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Health Care Provider Credential Verification, Privileges, and Practice Agreement Program

/s/

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1. PURPOSE AND SCOPE

To establish procedures for primary source credential verification, and granting of clinical privileges or practice agreements for health care providers at Bureau institutions. These providers include Bureau staff, Public Health Services (PHS) staff, consultants, and those who provide treatment using telehealth.

This Program Statement (PS) also establishes guidelines for corrective action procedures related to deficient clinical skills, knowledge, or practice, and establishes guidelines for participation in the National Practitioner Data Bank (NPDB). This Program Statement:

- Establishes requirements for primary source credential verification of professional credentials, licenses, and certifications for all health care providers discussed in this PS, including consultants, at Bureau institutions.
- Requires “Clinical Privileges” for health care providers classified as “Licensed Independent Practitioners (LIP),” such as physicians, dentists, optometrists, and podiatrists. Providers in these categories are authorized by a current and valid state license to practice medicine, dentistry, optometry or podiatry, independently. Additionally, licensed clinical psychologists at Medical Referral Centers may be privileged while working in Behavioral Health Units.
- Requires “Practice Agreements” between non-independent practitioners, such as a mid-level practitioners, dental hygienists, etc., and the LIPs who must authorize their clinical performance and provide clinical supervision. Practice agreements delegate specific clinical or dental duties to staff under an LIP’s supervision.

- Establishes requirement for Clinical Specialty Consultants and Dental Consultants to review credentials for all physician, psychiatrist, and dental officer candidates for employment in their respective region.
- Establishes the requirement for routine annual peer review of all providers who function under clinical privileges or practice agreements.
- Establishes requirement for a formal Clinical Director (CD), Chief Dental Officer (CDO), and Chief Psychiatrist (CP) peer review, once every two years, by a trained BOP reviewer, for any CD, CDO, or CP at a Bureau institution.
- Establishes procedures to follow when a health care provider's clinical knowledge/skills requires immediate review to determine whether corrective action is indicated to ensure knowledge/skills of the practitioner, or protection of patients.
- Establishes guidelines for participation in the National Practitioner Data Bank (NPDB).
- Establishes the option of using a Credential Committee at Bureau institutions for credential verification and recommendations for privileges and practice agreements.

a. **Program Objectives.** The expected results of this program are:

- Institutions will have established methods to participate in appropriate credentialing procedures and knowledge-/skills-based privileging or establishment of practice agreements for health care practitioners.
- Clinical supervisors will have established procedures to follow, prior to considering actions based on clinical knowledge/skills.
- Patients will be protected by procedures to ensure the quality and efficiency of care delivered in the Bureau of Prisons.
- The rights of the health care practitioners involved in various health care reviews will be protected by affording them due process and ensuring the timely resolution of any issues related to their professional knowledge or skills.

b. **Summary of Changes**

Policy Rescinded

P6027.01 Health Care Provider Credential Verification, Privileges, and Practice Agreement Program (1/15/05)

- The definition of privileging for licensed independent practitioners is explained in detail.
- The definition of practice agreements for mid-level practitioners (MLP) is explained in detail.
- The definition of protocols for nurses and paramedics is explained in detail.
- A requirement of written protocol for nurses and emergency medical technicians/paramedics was added for Medical Referral Centers and other facilities, even if LIPs are on site for 24 hours a day. These protocols will be negotiated locally.

- A clarification on which type of documentation should be maintained by the BOP and contract health care providers to support peer review process was included.
- A clarification on the requirement to query the NPDB for each practitioner initially and at least once every two years was included.

c. **Institution Supplement Required.** None. Should local facilities make any changes outside the required changes in the national policy or establish any additional local procedures to implement the national policy, the local Union may invoke to negotiate procedures or appropriate arrangements.

d. **Applicability.** The requirements of this Program Statement apply to all Bureau institutions. For Medical Referral Centers (MRC), adjustments to this Program Statement will be made to address the organization of various committees described in their Medical Staff By-Laws. Medical Staff By-Laws will be negotiated with the Union locally.

2. CREDENTIAL VERIFICATION

Each Health Services Unit (HSU) will ensure that professional credentials for all health care providers inside the institution are verified at the primary source (the issuer of the credential). Providers include Bureau staff, PHS staff, part-time staff, contract and consultant staff, and those who provide a diagnosis or treatment using telehealth.

a. **Credential Committee.** Institutions may elect to form a Credential Committee (recommended method) to evaluate verified credentials and make privilege or practice agreement recommendations to the privileging authority. Committee membership must include three members, including one person of the peer group of the individual seeking privileges, or practice agreements, and at least one LIP.

b. **Applicant Responsibility.** Applicants for privileges and/or practice agreements as health care practitioners must provide all required credentials for verification. Failure to provide required credentials precludes the granting of privileges or practice agreements. Credentials in the portfolio must be verified by primary source. Primary source verification of credentials may be accomplished through written, telephonic, or electronic contact with the primary source.

