

# Continuous Survey Readiness for CAHs Part 3

**Carolyn St.Charles**

Chief Clinical Officer, HealthTech

# Presenter



Carolyn St. Charles is the Chief Clinical Officer for HealthTech. Carolyn has extensive experience working with rural hospitals to develop and strengthen Swing Bed programs. St. Charles earned a master's degree in Business Administration from the Foster School of Business at the University of Washington and a bachelor's degree in Nursing from Northern Arizona University.

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# Self-Paced Certificate Courses

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### Leadership Development

\$499 - 20 Contact Hours

Leadership Development is a comprehensive course designed to address the critical need for cultivating leadership skills among middle managers who find themselves in leadership roles without formal training and staff members who aspire to grow into management and leadership roles.

### Lean Practitioner

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A Lean culture empowers individuals closest to the work to drive meaningful improvements. This Lean course equips frontline staff with the essential tools, resources, and knowledge to master and apply Lean principles effectively.

At its core, Lean focuses on enhancing process efficiency through fundamental concepts and tools. The four key principles for designing, assessing, and refining processes include defining the ideal state, identifying waste (muda), applying the four rules, and harnessing the power of observation. Critical tools such as value stream mapping and A3 problem-solving drive this methodology. While some may view Lean as a fleeting trend, its evidence-based history proves it to be a reliable, results-oriented approach with a proven track record of success. Lean isn't just a set of processes—it's a transformative mindset and methodology that fosters a safe, efficient, and high-quality environment for both patients and healthcare workers.

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### Care Coordination

HealthTech acknowledges the crucial role Care Coordination plays in driving success and sustainability within primary care. To empower the growth and sustainability of your programs, we provide a range of self-paced, asynchronous courses designed to enhance and expand services under CMS Care Coordination:

- **Care Coordination Fundamentals** – \$299, offering 12 contact hours
- **Behavioral Health Integration** – \$219, offering 9 contact hours
- **Transitional Care Management** – \$159, offering 8 contact hours
- **Annual Wellness Visits** – \$199, offering 7.5 contact hours
- **Advance Care Planning** – \$149, offering 6 contact hours

These courses are tailored to support the continued development of your care coordination services, ensuring your team stays at the forefront of primary care excellence. Each course is crafted to equip members of the professional primary care team—including nurses, health educators, health coaches, and other qualified health-care providers—with the essential knowledge, skills, and expertise to conduct comprehensive consultative visits and create personalized preventive care plans. Focusing on a team-based care model, the platform prioritizes coordinated care, harnessing the collective expertise of diverse team members. This approach enhances care coordination for patients with chronic and behavioral health conditions while reinforcing the integration of health promotion and prevention into everyday practice.



### Swing Bed Courses for Critical Access Hospitals

The Swing Bed concept allows a hospital to use its beds interchangeably for either acute care or post-acute care. The reimbursement "swings" from billing for acute care services to billing for post-acute skilled nursing services, even though the patient usually stays in the same bed. Swing Bed allows patients to receive care close to home. The two courses Basics and Beyond Basics provide the fundamentals to care for Swing Bed patients and meet regulatory requirements.

#### Swing Bed Basics for Critical Access Hospitals

\$299 - 9 Contact Hours

The Swing Bed Basics course focuses on the elements of a successful Swing Bed program including understanding and implementing CMS regulatory requirements found in the State Operations Manual Appendix W, State Operations Manual Appendix PP, and the Medicare Benefit Policy Manuals.

#### Swing Bed Beyond Basics for Critical Access Hospitals

\$299 - 9 Contact Hours

The Swing Bed Advanced Course is focused on strategies to grow and strengthen the Swing Bed program including understanding the requirements in Appendix PP that apply to Swing Bed strategies for increasing volume. The course is divided into six modules, with one bonus module discussing the MDS which is required for Swing Beds in a PPS hospital. Each module may take up to two-weeks, but the course is self-paced.

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For more information, visit: [www.health-tech.us](http://www.health-tech.us)  
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# Feb – Jun 2026 webinars

All webinars are recorded for on-demand viewing.

## Unlock the full potential of Care Coordination: What's new in 2026 for program growth and reimbursements?

**Presenter:** Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer  
**Date:** February 13, 2026 | **Time:** 12pm CST  
**URL:** <https://bit.ly/4r6lvOt>

## Compassion fatigue – Building resilience

**Presenter:** Brian Merry, M.Ed., CEMSO, NRP - Director of EMS  
**Date:** March 6, 2026 | **Time:** 12pm CST  
**URL:** <https://bit.ly/49KJOvp>

## Swing Beds: An important resource for CAH - Part 1

**Presenter:** Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer  
**Date:** April 3, 2026 | **Time:** 12pm CST  
**URL:** <https://bit.ly/4qwYF3R>

## Swing Beds: An important resource for CAH - Part 2

**Presenter:** Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer  
**Date:** April 17, 2026 | **Time:** 12pm CST  
**URL:** <https://bit.ly/45Pyq08>

## Continuous survey readiness for CAH - Part 1: Regulatory Requirements

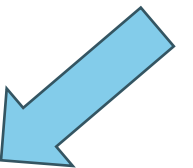
**Presenter:** Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer  
**Date:** May 15, 2026 | **Time:** 12pm CST  
**URL:** <https://bit.ly/3Nx2nMa>

## Continuous survey readiness for CAH - Part 2: Environment of care, life safety and emergency preparedness

**Presenter:** Michael Jones CHSP, CHCM, CSSGB, FAL, HACP-IC, HACP-CMS, HACP-PE  
**Date:** June 5, 2026 | **Time:** 12pm CST  
**URL:** <https://bit.ly/3YPJRkB>

## Continuous survey readiness for CAH - Part 3: Credentialing and privileging

**Presenter:** Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer  
**Date:** June 26, 2026 | **Time:** 12pm CST  
**URL:** <https://bit.ly/3NtjUA9>



# Jul – Dec 2026 webinars

All webinars are recorded for on-demand viewing.

