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 (FDC) have the proper credentials to practice within their field and 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. CHCC staff must meet equivalent level of class titles identified in this policy. Prior approval by the Health Services Director is required before any modifications to this program are instituted by the CHCC.

II. RELEVANT REGULATIONS/REFERENCE DOCUMENTS:

A. Sections 286.011, 394, 395.0191, 395.0193, 456.073, 456.0135, 458, 459, 464, 466, 490, 491, 766.101, 766.1015, and 945, Florida Statutes (FS)
B. Chapter 45 Code of Federal Regulations (CFR) Part 60
C. Florida Administrative Code (FAC) 60L-36, 64B9-4, 64B8-30.003, 64B15-6.003
D. American Correctional Association 4-4411
E. DH-MQA– On-line Department of Health (DH) *Supervision Data form* and *Application for Changes to Licensure and a Prescribing Physician Assistant* required of all Physician Assistants (PA).
F. Procedure 401.006, *Confidentiality of Health Services Medical Review Committees Information.*

III. DC CREDENTIALS FORMS:

1. DC4-513, *Renewal of Credentials for Health Services Assignment*
2. DC4-514H, *Cover Letter for Professional Reference Questionnaire*
3. DC4-514I, *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 Practice Registered Nurse*
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 Practice Registered Nurse (APRN) Protocol-Mental Health*
16. DC4-519B, *Advanced Practice Registered Nurse (APRN) Protocol-OB/GYN*
17. DC4-519C, *Advanced Practice Registered Nurse (APRN) Protocol-General Medicine*
18. DC4-519D, *Physician Assistant (PA) Protocol – General Medicine*
19. DC4-519E, *Physician Assistant (PA) Protocol – OB/GYN*
20. DC4-519F, *Physician Assistant (PA) Protocol – Mental Health*

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 Health Services Director to evaluate qualifications and identify any concerns regarding a practitioner's qualifications and clinical performance in the delivery of health care.

D. Comprehensive Health Care Contractor (CHCC) **-** private health care vendor designated by the Department of Corrections (FDC) or Department of Management Services (DMS) to provide medical, dental and mental health services at designated institutions within a particular region. Contractor will be responsible for coordinating the quality management program at these designated institutions. The CHCC will utilize staff that is comparable to the department for the management of the credentialing program.

E. Contracted Credentialed Health Services Practitioners – an entity that is qualified to provide health care services on a contractual basis for the Department and/or CHCC.

F. National Practitioner Data Bank (NPDB) – collects and releases certain information relating to the professional competence and conduct of physicians, dentists, and other health care practitioners. Reports adverse licensure or certification actions taken against health care practitioners, health care entities, providers, and suppliers, as well as certain final adverse actions taken by state law, fraud enforcement, and Federal Government agencies, and health plans against health care practitioners, providers and suppliers. A full definition and applicability of the NPDB can be found at 45 C.F.R. Part 60."

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. The quarters will begin with the fiscal year (July-June). This committee is formed by the executive leadership and consist of the following voting members:

1. Chief Clinical Advisor

2. Chief of Medical Services
3. Chief of Dental Services
4. Chief of Mental Health Services
5. Psychiatric Consultant

B. Committee Functions: review and make recommendations to the Chief Clinical Advisor regarding credentials for all newly hired providers and providers requiring renewal, to include peer review findings. Develop, approve, and periodically update all policies, procedures, health services bulletins (HSB) and forms regarding the Office of Health Services (OHS) credentialing and peer review programs.

C. The employee and employee's immediate supervisor will be notified in memo format (see memo example #1) by the CRC when credentialing status has been approved by committee.

D. Denial, reduction, or suspension of clinical practice will be handled in accordance to section IX. I.

VI. CREDENTIALING PROCESS:

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

1. Physician, all levels and specialties including psychiatry
2. Advanced Practice Registered Nurse (APRN), all specialties including board certified Psychiatric-Mental Health Nurse Practitioner
3. Physician's Assistant (PA)
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 must be knowledgeable of the specific educational requirements for each discipline and will obtain verification/documentation that applicant meets educational requirements.

C. It is the responsibility of the hiring supervisor to explain the credentialing process to the practitioner including that continued employment is contingent upon credentials approval.

1. All newly hired practitioners must receive and acknowledge receipt and understanding of the Credentialing & Essential Functions form (DC4-518 series) 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 90 days of official hire

date and every two (2) years for continuation of employment. The Credentialing Review Coordinator (CRC) on behalf of the committee may request other items not listed. Only the CRC, upon approval by the Chief Clinical Advisor, can grant extensions.

3. All Advanced Practice Registered Nurse (APRN) not registered and approved to practice autonomously must also complete the appropriate protocol form (DC4-519 series) acknowledging formal supervisory and standard protocols. As set forth in statute (s.) 458.348, when a physician enters into an established protocol with an advanced practice registered nurse, which protocol contemplates the performance of medical acts set forth in s. 464.012(3) and (4), the physician shall submit notice (see appendix #1) to the Board of Medicine. The APRN protocol form is to be maintained in the APRN's credentialing folder at employment location. A copy of the notice submitted to the Board of Medicine by physician is to be maintained in the physician's credentialing folder.
4. APRNs who have received approval from the Board of Nursing to practice autonomously in accordance with s. 464.0123 must submit registration and approval documentation for verification.
5. Physician Assistants (PA) must complete the Department of Health (DOH) *Supervision Data Form* pursuant to s. 458.347(7)(e) and s. 459.022(7)(d), F.S. Upon employment, a licensed physician assistant must notify the department in writing within 30 days after such employment and after any subsequent changes in supervision. Also, as a prescribing physician assistant a copy of DEA registration and the DOH form *Application for Changes to Licensure and a Prescribing Physician Assistant* pursuant to rules 64B8-30.003 and 64B15-6.003 are required. A copy of these documents is to be kept in the credentialing folder at employment location.
6. All practitioners are responsible for submitting renewals of professional license and certificates/registrations to their immediate supervisor for copying and placement in credentials folder via the credentialing coordinator.
7. 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 BLS 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 educational documentation will be accepted if credentials packet is available and can be obtained from storage or State Archives within a reasonable amount of time. The DC4-513 *Renewals of Credentials for Health Services Assignment*