Each credential portfolio must contain the following documents along with evidence of primary source verification for each credential:

(1) Documentation of professional education (diploma, FLEX/USMLE, ECFMG, Fifth Pathway, for foreign graduates).

- (2) Post-graduate training (internship, residency, preceptorship, etc.).
- (3) Professional licensure (active and inactive) or any certification such as NCCPA certification for PA-C. The file must always contain a current verified license. License verification should occur not sooner than 30 days from the date the provider is granted privileges of a practice agreement. An inactive license that remains on inactive status, requires initial verification only.
- (4) All past and pending actions taken against a practitioner's license or registration (state or district, Drug Enforcement Administration), clinical privileges, or the voluntary relinquishment of such. Complete details of any malpractice history.
- (5) National Practitioner Data Bank (NPDB) inquiry initiated, completed, and renewed every two years for licensed or certified staff by the Central Office, Health Services Division. See Attachment A for NPDB queries. This form must be filled out **completely** and submitted to the Office of Quality Management (OQM), Health Services Division (HSD), Central Office.
- (6) Reference letters from two professional peers for initial privileges. Peer reviews required in the Peer Review Section of this Program Statement are required for privilege or practice agreement renewal.
- (7) Names and addresses of affiliations (work history, hospital affiliations, etc.) for the past ten years or since completion of residency or fellowship.
- (8) Documentation of continuing medical education for the past three years or since completion of residency or fellowship.

c. **File Maintenance.** Verified credentials are kept in a credential portfolio for each provider **to include contract LIPs** and maintained by the Health Services Administrator (HSA) or designee. Each employee has the right to review, or receive a copy of, any information in his/her credential file.

Copies of the credential file for the CDs, CDOs, CPs, RMDs and MAST Physicians are maintained in Central Office. At each institution where the CD, CDO, CP, RMD or MAST Physician provides patient care, a credential file will be maintained with at least site-specific privileges, current and verified license, CPE, and other training and competency documents. The professional peer review documents for these providers will be maintained in their credential file in Central Office. The completion of the peer review will be verified by the Central Office for these providers for Program Review or the Joint Commission Survey upon request from the institutions. Primary source verification of credentials may be done through written, telephonic,

or electronic contact with the school, college, or university. Each credential portfolio must contain the following documents, along with evidence of primary source verification for each credential as it applies to each provider:

- Documentation of professional education (diploma, Federation or United States Medical Licensing Examination [FLEX/USMLE], Educational Commission for Foreign Medical Graduates [ECFMG], Fifth Pathway [for foreign graduates]).
- Post-graduate training (internship, residency, preceptorship, etc.).
- Professional licensure (active and inactive) or any national certification must be maintained by LIPs and non-LIPs prior to Enter On Duty, renewed as required by their professional category, and maintained on file during the course of BOP employment. An inactive license from another state that remains on inactive status only requires initial verification.
- Past and pending actions taken against a practitioner's license or registration (state or district, Drug Enforcement Administration), clinical privileges, or the voluntary relinquishment of such. Complete details of any malpractice history must be included in the Credential Portfolio.
- Fully completed Information for Queries form is sent via e-mail to the BOP-HSD/Quality Management~ mail box to initiate the query for all licensed or certified Health Services staff, contractors, and in-house consultants. A new query must be completed and the information from the NPDB must be reviewed before granting initial, renewed, or revised privileges to a licensed or certified Health Services Staff, contractors and consultants at a minimum every two years. See the Information for Queries form (Attachment A).
- Reference letters from two professional peers for initial privileges. Names and addresses of affiliations (work history, hospital affiliations, etc.) of residency, fellowship, or post-graduate training, as applicable. Documentation of continuing medical education for the past two years.
- Names and addresses of affiliations (work history, hospital affiliations, etc.) of residency, fellowship, or post-graduate training, as applicable. Documentation of continuing medical education for the past two years.

d. **Credentialing Sources.** The preferred manner, and order, for primary source credential verification is as follows:

(1) **Written Confirmation from the Issuing Authority.** The preferred manner to verify credentials is for the institution to seek verification of documents in the form of letters written to the issuing authority or by using the interagency agreement (IAG) with the Armed Forces Institute of Pathology (AFIP). When using AFIP, Central Office pays the cost of the credential verification (for Bureau or PHS staff). Institutions can use AFIP to verify credentials of consultants; however, the institution must purchase those verifications through normal purchasing procedures at the negotiated cost. AFIP may be contacted at:

