaluation needed and develop the IPPE. The IPPE may include chart review, monitoring clinical practice patterns, proctoring, external peer review, and discussion with other individuals involved in the care of each patient
- (d) The IPPE for Advanced Practice Nurses will include the standardized Public Health Nursing orientation and mentoring by physician preceptor as assigned. Advanced Practice Nurses will demonstrate familiarity with established PHN Protocols and current Primary Care protocols/texts and are charged with collaborating with physician preceptors to make necessary changes. Nursing protocols/ texts must be reviewed and signed on an annual basis.
- (e) IPPE for dentists will include the Quality Assurance Record Review and Direct Observation and will be documented on the Dental IPPE Summary Sheet.

Note: The time period for review may be extended if all issues have not been fully addressed or if additional concerns were identified during the evaluation.

- (f) The following indicators may be used to evaluate the current competencies and the performance of providers:
- Review of all materials in Credentialing and Privileging Folder
 - Results of Initial Professional Practice Evaluations;
 - QI monitoring;
 - Incident/Safety reports involving a provider;
 - Patient Satisfaction Complaints/Compliments;
 - Monitoring of Special Privileges as delineated on the privilege sheet.
- (g) When the provider has completed the requirements set out in the IPPE, the Regional Medical Director will review the information and prepare a written summary. The Regional Medical Director will make a recommendation to document successful completion of the IPPE, to continue monitoring for a specified period of time, or to begin dismissal procedures if deemed to be in the best interest of the agency. These recommendations will be made to the Regional Credentialing Committee.
- (h) In circumstances under which no other provider is qualified or credentialed to serve as a proctor, an outside proctor may be retained.
- (i) Performance issues with providers will be addressed in the same manner as all other employees, and the Regional Medical Director can contact Human Resources for guidance. Any action taken will be in accordance with Department of Human Resources "Performance Management System".

2. Ongoing Professional Practice Evaluation (OPPE)

Responsible privileging requires an ongoing evaluation of the competence of the providers to ensure they continue to provide safe and effective patient care.

- (a) The information gathered by the OPPE is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke

an existing privilege prior to or at the time of renewal.

(b) The OPPE criteria will be developed for each provider with privileges or who performs certain services under a limited Scope of Practice by the Regional Medical Director. The evaluation criteria will identify professional practice trends that impact quality of care and patient safety. An OPPE is documented in a Provider Specific Profile and reviewed by the Regional Medical Director on a continual basis and any outliers are promptly addressed.

(c) Monitoring of diagnostic and treatment techniques will be accomplished by periodic chart review, direct observation, and discussion with other individuals involved in the care of the patients, including peers and administrative personnel. Information on patient satisfaction will be obtained through the Patient Satisfaction Survey.

(d) Should the evaluation process uncover issues suggestive of an impaired professional, filing a complaint with the appropriate Board of Health Licensure and potential referral to appropriate peer assistance program will be considered.

(e) Performance issues with providers will be addressed in the same manner as all other employees, and the Regional Medical Director can contact Human Resources for guidance. Any action taken will be in accordance with Department of Human Resources "Performance Management System".

(f) The Regional Medical Officer will maintain and review provider specific profile, provide feedback to the provider, and use the information in formulating recommendations for maintaining or limiting existing privileges. The information may be used to revoke an existing privilege prior to re-privileging, at renewal or when a change in clinical privileges is requested. If an initial attempt to establish a specific privilege is not successful, (1) a repeat review may be offered after thirty days, (2) specific goal-directed CME may be required, or (3) privileges may be revoked. Inability to establish a specific privilege may lead to a change in work assignments. If a specific privilege is an essential component in performance of a particular position, inability to maintain said privilege will lead to dismissal.

V. REGIONAL MEDICAL DIRECTOR RESPONSIBILITIES:

The Regional Medical Director has responsibility for oversight of all clinical providers within his/her assigned region. He/she serves as chair of the Regional Credentialing Committee. He/she may designate other physicians for proctoring or peer reviews. He/she may designate other physicians or experienced advanced practice nurses for proctoring or peer reviews of advanced practice nurses. The Regional Medical Director will delegate oversight, proctoring, and peer review of dentists to the Regional Dental Director.

The Practitioner being evaluated shall keep a retrievable list of all cases proctored and the practitioner who observed in each case, keep track of the requirements set forth in the monitoring document and inform the Regional Medical Director when they have been completed, and report any adverse actions in any way associated with the patients to the Regional Medical Director.

The Regional Medical Director has the responsibility, in consultation with others, to determine successful completion of IPPE.

VI. REGIONAL CREDENTIALING COMMITTEE RESPONSIBILITIES

The Regional Credentialing Committee will have the responsibility to confirm by consensus the recommendation of a Regional Medical Director to confer credentials and privileges on individual clinical providers.

VII. PROFESSIONAL STANDARDS BOARD RESPONSIBILITIES

The Professional Standards Board membership mirrors the membership of the Medical Leadership Team.

The PSB serves in support of the Regional Credentialing Committees. Any Regional Medical Director, as chair of the Regional Credentialing Committee, may consult with the PSB membership about a proposed extension of IPPE, issues discovered during OPPE, or any other matter that is part of the credentialing and privileging process.

If a recommendation is made to the PSB that a negative professional review action should be taken against a physician, advanced practice nurse, or dentist, a simple majority of the members of the PSB must vote to pursue such action. After a majority vote by the PSB affirming potential infractions, the PSB must notify the physician, advanced practice nurse, or dentist of the infractions alleged and his or her rights before the board. Specifically, the PSB must notify the practitioner of his or her right to a fair hearing and what that process involves. Hearing and any appeals will be conducted in accordance with the Fair Hearing Process for the PSB as outlined on page 54 of this document.

If the PSB upholds a negative professional review action against a physician, advanced practice nurse or dentist, such action shall be reported to the National Provider Data Base and the appropriate Tennessee regulatory board within thirty days of the action.

Proposed negative professional review action involving a dental provider or an Advanced Practice Nurse will necessitate the expansion of the PSB. In the case of a dental provider, the PSB will be expanded to include one Regional Dental Director as a temporary voting member, in addition to the State Dental Director. Proposed action involving an Advanced Practice Nurse will require the PSB be expanded to include two Advanced Practice Nurses, as temporary voting members.