## Meeting the New CMS obstetric standards – Tips for compliance

**Presenter:** Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer  
**Date:** July 10, 2026 | **Time:** 12pm CST  
**URL:** <https://bit.ly/4vwkC5q>

## Beyond the Visit: Chronic Care Management That Works

**Presenter:** Marcella Wright, DNP, MS, RN - Director of Care Coordination and Lean Consulting  
**Date:** July 24, 2026 | **Time:** 12pm CST  
**URL:** <https://bit.ly/4eCH2ul>

## Swing Bed: A Care Model Redesign

**Presenter:** Cheri Benander, RN, MSN, CHC, C-NHCE, HACCP-CMS – Director of Clinical Services  
**Date:** August 7, 2026 | **Time:** 12pm CST  
**URL:** <https://bit.ly/4g5A8ka>

## Zero Balance Accounts (ZBA)

**Presenter:** Margaret Bistrovich - VP Revenue Cycle Client Services  
**Date:** August 28, 2026 | **Time:** 12pm CST  
**URL:** <https://bit.ly/4f0vl2e>

## Strengthening Cybersecurity in Healthcare

**Presenter:** Derek Morkel, CEO - HealthTech  
**Date:** September 11, 2026 | **Time:** 12pm CST  
**URL:** <https://bit.ly/4xSXIMU>



# Jul – Dec 2026 webinars, cont.

All webinars are recorded for on-demand viewing.

## Rural Health Clinic Survey Readiness Simplified: Part 1 – Navigating CMS Appendix G and Operational Standards

Presenter: Cheri Benander, RN, MSN, CHC, C-NHCE, HACP-CMS

Director of Clinical Services

Date: September 25, 2026 | Time: 12pm CST

URL: <https://bit.ly/4aisX4h>

## Rural Health Clinic Survey Readiness Simplified: Part 2 – Meeting CMS Requirements and Driving Performance Improvement

Presenter: Cheri Benander, RN, MSN, CHC, C-NHCE, HACP-CMS

Director of Clinical Services

Date: October 23, 2026 | Time: 12pm CST

URL: <https://bit.ly/4w9OYuG>

## Leadership Skills for all Leaders

Presenter: Greg Oelerich - VP of Business Development

Date: November 6, 2026 | Time: 12pm CST

URL: <https://bit.ly/4vxMDd3>

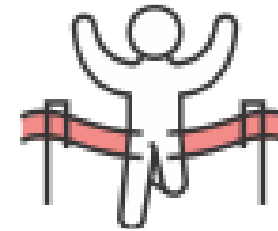
## Frequent Survey Findings for Critical Access Hospitals – and – Strategies for Compliance

Presenter: Cheri Benander, RN, MSN, CHC, C-NHCE, HACP-CMS

Director of Clinical Services

Date: December 4, 2026 | Time: 12pm CST

URL: <https://bit.ly/3QLXCQK>



# Instructions for Today

Please feel free to write questions in the Chat / Question Box



The webinar is recorded and the recording will be sent out within 3 business days



# Description

Credentialing is the process of evaluating and confirming various qualifications of healthcare practitioners, such as licensure, education, training, and certifications. Privileging authorizes a healthcare practitioner to perform specific clinical activities or procedures within their scope of practice.

The webinar will outline the elements of credentialing and privileging processes, including internal and external peer review, collection and review of quality data including low volume procedures, privileging tele-medicine providers, and physician oversight of Advance Practice Providers (APPs)

# Learning Objectives

Upon completion of the webinar, the participant will be able to:

1. Describe the difference between credentialing and privileging
2. Summarize the components of a medical staff file
3. List at least three ways to monitor provider performance
4. Identify requirements for a physician to oversee the practice of an Advance Practice Provider (APP)

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# Credentialing & Privileging Why It's Important



# Credentialing

**Formal process of verifying qualification,  
including  
education, training, licensure and professional history**

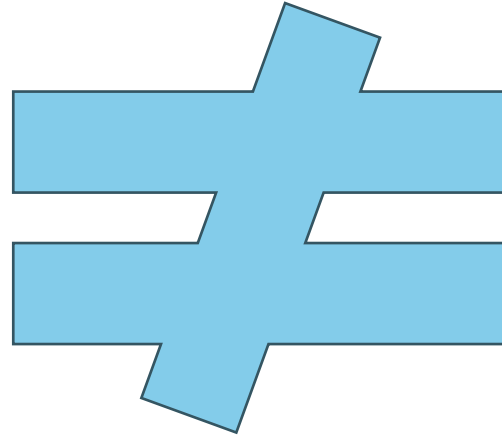


# Privileging

**Process to grant specific privileges to a provider based on qualifications**



# Credentialing and Privileging Related but NOT the same!



**You can be credentialed but not have privileges**

**You CANNOT have privileges if you are not credentialed**

# Why are Credentialing and Privileging Important?



# 1. Patient Safety & Quality of Care



# 2. Regulatory & Accreditation Compliance

## 2) Regulatory & Accreditation Compliance

C-0962 §485.627(a) Standard: Governing Body or Responsible Individual

Interpretive Guidelines

Criteria for selection of both new medical staff members and selection of current medical staff members for continued membership must be based on:

- Individual character
- Individual competence
- Individual training
- Individual experience, and
- Individual judgment

# 3. Legal & Risk Management



# 4. Organizational Integrity & Reputation



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# Credentialing & Privileging Basics



# Criteria for Selection

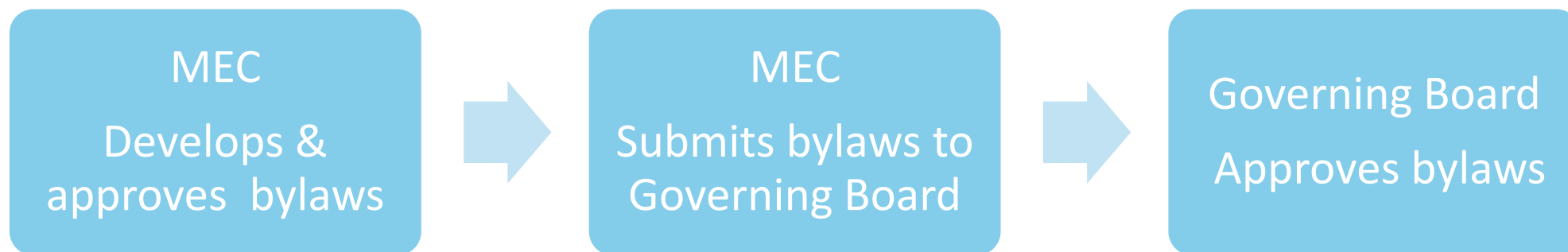
## **C-0962 §485.627(a) Standard: Governing Body or Responsible Individual**

