U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

PROGRAM STATEMENT
Health Care Credential and Privileging Program

Approved by	William K. Marshall III Director, Federal Bureau of Prisons
DPI	HSD
Number	6027.03
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Summary of Changes

Program Statement Rescinded:

- 6027.02 Health Care Provider Credential Verification, Privileges, and Practice Agreement Program (10/12/2016)

Changes:

- Comprehensive revisions were made to the entire program statement to ensure alignment with current clinical practices and established standards of care.
- Updated timelines for Practice Agreements and Privileges.
- Updated Peer Review requirements.
- Updated Corrective Action and Reporting Requirements.
- Updated Primary Source Verification Requirements.
- Removed Site-Specific Privilege Requirements.
- Removed Acting Privilege Requirements.
- Added Competency Requirements.
- Added Orientation Requirements.

1. PURPOSE AND SCOPE

To establish credentialing and privileging requirements for health care professionals providing clinical care to inmates at Federal Bureau of Prison (Bureau) institutions and/or through contracted services. This program statement also establishes procedures for corrective actions when deficiencies are identified in clinical skills, knowledge, or practice, up to and including abeyance and termination of privileges and National Practitioner Data Bank (NPDB) reporting. This program statement:

- Establishes procedures for initial and ongoing credential verification and performance improvement.
- Establishes procedures for participation in the NPDB.
- Establishes requirements for primary source credential verification of professional credentials, licenses, certifications, and qualifying education.
- Establishes criteria for application and granting of clinical privileges, practice agreements, and protocols for specific health care providers within the Bureau.
- Establishes the requirement for peer reviews.
- Establishes requirements for routine competencies.
- Establishes procedures to follow when a health care provider's clinical knowledge, skill, or performance requires immediate review, corrective action, abeyance or termination of privileges, practice agreements, or protocols.

a. **Program Objectives.**

- Institutions will have established methods to participate in appropriate credentialing procedures which include the knowledge-skills-based granting of privileges, practice agreements, and protocols for health care providers.
- Clinical supervisors will have established procedures to follow, prior to considering actions based on clinical knowledge/skills.
- Patients will be protected by procedures that ensure the quality and efficiency of care delivered in the Bureau.
- The rights of the health care providers 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. **Institution Supplement.** None.

c. **Definitions.**

- **Advanced Practice Providers (APPs).** Non-independent licensed providers such as physician assistants and nurse practitioners. Providers in this category must have a practice agreement with a licensed physician.
- **Applicable certifications.** Certifications applicable to the position that demonstrate a person's knowledge and skills in a specific area of health care whereby a certificate was obtained and verified. Examples of professions that may have certifications are physicians, physician assistants, nurse practitioners, pharmacists, physical therapists, registered dental hygienists, paramedics, etc.
- **Authority.** A person whose position grants clinical privileges, practice agreements, and protocols.
- **Competency.** The ability to demonstrate the knowledge and skills required in different practice settings to provide effective, safe, and high-quality care.

- **Credential Verification Officer.** Official credentialing officers within the Bureau Central Office National Credentialing Program are responsible for initial primary source verification of non-contracted physicians, registered nurses (RN), APPs, pharmacists, and dentists; all others are done by the institution's credentialing officer designee.
- **Credentialing.** The ongoing process of verifying and validating a health care provider's qualification and background to ensure they meet the standards for patient care through verification of applicable education, licensure, registrations, certifications, and training.
- **Direct medical care.** In the context of credentialing and privileging, the exercise of independent clinical judgment to diagnose, treat, or manage a specific patient's health condition, where the delivery of care is accomplished either in-person or via telehealth technologies..
- **External peer review.** An in-person peer review, usually conducted for Clinical Directors (CDs) and institution Chief Dental Officers (CDOs), which is conducted in a manner which receives a primary or secondary review by a reviewer outside of the institution (i.e., regional level). Staffing availability might also indicate the need for review outside of the institution.
- **Health care provider.** A licensed, certified, or otherwise credentialed person who provides health care services. All health care providers who perform direct medical care require a credential file.
- **Institution credentialing officer designee.** Individuals designated by the Health Services Administrator (HSA) to screen all health care candidates to assure the details of their credentialing documentation are accurate and verifiable.
- **Licensed Independent Providers (LIP).** Health care providers such as physicians, dentists, optometrists, podiatrists, licensed clinical social workers, and licensed clinical psychologists. Providers in these categories are authorized by a current and valid state license to practice independently in their field of expertise.
- **National Practitioner Data Bank (NPDB).** NPDB is a program that provides a "Continuous Query" to monitor all health care and independently licensed qualified mental health providers who are enrolled within the Bureau system. The NPDB will continue to monitor an individual license, and an alert report will automatically be sent from the NPDB system to Bureau Central Office National Credentialing Program via email if there has been a new, revised, or voided finding.
- **Non-independent licensed providers.** A professional whose ability to practice within the Bureau is tied to or requires the supervision or guidance of a physician or dentist, such as APPs and dental hygienists.
- **Peer review.** Routine function used to review the current practice, knowledge, and skills of health care providers by a professional peer..
- **Practice agreement(s).** Required between non-independent licensed providers and LIPs before providing health care in the institution. Practice agreements delegate specific clinical or dental duties to staff who work under the LIP's supervision. Practice agreements are granted based on the non-independent licensed provider's qualifications,

knowledge, skills, and experience. Additional health care providers working under expanded functions also require a practice agreement.