Professional Standards Board Process Steps

Pre-hire Steps

Obtain from applicant copy of-

- Completed State of Tennessee application for employment and current CV
- State of Tennessee professional medical/ nursing/dental license (HR verifies on BHLR website)
- List of all medical/ nursing/dental licenses ever held
- DEA number if applicable
- All current Professional Board Certifications and Certificates of Residency/Fellowship training
- Educational Commission for Foreign Medical Graduates (ECFMG), if applicable
- Name of hospital(s) applicant has admitting privileges
- CPR certification card-basic, advanced and/or trauma if applicable
- Valid driver's license
- Names and contact information for three (3) professional references if not included on employment application
- Contact information including email and cell phone number
- Completed and signed Release of Information Form

Medical Director/Dental Director Responsibilities-

- Complete standardized professional reference documentation for each reference
- Ensure that there are sufficient budgetary, spatial, equipment and staffing resources in place to support each requested privilege
- Ensure Primary Source Registry Checks (Tennessee Sex Offenders Registry, National Sex Offenders Registry, Tennessee Elder Abuse Registry and applicable registries from other states).

Credentialing Coordinator Responsibilities-

- Primary Source verification of Residency/Fellowship Perform National Practitioner Data Bank check (Central Office function)
- Primary Source verification of all professional licenses ever held Primary Source verification of Educational Commission for Foreign Medical Graduates (ECFMG), if applicable
- Primary Source verification of sex-offenders database
- Completed and signed copy of Disclosure of Ownership for Provider Person
- Statements concerning any lawsuit, civil action or other claims brought against the provider for malpractice of negligence, to include if requested by Regional Credentialing Committee, information from attorney, insurance company or court
- Proof of liability (malpractice) insurance, if applicable and perform Primary Source verification. All contracted providers shall maintain Professional Malpractice Liability with a limit of not less than one million dollars (\$1,000,000) per claim and two million dollars (\$2,000,000) aggregate.

Post-hire Credentialing Steps

Credentialing Coordinator Responsibilities-

- Create Credentialing and Privileging (C&P) folder in approved standard format
- Include in C&P folder copies of all pre-hire documents plus proof of Primary Source verification if applicable (State of Tennessee application, Tennessee professional medical license, list of all medical licenses ever held, DEA if applicable, Professional Board Certifications and Certificates of Residency/Fellowship training, Educational Commission for Foreign Medical Graduates (ECFMG), if applicable, CPR certification cards-basic, advanced and/or trauma if applicable, current CV, valid driver's license, and names and contact information for three (3) professional references if not included on employment application) All items will be included individually on checklist kept in front of C&P folder.
- Include in C&P folder completed standard professional reference documentation for each reference verified by Regional Medical Director
- Obtain completed and signed Privilege Request form or Scope of Practice
- Obtain copy of current privileges and data of professional practices review from other facilities where currently privileged, if available
- Complete and submit Medicaid application on TennCare web portal
- Secure CAQH login and password information, if applicable
- Create registration or update provider file in CAQH
- Enroll provider in National Practitioner Data Bank, if applicable
- Assist provider in completing any TennCare MCO credentialing applications, if applicable
- Notify Regional Medical Director/Dental Director of any adverse findings immediately
- Notify provider when it is time to re-attest in CAQH (every 120 days)
- Notify Regional Medical Director/Dental Director 90 days prior to re-privileging due date for each provider
- Notify provider 90 days prior to re-credentialing and re-privileging due date. Give provider list of documents needed.

Post-Hire Privileging Steps

Regional Medical Director Responsibilities- (for new physician and APN hires)

- Assess information regarding Declaration of Health, licensure, education, relevant training, experience, ability and current competence to perform requested privileges
- Review pertinent information concerning all malpractice claims, including evidence of an unusual pattern or an excessive number of professional liability actions, resulting in a final judgment against the provider
- Assess any challenges to any licensure or registration, voluntary or involuntary relinquishment of any licensure or registration, or revocation of any licenses or registration, voluntary or involuntary termination or medical staff membership, limitation, reduction, or loss of clinical privileges and derogatory references.
- Review relevant practitioner specific data, when available
- Establish an appropriate Initial Professional Practice Evaluation (IPPE)

- Submit completed and signed IPPS, copy of completed Credentialing and Privileging Checklist and written summary of Monitoring Plan to Professional Standards Board for approval. Copies retained in C&P folder.
- Notify provider if Professional Standards Board approved, denied or has pended request. Follow up, if applicable.
- Obtain proof of continuing education units

Regional Dental Director Responsibilities- (for new dentist hires)

- Assess information regarding Declaration of Health, licensure, education, relevant training, experience, ability and current competence to perform requested privileges
- Review pertinent information concerning all malpractice claims, including evidence of an unusual pattern or an excessive number of professional liability actions, resulting in a final judgment against the provider
- Assess any challenges to any licensure or registration, voluntary or involuntary relinquishment of any licensure or registration, or revocation of any licenses or registration, voluntary or involuntary termination or medical staff membership, limitation, reduction, or loss of clinical privileges and derogatory references
- Review relevant practitioner specific data, when available
- Perform Quality Assurance review within 8 weeks of hire
- Submit completed and signed Quality Assurance review, copy of completed Credentialing and Privileging Checklist and written summary of Monitoring Plan to Professional Standards Board for approval. Copies retained in C&P folder.
- Notify provider if Professional Standards Board approved, denied or has pended request. Follow up, if applicable.

