وزارة الصحة
Ministry of Health

Credentialing & Privileging

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Be Prepared!

Outline

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Module 5 : Decision-making Criteria and Process.

Module 6 : Managing files that meet Criteria.

Module 7 : Submitting Credentialing Application.

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Module 11: Credentialing and Primary Source Verification

Module 1

Introductions and Overview

Learning Objectives

- Direct the credentialing, privileging, and enrollment processes; monitors applications and follows-up as needed.
- in charge of processing accreditation and verification information.
- Makes sure that all medical personnel including doctors, assistants and other healthcare professionals comply with Credentialing & Privileging policies, JCI and CBAHI regulations.
- Oversee evaluation of credentialing/privileging requests and evidence of education, training, competence, ability to perform, and experience to determine eligibility.
- Oversee the submission of complete and accurate applications and/or practitioner data/roster to ensure timely approval and maintenance of network participation .

Learning Objectives

- Collecting and maintaining an accurate practitioner database and analyzing verification information and keeping the databases accurate
- Maintains copies of current licenses, certificates, and any other required credentialing documents.
- Sets up and maintains provider information in credentialing databases system.
- Processes applications for appointment and reappointment of privileges in the hospitals .

What is Credentialing?

- The process of obtaining, verifying and assessing the qualifications of a healthcare professional to determine if that individual can provide patient care services in or for a healthcare organization.

- ❖ Credentialing Definition by the National Committee for Quality Assurance (NCQA): organization reviews and evaluates qualifications of licensed independent practitioners to provide service to its members.
- ❖ Ensures that all patients receive quality care by competent and qualified practitioners

What is Privileging?

- The process of reviewing an individual’s credentials to determine the authority and responsibility to be granted to a practitioner for making independent decisions to diagnose, initiate, alter, or terminate a regimen of medical or dental care .
  - ❖ Privileging determines the physician’s scope of practice in the organization determined by his/her competencies.

Policy Definitions سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء :

Clinical Privilege: yb noissimrep detnarg si renoititcarp htlaeh a hcihw yb ssecorp eht sa denifeD raelc nihtiw ,(noitazilaiceps ot gnidrocca) secivres erac lacidem edivorp ot ,erachtlaeH ytilicaf a iduaS eht ni noitartsiger dna gnisnecil ,gniniart dnA ecnetepmoc lacinilc no desab ,stimil .seitlaicepS htlaeH rof noissimmoC

Special medical privileges: are specified By specialization according to the resources, devices, equipment and systems available in the health facility and the scope of services.

- Privileges are granted Clinical appointments for a period of more than two years, after which renewal takes place according to performance, with the privileges granted to him, or to add a new privilege.

Policy Definitions سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء :

Licensed Independent Practitioner: Any person who is permitted by law and by the health facility to provide care and services. without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

Verification of the main source: the accuracy of the qualification of the practicing physician.

- verification is determined in variety of ways, include but are not limited to:

.1correspondence Direct and verification over the phone

.2through the official e-mail of the university granting the academic qualification or the hospital the grantor of the certificate of experience or the training center that grants the certificate of training.

- ❖ Verification can be done through a third party called Applicant verification organizations, for example Dataflow

Policy Definitions سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء :

Reference dna lanoisseforp tnerruc eht ot tsetta nac ro nac ohw snosrep ro nosrep a morf rettel A : .ytilanosrep dna ecnetepmoc ,dnamed ,retneserp eht fo tnemgduj lacinilc

- Those references must fulfill the concept of “peer (elpoep yb dedivorp era yeht taht gninaem) ” .(tnacilppa eht sa eerged dna rojam lanoitapucco emas eht evah
- For applicants who have recently completed or Those still in the training program or postgraduate studies are required to submit one reference letter from the training program.
- Other applicants who are currently working in a health facility are required to obtain a letter of recommendation from a president Doctors or department heads in the health institution

Policy Definitions سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء :

- **Basic privileges:** taht ytlaiceps-bus ro noitazilaiceps eht rof segelivirp fo tes cificeps a snaem taht rof doirep gniniart eht ni thguat ylenituor si taht secivres erac tneitap laitnesse sedulcni .ytlaiceps-bus ro noitazilaiceps
- **Additional privileges:** medical privileges that are requested by the doctor according to what is new in his scientific or practical field or what needed by the health facility in the scope of services

❖ after the practitioner has obtained training, there must be an evidence of that training either by a certificate or an evaluation of a “consulting doctor in the same specialty and having the same privileges or a record of cases in which he practices. ”The privilege required at the time of training is documented and stamped by the granting authority, or all of the above, as the Privileges Committee deems appropriate.