- **Primary source verification (PSV).** The process for validating a health care provider's credentials, such as license, certification and/or registration, and accredited education directly from the original issuing authority (university, state board, etc.).
- **Privileging.** The process of granting a health care provider the authority to perform specific clinical activities and procedures within an organization based on their active licensures/certifications and experience. Privileging is the authority granted to LIPs to render patient care based on the individual's professional license, experience, and skills. The Bureau grants clinical privileges solely to LIPs, namely physicians, dentists, optometrists, podiatrists, licensed clinical social workers, and licensed clinical psychologists. These LIPs must have a current and valid state license to practice.
- **Professional Peer.** An individual from the same discipline with equivalent education and/or licensure. For example, physicians for physicians, dentists for dentists, APP for APP, etc.
- **Protocols.** A set of detailed, written instructions which provide a standardized approach to patient care and assessment, that permit clinical nurses, paramedics, or any others the privilege to assess and care for patients with pre-existing chronic conditions or acute/ urgent/emergent complaints, while ensuring consistent practice supported by complete and thorough documentation. Protocols are subject to limitations based upon individual scope of practice and are implemented in accordance with federal supremacy governing the health care provider's practice, at the discretion of the privileging authority.
- **Qualifying education.** Applicable and qualifying education specific to the job position. Verifies the education is creditable to the required applicant's position.
- **Statement of work.** A detailed document which outlines the scope, objectives, and requirements of a contracted health care provider or service.
- **Vacancy.** Labels a position that is currently empty, and the intent is to hire a new, permanent applicant to fill the position. This is not intended for those who are temporarily absent from a position, such as leave.

2. INITIAL CREDENTIALING PROCESS

a. **Applicant Responsibility.** Applicants are required to provide the necessary documentation for the credentialing process. A complete credential file is required prior to providing care for patients. The applicant must provide the following, to include but not limited to:

- Documentation of qualifying professional education
- Post-graduate training (internship, residency, and/or fellowship if applicable)
- All active and inactive professional licensures
- Professional active certifications and registrations as applicable to the job description
- All past and pending actions taken against an active or inactive license in any or every state or registration, such as:

- Drug Enforcement Administration
- Clinical privileges
- Voluntary relinquishment of license or registration

- Complete details of any malpractice history
- Release of information
- LIPs and APPs need to provide contact information for two professional references within the same field of practice
- Initial curriculum vitae/resume for LIPs that includes the names and addresses of affiliations (work history, hospital affiliations, etc.) for the past 10 years or since completing residency or fellowship

b. **Institution Credentialing Officer Designee Responsibility.**

- **Primary source verification.** Documentation of relevant education, post-graduate training, licenses, and applicable certifications must be primary source verified.
  - Verification from the primary source can be completed through telephonic, written, or web-based sources listed on the verification resources on the Bureau's intranet site. Regardless of method of primary source verification, documents require a printed or typed name and signature of the verifier and will include date of verification. Indicate the document is primary source verified.
  - For those with privileges or practice agreements, primary source verification of licensure and certifications need to occur within 90 days of initial privileges or practice agreements signed by the privilege granting authority. After initial issuance of privileges or practice agreements, the primary source verification of license(s) and/or certification(s) will only be required at the time of the health care providers' license(s) and/or certification(s) being reissued or renewed by the organization. The documents will not require reverification before the renewal of privileges or practice agreements.
  - Examples of verification of credentials through written forms and web-based sources include official transcript in a sealed envelope, email from registrar's office, transcript clearing house, education hospitals, etc.
  - Verification of credentials by telephone should be done when such verifications are needed on a short-term notice (if other avenues are not available). When verifying a credential by phone, in addition to the requirements above, 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 National Credential Verification Officer (CVO), or designee, will complete the initial primary source verification for non-contracted physicians, RNs, APPs, pharmacists, and dentists.

- The institution credentialing officer designee will complete the primary source verification requirements of health care disciplines not listed.
- After initial credentialing, the institution credentialing officer designee, is also responsible for primary source verifying any renewed or changed information for all disciplines.
- Primary source verified, current, non-expired, license(s) and/or certification(s) must be present in the credential file. The health care provider is responsible for ensuring these requirements do not lapse, and the local credentialing designee is responsible for ensuring appropriate file maintenance and accuracy.

- **National Practitioner Data Bank process.** An initial query must be completed before being hired and then continuously maintained for all health care and independently licensed qualified mental health providers; including onsite contractors, onsite consultants, and Bureau telehealth providers; regardless of their licensure, certification, or education. The information from the NPDB must be reviewed prior to providing patient care. All initial health care provider NPDB requests for positions other than physicians, APPs, RNs, pharmacists, and dentists, which are done by the National CVO, must be completed by the institution credentialing officer designee, and submitted to the CVO using the fillable form on the Bureau's intranet site. All sections of the form need to be completed and sent via email with the subject heading stating Initial NPDB. The HSA may designate credentialing duties as appropriate within the institutions.
- **Initial NPDB match process.** When there is an NPDB match or hit, a Professional Liability Case Reporting form (located on the Health Services Division Credentialing page of the Bureau's intranet site), along with any supporting documentation, must be completed by the applicant if any past or pending actions have been taken against the provider's license(s). All documents must be reviewed and sent to the CVO. The Medical Director or designee will review the applicant's submission and render a decision via memorandum. Only staff with applicable fully unrestricted licenses in all states will be approved to render patient care. This memorandum must be in the credential file. Even applicants with fully unrestricted licenses may be found to be unsuitable for Bureau employment if past professional conduct and NPDB findings are sufficiently serious or show trends in behavior that are likely to be repeated in a carceral setting.
- **File formats.** Credential files will be maintained in digital or paper form, unless otherwise specified by the Health Services Division's (HSD) Credentialing Section.
- **File components.** Each credential file must contain the following documents prior to delivering patient care. These initial documents must be retained based on the current Records and Information Disposition Schedule (RIDS):
  - Initial Curriculum vitae/resume to include:
    - Names and addresses of affiliations (e.g., work history, hospital affiliations) for the past 10 years or since completing residency or fellowship
    - Documentation of relevant professional education – primary source verified
    - Documentation of post-graduate training (if indicated) – primary source verified
    - Contact information from two professional peers