Provider Responsibilities

- Notify credentialing Coordinator if contacted directly from TennCare, an MCO or CAQH with credentialing requests/issues and forward copy of all correspondence received
- Respond to requests from Regional Medical Director/Dental Director or Credentialing Coordinator in a timely manner
- Provide Regional Medical/Dental Director with documentation of continuing education units when requested
- Notify Regional Medical Director/Dental Director of change in status (i.e., married and last name changes, additional certifications, license suspensions, changes in hospital or other facility staff status/privileges, lawsuits, criminal charges, convictions, etc.)
- Provide copy of updated professional license, DEA license and CPR certification card to HR and Credentialing Coordinator
- Reattest in CAQH every 120 days

Initial Credentialing and Privileging Checklist

Date Completed: _____

Next Review Date: _____

Provider Name: _____

Human Resources Officer					
Checklist Items	Met	Not Met	Date Met	Not Required	Comments
Verify medical/dental/ APN license on BHLR website	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Copy of TN medical/dental/APN license	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Copy of DEA registration	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Copy of CPR card	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Copy of CV	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Completed and signed TDH application or county equivalent	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Copy of valid driver's license or other valid state or federal photo identification	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Names and contact information for three (3) professional references if not included on employment application	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Name of hospital(s) applicant has admitting privileges	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Educational Commission for Foreign Medical Graduates (ECFMG)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
All Professional Board Certifications and Certificates of Residency/Fellowship training	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
List of all medical, nursing, dental licenses ever held	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Completed and signed Release of Information Form	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

HR Signature _____

Regional Credentialing Coordinator

Checklist Items	Met	Not Met	Date Met	Not Required	Comments
Primary Source verification of education, including board certifications and certificates of residency/fellowships	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Primary Source verification of all professional licenses ever held	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Signed Declaration of Health/ CEU form	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Completed and signed Privilege Request form or Scope of Practice	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Application completed and submitted on TennCare web portal	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Secure CAQH login and password information. Create registration or update provider profile in CAQH	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Provide information to Central Office for enrollment/verification in National Provider Data Bank (NPDB)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Verification liability insurance on all contracted providers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Completed TennCare Dental Benefit Manager application for dentists	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Obtained information regarding each lawsuit, civil action or other claim brought against the practitioner for malpractice or negligence. Confirmed with an objective attorney, insurance company or court	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Completed and signed Disclosure of Ownership	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Proof of continuing education units	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Primary Source verification of all medical licenses ever held	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Notified Medical/Dental/Regional Director of any adverse information found and outcomes of lawsuits, civil actions, or other claims against applicant	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

Regional Medical or Dental Director					
Checklist Items	Met	Not Met	Date Met	Not Required	Comments
Primary Source verification (written references or verbal verification) of professional references in standard format. Three (3) references documented	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Ensure Primary Source Registry Checks (TN Sex Offenders Registry, National Sex Offenders Registry, TN Elder Abuse Registry and applicable registries from other states)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Completed Initial Professional Practice Evaluation (IPPE) to include written summary of Monitoring Plan	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Monitoring of Continuing Education	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Ad hoc extension of IPPE, if needed	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

Privileging Status: Approved _____ Denied _____ Pended _____

Pended Explanation:

Primary Site _____

ALL Sites _____

Additional Sites

CLINICAL PRIVILEGES REQUEST FORM

Except where specified elsewhere, all staff physicians, dentists or nurse practitioners are permitted to treat minor conditions in the specialty areas, provided such a condition does not constitute a threat to the life, well being, or essential function of the patient. Check items (category and ages) for which privileges are requested.

Advanced Practice Registered Nurse

- All medical conditions of mild degree
 - Age less than 30 days or less than 3 kg.
 - Age 30 days to 2 years old
 - Age 2 years to 18 years old
 - Age 18 years and over

Procedure Specific

PRECEPTORS (For new applicants only)

Preceptors may be assigned. At designated intervals a log of cases treated will be inspected during the preceptor program.

PRIVILEGES

Check items (procedures and ages) for which privileges are requested. It is important that these privileges reflect what you would do at the Health Department, rather than what you would do in another setting, such as a hospital. If an area of the application does not apply, please write N/A.

- No Privileges Requested

Procedures

- Arthrocentesis
- Injection of joints or bursas

Surgical Procedures

- Repair of simple laceration
- Incision and drainage of superficial abscesses
- Excision of ingrown toenail
- Debridement of toenails
- Incision and drainage of felon and paronychia
- Removal of foreign body in the skin and subcutaneous tissues
- Paring of lesions, calluses, corns
- Removal of skin tag, wart

II. PROCEDURES

*Pediatric Age Designations: A - less than 30 days or less than 3 kg.

B - Under two (2) years old

C - Over two (2) years old

If you are requesting pediatric privileges, additional documentation of training and/or experience must be provided on a separate sheet of paper.

NOTE: Privileges requested are for adult patients except where indicated.

A. Arthrocentesis

Privileges Requested to Perform		Privileges Requested to Precept		Pediatric Privileges*			Training	Experience	Credentials Committee's Recommendation	
Yes	No	Yes	No	A	B	C			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Circle one) I have/have not treated/performed an adequate number to maintain proficiency.

Approximate # of cases treated/performed during last two years _____

Relevant CME course (Include title and number of CEUs earned) or explain experience.

B. Injection of Joints or Bursas

Privileges Requested to Perform		Privileges Requested to Precept		Pediatric Privileges*			Training	Experience	Credentials Committee's Recommendation	
Yes	No	Yes	No	A	B	C			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Circle one) I have/have not treated/performed an adequate number to maintain proficiency.

Approximate # of cases treated/performed during last two years _____

Relevant CME course (Include title and number of CEUs earned) or explain experience.

III. **SURGICAL PROCEDURES**

Pediatric Age Designations: A - less than 30 days or less than 3 k g.
 B - Under two (2) years old
 C - Over two (2) years old

NOTE: Privileges requested are for adult patient except where you indicate.