Overview

Hospitals and other types of health care organizations often employ credentialing specialists to make sure they are complying with Saudi Commission for Health Specialties, MOH, CBAHI and JCI standards.

Credentialing and re-credentialing requirements are applied to all licensed practitioners Classified by SCHS.

Overview

All clinical health professionals who work on permanent, part-time, visitor and locum basis must be credentialed prior joining by the Saudi Commission for Health Specialties

Credentialing must include all Medical and Dental Physicians, all Health care providers including Nursing, and any other independent practitioner have a relationship with the Patient care services and provide Health care under SCHS medical benefit.

Overview

Medical staff members are allowed to practice only within the privileges granted by the credentialing and privileges committeeز

The credentialing and privileging of the medical staff is based on an informed group decision.

Continue …

Credentialing and privileging committee:

- oversight on the credentialing and privileging processes.
- preferably chaired by the medical director
- ensures that only qualified physicians and dentists are appointed and granted privileges

Module 2

CBAHI standards

CBAHI standards …

HR.5 The hospital has a process for proper credentialing of staff members licensed to provide patient care.

- **HR.5.1** The hospital has a written policy describing the process used for the verification of credentials.
- **HR.5.2** The hospital gathers, verifies, and evaluates the credentials (license, education, training, certification and experience) of those medical staff, nursing staff, and other health professionals licensed to provide patient care.
- **HR.5.3** Credentials are verified from the original source.
- **HR.5.4** Job responsibilities and clinical work assignments/ privileges are based on the evaluation of the verified credentials.
- **HR.5.5** The hospital ensures the registration of all healthcare professionals with the Saudi Commission for Health Specialties.

CBAHI standards …

HR.5 The hospital has a process for proper credentialing of staff members licensed to provide patient care.

- **HR.5.6** Staff licensed to provide patient care must always have and maintain a valid license to practice only within their profession.
- **HR.5.7** The hospital maintains an updated record of the current professional license, certificate, or registration, when required by laws, regulations, or by the hospital for every medical staff, nursing staff and other healthcare professionals.
- **HR.5.8** When verification of credentials is conducted through a third party, the hospital must request for a confirmatory documentation.
- **HR.5.9** Verification process applies to all clinical staff categories (full time, part time, visitor, and locum).

CBAHI standards …

MS.3 The hospital has an effective process that supports the professional communication and coordination of care amongst medical staff.
MS.3.4 The medical executive committee reviews all relevant reports of other hospital committees for prioritizing the services needed and guiding the credentialing and privileging process

CBAHI standards …

MS.5 The credentialing and privileging of the medical staff is based on an informed group decision.

- **MS.5.1** The hospital has a credentialing and privileging committee chaired by the medical director or a designee.
- **MS.5.2** The credentialing and privileging committee provides oversight on the credentialing and privileging processes.
- **MS.5.3** The credentialing and privileging committee ensures that only qualified physicians and dentists are appointed and granted privileges.
- **MS.5.**4 Applicants for initial appointment submit a complete set of documents required for the credentialing and privileging process , including:
  - **MS.5.4.1** Curriculum vitae, detailing the professional history of the applicant.
  - **MS.5.4.2** Education, training, certificates, courses, experience, published research, and other relevant credentials.
  - **MS.5.4.3** List of references.
  - **MS.5.4.4** List of the privileges requested for approval

CBAHI standards …

- **MR.1** The Health Information Management (Medical Records) department has adequate qualified staff
  - **MR.1.2** The department director is credentialed in health information management through formal training as per the national/international guidelines.
  - **MR.1.4** Staff working in the department are credentialed in health information management through formal training as per the national/international guidelines .
  - **MR.1.5** Clinical coding staff working in the department are credentialed/certified in clinical coding through formal training as per the the national/international guidelines.
  - **MR.1.6** The department has one or more staff members who are credentialed in Clinical Documentation Improvement (CDI) through formal training as per the national/international guidelines.

Module 3

Credentialing and Privileging process

Why is Credentialing Important?

The primary purpose of credentialing is to protect our patients.