- Active and inactive professional licenses – all primary source verified within 90 days of initial issuance of privileges, practice agreements, and protocols. The file must always contain a current valid license.
- Professional certifications and registrations as applicable to job description such as board certifications and National Commission on Certification of Physician Assistants (NCCPA) certification for Physician Assistant – Certified (PA-C), which is required – primary source verified
- NPDB query
- NPDB match memorandum (if indicated)
- Complete details of any malpractice history must be included in the credential file along with a memorandum from the Medical Director.
- Current position description (PD) for Bureau staff or statement of work for contractors
- Authorization for release of information
- Proof of current Basic Life Support (BLS) certification
- Privileges, practice agreement, or protocols (if applicable)
- Orientation packet
- Competencies

Verified credentials are maintained through an electronic monitoring system, at the institution or office of record, by the HSA or designee. Each staff member has the right to review, or receive a copy of, any information in their credential file.

c. **Initial Credentialing – From Contracted Hospital or Other Credential Verification Organization.** Local primary source verification of onsite contract health care providers' personnel credentials (e.g., license, certification, registration, education) will not be required when the contractor is employed by an entity (contract company, integrated health system, hospitals, ambulatory clinic groups) that is accredited by a health care accreditation body (e.g., Accreditation Association for Ambulatory Health Care (AAAHC), Joint Commission, Accreditation Commission for Health Care (ACHC), National Committee for Quality Assurance (NCQA), National Commission on Correctional Health Care (NCCHC), or other entity deemed appropriate by the Bureau's Medical Director). A letter of assurance from the contracting company attesting the clinician is credentialed, the primary source verification of required documents has been completed, and the clinician holds the appropriate unrestricted license(s), certification(s), or education and training to perform the contracted service is sufficient.

The letter of assurance should stay current, being reissued to the institution at a minimum, every two years, or sooner if a contractor works under privileges, practice agreements, or protocols and would require verification sooner. Each institution is required to maintain an onsite copy of the contracted organization's credentialing policy.

- **Contractors from an accredited entity.** For onsite contract health care providers, the local institution will be responsible for maintaining a credential file. The credential file will include:
  - Orientation
  - NPDB
  - NPDB match memorandum (if indicated)
  - Two professional peer references' contact information for LIPs and APPs
  - Proof of current BLS certification (can be included within letter of assurance)
  - Statement of work
  - Letter of assurance (current and updated with privilege, practice agreement, and protocol renewals)
  - Privileges, practice agreement, or protocols as indicated
  - Competencies
- **Contractors from a nonaccredited entity.** For onsite contract health care providers, the local institution will be responsible for maintaining a credential file. The credential file will include all components as outlined under File Components in Section 2.b.

d. **Central Office Clinicians Credentialing and Privileging.** All Central Office staff in a health care provider PD will have an active credential file which includes licensure, NPDB, and BLS certification. Only those providing individualized patient care that require privileges or practice agreements will undergo a peer review. Privileges and practice agreements are indicated at the discretion of the Medical Director.

Commissioned Corps of the U.S. Public Health Service (USPHS) clinicians who require annual clinical hours and do so within the Bureau, are required to complete temporary privileges or practice agreements prior to completing clinical hours and will undergo an abbreviated peer review following the temporary duty assignment.

e. **Temporary Privileges/Practice Agreements During Emergencies/Critical Staffing Needs.** Regional and Central office health care providers, who are in non-clinical PDs currently (e.g. Health Services Analysts, Health Service Administrators, etc.), may be granted temporary privileges or practice agreements by their respective privilege-granting authority (Bureau Medical Director, National Chief Dentist, or their designee), in the event of critical patient care needs. Temporary privileges or practice agreements may be granted prior to a temporary duty assignment upon completion of the appropriate credentialing. The privileges must be based on primary source verification of a current state license, an NPDB report that is clear of licensure action and has no malpractice history triggering a review of the Medical Director, BLS certification, and a signed temporary privilege or practice agreement. The request for temporary privileges or practice agreement must come from the health care providers themselves, with supervisor approval. The temporary privileges or practice agreement may not be granted for more than 120 consecutive days. If an individual works longer than 120 consecutive days, a transition to non-temporary privileges or practice agreement must be completed before the end of

the 120 days. Following a temporary duty assignment, and upon expiration of the 120-day period from the date temporary privileges or practice agreement were granted, an abbreviated peer review must be completed within 60 days. The temporary privileges and abbreviated peer reviews must be maintained in their credential file.