A. Repair of simple laceration

Privileges Requested to Perform		Privileges Requested to Precept		Pediatric Privileges*			Training	Experience	Credentials Committee's Recommendation	
Yes	No	Yes	No	A	B	C			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. Incision and drainage of superficial abscess

Privileges Requested to Perform		Privileges Requested to Precept		Pediatric Privileges*			Training	Experience	Credentials Committee's Recommendation	
Yes	No	Yes	No	A	B	C			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Excision of ingrown toenail

Privileges Requested to Perform		Privileges Requested to Precept		Pediatric Privileges*			Training	Experience	Credentials Committee's Recommendation	
Yes	No	Yes	No	A	B	C			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. Debridement of toenails

Privileges Requested to Perform		Privileges Requested to Precept		Pediatric Privileges*			Training	Experience	Credentials Committee's Recommendation	
Yes	No	Yes	No	A	B	C			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. Incision and drainage of felon and paronychia

Privileges Requested to Perform		Privileges Requested to Precept		Pediatric Privileges*			Training	Experience	Credentials Committee's Recommendation	
Yes	No	Yes	No	A	B	C			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F. Removal of foreign body in the skin and subcutaneous tissues

Privileges Requested to Perform		Privileges Requested to Precept		Pediatric Privileges*			Training	Experience	Credentials Committee's Recommendation	
Yes	No	Yes	No	A	B	C			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G. Paring of lesions, calluses, corns

Privileges Requested to Perform		Privileges Requested to Precept		Pediatric Privileges*			Training	Experience	Credentials Committee's Recommendation	
Yes	No	Yes	No	A	B	C			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

H. Removal of skin tag, wart

Privileges Requested to Perform		Privileges Requested to Precept		Pediatric Privileges*			Training	Experience	Credentials Committee's Recommendation	
Yes	No	Yes	No	A	B	C			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**TENNESSEE DEPARTMENT OF HEALTH DEPARTMENT
CLINICAL PRIVILEGES REQUEST FORM for DENTISTS**

Except where specified elsewhere, all staff dentists are permitted to treat minor conditions in the specialty areas, provided such a condition does not constitute a threat to the life, wellbeing, or essential function of the patient.

Check items (category and ages) for which privileges are requested.

I hereby request the following STAFF Status

_____ Initial (IPPE)
Adult and Pediatric

_____ Renewal (OPPE)
Adult and Pediatric

The Scope (Type) of Practice at the Health Department is General Dentistry Services and consultation.

Age Specific

- Age less than 30 days or less than 3 kg. – **Consultation Only**
- Age 30 days to 3 years old
- Age 3 years to 21 years old
- Age 21 years and over

Procedure Specific:

- Preventive Dentistry
- Operative dentistry
- Endodontics
- Periodontics
- Removable Prosthodontics
- Fixed Prosthodontics
- Oral Surgery

I hereby request clinical privileges in the department/service checked above.

Name (Printed Legibly or Typed)

Signature

Date

List Primary Work Site _____ **Secondary Clinical Sites** _____

A. Preventive Dentistry

Privileges Requested To Perform				Credentials Committee's Recommendation	
Yes	No	Training	Experience	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. Operative Dentistry

Privileges Requested To Perform				Credentials Committee's Recommendation	
Yes	No	Training	Experience	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Endodontics

Privileges Requested To Perform				Credentials Committee's Recommendation	
Yes	No	Training	Experience	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. Periodontics

Privileges Requested To Perform				Credentials Committee's Recommendation	
Yes	No	Training	Experience	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Circle one) I have/have not treated/performed an adequate number to maintain proficiency for gingivectomy (D4210, D4211)

Approximate # of cases treated/performed during last two years _____

Relevant CME course (Include title and number of CEUs earned) or explain experience.

E. Removable Prosthodontics

Privileges Requested To Perform				Credentials Committee's Recommendation	
Yes	No	Training	Experience	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F. Fixed Prosthodontics

Privileges Requested To Perform				Credentials Committee's Recommendation	
Yes	No	Training	Experience	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G. Oral Surgery

Privileges Requested To Perform				Credentials Committee's Recommendation	
Yes	No	Training	Experience	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Circle one) I have/have not treated/performed an adequate number to maintain proficiency for excision of benign lesion (D7410), removal of exostosis per site (D7471) and frenulectomy (D7960).

Approximate # of cases treated/performed during last two years _____

Relevant CME course (Include title and number of CEUs earned) or explain experience.

I hereby request clinical privileges in the department/service checked above.

Name (Printed Legibly or Typed)

Signature

Date

TENNESSEE DEPARTMENT OF HEALTH PROFESSIONAL REFERENCE REQUEST

Name _____ Phone/Fax _____

RE: _____ Practice _____

How long have you known the applicant? _____

In what setting/role did you observe the applicant? _____

What was your professional title/position at that time? _____

Have you ever observed or been informed of any physical and/or mental health condition, including alcohol, substance abuse and/or dependence or other problems the applicant has or had that could impair his/her ability to perform his/her clinical duties? Yes or No

To the best of your knowledge, has the applicant's license, clinical privileges, facility staff membership or other professional status ever been denied, challenged, suspended, revoked, modified, or voluntarily or involuntarily surrendered? Yes or No

The patient care provided by this practitioner was compassionate, effected, and followed appropriate clinical pathways. Acceptable Marginal Unacceptable

This practitioner demonstrated good medical/clinical knowledge, practiced within their scope, and facilitated learning of others. Acceptable Marginal Unacceptable

This practitioner demonstrated interpersonal and communication skills that enabled them to establish and maintain professional relationships with patients, families, and other members of health care teams. Acceptable Marginal Unacceptable

This practitioner demonstrated a commitment to continuous professional development, ethical practice, and a responsible attitude towards their patients, profession, and society. Acceptable Marginal Unacceptable

Any reservations, concerns, comments, information or recommendations you believe relevant to the applicant's membership and clinical privileges?

- Recommend applicant
- Recommend applicant with reservations noted above
- Do not recommend applicant

Signature _____ Specialty _____ Date _____

Verified telephonically by _____

DECLARATION OF HEALTH

Do you attest that you are in full possession of physical and mental abilities to successfully perform the duties of your position?

_____ Yes _____ No

Most Recent Examination Date: _____

CONTINUING EDUCATION CREDITS (CMEs)

Do you attest that you have attended CME activities in the past two years that relate to your area of practice, and that you will be able to provide proof of attendance and program content upon request?

_____ Yes _____ No

SIGNATURE/CERTIFICATION

I certify the information in this document is true and complete.

_____ Date _____
Signature

Print Name

The Tennessee Department of Health does not discriminate on the basis of race, color, sex, religion, or age.