Department of Legal Medicine
Armed Forces Institute of Pathology
1335 East-West Highway
Suite 600
Silver Spring MD 20910
Phone: (301) 295-7274/or 8118
(Address and phone number subject to change without Union negotiation)

(2) **From a Credential Verification Organization.** Institutions may accept primary source credential verification for contract/consultant staff from a JCAHO accredited hospital with which the health care provider is affiliated. Then, the hospital is performing as a Credential Verification Organization (CVO). If the Bureau institution accepts credential verification from this source, the following conditions must be met:

(a) A copy of the hospital's credential verification policy will be maintained at the institution. If this information is contained in the hospital's By-Laws, or Rules and Regulations, a copy of those documents is required. The hospital acting as the CVO should also provide evidence to the Bureau institution that the hospital satisfied standards applicable to credentialing and privileging on their most recent accreditation audit. A copy of the most recent accreditation report should be maintained on file.

(b) Copies of all verified credentials, with a statement that certifies these credentials were verified at the primary source, must be maintained at the institution. If the hospital will not provide copies of the credentials, the hospital will provide a letter stating that the physician is a member in good standing on the hospital staff and that the physician meets all requirements for staff membership/employment as defined in the hospital's By-Laws, or Rules and Regulations.

(c) Evidence of periodic peer review by peers at the hospital or group practice.

(d) If the Bureau institution accepts queries from the NPDB on consultants affiliated with that hospital, the Medical Director must clear any query that reflects a "match" for a malpractice payment or clinical knowledge/skills issue, as described in NPDB section of this PS.

(3) **Telephonic Verification** from the primary source. Verification of credentials by telephone should be done when such verifications are needed on a short-term notice (not allowing time for a written verification) such as in granting temporary privileges. When verifying a credential by phone, an annotation will be made on the credential indicating:

- The date of the phone call.

- The agency contacted.
- The agency phone number.
- The name of the agency representative who verified the information.

The Bureau staff member who performed the telephone verification must also date and sign the document.

(4) The **AMA Masterfile Physician Profile** may be used for primary source credential verification for license, U.S. medical school, or residency graduation. The AMA will charge the institution a nominal fee for this service. Contact the AMA at 1-800-665-2882 or <http://www.ama-assn.org> for further information.

(5) **Internet or World Wide Web Verifications** are acceptable only if they meet the criteria for primary source verification. This must be accomplished by links to state licensing departments, or educational institutions.

Verifications from license “clearing houses” are not considered primary source verification.

e. **Physician and Dentist Candidates for Employment.** Verified credentials for physician and dentist employment candidates should be forwarded to the institution’s appropriate Clinical Specialty Consultant or Dental Consultant for clearance prior to being offered a position.

f. **Renewal.** Once the credentials in the portfolio are initially verified, there is no need to re-verify all of them when renewing privileges or practice agreements. Only those documents that have expired and have been renewed, such as license(s) and certification(s), need to be re-verified at the primary source (each and every time they are renewed).

It is the practitioner’s responsibility to provide a copy of renewed professional licenses or certifications (or evidence of application to renew) to the HSU on or before the date the current license or certification expires. It is the Health Service Administrator’s or designee’s responsibility to verify the renewed license(s) or certification(s) with the primary source.

3. **GRANTING OF CLINICAL PRIVILEGES, PRACTICE AGREEMENTS, AND PROTOCOLS**

Only LIPs will apply for, and be granted, clinical privileges in the Bureau. All physicians, dentists, and other LIPs, including contract/consultants, and those who provide a diagnosis or recommend treatment using telehealth, must have approved clinical privileges before delivering health care inside the institution, or by use of telehealth.

a. **Privileging.** Privileging is the authority granted to specific health care practitioners to render patient care based on the individual's professional license, experience, and skills. The BOP grants clinical privileges solely to LIPs, namely physicians, dentists, optometrists, and podiatrists. These LIPs must have a current and valid state license to practice medicine, dentistry, optometry, or podiatry. Clinical Directors (medical, optometry, and podiatry) and CDO (dentistry) may grant privileges to BOP or contract LIPs once they have assured both peer review and the absence of any unresolved adverse actions restricting the applicant's practice.

(1) **Physicians and Dentists.** A physician seeks privileges by completing the Application for Appointment to the Medical Staff (Physician) (BP-A0601), and Dental Officers complete the Request for Dental Privileges form (BP-A0603). These privileges are to be granted based on the practitioner's qualifications, knowledge/skills, and experience as identified and verified in the credentials portfolio. Clinical privileges may be granted for a period not to exceed two years. Newly employed Physicians and Dental Officers should be granted privileges for a period of one year. Licensed Clinical Psychologists at an MRC with Behavioral Health Programs may also be included in this category.