3. ONGOING CREDENTIALING PROCESS

After the initial credentialing process is finalized, specific items within the credential file will require routine maintenance. Some of the components requiring maintenance include, but are not limited to:

a. **License(s).** According to this program statement, licenses must be maintained as current and primary source verified initially and upon renewal. If the health care provider elects to allow a non-essential license (e.g., held in more than one state or other profession) to be inactive, the health care provider must notify the credentialing authority in writing of their decision. Primary source verification of the inactive license is required, one time.

b. **Certifications and Registrations (as applicable).** Certifications and registrations must be maintained as current and primary source verified upon renewal if an expiration date is present. If they do not have an expiration date, they are primary source verified within 90 days of renewing privileges or practice agreements. If the health care provider elects to allow a non-essential certification to be inactive, the health care provider must notify the credentialing authority in writing of their decision. Primary source verification of the inactive certification/ registration is required, one time.

c. **Competencies.** Competencies should be completed initially, and then every two years, at a minimum, except for certain disciplines at Federal Medical Centers (FMCs). See Section 5 for further requirements regarding competencies.

d. **Peer Review.** All health care providers who are providing direct medical care, and working under privileges or practice agreements must have a peer review. A peer review must be performed by a professional peer prior to the renewal of privileges or practice agreements. See Section 6 for further requirements regarding peer reviews.

e. **Protocols.** Protocols vary from institution to institution and will be reviewed and signed annually by the Clinical Director (CD) or their designee. Proof of the health care provider's authorization to utilize specific protocols will be placed in the local credential file. Signed competency training for staff who work under protocols is required; this includes, but is not limited to clinical nurses, paramedics, medication technicians, medical assistants, etc.

f. **Privileging.** All LIPs must have current privileging that reflects their current standardized

PD. The privileging date is the date in which the privileges were signed by the privilege granting authority. The timelines that follow apply to providers who are providing safe medical care, and run successful programs:

- The initial privileges are signed and may not exceed six months.
- The first peer review will be conducted prior to the expiration date of privileges (within six months) and based on the results, privileges are renewed for a second period, not to exceed 12 months.
- A second peer review will then be completed prior to the expiration date of privileges (within 12 months). Based on the results from this peer review, privileges can be renewed on a two-year cycle.
- More aggressive timelines or higher-level reviews will be triggered when a peer review highlights gaps in clinical knowledge, poor decision making, or trends in care that has or is likely to result in poor patient outcomes. Section 6 gives more detail into more aggressive timelines for peer reviews and Section 8 describes higher-level reviews.

g. **Practice Agreements.** All APPs, dental hygienists, clinical pharmacists, and other clinical positions with expanded functions, must have a current practice agreement that reflects their current standardized PD, and applicable advanced functions. Providers with advanced training or certification, such as physical therapists, occupational therapists, clinical nurse specialists, or others with appropriate advanced education/licensure, must have practice agreements for their advanced functions if they are in a position providing direct medical care. The practice agreement date is the date in which the practice agreement was signed by the privilege granting authority.

- The first peer review will be conducted prior to the expiration date of practice agreements (within six months) and based on the results, renewed for a second period, not to exceed 12 months.
- A second peer review will then be completed prior to the expiration date of practice agreements (within 12 months). Based on the results from this peer review, practice agreements can be renewed on a two-year cycle.
- More aggressive timelines or higher-level reviews will be triggered when a peer review highlights gaps in clinical knowledge, poor decision making, or trends in care that have or are likely to result in poor patient outcomes. Section 6 provides more detail into more aggressive timelines for peer reviews and Section 8 describes higher-level reviews.

h. **NPDB.** After the Bureau has obtained an initial query for all licensed providers; also including onsite contractors, onsite consultants, and Bureau telehealth providers; a continuous query is acceptable for ongoing NPDB information. A new query is not required for renewal of privileges or practice agreements; however, continuous query quarterly reports received from the CVO or designee, should be reviewed by the institution credentialing officer designee, to verify the health care provider is undergoing a continuous query.

i. **Proof of Current BLS Certification.** All healthcare providers are required to maintain BLS certification. In the event that a healthcare provider's BLS certification lapses or expires, the provider must immediately notify the HSA. Failure to maintain current certification will result in restriction or suspension of clinical duties until compliance is restored.

j. **Additional Credential File Components.** It is the provider's responsibility to provide a copy of renewed professional licenses, registrations, or certifications (or evidence of application to renew) to the credentialing officer before the date the current license, registration, or certification expires. It is the credentialing officer's responsibility to verify the submitted information is primary source verified according to this program statement. The verification needs to occur on or before the expiration date.

4. GRANTING OF CLINICAL PRIVILEGES, PRACTICE AGREEMENTS, AND PROTOCOLS

Granting authorities may grant privileges, practice agreements, and protocols to approved health care providers based on appropriate review of their knowledge, skills, performance, completion of orientation, and the overall peer review process, as applicable. They must also verify, through the NPDB query, no adverse actions are reported that would restrict the applicant's ability to practice in any state a licensure is held.

a. **Governing Body Representation.** The Bureau, through the Assistant Director, HSD, assigns the Medical Director as the privileging granting authority.

b. **Bureau-Wide Coverage.** Credentials within the Bureau fall under federal supremacy. Specific health care providers will have and be granted privileges, practice agreements, or protocols that will be valid at all Bureau facilities regardless of state affiliation. In addition, all other Bureau health care providers who are credentialed to provide patient care will also have bureau wide credentials. Site-specific privileges, practice agreements, protocols, and other credentials are not required. However, those working under protocols should become familiar with all local, site-specific, protocols as appropriate. Temporary duty (TDY) staff credentials can be verified via memorandum or other electronic methods.

Federal supremacy allows contractors to work in a federal facility, even if the facility is in a state where the contractor is not licensed; however, each institution must ensure a credential file is current and maintained and that services provided fall within the approved statement of work.

Health Service Administrators and other staff in non-clinical positions can remain clinically active at the institution during emergencies, and periods of critical staffing shortages, but only if they have current credentials, pertinent to their professions, prior to performing any clinical duties. Institutional specific situations can be reviewed on a case-by-case basis.