### **Interpretive Guidelines**

Criteria for selection of both new medical staff members and selection of current medical staff members for continued membership must be based on:

- Individual character
- Individual competence
- Individual training
- Individual experience, and
- Individual judgment

# Authority for Credentialing & Privileging



# Governing Board

**The Governing Board holds the ultimately authority and responsibility for credentialing and privileging processes and for decisions**



# Categories of Medical Staff

## Will depend on medical staff bylaws.....

- **Provisional**
  - Period of evaluation prior to being granted active privileges
- **Active**
  - Full membership
- **Courtesy**
  - Admit not more than 10 patients per year
  - Active at another hospital
- **Consulting**
  - May only provide consultation --- not active treatment
- **Emeritus**
  - At least 10 years continuous service
- **Allied Health**
  - Physician assistants
  - Nurse practitioners
  - Dentist
  - Mental health professionals
- **Tele-Medicine**
  - Radiology
  - Stroke
  - Psychiatry
- **Temporary**
  - Short period until governing board meets
- **Emergency Privileges**

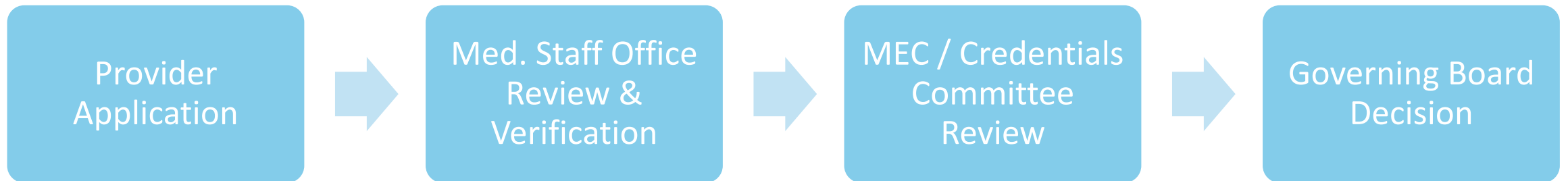
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# Credentialing



# Credentialing

**Formal process of verifying qualifications  
including  
education, training, licensure and professional history**



**Credentialing & Privileging processes are usually concurrent**

# Application (May vary by hospital)

## **Professional Identifiers**

- NPI
- Social Security Number
- TIN
- Medicare/Medicaid provider numbers

## **Education & Board Certification**

- Academic transcripts and diplomas
- Residency/fellowship certificates
- Board certification

## **CME**

- Certificates past 3 years
- Specialty-specific education

## **Licenses (state-specific)**

- Active licenses by state
- Disciplinary actions – if any

## **DEA Registration**

## **Employment History**

## **Hospital Affiliations**

## **Peer References**

## **Malpractice & Legal History**

- Coverage
- Claims History

## **Legal & Disciplinary Issues**

# Verification Hospital or Credentialing Agency

- License (each state)
- State Medical Board
- Specialty Boards
- \*OIG – \*AMA - \*NPDB
- Criminal Background Check
- Disciplinary Actions
- Employment history
- DEA if required
- CME if required
- Malpractice Insurance and claims
- References



# Verification Sources

**AMA:** Primary-source-verified data for medical education, training, board, certification, licensure, DEA, CSR, action notifications

**ECFMG:** Verification with foreign medical school

**NPDB:** The National Practitioner Data Bank (NPDB) is a US government program that gathers and provides data to authorized users. The data collected includes negative complaints, malpractice cases, awards, loss of privileges, professional society membership, suspension of license, revocation, or expulsion from participation in Medicaid or Medicare programs. Congress created the NPDB to protect the public and decrease healthcare fraud and abuse. The NPDB contains medical malpractice payment and adverse action reports on health care professionals

**OIG:** The Department of Health and Human Services Office of Inspector General maintains the LEIE, a database of individuals and entities excluded from Medicare, Medicaid, and all other federal healthcare programs. Anyone who hires an excluded individual may face civil monetary penalties. The OIG updates its List of Excluded Individuals/Entities (LEIE) monthly

# What's Different About Credentialing for APPs?

Nothing except.....

Some states still require a supervising physician for physician assistants



# What's Different About Credentialing for Tele-Medicine Providers?

Nothing.... If hospital credentials and privileges

Kind of different --- if delegated credentialing or credentialing by proxy ---  
**MORE LATER!**



# Credentialing Red Flags

- Unwilling to have prior employer contacted
- Lack of references - or vague references - or poor references
- Extensive number of medical malpractice cases
- Termination of license
- Actions / restrictions against license
- Loss of privileges
- Gaps in clinical practice
- Gaps in insurance coverage
- Short tenure multiple hospitals



# CRITICAL ----- Follow-Up on Concerns

If there are areas in the application that cause concerns, most facilities will do a more in-depth investigation, including interviews with the applicant and the medical staff credentialing committee or medical staff executive committee.

**The burden of proof is on the applicant!**  
**The MEC & Governing Board should ask questions!!!**  
**Negligent Credentialing can cost the hospital millions**

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# Privileging



# Privileging

**Process to grant specific privileges to a provider based on qualifications**



# Core and Non-Core Privileges

**Core Privileges:** Skills that are part of “core” for a specific specialty or sub-specialty based on residency, education, experience, references.

**Non-Core or Special Privileges:** Privileges that require additional training, experience, and specific evidence of competency

# Core and Non-Core Privileges

**Core Privileges:** Skills that are part of “core” for a specific specialty or sub-specialty based on residency, education, experience, references.