(2) **Mid-level practitioners (MLP),** which include graduate physician assistants (certified or non-certified), nurse practitioners, and unlicensed medical graduates must have a "Practice Agreement" with a licensed physician prior to providing any health care in the institution. MLPs represent a category of practitioners who do not practice independently.

These Practice Agreements are to be granted based on the MLP's qualifications, knowledge/skills, and experience, as identified and verified in the credentials portfolio. Practice agreements will be valid for a period not to exceed two years (see Mid-Level Practitioner (MLP)/Sponsor Physician Practice Agreement [BP-A0823]).

Dental Hygienists and Dental Assistants must have a "Practice Agreement" with a licensed dentist prior to providing any dental care in the institution.

(3) **Other healthcare providers,** such as clinical nurses, emergency medical technicians, or any others that a local governing body deems appropriate, must work under guidance of LIP approved protocols (physician or dentist) while delivering health care inside the institution. When approving protocols, the institution should ensure that the protocols comply with the state practice act for the appropriate profession.

b. **Practice Agreements.** The BOP requires "practice agreements" and not privileges between non-independent providers such as mid-level practitioners (physician assistants, nurse practitioners, unlicensed medical graduates) and the LIPs before providing health care in the institution. The practice agreement with a licensed physician will not only authorize his/her

clinical performance but also supervise his/her clinical care. Practice agreements delegate specific clinical or dental duties to staff who work under the LIP's supervision. Bureau of Prisons and contract MLPs represent a category of practitioners who do not practice independently.

Practice agreements are granted based on the MLP's qualifications, knowledge, skills, and experience. Initial practice agreements are valid for a period not to exceed one year and renewals are valid for a period not to exceed two years. MLPs and their supervising physician complete the practice agreement together to ensure all areas are in agreement (see BP-A0823, Mid-Level Practitioner (MLP)/Sponsor Physician Practice Agreement).

Practitioners with Advanced Training or Certification, such as Physical Therapists, Occupational Therapists, Clinical Nurse Specialists, Clinical Pharmacists, or others with appropriate advanced education/licensure must have practice agreements based on the established protocols for their advanced functions.

Dental Hygienists must have a practice agreement with a licensed dentist prior to providing care in the institution and follow the procedure noted above. Dental Assistants may be granted a practice agreement depending on the training and experience on a case-by-case basis.

c. **Protocols.** Other health care providers, such as Clinical Nurses, Emergency Medical Technicians/ Paramedics, or any others that a local Governing Body deems appropriate, must work under guidance of LIP approved protocols (Physician or Dentist) while delivering health care inside the institution. When approving protocols, the institution should ensure that the protocols comply with the state practice act for the appropriate profession. The presence of an LIP onsite does not supersede the requirement to have written nursing or technician protocols that standardize clinical practice for all employed and contracted non-independent nurses and paramedics, especially protocols related to medical emergency response. A written protocol for the nurses and emergency medical technicians/paramedics is required at MRCs and other facilities even if LIPs are on site for 24 hours a day. The protocols will be negotiated locally.

Privileges, practice agreements, and protocols must be institution-specific (limited to those services and procedures that are actually performed in the institution).

Privileges and practice agreements granted to LIPs and MLPs will be valid for no more than two years.

Temporary privileges or practice agreements may be granted for up to 120 days under special circumstances, such as a new or temporary-duty employee or temporary CD. For permanent transfers or temporary duty providers, privileges or practice agreements must be granted at the

new institution before the provider is allowed to deliver health care. When granting temporary privileges or practice agreements, the institution must verify, at a minimum, the current professional license or certification and professional education/degree.

If the provider being granted temporary privileges or a practice agreement is on temporary duty from another Bureau institution, evidence of verification from the employee's home institution, which must be in hard copy form and be on site at the new institution, will satisfy this requirement.

c. **Authority.** Authority to grant institution-specific clinical privileges, practice agreements, and protocols is defined as follows:

(1) The Medical Director is the privilege granting authority for institution physicians designated as the Clinical Director (CD), including a physician who is appointed as Acting CD while the permanent position is vacant.

(2) The Medical Director is the privilege granting authority for Clinical Specialty Consultants, Chief Dental Officers, and Chief Psychiatrists.

(3) The institution CD is the privilege granting authority for other LIPs who deliver medical health care at the institution, including contractors/consultants, including those using telehealth. The CD establishes Practice Agreements with MLPs; however, in institutions with a Credential Committee, PCPT (Primary Care Provider Team), or more than one physician, the CD may delegate this authority to another LIP (physician or dentist if appropriate).