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

- The Bureau Medical Director or the acting designee, is the privilege granting authority for:
  - Regional Medical Directors
  - National Chief Dentist
  - National Chief Psychiatrist
  - Central Office Social Workers
  - Federal Bureau Telehealth Staff
  - Clinical Specialty Consultants
  - National Chief Pharmacist
  - Other Central Office health care providers (e.g., Central Office Pharmacists, Population Health, Addiction Medicine, Transitional Care) identified by the Bureau Medical Director
- The Bureau Chief, Health Programs or the acting designee, is the privilege granting authority for:
  - MRC CDs
- The Bureau National Chief Dentist or the acting designee, is the privilege granting authority for:
  - Regional Chief Dentists
  - National Clinical Specialists, including prosthodontists and periodontists
- The Bureau National Chief Psychiatrist or the acting designee, is the privilege granting authority for:
  - National Telepsychiatry Providers
- The Regional Medical Director or acting designee, is the privilege granting authority for:
  - Regional Physicians and other health care providers
  - Institution CDs within the region, other than MRCs
  - Acting Institution CDs within the region
- The Regional Chief Dentist or acting designee, is the privilege granting authority for:
  - Regional Dentists within the region
  - Institution CDOs within the region
- The Institution CD or acting designee, is the privilege granting authority for:
  - Bureau staff health care providers at the institution
  - Contract staff health care providers who provide care onsite at the institution
- The Institution CDO or acting designee, is the privilege granting authority for:
  - Bureau staff dental health care providers at the institution
  - Contract staff dental health care providers who provide care onsite at the institution

d. **Vacancies of Local Privilege Granting Authorities.**

- **Vacancies of institution CDs.**

- The Regional Medical Director will assign an Acting CD and notify the Institution Warden and HSA. The notification will include an effective date and an end date not to exceed the appointment of a new CD or the current expiration date of the Acting CDs privileges.
- The Regional Medical Director will be the Acting CD when a vacancy occurs in the CD role at an institution within the region, unless delegated by memorandum to another physician. The acting delegation memorandum needs to be placed in the physician's credential file who is assuming the acting role.
- The physician assuming the Acting CD role is required to review all current privileges, practice agreements, and protocols they are the privilege granting authority for, to ensure they are current, and they concur with the provisions afforded within them. This review will take place within 60 days of the Acting CDs appointment. The Acting CD will sign a memorandum to be placed in the credential file of each health care provider attesting to the review. The 60-day time frame does not give any providers additional time for their renewals of privileges, practice agreements, or protocols. They are still required to be renewed prior to their expiration date.
- Once a CD position is hired, , the new CD is required to review all current privileges, practice agreements, and protocols, to ensure they are current, and they concur with the provisions afforded within them. This review will take place within 60 days of the CDs appointment. The CD will sign a memorandum to be placed in the credential file of each health care provider attesting to the review. The 60-day time frame does not give any providers additional time for their renewals of privileges, practice agreements, or protocols. They are still required to be renewed prior to their expiration date. If the Acting CD is selected for the CD position, the 60-day review requirement will not apply, as it has already been completed.
- If any privileges, practice agreements, or protocols lack concurrence, updated and signed privileges, practice agreements, or protocols must be obtained.

- **Vacancies of institution CDOs.**
  - The Regional Chief Dentist will notify the Warden and HSA of the institution by memorandum who the Acting CDO will be and include an effective date and an end date not to exceed the appointment of a new CDO or current expiration date of the Acting CDO's privileges.
  - The Regional Chief Dentist will be the Acting CDO when a vacancy occurs in the CDO role at an institution within the region, unless otherwise delegated by memorandum to another dentist. The acting delegation memorandum needs to be placed in the providers credential file who is assuming the acting role.
  - The dentist assuming the Acting CDO role is required to review all current privileges, practice agreements, and protocols they are the privilege granting authority for, to ensure they are current, and they concur with the provisions afforded within them. This review will take place within 60 days of the CDO's appointment. The CDO will sign a memorandum to be placed in the credential file of each health care provider attesting to the review. The 60-day time frame does not extend providers deadlines for

renewals of privileges, practice agreements, or protocols. They are still required to be renewed prior to their expiration date.

- Once a Chief Dentist position is hired, , the new CDO is required to review all current privileges, practice agreements, and protocols, to ensure they are current, and they concur with the provisions afforded within them. This review will take place within 60 days of the CDO's appointment. The CDO will sign a memorandum to be placed in the credential file of each health care provider attesting to the review. The 60-day time frame does not give any providers additional time for their renewals of privileges, practice agreements, or protocols. They are still required to be renewed prior to their expiration date. If the Acting CDO is selected for the CDO position, the 60-day review requirement will not apply, as it has already been completed.
- If any privileges, practice agreements, or protocols lack concurrence, updated and signed privileges, practice agreements, or protocols must be obtained.

- **Vacancies of Regional and Central Office health care providers.** Vacancies of Regional and Central Office health care providers will be referred to the Medical Director or National Chief Dentist. The Medical Director will appoint acting Central Office privilege granting authority to providers during vacancies (e.g., Acting Regional Medical Director/Regional Chief Dentist). Those serving in the acting role will review all assigned privileging packets within 60 days of appointment to ensure these are current and in accordance with indented provisions.
  - The Medical Director will appoint the Acting Regional Medical Director (RMD)/ Regional Chief Dentist (RCD) role in a memorandum that is placed in the Acting RMD/RCD credential file.
  - The Acting RMD/RCD will sign a concurrence memorandum to be placed in the credential file of each health care provider reviewed during the period of vacancy.
  - If alterations to the privileges are necessary, a new privilege application will be completed within 60 days of appointment.
  - The 60-day time frame does not give any providers additional time for their renewals of privileges. They are still required to be renewed prior to their expiration date.

e. **Emergency Clinical Support.** In the event of a mass casualty incident, state of emergency, or other disaster, the Bureau privileging authority (i.e., Medical Director) may authorize Bureau clinicians who hold an active, unrestricted license and/or certification to be deployed to institutions without the requirement for an active, signed privilege or practice agreement. This provision is intended to facilitate the rapid deployment of qualified health care personnel in critical situations only. Should the time of emergency deployment occur beyond 180 days, a peer review will be conducted.