**Non-Core or Special Privileges:** Privileges that require additional training, experience, and specific evidence of competency

**CRITERIA MUST BE DEVELOPED FOR BOTH CORE AND NON-CORE  
COMPETENCY MUST BE VERIFIED FOR BOTH CORE AND NON-CORE**

# Core Privilege Example – Emergency Dept.

**Training:** Successful completion of an ACGME- or AOA-accredited postgraduate training program in emergency medicine or family medicine

Current certification or active participation in the examination process leading to certification in emergency medicine by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine; or certification in family medicine by the American Board of Family Medicine

**Certification:** Current BLS, American Heart Association ACLS, PALS, and ATLS For ABEM/ AOBEM Certified Emergency Medicine Physicians and ABS/ AOBS Certified Surgeons BLS, ACLS, PALS AND ATLS may be deferred For all other board certified physicians, certification in CALS (Comprehensive Advanced Life Support) can substitute for ATLS after initial ATLS certification is completed

# Core Privilege Example – Emergency Dept.

**Experience:** Applicants: Minimum of 2000 Emergency Department practice hours in the past 24 months



**Critical that number of cases is verified**

**Re-applicants:** Current demonstrated competence and an adequate volume of experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes.



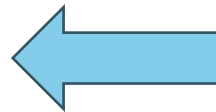
**Competency determined by peer review**

# Core Privilege Example – Emergency Dept.

**Core Privileges:** Assess, evaluate, diagnose and initially treat patients of all ages who present in the ED with any symptom, illness, injury or condition. Provide immediate recognition, evaluation, care, stabilization, and disposition in response to acute illness and injury. Privileges include the performance of history and physical examinations, the ordering and interpretation of diagnostic studies, including laboratory, diagnostic imaging, and electrocardiographic examinations, and the administration of medications normally considered part of the practice of emergency medicine.

The core privileges in this specialty include the procedures on the procedure list below and such other procedures that are extensions of the same techniques and skills

- Airway adjuncts
- Capnometry
- Cricothyrotomy
- Foreign body removal
- Intubation
- Mechanical ventilation
- Non-invasive ventilatory management
- Percutaneous transtracheal ventilation
- ETC.



**Very important that core privileges also included list of typical procedures.....**

# Special Privileges – Emergency Dept.

To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth in the medical staff policies governing the exercise of specific privileges.

**Emergency Ultrasound:** Document Initial and Ongoing Training, Estimated Career Volume, and Actual Volume in Past 24 Months. Refer to ACEP Emergency Ultrasound Guidelines 10/2008 – revised 2016)

Proof of completion of emergency ultrasound course and a minimum of 5 documented proctored exams for each application requested.

- US Abdominal Aorta
- US Biliary
- US Cardiac
- US DVT
- US Ocular
- ETC.



**Critical that proctoring is documented  
- and completed before provider can  
perform independently**

# Core & Special Privileges – Different Requirements Depending on Specialty

Family Practice

OB/GYN

Surgeon

Anesthesiologist  
CRNA

Non-Core:  
C-Section

Core:  
C-Section

Non-Core:  
Moderate  
Sedation

Core: Anesthesia  
(includes mod.  
sedation)

Special Training  
/ Residency /  
Proctoring

Board Certified  
OB/GYN

ACLS / Ability to  
Rescue / Test

Board Certified  
Anesthesia

# Low Volume Considerations

- 1) Utilize a proxy such as education / test / simulation
- 2) Rotation at larger hospital
- 3) 100% of cases reviewed externally
- 4) For APPS require physician to performs low volume / high-risk procedures (Do not include on APP privilege list)

**The answer is NOT to have less-qualified providers**

**If you use education / test / simulation it needs to be periodic ---- not one time**

# Temporary Privileges

Most medical staff bylaws allow temporary privileges.

However... they must be reserved for situations in which the medical staff file is complete

And waiting for governing board meeting to occur





# Emergency & Disaster Privileges



# All Different and Not The Same

**1. Emergency Privileges**

**2. Emergency Operations Plan Activated – Disaster Privileges**

**3. Disaster Privileges – 1135 waiver**

# Emergency Privileges Credentialed Providers

Emergency privileges are those privileges that the medical staff has granted to existing members to do whatever is necessary (within the scope of each practitioner's license) to save the life, limb, or organ of a patient.

## Bylaws

In the case of any emergency, any individual, to the degree permitted by his or her license, and regardless of staff status or Clinical Privileges, shall be permitted to do everything possible to save the life of a patient, using every facility of the Hospital necessary.

When the emergency situation no longer exists, the individual must then request the privileges necessary to continue to treat the patient, or the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an "emergency" is defined as a condition which could result in serious permanent damage to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

# Disaster Privileges

Implemented when practitioners outside the medical staff require privileges to treat patients in your institution due to a disaster in the community and the Emergency Operations Plan is activated.

Develop policy for rapid credentialing process – and the minimum that needs to be verified.



# Disaster Privileges– 1135 Waiver Stafford Act

**Section 1135 Emergency Waiver Policies and procedures must specifically address the facility's role in emergencies where the Secretary waives or modifies certain statutory and regulatory requirements for healthcare facilities in response to emergencies under section 1135 of the Act related to the provision of care at an alternate care site identified by emergency officials.**

The Secretary is authorized to issue a section 1135 waiver only when both the President declares a disaster or emergency under the **Stafford Act or the National Emergencies Act**, and the HHS Secretary declares a Public Health Emergency under section 319 of the Public Health Services Act. Examples of 1135 waivers issued during prior emergencies have included waivers of various CoPs and CfCs; Licensure for Physicians or others to provide services in the affected State; EMTALA requirements; and Medicare Advantage out of network providers and HIPAA.

**Facilities' policies and procedures should address what coordination efforts are required during a declared emergency in which a waiver of federal requirements under section 1135 of the Act has been issued by the Secretary related to alternate care sites.**

**For example, due to a mass casualty incident in a geographic location, the Secretary may waive licensure requirements for physicians in order for these individuals to assist at a specific facility where they do not normally practice.** In such cases, the provider or supplier should have policies and procedures which address the responsibilities of these physicians during this waiver period. The policies may establish, for example, a lead person in charge for accountability and oversight of assisting physicians not usually under contract with the facility.