An LIP (physician or dentist) approves all protocols used by staff such as clinical nurses, dental assistants, and emergency medical technicians.

(4) The Medical Director delegates the privilege granting authority for physicians occupying the position of Chief of Psychiatry at Bureau institutions to the BOP Chief Psychiatrist.

(5) The BOP Chief Dental Officer is the privilege granting authority for all institution Chief Dental Officers.

(6) The institution Chief Dental Officer is the privilege granting authority for dentists and establishes Practice Agreements for dental hygienists and dental assistants, including contractors/consultants.

(7) When the institution privileging authority changes previously granted privileges, practice agreements, and protocols, the new privileging authority may continue for a period not to exceed

90 days. After the 90-day period, the new CD or CDO, even in an acting capacity, must renew the privileges, agreements, and protocols. At institutions with a Credential Committee, the Committee will convene to address credentialing needs.

(8) Each Warden is required to sign off on all privilege applications and practice agreements. This requirement does not indicate that a Warden has authority to grant these privileges or practice agreements, but rather that the Warden is aware of the terms of the privileges or agreements granted, and to whom. This procedure is required because the Warden is the institution's representative to the Health Services Governing Body.

(9) For the position of CD, the institution must seek the appropriate Regional Director's concurrence in memorandum format, prior to submitting the application for privileges, in addition to verified credentials described earlier, to the Medical Director. The Regional Director's concurrence must accompany the privilege application to the Medical Director.

The institution must request renewal of clinical privileges for CDs, to the Medical Director every two years and must be accompanied by a current CD Peer Review and the documents listed in Section 2 of this Program Statement.

(10) All Health Service Administrators (HSA) or Assistant HSAs who are health care practitioners, and remain clinically active at the institution, must have a current practice agreement or protocols pertinent to their professions prior to performing any clinical duties.

4. PEER REVIEW

Peer review is a routine function used to review the current knowledge and skills of health care providers. All Bureau health care providers who are privileged must have at least one external peer review conducted every two years. The contract LIPs who are working with privileges must have at least one external peer review conducted every two years. Those who are working under a practice agreement must have at least one routine peer review conducted every two years, which may be conducted by a peer at the institution. A peer is defined as another provider in the same discipline (physician, dentist, MLP, etc.) who has firsthand knowledge of the provider's clinical performance.

The peer review should evaluate the professional care the provider has given using a sample of the provider's primary patient load, and comment on the following aspects of provider knowledge/skills:

- Actual clinical performance (treatment provided consistent with assessment, etc.).
- Appropriate utilization of resources.

- Participation in, and results of, performance improvement activity.
- Clinical judgment.
- Technical skills.

Additionally, each CD, CDO, and CP must have a peer review performed and documented by an approved BOP Peer Reviewer, at least once every two years, normally within six months of privilege expiration and renewal. The CD, CDO, CP Peer Review programs are managed by OQM, HSD, and this office is responsible for notification and scheduling of these reviews.

5. CORRECTIVE ACTION REVIEWS RELATED TO CLINICAL KNOWLEDGE, SKILL

Corrective action, discussed in this section, refers to those actions necessary to correct deficiencies in clinical knowledge/skills. Corrective actions may take the form of:

- Increased clinical supervision.
- Additional clinical training.
- Additional education.
- Changes to clinical privileges for LIPs or to the practice agreement for MLPs.

Normally, additional training or education is the first step in correcting deficient clinical knowledge or skills. Changes to MLP Agreement categories will normally be made in a progressive manner, (i.e., 1:2, 2:3).

a. **Training and Education.** Health care practitioners provide patient care dependent on their clinical knowledge, skills, and experience. Medical technology and treatment modalities available for use in health care professions change continuously. Health care practitioners assume responsibility to maintain and improve their knowledge and skills in order to deliver quality care consistent with accepted current standards of practice. The Bureau, in recognition of this, provides resources annually to health care practitioners so that they may request and receive continuing professional education (CPE) to address their continuing educational needs.

This section describes the management of health care practitioners who function under clinical privileges, practice agreement, or protocols, who demonstrate deficient clinical knowledge or skills in performing their clinical duties. (Normally, additional training or education is the initial step in correcting a clinical deficiency.) For deficiencies related to clinical skills or knowledge, supervisors must adhere to approved policies to document and discuss performance with employees; i.e.; performance logs, performance improvement plans, etc.