5. COMPETENCIES

Except for LIPs, competencies are required for all health care providers who deliver direct medical care. Competencies must be completed during orientation and subsequently at intervals

not to exceed two years. For health care providers who also undergo peer review (APPs and pharmacists working under a practice agreement), clinical skill competencies may be integrated into the peer-review process; however, this integration does not replace or diminish any required components of the peer review itself.

- Institutions with special missions such as FMCs may require nursing staff and paramedics' competencies to be completed annually; this decision is made at the discretion of the CD.
- Generally, clinical skills training contains the basic competencies of the respective discipline throughout all institutions, and mission specific competencies can be added as needed. Clinical skills training should be provided by a health care staff member with a higher scope of practice or competency (e.g., APP to train RN). However, it is also appropriate to have a skilled peer of the same discipline provide clinical skills training.
- Evidence of the health care providers' competency completion should be maintained in their credential file. The appropriate and most up to date forms should be utilized, reviewed, and signed by the appropriate parties.
- Standardized competency documents and additional competency requirements for specific disciplines can be found on the Bureau's intranet site.
- When a certified/registered specialized technician (e.g. Sonographer, Electroencephalography tech, etc.) is contracted from an accredited entity to provide direct medical care, a letter of competency assurance from the contracting company may be utilized to fulfill the competency requirement. The letter must be current and renewed at intervals not to exceed two years.

6. PEER REVIEW

Peer review is a routine function used to monitor the current knowledge and skills of health care providers. All health care providers assigned direct medical care working under privileges or practice agreements, including pharmacists with practice agreements, must have a peer review. In the absence of a professional peer at the institution, it is appropriate to have an external peer or someone with a higher scope of practice such as a physician or CD perform the review. As an example, in situations where a professional peer is not available, a dentist can complete a peer review for a dental hygienist. External peer reviews will be required to be completed in person.

- An initial peer review is conducted, not to exceed six months from the initial privileging or practice agreement date.
- Based on the results of the initial peer review, privileges or practice agreements may be renewed for a second period, not to exceed 12 months. A second peer review will be required prior to the expiration of the privileges or practice agreement.
- If clinical care standards are not meeting expectations on the initial review, a second expiration date for privileges or practice agreement date should not exceed six months. A peer review will need to be conducted prior to the expiration of the privileges or practice agreement.

- Based on the results from the second peer review, the privileges may be renewed on a two-year cycle.

Selection of an individual to a higher-level privileging authority (e.g., Staff Physician to CD, Staff Dentist to institution CDO, CD to Regional Medical Director, institution CDO to Regional Chief Dental Officer) shall require completion of a peer review within one year of the appointment. Based on the results of the peer review, privileges may be granted for a period not to exceed two years.

When a peer review is required, it should be conducted within 60 days prior to renewal of any privileges or practice agreements. Privilege granting authorities may complete peer reviews more often if clinical concerns arise, or if clinical care, internal focus, or external focus review is deemed necessary. See Section 8 for more details regarding clinical care, internal, or external reviews.

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

Salient peer review findings, corrective action, and recommendations will be noted in the cover memorandum. Any requests for corrective actions noted on the peer review report summary must be listed on the cover memorandum and require a response. General recommendations will not require responses. Response to corrective actions is warranted within 30 days to ensure the items are addressed and will foster clinical performance improvement. Section 8.e. has more information on corrective actions. Unless otherwise indicated, the health care provider should provide evidence of sustained improvement prior to the next scheduled peer review to the privilege granting authority. The provider must comply with a response to corrective actions within the established timeline; failure to comply within the established timeline may result in reporting to the NPDB.

7. TRAINING AND EDUCATION

Health care professionals 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 providers assume responsibility to maintain and improve their knowledge and skills to deliver quality care consistent with accepted current

standards of practice and performance requirements. The Bureau, in recognition of this, provides resources annually to health care providers so they may request and receive continuing professional education (CPE) to address their continuing educational needs.

Orientation for health care providers must be conducted in accordance with the requirements established by the respective clinical discipline Chief Professional Officers to ensure role expectations are clearly communicated and formally acknowledged by the health care provider. At minimum, the national template for the health care providers' respective discipline is required to be utilized and will be found on the Health Services Division, Credentialing page of the Bureau's intranet site. If necessary, information can be added to address facilities' specific needs. The completed and signed orientation checklist will be maintained in the credential file of the health care provider.

Health care providers can request training through Health Services (local, regional, and national) and/or through their local needs assessment process with the local Employee Development Office. Regardless of the method, all efforts to utilize the national Continuing Medical Education (CME) project code for funding should occur prior to using local training funds. See Program Statement **Health Services Administration** for more information on continuing medical education.

8. CLINICAL CARE AND FOCUS REVIEWS RELATED TO DEFICITS IN CLINICAL KNOWLEDGE, SKILLS, AND PERFORMANCE

a. **Expectations of Clinical Providers.** All health care providers granted clinical privileges, practice agreements, or protocols are expected to maintain appropriate clinical knowledge, skills, judgment, and performance consistent with professional standards, Bureau policy, and patient safety requirements.

Health care providers are responsible for:

- Practicing within the scope of their granted privileges or agreements
- Maintaining clinical competence
- Participating in required training, education, and quality improvement activities
- Cooperating fully with any clinical review or corrective action process

Failure to meet these expectations may result in clinical review, corrective action, modification of privileges, or revocation of privileges, as outlined below.