**Emergency Privileges:** Bylaws

**Hospital Emergency Operations Plan Disaster Privileges:** Bylaws  Hospital Emergency Plan  Policy

**Federal Disaster - 1135 waiver:** Hospital and/or medical staff policy (usually not in bylaws)

# Privilege Requests & Approval

# Privilege Requests

Privilege requests are completed by the provider when they request privileges.

It is the responsibility of the requesting provider to only request privileges that they are competent to perform and to provide documentation that criteria is met. (Sometimes volume data will be collected by the quality or medical staff department)

**However, it is the responsibility of the medical staff to ensure that privilege forms are current, including criteria and that criteria represents evidence-based care**

Provider Name:

Privilege	REQUESTED	RECOMMENDED	NOT RECOMMENDED		
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**Qualifications**

To be eligible for core privileges in emergency medicine, the physician applicant must meet the following qualifications:

**Licensure:** MD or DO

**Training:**

o Successful completion of an ACGME- or AOA-accredited postgraduate training program in emergency medicine or family medicine  
 o Current certification or active participation in the examination process leading to certification in emergency medicine by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine; or certification in family medicine by the American Board of Family Medicine

o Current BLS, American Heart Association ACLS, PALS, and ATLS  
 For ABEM/ AOBE Certified Emergency Medicine Physicians and ABS/ AOBS Certified Surgeons BLS, ACLS, PALS AND ATLS may be deferred  
 For all other board certified physicians, certification in CALS (Comprehensive Advanced Life Support) can substitute for ATLS after initial ATLS certification is completed

**Experience:**

**Applicants:** Minimum of 2000 Emergency Department practice hours in the past 24 months  
**o Re-applicants:** Current demonstrated competence and an adequate volume of experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

**INITIAL THE LINE UNDER "REQUESTED" COLUMN FOR PRIVILEGES YOU ARE REQUESTING**

EMERGENCY MEDICINE CORE PRIVILEGES	REQUESTED	RECOMMENDED	NOT RECOMMENDED		
Assess, evaluate, diagnose and initially treat patients of all ages who present in the ED with any symptom, illness, injury or condition. Provide immediate recognition, evaluation, care, stabilization, and disposition in response to acute illness and injury. Privileges include the performance of history and physical examinations, the ordering and interpretation of diagnostic studies, including laboratory, diagnostic imaging, and electrocardiographic examinations, and the administration of medications normally considered part of the practice of emergency medicine. The core privileges in this specialty include the procedures on the procedure list below and such other procedures that are extensions of the same techniques and skills.	—	—	—	—	—
<b>AIRWAY TECHNIQUES</b>					
Airway adjuncts	—	—	—	—	—
Capnometry	—	—	—	—	—
Cricothyrotomy	—	—	—	—	—
Foreign body removal	—	—	—	—	—
Intubation	—	—	—	—	—
Mechanical ventilation	—	—	—	—	—
Non-invasive ventilatory management	—	—	—	—	—
Percutaneous transtracheal ventilation	—	—	—	—	—

# Verification

When the medical staff has determined specific requirements  
(i.e. training, education, minimum volume, certification, etc.)

**THERE MUST BE VERIFICATION  
before privileges are granted**



# Medical Staff Profile – Minimum Volume

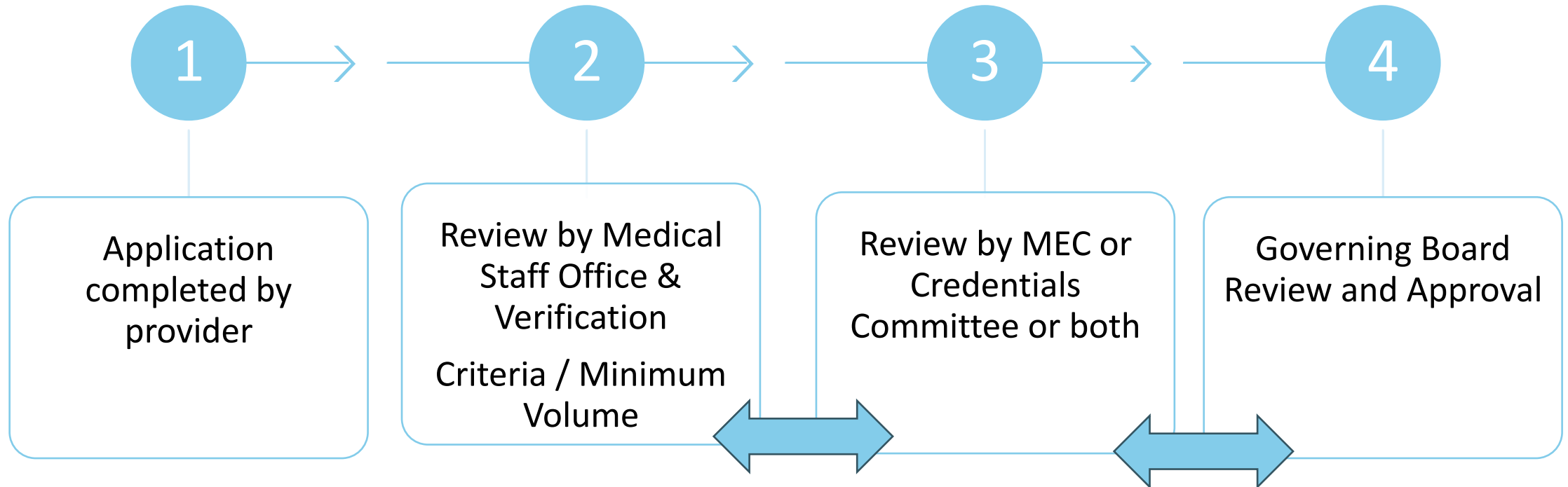
<b>Obstetrics &amp; Gynecology</b>						
	<b>Annual</b>	<b>Qtr 1</b>	<b>Qtr 2</b>	<b>Qtr 3</b>	<b>Qtr 4</b>	<b>YTD</b>
<b>Minimum Volume: C-sections</b>	5	1	0	0	1	2
<b>Minimum Volume -- Procedure</b>						
<b>Emergency Department</b>						
	<b>Annual</b>	<b>Qtr 1</b>	<b>Qtr 2</b>	<b>Qtr 3</b>	<b>Qtr 4</b>	<b>YTD</b>
<b>Abdominal Ultrasound</b>	5	1	0	0	1	2
<b>Intubation</b>	5	3	2	0	0	5
<b>Minimum Volume -- Procedure</b>						