The HSA, CD, or CDO should always confer with the institution Human Resource Manager prior to initiating any level of clinical performance review described in this section. Bargaining Unit employees, subject to any review described in this section, are entitled to Bargaining Unit representation through all phases of the review process described in this section, if requested, and will be notified in writing upon initial notification.

Deficits health care practitioners demonstrate in clinical knowledge, skills, expertise, or judgment can result in adverse patient outcomes, and such deficits require an intense review of the health care the practitioner provided.

During the course of these reviews, the health care practitioner's clinical privileges, or practice agreement, may be held in abeyance for a period not to exceed 30 calendar days during the course of a review. Attachment B provides a sample notification to employee of privilege or practice agreement abeyance.

There are three levels of reviews to evaluate suspected deficiency in clinical knowledge/skills.

(1) Clinical Care Review. When a possible deficiency in clinical care is suspected, this is the initial internal step to evaluate the provision of care. This review is a health record or other document review initiated by a physician, dentist, or peer, in response to a specific negative patient outcome. A peer staff member appointed by the CD or Chief Dentist will complete this review for MLPs or other non-independent practitioners. Only peers can conduct a clinical care review on a LIP (physician or dentist). The affected practitioner is notified by memorandum of the nature of the review, and the review must be completed within 10 working days (from date of notice).

When the clinical care review is completed, a report is provided to the CD or Chief Dentist, who will determine what corrective action, if any, is warranted. The CD or Chief Dentist will discuss the report with the affected employee, within seven working days of the review's completion. Reports of clinical care reviews will be maintained in the employee's credential file until the next renewal of clinical privileges, practice agreement, or protocol, not to exceed a period of two years. The CD, or Chief Dentist may also recommend, if the result of the review warrants, the next level of review, the internal focus review. The affected employee can request an internal focus review if the employee disagrees with the clinical care review.

(2) Focus Review (Internal). When a clinical care review indicates there may be a significant deficiency in clinical knowledge/skills that may endanger patient care beyond an isolated episode, or it identifies trends in deficient knowledge/skills, the CD or Chief Dentist should initiate an internal focus review. Internal focus reviews should consist of a committee of at least

three people, consisting of an LIP and two peers (excluding the peer who performed the clinical care review), if staffing permits.

The focus review committee will review randomly selected records of similar providers to determine if the level of care given by the provider under review is consistent with the level of care provided by peers at that institution. The affected practitioner is notified by memorandum of the nature of the internal focus review and is also notified that the focus review must be completed within 15 working days (from date of notice).

When the internal focus review is completed, a report is provided to the CD or Chief Dentist, who will determine what corrective action, if any, is warranted. The result of the review will be discussed with the affected employee, within seven working days of the review's completion. Reports of internal focus reviews will be maintained in the employee's credential file until the next renewal of clinical privileges, practice agreement, or protocol, not to exceed a period of two years.

(3) Focus Review (External). When the internal focus review indicates there may be a significant deficiency in clinical knowledge/skills that may endanger patient safety or threaten the institution's security, the Warden may request an external focus review. An external focus review may also be the option when a sufficient number of LIP staff do not exist at the institution to conduct the internal focus review. The Warden should request this review by memorandum to the Medical Director, Health Services Division, through the respective Regional Director.

(a) The OQM will obtain all pertinent information for review (such as the health record). Various reports generated regarding the issues will be sent to the OQM for provisional review.

(b) When the preliminary review indicates further review is **not** necessary, the Medical Director may terminate the review. In some cases, it may be necessary to direct a corrective action.

(c) When the preliminary review indicates further intensive study is necessary, the Chief of OQM will constitute a Focus Review Committee (FRC). The FRC will consist of at least two physicians (one will be the Chairperson), one additional person depending on the issue, and any other experts needed. The additional person will represent the expertise in the area of the focus review.

(d) Whenever the Medical Director suspects there are medical legal implications in any case, based on OQM's preliminary findings, the Medical Director will consult with the General Counsel. In the event it is determined that legal action is probable, the health care practitioner will be notified.

(e) The Warden will provide all necessary information and support to the FRC to conduct the review. The requesting institution should also provide pertinent clinical information, such as copies of medical records or reports with the request to the Medical Director.

(f) The affected practitioner is notified by memorandum of the nature of the external focus review, and is also notified that the focus review must be completed within 30 working days (from date of notice).

(g) The FRC will review all pertinent information, conduct interviews, and inspect relevant facilities to conduct the review objectively.

(h) The FRC will report its findings and recommendations to the Medical Director, who will then report the findings and recommendations to the Warden. If negative action is taken against a bargaining unit employee as a result of the FRC report, the employee and/or his/her designated representative may request and receive a copy of this report, to include a listing of all medical records used. Privacy concerns of other employees named in this report must be adhered to in releasing the report.