Health care providers are legally required to report certain incidents to higher authorities inside and outside of the Bureau. This obligation is known as mandatory reporting and is designed to protect vulnerable populations from harm. The laws vary by state and institutions are directed to become familiar with their specific responsibilities. Mandatory reporters include physicians,

nurses, dentists, mental health professionals, social workers, and emergency personnel. The duty to report is triggered by a reasonable suspicion in situations defined by law to address harm to patients, especially in vulnerable populations. Employee Law Branch is required to report any initiation of cases involving a clinician to the privileging authority. The Warden will provide all necessary information and support to the privilege granting authority.

b. **Authority to Initiate Clinical Care or Focus Reviews.** Clinical care reviews may be initiated or completed by privileging granting authorities whenever there is suspected or confirmed deficiency in the health care provider's:

- Clinical knowledge,
- Skills,
- Judgment, or
- Clinical performance.

Reviews may be initiated at any time, including health care providers who already hold privileges, practice agreements, or protocols.

In most cases, additional training or education is the first step in addressing identified deficiencies.

c. **Immediate Action for Egregious Clinical Deficiencies.** If deficient clinical care is egregious, it poses an immediate risk to patient safety, or it threatens institutional security:

- Clinical privileges, practice agreements, or protocols may be immediately restricted or removed by the privileging granting authority (see Section 8.g.); and
- The health care provider may be reported to the appropriate state or federal licensing or certifying authority, professional board, or the NPDB, as warranted.

d. **Notifications and Administrative Oversight.** The HSA, CD, or CDO will notify the Human Resource Manager of all ongoing clinical or focus reviews described in this section.

- During any review phase, a health care provider's clinical privileges, practice agreement, or protocols may be held in abeyance, when necessary, for periods not to exceed 30 calendar days, unless otherwise specified.
- Decisions regarding abeyance are made case-by-case, based on patient safety and institutional needs.

e. **Corrective Actions.** Corrective action refers to actions necessary to address deficiencies in clinical knowledge, skills, judgment, or performance. Corrective actions may include, but are not limited to:

- Increased clinical supervision
- Completion of additional clinical training or education
- Modification of clinical privileges for LIPs or practice agreements for non-independent licensed providers
- Recommendation for implementation of a Performance Improvement Plan (PIP) in accordance with Bureau policy
- Revocation of clinical privileges for LIPs or practice agreements for non-independent licensed providers

f. **Levels of Review.** There are three levels of review used to evaluate suspected deficiencies. While corrective action should ideally be resolved at the lowest level, privileging authorities may initiate any level of review deemed appropriate based on the severity, frequency, or impact of the concern.

A health care provider may undergo an External Focus Review without having completed a Clinical Care Review when circumstances warrant.

- **Level 1: Clinical Care Review.**
  - **Purpose.** An initial review to address reported or suspected isolated deficiencies in clinical care where such reports/suspicions have not yet been investigated or substantiated. May be initiated due to concerns raised by staff, contractors, patients, or through direct observation.
  - **Process.** The CD/CDO will coordinate the clinical care review and notify the HSA, Warden, and Human Resources of a clinical care review initiation and appoint a peer reviewer. The affected provider is notified by memorandum of the nature of the review and the requirement that the review be completed within 10 calendar days of the notification. The CD/CDO will discuss findings and recommendations with the provider within five calendar days of the review completion. The provider must comply with the recommendations within the established timeframe; failure to comply within the established timeframe may result in reporting to the NPDB.
  - **Outcomes.** Findings, provider response, and resolution are maintained in the credential file per the Records and Information Disposition Schedule (RIDS).
    - If the provider's response is unsatisfactory, or if clinical concerns persist:
      - The CD/CDO may recommend an Internal Focus Review
      - The provider may also request an Internal Focus Review if they disagree with the findings
      - An abeyance of privileges may or may not be required, based on circumstances
- **Level 2: Internal Focus Review.**
  - **Purpose.** To evaluate significant or recurring deficiencies, trends in care, or concerns that may have endangered patient safety. A Clinical Care Review is not required prior to initiation.

- **Process.** The CD/CDO will coordinate the internal focus review and notify the HSA, Warden, and Human Resources of an internal focus review initiation. The review is conducted by a committee of at least three members, including one LIP and two peers (excluding any prior reviewer), appointed by the CD/CDO. The affected provider is notified by memorandum, and the review must be completed within five calendar days of the notification. The findings and recommendations are discussed with the provider within five calendar days of completion. The provider must comply with the corrective actions identified within the specified timeline; failure to comply within the established timeline may result in reporting to the NPDB.
- **Outcomes.** Findings, provider response, and resolution are maintained in the credential file per the Records and Information Disposition Schedule (RIDS).
  - If the review confirms deficiencies that endanger patient safety, threaten institutional security, or cannot be adequately reviewed internally, the CD or HSA will request an External Focus Review.
  - An abeyance of privileges may or may not be required, based on circumstances.