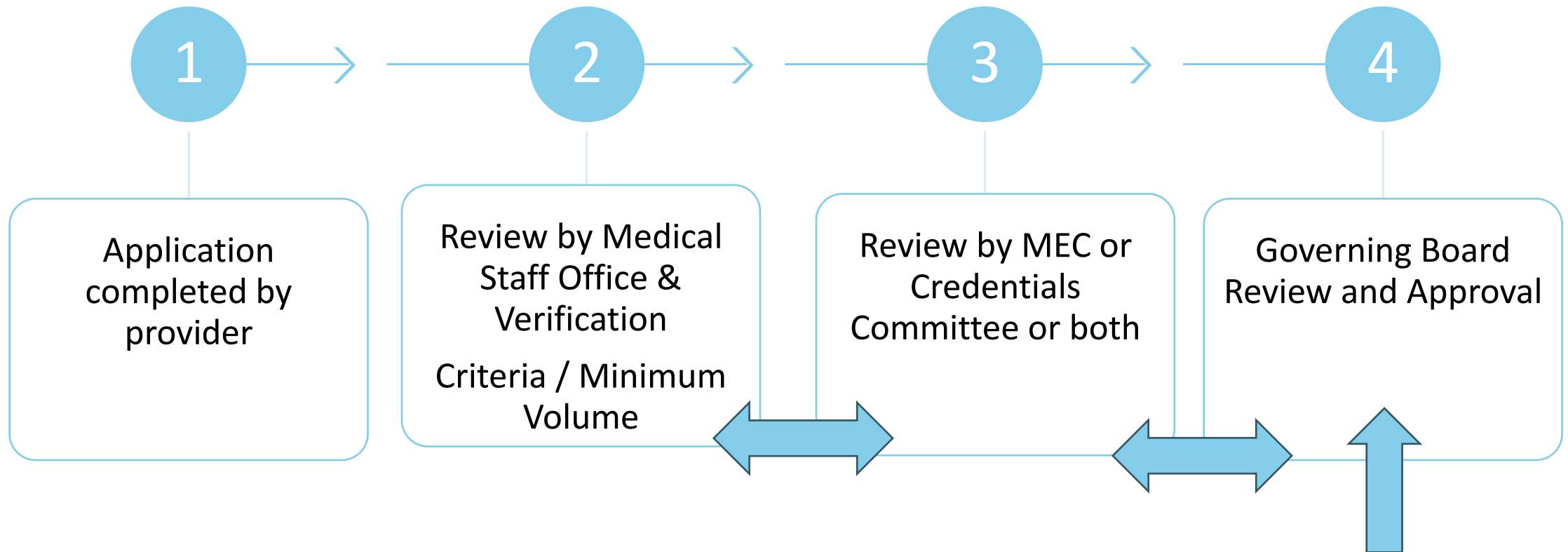
# Who is Responsible for Collecting Volume Information?

1. Medical Records (case logs)
2. Department (ED, Surgery, etc.)
3. Quality Department
4. Provider

If the provider practices at another hospital – you can request they provide you with case logs

<b>Obstetrics &amp; Gynecology</b>						
	<b>Annual</b>	<b>Qtr 1</b>	<b>Qtr 2</b>	<b>Qtr 3</b>	<b>Qtr 4</b>	<b>YTD</b>
<b>Minimum Volume: C-sections</b>	5	1	0	0	1	2
<b>Minimum Volume Procedure</b>						
<b>Emergency Department</b>						
	<b>Annual</b>	<b>Qtr 1</b>	<b>Qtr 2</b>	<b>Qtr 3</b>	<b>Qtr 4</b>	<b>YTD</b>
<b>Abdominal Ultrasound</b>	5	1	0	0	1	2
<b>Intubation</b>	5	3	2	0	0	5
<b>Minimum Volume Procedure</b>						





- NOT A PAPER PROCESS
- NOT JUST BECAUSE MEDICAL STAFF RECOMMENDED



# Frequency of Reappointment



# Frequency of Reappointment

## **The Joint Commission (TJC) MS.06.01.07 EP 9**

Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter

## **The Joint Commission (TJC) MS.07.01.01 EP 3**

The organized medical staff uses the criteria in appointing members to the medical staff and appointment does not exceed three years or the period required by law and regulation if shorter

## **Det Norske Veritas (DNV)**

SR.10 Appointment or reappointments to the medical staff and the granting, renewal, or revision/amendment of clinical privileges shall be made for a period defined by state law or, if permitted by state law, not to exceed three years.

# Frequency of Reappointment

There is no requirement in Appendix W that speaks to the frequency of re-credentialing  
- **EXCEPT – for surgical privileges**

**But it doesn't really say re-credentialing--- just REVIEW~!**

C-1142 Interpretive Guidelines §485.639(a)

Surgical privileges should be reviewed and updated at least every 2 years.

Survey Procedures §485.639(a)

- Review the CAH'S method for reviewing the surgical privileges of practitioners. This method should require a written assessment of the practitioner's training, experience, health status, and performance.



# Quality of Care Peer Review



# Provisional / Probationary Period

When a provider is first appointed to the medical staff and granted privileges, most organizations have a probationary period. This time can vary by organization.

The medical staff will identify specific parameters for monitoring during the provisional period which may include observation and/or chart reviews.

In some instances, a provider is not allowed to perform a procedure independently until they have completed the required review.



**Important:** It is critical that any requirements set by the medical staff during the provisional period are **monitored and documented!**



**Important: Identify responsibility** for monitoring and reporting to MEC or credentials committee

# Quality and appropriateness of the diagnosis and treatment furnished by APPs

**C-0984 §485.631(b)(1)(iii)** In conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the CAH'S patient records, provides medical orders, and provides medical care services to the patients of the CAH; and

**C-0986 §485.631(b)(1)** [The doctor of medicine or osteopathy-

(iv) Periodically reviews and signs the records of **all inpatients** cared for by nurse practitioners, clinical nurse specialists, or physician assistants.