Claims Status Report

NAME: _____ DATE: _____

- A. _____ I have not had any involvement in administrative, professional or judicial proceedings, including Federal tort claims proceedings, in which malpractice is or was alleged. *(Please include cases which are either new or were pending during your last appraisal. DO NOT INCLUDE settled cases which were reviewed during your initial appointment or last appraisal.)*
- B. _____ I have been involved in administrative, professional or judicial proceedings, including Federal tort claims proceedings, in which malpractice is or was alleged as follows:

Date of Claim:	
Status (Circle all that are applicable):	Settled Dismissed with Prejudice (Can't refile) Dismissed without Prejudice (Can refile) Pending Trial Verdict for Plaintiff (Patient) Verdict for Defendant (Physician) Pending Appeal Under Investigation
Insurance company involved (please include address):	
Attorney's name and address:	
Amount of claim:	
Was it taken to trial?	YES NO
Amount of award:	

<p>Court/location where documentation may be obtained:</p> <p>(Please add title of case and names of all plaintiffs and defendants)</p>	
<p>Was it settled out of court?</p> <p>Amount of award:</p>	<p>YES NO</p>
<p>Description of claim (including specific acts of negligence claimant alleged that <u>YOU</u> were responsible for):</p>	

**TENNESSEE DEPARTMENT OF HEALTH
CREDENTIALING RELEASE OF INFORMATION AUTHORIZATION**

In order for the Tennessee Department of health to access and verify my educational background, professional qualifications, and suitability for employment, I hereby authorize the Tennessee Department of Health to make inquiries and consult with all persons, places of employment, education, malpractice carriers, State licensing boards, or other similar government and non-governmental entities who have or may have information bearing on my moral, ethical and professional qualifications and competence to carry out the privileges I have requested.

I consent to the release of information about my ability and fitness for employment and I authorize release of such information and copies of related records and/or documents to TDH officials to include not only the requested information for verification but information concerning each lawsuit, civil action, or other claim brought against me for malpractice or negligence; each disciplinary action under consideration or taken; any open or previously concluded investigations; and any changes in the status of a credential and all supporting documentation related to the information provided.

I authorize the TDH to disclose to such persons, employers, institutions, boards or agencies identifying and other information about me sufficient to enable the TDH to make such inquiries.

I release from liability all those who provide information to the Tennessee Department of Health in good faith and without malice in response to such inquiries.

Full Name	Date
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Signature

Attach recent photograph

IPPE PHYSICIAN/ADVANCED PRACTICE NURSE/DENTIST ORIENTATION CHECKLIST

ORIENTEE

COUNTY

ORIENTATION TIME PERIOD

AREA OF ORIENTATION	ORIENTEE INITIALS	PRECEPTOR INITIALS	DATE COMPLETED
Facility Orientation			
Location of Emergency Equipment including crash cart, AED, PPE, Spill Kit, Review of Emergency Plan, Fire Plan			
Location of Work Station, Pharmacy, Medical Record Forms, Patient Education Information			
Title VI Training			
HIPAA			
Attendance & Leave / Edison			
Travel Claim / Edison			
Assignment of PTBMIS user ID & provider number			
Community Referral Resource List			
Organizational Charts, Region Map, Pertinent Contact Information			
Personnel Issues:			
Review and Sign SMART Job Plan			
Review Probationary Period, Interim & Performance Reviews, Disciplinary Action			
Review Benefits Information with Regional Personnel Director			
Insure completeness of Credentialing and Privileging Folder (as applicable): Professional License, Certification of Specialty, DEA certification, NPI number, CPR training			
Proof of Malpractice Coverage (as applicable)			
Photo ID / name tag			
Credentialing with CAQH (as applicable)			
Cellular phone/pager assignment (as applicable)			
Employee Assistance Program (as applicable)			
Occupational Health:			
TB Skin Test or CXR			
Hepatitis B Vaccinations/Status			
MMR Vaccination or Immunity			
Varicella Vaccination or Immunity			
Td/Tdap			
FIT respirator testing (as applicable)			
OSHA / Bloodborne Pathogens Training			
Incident/Accident Reporting			
Safety Data Sheet (SDS) training			
Review &/or Sign the Following:			
Confidentiality Statement, Drug Free Workplace, Workplace Harassment Policy, Conflict of Interest Statement, Internet Agreement, Smoke Free Policy, TennCare Impartiality Statement			
Primary Care APN Protocols			
Exposure Control Plan			
PHN Protocols			

AREA OF ORIENTATION	ORIENTEE INITIALS	PRECEPTOR INITIALS	DATE COMPLETED
Locate the Following:			
<i>Community Health Services Policies and Procedures Manual</i>			
<i>Primary Care Guidelines</i>			
<i>TDH Directory of Laboratory Services Manual</i>			
<i>Laboratory Policies and Procedures Manual</i>			
<i>Quality Improvement Manual</i>			
<i>Blood Borne Pathogens/Infection Control Manual</i>			
<i>TB Elimination Manual</i>			
<i>TN Breast & Cervical Cancer Screening Program Manual</i>			
<i>TDH Intranet (http://10.171.139.47/Login.asp)</i>			
<i>PTBMIS Codes Manual</i>			
<i>WIC Manual</i>			
<i>ICD-9 & CPT texts</i>			
<i>Laboratory Tests and Diagnostic Procedures Manual or equivalent</i>			
<i>Sanford Guide to Antimicrobial Therapy</i>			
<i>US Preventive Services Taskforce Guide to Clinical Preventive Services</i>			
<i>Standards of Practice for Dental Public Health</i>			
Professional Practice			
<i>Legal Issues / Policies</i>			
<i>Prescriptive Policies / Pharmacy Services</i>			
<i>Documentation & Medical Record Management</i>			
<i>Coding</i>			
<i>Laboratory Services</i>			
<i>After Hours Call</i>			
<i>Continuing Education</i>			
<i>Dress Code Policy</i>			
<i>Referral/Consultation Guidelines</i>			
<i>TennCare Advocacy</i>			
<i>Quality Improvement</i>			
Program Orientation (as applicable):			
<i>Introduction to Public Health</i>			
<i>Communicable & Environmental Disease Services / STD / HIV</i>			
<i>Child Health / WIC / Immunizations</i>			
<i>Family Planning / Women's Health</i>			
<i>Lab / Pharmacy / QI</i>			
<i>Primary Care</i>			
<i>Dental</i>			
<i>Community Development</i>			
<i>General & Environmental Health Services</i>			
<i>Emergency Preparedness & Response / ICS / NIMS</i>			
<i>Home Visiting</i>			