Darling v. Charleston Memorial Hospital (1965),
Johnson v. Misericordia Community Hospital (1981), and
Frigo vs. Silver Cross Hospital (2007).

Credentialing purpose:

1. To improve the quality of care
2. Met the accreditation requirements
3. To participate in other Health care program.
4. For Patient Safety

Credentialing and Privileging process

- A hospital's medical staff plays a critical role in assuring quality care and improving patients' outcomes in the hospital
- A good hospital should always have a clear structure of its medical staff, including departments, divisions, and medical committees.

Credentialing Objectives:

1. Ensures that the credentialing and re-credentialing process is conducted in a manner that is nondiscriminatory.
2. Ensures that the credentialing verification process does not exceed the prescribed time.
3. Ensures that practitioners' re-credentialing occurs at least every 24 months.
4. Meets MOH, SCHS, CBAHI & JCI standards for credentialing.
5. Complies with SCHS requirements.
6. Ensures the confidentiality of all applications received.
7. Ensures that all practitioners providing care under SCHS are credentialed.
8. Ensure that licensed health care practitioners meet standards for participation in the Health care practitioner panel.

The credentialing requirements:

The basic or the core requirements most often associated with application for medical staff credentialing are reflected in the education, training, experience, and licenses of the applicants. The listed requirements should be outlined in the policy, bylaws, rules, and regulations.

General Credentialing Qualifications:

1. Licensure: currently valid SCHS.
2. Professional Education and Training: Graduate of an Approved Medical or Dental School or certified by the Educational council for foreign Medical Graduates, with approved postgraduate training program.
3. Clinical Performance: current experience, clinical result and utilization practice patterns, documenting a continuing to provide patient care services at an acceptable level of quality.
4. Cooperativeness: Demonstrate ability to work with and other Medical Staff members, members of other health disciplines, hospital management and employees.
5. Satisfaction of Membership Obligation: satisfactory compliance with the basic obligations accompany appointment to the medical staff as set in the Bylaws.

General Credentialing Qualifications:

6. Professional Ethics and Conduct: to adhere to generally recognized standards of medical and professional ethics.
7. Disability: To be free of or have under adequate control any significant physical or mental health.
8. Verbal and written communication skills: Ability to understand and to communicate in written and verbally in an intelligible manner.
9. Professional Liability Insurance: Professional liability insurance to cover malpractice when occurs.

Specific Credentialing requirements: -

1. Employment Application Form
2. Copy of national ID / PASSPORT
3. Applicants Complete Updated Resume
4. Bachelor Degree/ or other Certificate
5. Residency Certificate (Doctors)
6. Fellowship Certificate (Doctors)
7. Specialty Board Certification (Doctors)

Specific Credentialing requirements: -

8. Sub-specialty Board Certification (if applicable)
9. Experience Certificates - Up to date 3 reference letters
10. Releasing of Information Letter or consent (as a form)
11. License Registration (must be valid)
12. Valid BLS, or ACLS, or any related to specific specialty
13. Insurance agreement or malpractice agreement (some specialty)

Medical staff bylaws:

Medical staff bylaws: govern the organization, functions, and responsibilities of the medical staff, and serve as the primary source for the appropriateness of the professional performance and ethical practice

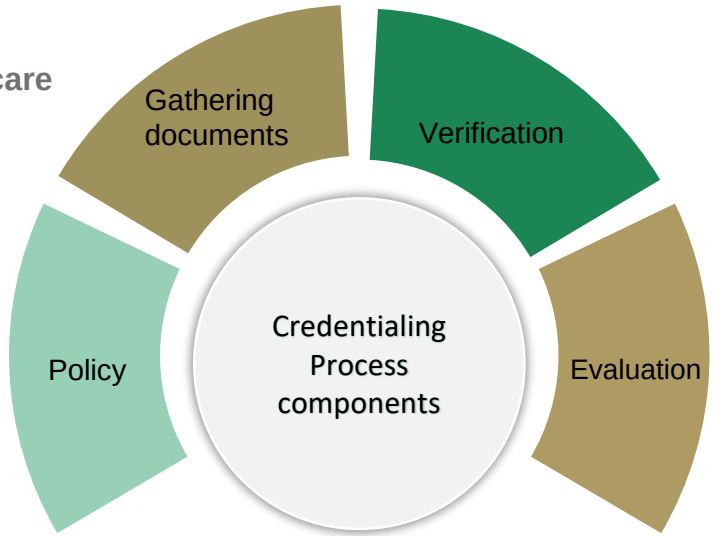
- Approved by the governing body.
- Consistent with acceptable medical staff practices.
- Consistent with laws and regulations.
- Describe the organizational structure of the medical staff.