(v) Periodically reviews and signs a **sample of outpatient records** of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants only to the extent required under State law where State law requires record reviews or co-signatures, or both, by a collaborating physician.

# Quality and appropriateness of the diagnosis and treatment furnished by APPs

**C-0999 §485.631(d)** Standard: Periodic review of clinical privileges and performance. The CAH requires that—

(1) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialist, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH.

**Even though there is an ongoing review of mid-level practice by a physician - there should be a summary provided at the time of reappointment or periodically as required by medical staff bylaws.**

# Quality and appropriateness of the diagnosis and treatment furnished by Physicians

**C-0999 §485.631(d)** Standard: Periodic review of clinical privileges and performance. The CAH requires that—

(2) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by—

(i) One hospital that is a member of the network, when applicable;

(ii) One Quality Improvement Organization (QIO) or equivalent entity;

(iii) One other appropriate and qualified entity identified in the State rural health care plan;

(3) The CAH staff consider the findings of the evaluation and make the necessary changes as specified in paragraphs (b) through (d) of this section

# Quality and appropriateness of the diagnosis and treatment furnished by Physicians

**C-0999 §485.631(d)** Standard: Periodic review of clinical privileges and performance. The CAH requires that—

(2) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by—

(i) One hospital that is a member of the network, when applicable;

**Many hospitals are not members of a network!**

(ii) One Quality Improvement Organization (QIO) or equivalent entity;

**The QIO does not provide performance reviews**

(iii) One other appropriate and qualified entity identified in the State rural health care plan;

**Most Rural Health Plans do not include a qualified entity**

**And so that leaves an equivalent entity!**

# Quality and appropriateness of the diagnosis and treatment furnished by Physicians

There is no requirement in the CoPs for the number of records that must be sent for external review – some facilities send a minimum of 1 – 2 per year. Others send a representative sample of records such as 10%.

Although your records may be sent out for external review when there is not a physician internally who can review the record – or – there is a significant occurrence, those cannot be the only records sent for external review. Every physician must have evidence of external review.

**There must be external review for every physician on the medical staff in a CAH**

# Quality and appropriateness of the diagnosis and treatment of Tele-Medicine Providers

**C-0872: (iv)** With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, **the CAH has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such information for use in the periodic appraisal of the individual distant-site physician or practitioner.**

At a minimum, this information must include

- all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH's patients
- and all complaints the CAH has received about the distant-site physician or practitioner.

# Peer Review – not just physician record review

**Internal Review – All providers**

**External Review – Physicians only**

**Quality metrics & minimum volume(s) developed by medical staff for each specialty**

**Data collected by staff**

**+**

**Chart review (internal and external physician) (internal APPs)**

**=**

**Peer Review**

# Scorecard - Example

Obstetrics & Gynecology						
Minimum Volume	Annual target	Qtr 2	Qtr 2	Qtr 3	Qtr 4	YTD
C-Section	5					
Quality Measures	Target	Trigger	Score	Score	Score	Score
Number of Patient, Family, Staff, or Peer Complaints	2 or <	3 or >				
Number of delinquent medical records that are 30 days or older.	2 or <	3 or >				
Number of readmissions within 30 days of discharge all causes for providers with admitting privileges. (Attributed to the provider who discharged the patient on the initial visit.) (Percentage)	7 or <	10 or >				
Return to OR within the same visit (unplanned)	1 or <	2 or >				
Return to ER after 72 hours of a surgical procedure that is related to the surgical procedure	0	1 or >				
Ratio of non-transfused cross-matched blood, platelets, fresh frozen platelets or cryo. Note: referral from the pathologist will also trigger a review (Ratio)	2.0 or <	2.1 or >				
Obstetric trauma (3rd or 4th degree lacerations)	2 or <	3 or >				
Complications in term newborn including shoulder dystocia and complications related to vacuum extraction	1 or <	2 or >				
Peer review cases (internal)						
Peer review cses with recommendations (internal)						
Peer review cases (external)	>1					
Peer review cases with recommendations (external)						

# Scorecard - Example

Emergency Medicine						
Minimum Volume	Annual Target	Qtr 2	Qtr 2	Qtr 3	Qtr 4	YTD
Abdominal Ultrasound	5					
Quality Measure	Target	Trigger	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of Patient, Family, Staff, or Peer Complaints- % of Complaints/Visits	2% or <	3% or >				
Number of delinquent medical records that are 30 days or older.	2 or <	3 or >				
Number of returns to the ER within 72 hours (% of total ED visits)	7% or <	10% or >				
ER Time of arrival to discharge home. (Median, in minutes)	150 mins. or <	200 mins. or >				
Ratio of non-transfused cross-matched blood, platelets, fresh frozen platelets or cryo. Note: Referral from the pathologist will also trigger a review. (Ratio)	2.0 or <	2.1 or >				
Number of cases with general anesthesia, MAC, moderate sedation or opioids that required Narcan or other reversal agents for oversedation.	1 or <	2 or >				
Peer review cases (internal)						
Peer review cses with recommendations (internal)						
Peer review cases (external)	>1					
Peer review cses with recommendations (external)						

# Mandatory Physician Review Examples...

- Adverse or unexpected outcome
- Unexpected death
- Sentinel Event
- Blood transfusion reaction
- Medication error resulting in harm
- 4<sup>th</sup> degree laceration childbirth
- Emergency C-Section
- Staff report of harassment

# Track by Provider



Peer Review By Qtr					
	Qtr 1: Mandatory Reviews	Qtr 1: Random – or Focused Reviews	Total	# external reviews	# with recommendations
	Internal or External	Internal or External			
Dr. A.					
Dr. B.					
Dr. C.					
PA 1					
NP 1					
CRNA					

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# Delegated Credentialing

# Credentialing by Proxy



# Delegated Credentialing

**C-0872 §485.616(c)(2)** When telemedicine services are furnished to the CAH's patients through an agreement with a distant-site hospital, the **CAH's governing body or responsible individual may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site hospital regarding individual distant-site physicians or practitioners.**

**Governing board must still approve privileges**

# Distant-Site Hospital

**§485.616(c)** Standard: Agreements for credentialing and privileging of telemedicine physicians and practitioners.

(1) The governing body of the CAH must ensure that, when telemedicine services are furnished to the CAH's patients through an agreement with a distant site hospital, **the agreement is written and specifies that it is the responsibility of the governing body of the distant-site hospital** to meet the following requirements with regard to its physicians or practitioners providing telemedicine services:

# Distant-Site Hospital - Requirements

- i) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.
- ii) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff.
- iii) Assure that the medical staff has bylaws.
- iv) Approve medical staff bylaws and other medical staff rules and regulations.
- v) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.
- vi) Ensure the criteria for selection are individual character, competence, training, experience, and judgment.
- vii) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society.