REGIONAL HEALTH OFFICERS CONTINUE; ALL OTHER PROVIDERS STOP HERE

AREA OF ORIENTATION	ORIENTEE INITIALS	PRECEPTOR INITIALS	DATE COMPLETED
Tennessee Code Annotated			
Administrative Orders			
Judicial Remedies			
Disease Control Health Threat Procedures			
Quarantine			
Rabies			
County Boards of Health			
Child Fatality Review Team			
Emergency Preparedness Role			
Performance Evaluation Training			
Customer Focused Government training			
Policies and Practices for Supervisors			
Respectful Workplace for Managers			
Media Responses			
Foreign Travel & Immunization Exceptions (asplenia, transplant pts, etc)			
Animal Hoarding			
Transfer of Corpses to Foreign Countries for Burial Rites			
Inmate Issues / Complaints			

Orientee: _____

Preceptor: _____

Supervisor: _____

Date of Completion: _____

**IPPE PHYSICIAN/ADVANCED PRACTICE NURSE
ORIENTATION EVALUATION**

*Indicate N/A if not applicable

This form is to be used when evaluating the orientee's performance. Both the orientee and the preceptor may write comments. Please rate on a scale of 1 (low) to 5 (high) how well prepared the Orientee functions in the following areas:

NAME OF ORIENTEE

COUNTY

ORIENTATION TIME PERIOD

MEDICAL CARE/SERVICE	DATE	REVIEWER	RATING	COMMENTS
Documentation				
Performs prompt recording on appropriate records				
Documents accurately, completely, and legibly				
Uses approved abbreviations				
Utilizes SOAP format				
Demonstrates accurate coding				
Working relationships with Co-workers				
Accepts individual differences				
Maintains confidentiality				
Maintains constructive communication				
Collaborates effectively				
Interview Style				
Utilizes objective questions				
Demonstrates respectful approach				
Performs sufficient data acquisition				
Diagnostic Acumen				
Forms a reasonable differential diagnosis				
Treatment Choices				
Considers range of possible therapeutic options				
Able to discuss rationale for choice of treatment				

MEDICAL CARE/SERVICE	DATE	REVIEWER	RATING	COMMENTS
Planning/Follow Up				
Demonstrates appropriate timeframe for workup and initiation of treatment.				
Demonstrates appropriate follow-up schedule				
Accessing resources for diagnostics/treatment				
Identifies and utilizes available resources appropriately				
Specific disease/condition management—technical skills				
Family planning (Pap Smear, Gen-Probe, wet prep, breast exam)				
Diabetes (diabetes checklist)				
Heart Disease/hypertension/lipid abnormality				
Sexually-transmitted disease				
Organization of Work				
Demonstrates effective utilization of work time				
Displays quantity of work/prioritization				
Demonstrates adaptability and flexibility				
Productivity goals: 12-15 encounters/day and 25 RVU/day				
Qualities contributing to effectiveness				
Utilizes good communication skills				
Demonstrates compliance with Department initiatives				
Displays willingness to accept and share responsibility				
Seeks learning opportunities				
Demonstrates promptness and attendance				
Displays reliability				
Accepts adherence to dress code				
Demonstrates professional behavior/actions				

INITIAL PROFESSIONAL PRACTICE EVALUATION (IPPE)
PHYSICIAN / NURSE PRACTITIONER PROCEDURE REVIEW

PROVIDER: _____ PERIOD OF REVIEW: _____

PROCEDURES (Must match with Clinical Privileges Request Form)
 (Mark only those procedures applicable to provider under review. In order to perform a procedure on ongoing basis, provider must have observed peer review every two years)

Date of Observation	Circle Rating		
○ <u>Pap Smear</u> _____	acceptable	marginal	unacceptable
○ <u>Progestin implant</u> _____	acceptable	marginal	unacceptable
○ <u>IUD insertion</u> _____	acceptable	marginal	unacceptable
○ <u>Other</u> _____	acceptable	marginal	unacceptable
○ <u>Other</u> _____	acceptable	marginal	unacceptable
○ <u>Other</u> _____	acceptable	marginal	unacceptable
○ <u>Other</u> _____	acceptable	marginal	unacceptable
○ <u>Other</u> _____	acceptable	marginal	unacceptable
○ <u>Other</u> _____	acceptable	marginal	unacceptable
○ <u>Other</u> _____	acceptable	marginal	unacceptable
○ <u>Other</u> _____	acceptable	marginal	unacceptable

COMMENTS

 Provider signature

 Reviewer signature

 Date

**ADDITIONAL COMMENTS:
NOTE STRENGTHS AND WEAKNESSES**

GOALS FOR IMPROVEMENT
PRECEPTOR NOTES:

Submit to Base Supervisor after completion

Orientee

Preceptor

Supervisor

Date

Preceptor

Preceptor

**IPPE DENTIST
ORIENTATION EVALUATION**

*Indicate N/A if not applicable

This form is to be used when evaluating the orientee's performance. Both the orientee and the preceptor may write comments. Please rate on a scale of 1 (low) to 5 (high) how well prepared the Orientee functions in the following areas:

NAME OF ORIENTEE

COUNTY

ORIENTATION TIME PERIOD

DENTAL CARE/SERVICE	DATE	REVIEWER	RATING	COMMENTS
Documentation				
Successful completion of QA record review				
Medical/Dental history				
Documents accurately, completely, and legibly				
Patient exam				
Uses approved abbreviations				
Radiographs				
Treatment				
Progress notes				
Appropriate and accurate coding				
Working relationships with Co-workers				
Accepts individual differences				
Maintains confidentiality				
Maintains constructive communication				
Collaborates effectively				
Interview Style				
Utilizes objectives questions				
Demonstrates respectful approach				
Obtains sufficient data acquisition				
Diagnostic Acumen				
Forms a reasonable differential diagnosis				
Treatment Choices				
Considers range of possible therapeutic options				
Able to discuss rationale for choice of treatment				
DENTAL CARE/SERVICE	DATE	REVIEWER	RATING	COMMENTS