When the external focus review is completed, a report is provided to the Medical Director, who in turn submits a report to the Warden. The Warden will determine what corrective or other action, if any, is warranted. The result of the review will be discussed with the affected employee, within seven working days of the Warden's receiving the report. Reports of external focus reviews will be maintained in the employee's credential file until the next renewal of clinical privileges, practice agreement, or protocol, not to exceed a period of two years.

b. Revocation/Restriction of Privileges. If attempts at corrective action fail to improve clinical knowledge/skills, a decision may be made to deny, restrict, or remove specific clinical privileges or specific areas of a practice agreement previously granted, or being requested. When a decision is made to deny or revoke clinical privileges, practice agreement, or protocol, the employee will be provided a written report detailing the rationale for such action. The employee will have 30 working days to dispute the report. After the employee has submitted his/her response, the Warden will make a final decision.

If the employee is a bargaining unit member, he/she may pursue the matter through the grievance process. If the employee pursues the issue through the grievance process, the proposed action will be withheld pending the outcome of the disputed action. During this period, clinical privileges, practice agreement, or protocol will be held in abeyance pending the outcome of the disputed action. It is recommended that any such proposed action, based on deficient clinical knowledge or skills, should be discussed fully with the Human Resource Management Department.

6. NATIONAL PRACTITIONER DATA BANK (NPDB)

The BOP is required to participate in the NPDB operated by the U.S. Department of Health and Human Services (HHS). These requirements are established in Title V Regulations, 45 CFR; Part 60, 1-14. Further details on NPDB participation and procedures for reporting staff to the NPDB are detailed in the Interagency Agreement (IAG) between the BOP and HHS.

Bureau of Prisons staff, including the Warden, are prohibited from entering into express or implied written or oral agreements not to report an employee in return for a personnel action such as resignation, retirement, accepting a reassignment, etc.

a. **Definitions.** The following definitions apply in the IAG between the BOP and HHS for NPDB participation.

(1) **Physician** means a doctor of medicine or osteopathy legally authorized to practice medicine or surgery by a state or territory. This applies to practitioners who are employed by the BOP, who are assigned to the BOP by the PHS, or who provide contract and consultant physician services to the BOP.

(2) **Dentist** means a doctor of dental surgery, doctor of dental medicine, or the equivalent, who is legally authorized to practice dentistry by a state or territory. This definition applies to practitioners who are employed by the BOP, who are assigned to the BOP by the PHS, or who provide contract and consultant services to the BOP.

(3) **Health Care Practitioner** means an individual other than a physician or dentist who the BOP authorizes to provide direct health care services. This definition applies to practitioners who are employed by the BOP, assigned to the BOP by the PHS, or provide consultant services to the BOP. Other practitioners include but are not limited to:

- Dental Assistants.
- Dental Hygienists.
- Dieticians.
- Emergency Medical Technicians.
- Licensed Practical/Vocational Nurses.
- Medical Assistants.
- Medical Technologists.
- Nurse's Aides.
- Nurse Anesthetists.
- Nurse Practitioners.

- Occupational Therapists.
- Optometrists.
- Pharmacists.
- Physician Assistants.
- Physical Therapists.
- Psychologists.
- Radiologic Technologists.
- Registered Nurses.
- Respiratory Therapists.
- Respiratory Therapy Technicians.
- Social Workers, Clinical.

b. **Authority.** The Chief of OQM and the BOP's Medical Director evaluates the NPDB reports of each health care provider and provides guidance to the institution regarding suitability for appointment, conversion to probationary appointment, or permanent appointments, as appropriate. The Chief of OQM or the Medical Director reviews the professional case liability reporting form from individuals with adverse actions in the NPDBs and provides guidance to the institution on appropriate actions to be taken prior to signing the clearance memorandum. NPDB queries are conducted before initial employment and at least every two years during employment.

The BOP's Medical Director is the only authorized official to approve and sign any reporting of a staff member to the NPDB. The BOP's Medical Director may delegate authority for technical aspects of the query and reporting processes to the OQM, and may delegate authority for review of documents and development of NPDB recommendations to the OQM, or to a panel of BOP physicians and dentists.

The institution maintains all reports and information in the practitioner's credentials or privileging folder.

c. **Queries.** The BOP is required to query the NPDB before granting initial, renewed, or revised privileges and no less than once every two years, on every physician, dentist, or other health care practitioner providing professional care in a BOP institution. This applies not only to permanent BOP or PHS staff, but to consultants or contractors.