Medical staff bylaws address the following:

- The medical staff ranking and the qualifications required for each rank.
- Categories of the medical staff membership (e.g., full time, part time, and locum).
- Roles and responsibilities of the medical staff members.
- Appointment, promotion, and reappointment of medical staff members.
- Disciplinary procedures for medical staff members, including corrective actions and appeals.
- The process for verification of the medical staff credentials.
- Granting and maintaining clinical privileges, including temporary privileges

Credentialing

- Staff
- Providing Pt. care



- Primary source

- Written
- Approved

- Certificates
- licence
- Registration

Policy

وزارة الصحة
Ministry of Health

سياسات وإجراءات إدارية			
عنوان السياسة	سياسة الامتيازات والصلاحيات الإكلينيكية للأطباء	تاريخ بداية التطبيق	مارس 2023م
التطبيق	تطبق هذه السياسة بجميع مستشفيات وزارة الصحة ويمكن الاسترشاد بها لجميع القطاعات الصحية	تاريخ المراجعة	مارس 2026م
عدد الصفحات	13	أخر إصدار	أبريل 2019م

Gathering Documents

- Curriculum vitae
- Detailed the professional history.
- Education
- Training
- Certificates
- Courses
- Experience
- published research
- List of references.
- Any and other relevant credentials.

Verification

Verification can be performed by:

- ❖ The organization
- ❖ 3rd party: hospital must request for a confirmatory documentation

Verification process applies to all clinical staff categories

- Full time
- Part time
- Visitor
- Locum

Primary source verification

Policy : سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء

The procedures for verifying credentials and documentation are as follows:

1. Verifying and documenting the medical credentials provided by the physician, including four aspects (Saudi Council classification, academic qualification, training, and experience) according to the type of privilege granted.

- at least basic Verification, which is the academic qualification and experience Training according to the type of qualification required.

2. Verification and documentation must be through the source, university, hospital or training center.

3. Verification and documentation can be done through the health facility or through an approved third party (for example, dataflow).

Policy : سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء

Methods of verification and documentation from the primary source include (but not limited to):

1) Verification and documentation through direct contact (and it must be properly documented so that the Assign the contact person from the Human Resources Department and specify the contact person with documentation date and time of call and response).

2) Verification and documentation through an official letter issued by the primary source.

3) Verification and documentation through the website or the official e-mail of the concerned authority.

- Verification and authentication can be done through a third party (e.g. Dataflow).

Evaluation

The institution must have updated record for all employees for:

- Certificates
- License
- Registration

Evaluation is the basis for **PRIVILEGING**

Certificates

- Academic certificates
- Professional training
- Fellowships
- Residency programs

Licence

- Valid licence at all times
- Within profession

Registration

- The hospital ensures the registration of all healthcare professionals
- Required by laws
- All members of the medical staff must be registered with the **Saudi Commission for Health Specialties** before allowed to work independently

Re-credentialing:

1. Re-credentialing is the continuous cycle of credentialing practitioners, as well as upholding quality of service.

2. Re-credentialing is the process to obtaining and evaluating data to support the continued competence of the healthcare practitioner to provide patient care service in or for a healthcare institution.

3. The initial appointment process focuses on the practitioner’s education, training, and other professional experience before obtaining membership and privileges at an institution. The information required for this process comes mainly from external sources.

Re-credentialing:

4. The re-credentialing/reappraisal process focuses on the practitioner’s professional behavior and competence while functioning within the institution. During this process the medical staff is required to reappraise the individual’s adherence to medical staff membership requirements and the performance of clinical privileges.

- For the Joint Commission accredited hospitals, the re-credentialing process includes a review of information collected during the Ongoing Professional Practice Evaluation (OPPE) process.

Re-credentialing requirements:

1. Must include all that is required in the Credentialing requirements (if newly granted).
2. Ongoing Monitoring and Interventions must be included for re-credentialing:
   a) Credentialing Office continuously monitors practitioners between re-credentialing and privileging cycles and takes appropriate action when it identifies occurrences of poor quality of member care and service.
   b) Practitioners with an expired clinical license to practice are terminated or suspended.
   c) Re-credentialing is conducted at least every 24 months in accordance with the credentialing and re-credentialing process.
   d) The re-credentialing process is conducted with the same standards as those for initial credentialing.
   e) The decision concerning re-appointment or failure to re-appoint will be conveyed to the physician/provider in writing.