Planning/Follow Up				
Demonstrates appropriate timeframe for workup and initiation of treatment.				
Demonstrates appropriate follow-up schedule				
Accessing resources for diagnostics/treatment				
Identifies and utilizes available resources appropriately				
Organization of Work				
Demonstrates effective Utilization of Work Time				
Displays Quantity of Work/Prioritization				
Demonstrates Adaptability and Flexibility				
Productivity goals: 10 encounters/day and 25 RVU/day				
Qualities contributing to effectiveness				
Utilizes good communication skills				
Demonstrates Compliance with Department Initiatives				
Displays Willingness to Accept and Share Responsibility				
Seeks learning opportunities				
Demonstrates Promptness and Attendance				
Displays reliability				
Accepts Adherence to Dress Code				
Demonstrates professional behavior/actions				

**ADDITIONAL COMMENTS:
NOTE STRENGTHS AND WEAKNESSES**

GOALS FOR IMPROVEMENT
NOTES:

Submit to Base Supervisor after completion

Orientee

Supervisor

Date

Reviewer

Date

IPPE SUMMARY EVALUATION OF THE PROVIDER'S PRACTICE

1. **Patient Care:** Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

- Compassionate = Communication with patients and families, and other staff members
- Effective = Positive Outcomes
- Appropriate = Care provided followed acceptable clinical pathways,
 - appropriate orders written
 - appropriate diagnosis
 - appropriate medication usage
 - appropriate management of complications
 - appropriate treatment/referrals

Acceptable

Marginal

Unacceptable

Comments: _____

2. **Medical/Clinical/Dental Knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.

- Demonstrated knowledge of established and evolving biomedical, clinical, and social sciences, and apply that knowledge to patient care and educating others.
- Practiced within scope
- Used scientific evidence and methods to investigate, evaluate, and improve patient care practices.
- Facilitated learning of others

Acceptable

Marginal

Unacceptable

Comments: _____

3. Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

- Demonstrated skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams.
- Medical/dental record documentation - legible notes providing adequate information
- Listening skills
- Creation of therapeutic relationships with patients
- Communication in difficult situations: breaking bad news, managing non-compliant patients, frightened patients, or patients whose ethnicity differs from the resident's ethnicity.

Acceptable Marginal Unacceptable

Comments: _____

4. Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.

- Demonstrate behaviors that reflect commitment to continuous professional development, ethics, and sensitivity to diversity, as well as responsible attitudes toward patients, the profession, and society.
- Compliance with institutional and departmental policies
- Reliability and commitment

Acceptable Marginal Unacceptable

Comments: _____

Additional time needed for evaluation? NO

YES (if yes, date report will be submitted) _____

Comments: _____

Practitioner's Typed (or Printed) Name and Signature @ Initial Date

Practitioner's Typed (or Printed) Name and Signature @ Completion Date

Proctor's Typed (or Printed) Name and Signature @ Initial Date

Proctor's Typed (or Printed) Name and Signature @ Completion Date

Regional Medical/Dental Director @ Initial Date

Regional Medical/Dental Director @ Completion Date

Ongoing Credentialing and Privileging Checklist

Date Completed: _____ **Next Review Date:** _____

Provider Name: _____

Regional Credentialing Coordinator					
Checklist Items	Met	Not Met	Date Met	Not Required	Comments
Copy of current TN medical/dental/APN license	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Copy of current DEA registration	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Copy of Current CPR card	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Name of hospital(s) applicant has admitting privileges	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
All Professional Board Certifications and Certificates of Residency/Fellowship training since hire date	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Primary Source verification of education, including board certifications and certificates of residency/fellowships since hire date	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Completed and signed Privilege Request form or Scope of Practice	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

Regional Medical or Dental Director					
Checklist Items	Met	Not Met	Date Met	Not Required	Comments
Completed Ongoing Professional Practice Evaluation (OPPE)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Written summary of Monitoring Plan, if needed	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Monitoring of Continuing Education	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Ad hoc extension of OPPE, if needed	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Review continuing education units	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

Privileging Status: **Approved** _____ **Denied** _____ **Pended** _____

Pended Explanation:

Primary Site _____ ALL Sites _____

Additional Sites

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)
PHYSICIAN / NURSE PRACTITIONER PEER REVIEW

PROVIDER: _____ PERIOD OF REVIEW: _____

COMPLETE PHYSICAL EXAMINATION

Date of Observation _____

acceptable marginal unacceptable

In House LABS

Date of Observation _____

- o Wet Prep acceptable marginal unacceptable
- o GenProbe acceptable marginal unacceptable

PLAN OF CARE

Date of Observation _____

Treatment plan acceptable marginal unacceptable
Teaching acceptable marginal unacceptable_
Referrals acceptable marginal unacceptable

COMMENTS

Provider signature

Reviewer signature

Date

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)
PHYSICIAN / NURSE PRACTITIONER PEER REVIEW

PROVIDER: _____ PERIOD OF REVIEW: _____

OUTCOME FOCUSED CHART REVIEWS: to be completed annually for physicians and practitioners providing chronic disease management in primary care settings.

DIABETES:
 (six charts annually)

Chart Number						
DOS evaluated						
A1C at goal; progress towards goal						
Medication Compliance improvement						
Disease focused education						
Documentation or administration of all recommended immunizations for age						
Following ADA guidelines for monofilament microalbumin						
Reviewer's initials						

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)
PHYSICIAN / NURSE PRACTITIONER PEER REVIEW

PROVIDER: _____ PERIOD OF REVIEW: _____

OUTCOME FOCUSED CHART REVIEWS: to be completed annually for physicians and practitioners providing chronic disease management in primary care settings.

HYPERTENSION (six charts annually)

Chart Number						
DOS evaluated						
HTN at goal; progress towards goal						
Medication Compliance improvement						
Disease focused education						
Documentation or administration of all recommended immunizations						
Reviewer's initials						

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)
PHYSICIAN / NURSE PRACTITIONER PEER REVIEW

PROVIDER: _____ PERIOD OF REVIEW: _____

OUTCOME FOCUSED CHART REVIEWS: to be completed annually for physicians and practitioners providing chronic disease management in primary care settings.