(1) If NPDB screening shows any adverse action, the applicant submits the Professional Case Liability Reporting Form. The Central Office verifies that the applicant (or employee) fully disclosed the related information required and requested by the BOP in its pre-employment, credentialing, and clinical privileging procedures.

(2) When any initial, biennial, or other NPDB report calls into question the professional competence or conduct of an individual appointed or used by the BOP, the Chief of OQM or the BOP's Medical Director reviews all reports and relevant information. The Medical Director provides guidance to the institution about appropriate actions to be taken, which may include revision or removal of clinical privileges. The institution and the individual are required to submit information regarding the NPDB report during this process.

(3) The institution maintains copies of the NPDB results in the Credentials and Privileges folder for each practitioner.

Use the Information for Queries form (Attachment A) to submit requests for NPDB queries to OQM.

7. PROVIDER HEARING AND APPEALS RELATED TO NPDB REPORTS OR PRIVILEGING ACTIONS (SUSPENSION, REVOCATION OR DENIAL) THAT EXCEED 30 DAYS

Any LIP whose clinical privileges are denied, reduced, restricted, or revoked for more than 30 days is entitled to a fair and equitable remedy process.

Any practitioner (LIP or non-LIP) whom the Medical Director intends to report to the NPDB as defined in Section 6 is entitled to a fair and equitable remedy process.

The provider who will be the subject of the privilege/practice agreement action (i.e., suspension, denial, revocation) has 30 calendar days from the date of receiving the Bureau's intent to refute the intended action. As indicated in the Master Agreement, bargaining unit employees have the right to representation.

Once an employee has requested to refute the action, the employer must render a final decision with justification. All action will be withheld until the final outcome of the process as outlined in the Master Agreement.

If the **final** decision is to suspend, deny, or revoke privileges or a practice agreement for a period beyond 30 days, the provider will be reported to the NPDB within 15 days of the **final** action.

REFERENCES

Program Statements

P3000.03 Human Resource Management Manual (12/19/07)
P6010.05 Health Services Administration (6/26/14)
P6031.04 Patient Care (6/3/14)

45 CFR, Part 60, 1-14

BOP Forms

BP-A0601 Application for Appointment to the Medical Staff (Physician)
BP-A0603 Request for Dental Privileges
BP-A0823 Mid-Level Practitioner (MLP)/Sponsor Physician Practice Agreement

Standards Referenced

American Correctional Association 4th Edition Standards for Adult Correctional Institutions:
4-4380(M), 4-4381(M), 4-4382(M), 4-4384(M), and 4-4411(M)
American Correctional Association 3 Edition Standards for Adult Local Detention Facilities:
3-ALDF-4E-9(M) and 3-ALDF-4E-10(M)

Records Retention Requirements

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) system on Sallyport.

Attachment A. Information for Queries

One form is completed for each practitioner. Complete all applicable information.

Query for: (Select One Type of Practitioner and One Query Type)

Practitioner Type: BOP/PHS Staff _____ Contractor _____

Query Type: Initial Appointment _____ Mandatory Two-Year _____

Practitioner Name: Last Name:

First Name: _____

Middle Name: _____

Other Names Used: Last Name:

First Name: _____

Middle Name: _____

SSN: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

Home Address: _____

City _____

State _____ Zip _____ Country _____

BOP Institution Address: _____

City _____

State _____ Zip _____

License Number: _____ State _____

Field Of Licensure: _____

If licensed in multiple states or fields, list all on an additional sheet.

Federal DEA Number _____

Professional School(s) Attended (Use Additional Sheet if Necessary)

Name of School: _____

City _____

State _____ Zip _____ Country _____

Year of Graduation _____ 19 _____

Attachment B. Sample Format for Notification of Privilege/Practice Agreement Abeyance

MEMORANDUM FOR (NAME OF PROVIDER)

FROM: (Name of CD or CDO)

SUBJECT: Notification of Clinical Privilege/Practice Agreement Abeyance

You are hereby notified that your clinical privileges are being held in abeyance for the following reason. This notice is being provided in compliance with procedures defined in the Program Statement **Health Care Provider Credential Verification, Privileges, and Practice Agreement Program**.

(In this section, state the reason, type of review [clinical care, internal focus, external focus], the specific deficiencies being evaluated, and the length of the review).

These deficiencies have, or could have had, the following adverse effects on patient care. (List.)

Abeyance is a temporary removal of clinical privileges for a period not to exceed thirty work days. It is during this period that the deficiencies will be evaluated as determined by the Clinical Director. During this period of time you will be assigned to other duties, described as follows. (List here).

Abeyance is not an adverse clinical privilege action and need not be disclosed as such on future applications for clinical privileges.

You will be notified of the results of this review process.

cc: Credential file
AFGE Local