Activity 2.6: Recredentialing/Reappointment

- Review the scenario
- Discuss and list options
- Pick one person from your table to report

Verifying Expirables – Why is this Important?

1. Validate current credential and disciplinary action
2. Ensure ongoing eligibility with the organization – meet bylaws requirements
3. Meet accreditation and regulatory requirements

Privileges

As credentialing practices vary despite a centralized body - namely the SCHS - privileging, which is an internal or institutional issue, varies largely from sector to sector and from provider to provider.

The medical authorization and privilege grant policy provides a mechanism for granting medical privilege to a health practitioner …… (POLICY)

Continue ….

- Most hospitals use some form of ‘laundry list’ for privileging, whereby the healthcare worker is offered a checklist of privileges to choose from that can be initially verified by the Department Head followed by the Credentialing and Privileging Committee (CPC) within this hospital, or in the case of the General Directorate for Health Affairs - Riyadh, a final decision is taken based on the simple verification of training and experience.
- the basic privileges for a given specialty are expected, while practices that are based on intuition are excluded.
- Other hospitals and sectors may conduct competence-based privileging; in this process, the training and experience per each privilege - especially for carrying out advanced or high-risk medical procedures - is thoroughly evaluated in terms of training quality, actual experience, and mentoring.

Policy : سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء

- all practicing physicians are qualified and have clinical privileges according to their field and Specialty.
- Each facility is obligated not to authorize any doctor to practice before obtaining the clinical privileges
- Each practicing physician obtains clinical privileges according to the classification of the Saudi Commission for Health Specialties for independent practice.
- A physician may be granted emergency medical privileges in an emergency without having the emergency clinical privileges to save lives under specific conditions and according to the standards of the Saudi Center for Accreditation Health facilities.

Policy : سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء

- Each health facility must develop a mechanism for granting initial medical privileges, renewing medical privileges, or refusing medical privileges.
- Privileges grant according to the need of the facility and the documents provided by the doctor.
- Before the health facility grants medical privileges, it must ensure that the physicians requesting the medical privilege have appropriate specialization and classified by the Saudi Commission for Health Specialties and all the credentials necessary to perform their privileges.

Policy : سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء

- The health facility must collect information related to the requirements for granting medical privileges to licensed physicians Verify and evaluate them, including:

1. Qualifications
2. Current license
3. Training
4. Current competency
5. Record or certificate showing the number of cases proving his experience of the required privilege.

Policy : سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء

privilege is classified into four categories:

1. **Basic privileges :** granted to any trainee in the training program for the same specialization performs before complete the training and be classified in the Commission for Health Specialties at least as a resident or deputy physician related specialty.
2. **Advanced privileges in the same specialty** after completing training and classified in the Saudi Commission for Health Specialties at least as a first deputy or consultant in the same specialty.
3. **Additional privileges**, which are the privileges for the subspecialties of the same basic specialization, after being classified in the Saudi Commission for Health Specialties, and obtains them in the same way as assessing the basic and advanced privileges.

Policy : سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء

4. privileges for advanced or new skills in the field of specialization that require additional training, which are not classified In the Saudi Commission of Health Specialties and for consultants classified in the same specialty after evaluation auditing and submitting supporting documents (such as a training certificate, its duration and source, a reference certificate and a record The training cases are documented by the training supervisor, the training body, and the evaluation of the training specialist consultant).

Policy : سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء

Current Privilege: It is the medical privilege granted to the doctor after the approval of the Medical Privileges and Accreditation Committee for a period not exceeding two years, The practitioner is then re-evaluated according to his performance in applying the privileges granted to him or to add a new privilege

Temporary Privilege: It is the medical privilege granted to a physician with a permanent or partial contract, or a visiting physician who has been newly appointed to practice medicine. For a specified period of time (provided that it does not exceed 90 days and it is not renewable).