CHRONIC LUNG DISEASE/ASTHMA (six charts annually)

Chart Number						
DOS evaluated						
Medication Compliance improvement						
Disease focused education						
Documentation or administration of all recommended immunizations						
Reviewer's initials						

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)
PHYSICIAN / NURSE PRACTITIONER PEER REVIEW

PROVIDER: _____ PERIOD OF REVIEW: _____

OUTCOME FOCUSED CHART REVIEWS: to be completed annually for physicians and practitioners providing chronic disease management in primary care settings.

PRIMARY PREVENTION/HEALTHY LIFESTYLE (six charts annually)

Chart Number						
DOS evaluated						
Weight management promotion						
Exercise promotion						
Healthy lifestyle focused education (moderation in food and alcohol intake; avoidance of illegal drugs or prescription drugs in excess)						
Smoking cessation promotion						
Documentation or administration of all recommended immunizations						
Reviewer's initials						

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)
PHYSICIAN / NURSE PRACTITIONER PEER REVIEW

PROVIDER: _____ PERIOD OF REVIEW: _____

OUTCOME FOCUSED CHART REVIEWS: to be completed annually for physicians and practitioners providing chronic disease management and prevention services in primary care settings.

WOMEN’S HEALTH/FAMILY PLANNING (six charts annually)

Chart Number						
DOS evaluated						
BMI measured and addressed if <18 or >24						
Pap smear collection and result triage completed according to latest ASCCP Guidelines						
Breast cancer surveillance counseling and referral for screening, per USPSTF Guidelines for breast cancer surveillance						
STD counseling, testing, and treatment, per CDC STD Treatment Guidelines						
Appropriate referrals made and documented based upon patient history, physical exam, and screening/diagnostic test results						
Contraception method selection consistent with CDC Medical Eligibility Criterion and Family Planning Program education conducted in compliance with program guidelines						
Documentation of counseling on and/or administration of all immunizations, per ACIP Recommended Immunization Schedule						
Reviewer’s initials						

OPPE DENTAL REVIEW FORM

Section III of the Standards of Practice for Dental Public Health details process of record review and direct observation for dental providers.

This will serve as OPPE for purposes of PSB.

Fair Hearing Process for the Professional Standards Board

Department management shall notify the Professional Standards Board (“PSB”) of any alleged infraction against established professional standards. After a majority vote by the PSB affirming potential infractions, the PSB must notify the practitioner of the infractions alleged and his or her rights before the board. Specifically, the PSB must notify the practitioner of his or her right to a fair hearing and what that process involves.

FAIR HEARING PROCESS

The PSB should notify any practitioner who it believes has committed an infraction the specifics of the alleged infraction and his or her right to a fair hearing. Such notification should be in writing, and all timelines should be specifically set forth in the letter. Practitioners who wish to request a fair hearing shall contact the appropriate PSB staff (set out in the letter) within ten (10) calendar days from the date of the letter notifying the practitioner of the alleged infractions and potential adverse action. The hearing shall be held within twenty (20) calendar days from receipt by the PSB of the hearing request. The PSB shall provide the practitioner with at least ten (10) calendar days advanced written notice of the time and place of the hearing.

The PSB shall provide the practitioner or the practitioner’s representative an opportunity to:

1. Review, prior to and during the hearing, documents and records presented to support the alleged infractions under review;
2. Be assisted or represented by an attorney or other persons, if desired;
3. Bring witnesses to testify;
4. Present oral or documentary evidence supporting his or her position and question or refute testimony or other evidence; and
5. Question any adverse witnesses.
6. Provide an opportunity at the PSB’s expense for a court reporter to preserve the hearing record for review by the Commissioner of Health (“Commissioner”).

The PSB shall review the information presented at the fair hearing, and determine whether the alleged infractions are founded and whether an adverse action is appropriate. The basis of the decision shall be in writing and shall be the final binding decision of the Tennessee Department of Health, unless the practitioner appeals the decision to the Commissioner. A decision shall be reached and written notification of the decision forwarded to the person no later than ten (10) calendar days after the receipt of the transcript from the court reporter.

The practitioner may appeal the PSB’s decision to the commissioner of the department of health within ten (10) calendar days of the date of the written notification of the PSB’s decision. The appeal must be in writing and should specifically state the reasons that the decision of the PSB is not supported by the evidence or is otherwise incorrect. The Commissioner or his designee (who should not have participated on the hearing panel) should review the record of the hearing and the information provided by the appealing practitioner. The Commissioner’s decision shall be reached and written notification of the decision forwarded to the person no later than ten (10) calendar days after practitioner’s written notification of appeal was received by the Commissioner’s office.

NATIONAL PRACTITIONERS DATA BANK

After the conclusion of all proceedings, the PSB shall report to the National Practitioner Data Bank in accordance with TDH policy and the provisions of 45 C.F.R. § § 60.1 – 60.16.



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
ANDREW JOHNSON TOWER
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243

NOTICE OF A PROPOSED PROFESSIONAL REVIEW ACTION

To: Dr. John Doc
123 Elm Street
City, State 12345

You are hereby notified that the Tennessee Department of Health Professional Standards Board in a meeting duly called and held on <date>, made the following recommendation or took the following action, for the accompanying reason:

(Recommendation or Action) xxxx

(Reason)

XXX

This decision was made after careful consideration of all the facts. If you do not agree with this decision, you have the right to an appeal. Pursuant to the provisions of the Professional Standards Board Appeal and Fair Hearing Process, a copy of which is enclosed, you have the right to a fair hearing governed in accordance with the Professional Standards Board's policy if you file a written request for such a hearing to this body within ten(10) calendar days after your receipt of this notice. A request filed by mail must be postmarked within ten (10) days of date of this notice.

Failure to file such a request within the set time period will constitute a complete and final waiver by you of any right to a hearing and an appellate review of the matter, and the decision of the Professional Standards Board will be final.

If you file a request for a hearing, you will be notified of the time, place, and date of the hearing, in accordance with the Appeal and Fair Hearing Process.

Sincerely,