will be accepted in lieu of the DC4-517B, *Health Care Professional Appointment & Training History* form for credentialed practitioners with breaks in service of 180 days or less. Practitioner's credentials packets may be placed in State Archives with employment breaks of four (4) years or longer.

F. All FDC 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, and state 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 registration (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 for prescribing practitioners and/or other credentialed providers at the request of the hiring authority (queries are done by CRC for employees; vendors must query all credentialed providers and submit contract employee findings to OHS CRC if requested or by contract agreement)
6. Practitioner's curriculum vitae including copy of professional diploma and, if in a non-licensed mental health position, an official copy of college transcript.
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 card (DC mandated compliance) as defined in section VI. D. above.

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. CENTRAL OFFICE RESPONSIBILITIES:

A. The CRC will directly manage the credentialing program for Central Office employees.

B. The discipline director or immediate supervisor will notify the credentialing coordinator of new hires and their start date; and at the same time request professional references, if needed.

C. All new hires are to report to the credentialing coordinator on start date for instruction and acknowledgement of credentialing and essential functions. Initial credentialing must be completed within 90 days of hire. Continued employment is

contingent upon credentialing approval at initial credentialing and renewal of credentialing every two years. Failure to comply with meeting deadlines set for credentialing review may lead to disciplinary action.

D. Once credentialing documents are compiled, the discipline director or immediate supervisor will review credentialing documents for verification that the employee meets all requirements for credentialing. Any additional documentation requested by director or supervisor is to be submitted to CRC for retrieval from employee or outside entity if appropriate.

VIII. INSTITUTIONAL RESPONSIBILITIES:

A. The Health Services Administrator (HSA) will manage the credentialing program with the assistance of the health discipline supervisor for their facility. A copy of the credentialing documents will be maintained at the institution.

B. The health discipline supervisor has the option to request professional references at the time of hire (this may be unneeded if all personal and professional queries are clear). However, reviewing regional discipline director may request professional references if not provided at the time of review.

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 always be maintained in a locked/secured cabinet/area ..

E. The HSA will ensure that the DC4-515, *Credentialed Staff Status Change* form is completed (placed in institutional' s file) and submitted to the CRC with a copy going to the regional health services manager (RHSM) for notification purpose. 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 institution/location's copy of the inactive file should be kept in house for a period of 4 years unless approval to destroy file is given by the Central Office CRC.

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

IX. REGIONAL DISCIPLINE DIRECTORS, REGIONAL HEALTH SERVICES MANAGER (RHSM) AND REGIONAL MEDICAL DIRECTOR (RMD) RESPONSIBILITIES:

A. Each regional 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 regional discipline director will ensure compliance with this 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.

X. ADVERSE PRACTITIONER INFORMATION:

A. Adverse information includes, but is not limited to, the following: actions against a professional healthcare license (revocation, suspension, and modification); sanctions; criminal activity; and lawsuit resulting in either a settlement or a judgment for a plaintiff who was the practitioner's patient, or Agency for Healthcare Administration and/or Department of Health 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 HSA 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 CHCC Statewide Medical Director and to the Office of Health Services Chief Clinical Advisor 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 by determining employment status up to termination.

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 33-208.003; and Procedure 208.039, *Employee Counseling & Discipline*, if applicable.

G. Grounds for 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 Health Services Administrator (HSA) or to immediate supervisor 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 or the CHCC Statewide management office if applicable and will be afforded an opportunity to an interview prior to a final decision by the Chief Clinical Advisor or the equivalent CHCC position.

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

K. The Chief Clinical Advisor or the equivalent CHCC position 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.

XI. 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 by the Chief Clinical Advisor or CHCC equivalent position 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 employed health services staff of the same agency.

C. The RMCH governing board will also appoint a peer review panel in accordance with this HSB and RMCH Peer Review Policies and Procedures no. 01.023.

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 and credentialed positions that do not provide direct patient care, must have a 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) Physician's Assistant (PA),

b) Advanced Practice Registered Nurse (APRN), 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 Chief Clinical Advisor, or Chief of Medical Services, or by the CHCC equivalent position, 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 Chief Clinical Advisor or Chief of Medical Services or CHCC equivalent position 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 Chief Clinical Advisor or Chief of Medical Services' or CHCC equivalent position 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 Chief Clinical Advisor or Chief of Medical Services or CHCC equivalent position. A copy of the report will be sent to the Credentials Review Coordinator to be placed in the practitioner's credentials file.
2. The Chief Clinical Advisor, the appropriate central office clinical discipline director, the Regional Medical Director, and/or the Regional discipline director (or CHCC equivalent positions) 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, whether temporary or permanent). The practitioner involved will be notified in writing of any such proposed action before it is taken.
4. For adverse recommendations refer to section IX paragraphs I. – K. of this policy.
5. 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.

Health Services Director 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.
HSB 15.09.05 dated 02/21/13,10/08/14, 10/14/15, 11/7/17, 10/26/2018
AND 10/15/2019