- **Level 3: External Focus Review (EFR).**
  - **Purpose.** An independent, external review of serious or complex clinical deficiencies. An External Focus Review is also appropriate when insufficient LIP or peer staff exist at the institution to conduct the Internal Focus Review.
  - **Requesting EFR.**
    - A written request for EFR will be sent from the facility HSA or CD/CDO to the RMD/RCD.
    - Request copies are provided to:
      - HSD Medical Director
      - National Credentialing Program Chief
      - Regional Director (RD)
      - Institution Warden
    - The requesting institution submits all relevant clinical records and prior review findings.
  - **Review Determination.** The National Credentialing Program Chief conducts a provisional review and provides recommendations to the RMD/RCD.
    - If the RMD/RCD determines no further review is warranted, they may issue a response memorandum to the facility to:
      - Terminate the review, or
      - Recommend direct corrective action.
    - If the RMD/RCD determines further review is required, a Focus Review Committee (FRC) is convened.
  - **Process.** The National Credentialing Program Chief will coordinate the EFR at the direction of the RMD/RCD. The affected provider is notified of the review by memorandum, and the review and final reporting must be completed within 30 calendar days. The review is conducted in person (if possible) by a committee of at

least two physicians or two dentists (one serving as Chair), and additional subject matter experts as needed. The findings from the FRC are reported to the RMD/RCD.

- **Outcomes.** Findings, provider response, and resolution are maintained in the credential file per the Records and Information Disposition Schedule (RIDS).
  - The RMD/RCD issues, via memorandum, the findings from the FRC and required actions to the Warden.
  - Findings are discussed with the provider within seven calendar days of the Warden receiving the report.
  - Decisions regarding privileges are issued by the privileging granting authority.
  - The Warden retains authority over employment decisions but may not reverse privileging determinations.

g. **Revocation or Restriction of Privileges.** Privileges may be denied, suspended, restricted, or revoked by the privilege granting authority at any time if:

- Deficient clinical care is egregious, poses an immediate risk to patient safety, or threatens institutional security; or
- Corrective actions fail to resolve deficiencies.

The provider will receive a written notice detailing the rationale. The provider has 30 calendar days to dispute the decision.

After reviewing all documentation and the provider's response:

- The Medical Director will make a final privileging decision.
- The Warden retains final authority over all disciplinary and employment actions, including reassignment to non-clinical duties.

9. NATIONAL PRACTITIONER DATA BANK (NPDB) AND REPORTING REQUIREMENTS

The National Credentialing Program Chief and the Bureau's Medical Director review the NPDB memorandum of each health care provider and provide guidance to the institution regarding suitability for appointment, conversion to probationary appointment, or permanent appointments, as appropriate. The National Credentialing Program Chief and the Medical Director review the Professional Liability Case Reporting form from individuals with adverse actions in the NPDB and provide guidance to the institution on appropriate actions to be taken prior to signing the clearance memorandum.

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

The Bureau Medical Director is the only authorized official to approve and sign any reporting of a Bureau health care provider or contractor to the NPDB which may be applicable to situations such as, adverse clinical privileges actions, federal and state licensure and certification actions, health care related criminal convictions, and more per the NPDB reporting requirements listed on the U.S. Department of Health and Human Services NPDB website. If the health care provider's privileges, practice agreements, or protocols are suspended, denied, restricted, or revoked due to actions related to professional competence or conduct, for a period longer than 30 days they will be reported to the NPDB and state licensure or certification boards. The Bureau Medical Director may delegate authority for technical aspects of the query and reporting processes to the National Credentialing Program and may delegate authority for review of documents and development of NPDB recommendations to the National Credentialing Program or to a panel of Bureau physicians and dentists.

The institution maintains all reports and information in the provider's credential file.

■ **NPDB Queries.** The Bureau requires a continuous query NPDB before granting initial, renewed, or revised privileges on every physician, dentist, or other licensed provider providing professional care in a Bureau institution.

- If NPDB initial screening shows any adverse action, the applicant submits the Professional Liability Case Reporting form. Central Office verifies the applicant, or staff member, fully disclosed the related information required and requested by the Bureau in its pre-employment, credentialing, and clinical privileging procedures. The Medical Director or designee reviews all reports and provides a decision on whether the applicant is suitable for employment in the Bureau.
- When during a continuous query, the NPDB report calls into question the professional competence or conduct of an individual appointed or used by the Bureau, the National Credentialing Program and the Bureau Medical Director or designee review all reports and relevant information. The Medical Director or designee provides guidance to the institution about appropriate necessary actions, which may include no further action, revision, or removal of clinical privileges. The institution and the individual are required to submit information regarding the NPDB report during this process.
- The Medical Director or designee will review the provider's submission and render a decision via memorandum. This memorandum must be in the credential file before providing patient care.
- The institution maintains copies of the NPDB results in the credential file for each provider.

The information on how to submit NPDB queries is located on the HSD Credentialing Section page of the Bureau's intranet site.

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

Any health care provider whose clinical privileges, practice agreements, or protocols are suspended, denied, restricted, or revoked for more than 30 days is entitled to a fair and equitable remedy process.

Any health care provider 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 health care provider who will be the subject of the clinical privileges/practice agreement/protocols action (i.e., suspension, denial, restriction, revocation) has 30 calendar days from the date of receiving the Bureau's intent to refute the intended action. Once a staff member has requested to refute the action, the employer must make a final decision with justification.

Any decision to suspend, deny, restrict, or revoke clinical privileges, practice agreement, or a protocol for a period beyond 30 days, will result in the provider being reported to the NPDB within 15 days of the decisive action.

REFERENCES

Program Statements
Health Services Administration

ACA Standards
Performance-Based Standards and Expected Practices for Adult Correctional Institutions (5th Edition): 5-ACI-6B-01M, 5-ACI-6B-02M, 5-ACI-6B-03M, 5-ACI-6D-03M

Performance-Based Standards and Expected Practices for Adult Local Detention Facilities (5th Edition): 5-ALDF-4D-01M, 5-ALDF-4D-02M, 5-ALDF-4D-03M, 5-ALDF-4D-05M, 5-ALDF-4D-32M

Standards for the Administration of Correctional Agencies, 2nd Edition: 2-CO-4E-01

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) on the Bureau's intranet site.