# Distant-Site Hospital Credentialing Decision

(2) When telemedicine services are furnished to the CAH's patients through an agreement with a distant-site hospital, the CAH's governing body or responsible individual **may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site hospital** regarding individual distant-site physicians or practitioners. The CAH's governing body or responsible individual must ensure, through its written agreement with the distant-site hospital, that the following provisions are met:

# Distant Site Hospital - Requirements

- (i) The distant-site hospital providing telemedicine services is a Medicare-participating hospital.
- (ii) The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician's or practitioner's privileges;
- (iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the CAH is located; and
- (iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician's or practitioner's performance** of these privileges and sends the distant-site hospital such information for use in the periodic appraisal of the individual distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH's patients and all complaints the CAH has received about the distant-site physician or practitioner

# Tele-Medicine Entity

(3) The governing body of the CAH must ensure that when telemedicine services are furnished to the CAH's patients through an agreement with a distant-site telemedicine entity, **the agreement is written and specifies that the distant-site telemedicine entity is a contractor of services to the CAH and as such, in accordance with [§ 485.635\(c\)\(4\)\(ii\)](#), furnishes the contracted services in a manner that enables the CAH to comply with all applicable conditions of participation for the contracted services**, including, but not limited to, the requirements in this section with regard to its physicians and practitioners providing telemedicine services.

# Tele-Medicine Entity Credentialing Decision

(4) When telemedicine services are furnished to the CAH's patients through an agreement with a distant-site telemedicine entity, the CAH's governing body or responsible individual **may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site telemedicine entity** regarding individual distant-site physicians or practitioners. The CAH's governing body or responsible individual must ensure, through its written agreement with the distant-site telemedicine entity, that the following provisions are met

# Tele-Medicine Entity

- (i) The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at [paragraphs \(c\)\(1\)\(i\)](#) through [\(c\)\(1\)\(vii\)](#) of this section.
- (ii) The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services, which provides a current list to the CAH of the distant-site physician's or practitioner's privileges at the distant-site telemedicine entity.
- (iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the CAH whose patients are receiving the telemedicine services is located.
- (iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site telemedicine entity such information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH's patients and all complaints the CAH has received about the distant-site physician or practitioner

# Summary

Delegated credentialing occurs when another entity (i.e., tele-radiology) credentials the applicant and provides the information to the organization where the provider will be practicing.



**Important:** Contracts must include ALL regulatory requirements



**Important:** Requirements differ slightly between distant-site hospital and tele-medicine entity – but are essentially the same



**Important:** There must be evidence of peer-review – and that information must be shared with the hospital at the same frequency required by your internal policy for other providers

# Summary, cont.



**Important:** The governing board must approve the tele-medicine provider privileges



**Important:** The tele-medicine entity should provide information to the organization regarding license or certification renewals. If not the organization is responsible for checking the information to ensure it is current.



**Important:** Many tele-medicine entities will not share results of OIG. If they do not, the organization should run a query.



**Important:** The tele-medicine entity may not complete a criminal background check. If they do not, the organization must complete the background check



# Medical Staff File



# Contents of Medical Staff File

- 1) Application including a statement of fitness to work and history of malpractice claims
- 2) \*Picture Identification**
- 3) References (usually 3) at appointment and reappointment
  - Individual character
  - Individual competence
  - Individual training
  - Individual experience, and
  - Individual judgment
- \*Send picture ID with references**
- 4) National Practitioner Data Bank
- 5) AMA profile
- 6) CMEs (if required)
7. State License (current) – primary source
8. NPI (National Provider Identification)
9. DEA License, if applicable
10. Controlled Substance Certificate or License, if applicable
11. Insurance coverage
12. Officer of Inspector General (OIG) Check
13. Immunizations and/or physical as required by policy

# Contents of Medical Staff File

- 14) Privilege request (each appointment period)
- 15) Privilege approval (each appointment period)
- 16) Documentation of proctoring or requirements during provisional period or when new privilege granted
- 17) Evidence of meeting any special requirements such as minimum volume, written test, etc. if required by the medical staff and the privilege requested
- 18) Current certification(s) if required for privileges
- 19) Documentation of peer review (internal and external for physicians) (internal for CRNAs and APPs)
- 20) Application each appointment period

# AND....Provider Orientation

- 1) Infection Prevention (required by CoPs)
- 2) Antibiotic Stewardship (required by CoPs)
- 3) Disaster / Emergency preparedness / Emergency codes and response (required by CoPs)
- 4) Electronic Medical Record
- 5) Chain of Command
- 6) Abuse recognition and reporting
- 7) Department specific policies (i.e. surgery)

# Summary

- 1) Use a checklist to ensure ALL required documents are in the medical staff file
- 2) Develop system to alert when license, certifications, are due for renewal (most medical staff software systems have this function)
- 3) Track volume and other requirements specific to the privileges granted
- 4) Develop on-site or virtual orientation

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# References



# References

1. §485.42 CFR Part 485 Subpart F: Conditions of Participation Critical Access Hospitals  
<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485/subpart-F>
2. State Operations Manual for Critical Access Hospitals Appendix W  
[https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap\\_w\\_cah.pdf](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_w_cah.pdf)
3. State Operations Manual Appendix Z- Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance Table of Contents (Rev. 204, Issued: 04-16-21)  
[https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap\\_z\\_emergprep.pdf](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_z_emergprep.pdf)

# THANK YOU



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