Emergency Privilege: It is the medical privilege granted to a doctor in emergency cases (provided that it does not exceed 90 days and is non-transferable) not renewable

Policy : سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء

The Clinical Privileges and Privileges Policy applies to all medical practitioners who are independent medical practitioners in health sector facilities at the Ministry of Health, including:

1. **A practicing consultant physician** who has obtained the registration of the Saudi Commission for Health Specialties.
2. **The physician is a senior specialist practitioner** and holds the registration of the Saudi Commission for Health Specialties.
3. **A practicing specialist physician** and holds the registration of the Saudi Commission for Health Specialties.

Policy : سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء

The Clinical Privileges and Privileges Policy applies to all medical practitioners who are independent medical practitioners in health sector facilities at the Ministry of Health, including:

4. **Resident physician** and holder of the registration of the Saudi Commission for Health Specialties.

5. **A visiting doctor**, a doctor on a part-time contract, or a volunteer who has obtained the registration of the Saudi Commission for Health Specialties.

6. **An intern** or intern who works under the supervision of one of the medical categories above

Clinical Staff who require Privileging:

1. Clinical staff include all staff who provide clinical services (for example, medical services, dental services, behavioral health services).
2. Clinical staff are licensed independent practitioners (LIPs), other licensed or certified practitioners (OLCPs), and other clinical staff who are health center employees, individual contractors, or volunteers.
3. Examples of LIPs include: physician, dentist, physician assistant, nurse practitioner, clinical psychologist.
4. Examples of OLCPs1 include: registered nurse, licensed practical nurse, certified medical assistant, phlebotomist, respiratory therapist, licensed or certified behavioral health support staff.

Clinical Staff who require Privileging:

5. Examples of other clinical staff include: medical assistants, peer navigators or community health workers in states, territories or jurisdictions that do not require licensure or certification.
6. The health center chooses the timeframe for recurring credentialing and renewal of privileges (for example, every 2 years).
7. The health center chooses what specific credentialing activities apply to “other clinical staff.” For example, if KSA does not certify medical assistants, you would verify their training instead of licensure.
8. A health center that does not employ “other clinical staff” would not need to include them in its operating procedures or make that type of provider file available for review.

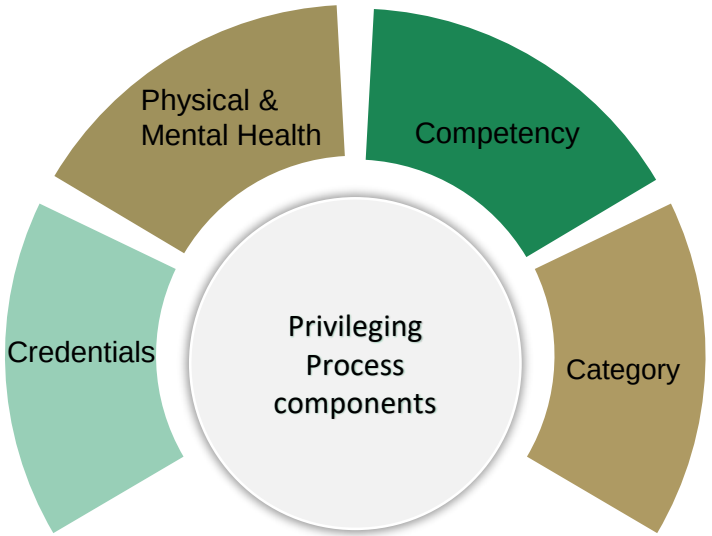
Examples of Privileging Documentation

Verification of fitness for duty to assess to ensure all clinical staff have the physical and cognitive ability to safely perform their duties.	**Completed statement or attestation of fitness for duty from the provider that is confirmed either by the director of a training program, chief of staff/services at a hospital where privileges exist, or a licensed provider designated by the health center.**
Verification of immunization and communicable disease status	***Immunization Status:*** Copy of immunization records/status in provider's file or provider attestation, including, if applicable, any declinations. (To follow recent approved national guidelines in this regard) ***Communicable Disease Status:*** Copy of completed tuberculosis (TB) test or screening (for example, copy of purified protein derivative (PPD) testing and chest x-ray (CXR)) and any other communicable disease testing or screening as determined by the health center (for example, Hepatitis). (To follow recent approved national guidelines in this regard)
Verification of current clinical competence	For initial privileging: Verification of current clinical competence via training, education, and, as available, reference reviews. For renewal of privileges: Verification of current clinical competence via peer review or other comparable methods (for example, supervisory performance reviews).


Facility Privileges
Physician Privileges
Granted Privileges

Privileging

- Evaluation of capabilities



- Outcome of care

- License
- Education
- Training
- Experience

- Consultant
- Specialist
- Resident

Privileging

Clinical privilege are granted for a period not exceeding two years, and consider when renewed the qualification in terms of the number of cases served, number of serious events, medical errors, and other issues related to privileges).

Temporary or emergency privileges can be granted:

- ❑Not more than 90 days
- ❑Not renewable.
- ❑The circumstances to be granted must be identified

Privileging

- Medical staff are allowed to practice only within the privileges granted by the credentialing and privileging committee.
- When a new privilege is requested by a medical staff member, the relevant credentials are verified and evaluated prior to approval.
- while it is an internal process carried out primarily by the hospital, health directorate or equivalent - the SCHS establishes and oversees many scientific societies that can outline the privileges for relevant specialties and subspecialties.

Privileging

- Members of the medical staff are not ALLOWED to practice any medical practices or privileges different from their classified medical specialty.
- Members of the medical staff are not ALLOWED to practice any new medical practices or privileges before studying it and obtaining approval from the Privileges Committee (Except in the emergency cases stipulated at the beginning of the policy).

Privileging

- The performance & competency of the medical staff members is evaluated on an ongoing basis to ensure competency:
  - By department head
  - Planned vs Unplanned
    - Planned: at least annually
    - Unplanned: when indicated

Policy : سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء

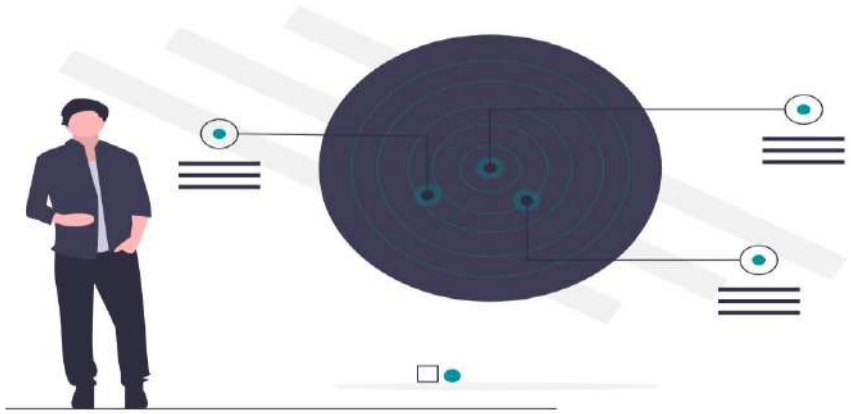
- There must be a specialized department or entity to follow up the work of accrediting medical privileges like HR or quality…..).
- This department is responsible for overseeing the process, Approval of granting medical privileges to specialties according to the scope of services and the need of the health facility, and confirmation the completion of the justifications for granting the medical privilege.
- the medical staff must fulfill the requirements of the Saudi Commission for Health Specialties and the rules and regulations of the Ministry of Health for the practice of the medical profession.

Policy : سياسة الامتيازات والصلاحيات الاكلينيكية للأطباء

- ❑ The department head must ensure that all applicants have completed all requirement form to obtain the medical privilege to practice in the health facility.
- ❑ The application must be submitted with a complete set of documents for the approval process according to the approved policy.

Low/No Volume Practitioner Data

Peer recommendations: Peer recommendations should include reference to the applicant's competence and ability to perform the privileges requested
Data from other facilities: Peer recommendations should include reference to the applicant's competence and ability to perform the privileges requested
Procedure logs: Practitioners may be asked to provide procedure or case logs showing procedures performed in the office setting.



Assessing Current Competency

- Proficiency requires practice
- High-risk procedures
- Use both internal and external sources to assess competency
- Assess low-volume practitioners
- Consider impact of age on competency

Performance & Competency evaluation

Examples

Assessment of patients.

Adverse events.

Moderate and deep sedation.

Quality of medical records.

Medication errors.

Performance & Competency evaluation

Examples

Sentinel events.

Outcome of high-risk procedures and surgeries.

Morbidities and mortalities.

Blood and blood product usage.

Discrepancies between pre and post-operative pathological diagnoses.

Appropriateness of admissions from the ER & OPD.

Performance & Competency evaluation

The data and information resulting from the medical staff performance review are used to:

- Provide feedback and counseling to the medical staff regarding their performance.
- Recommend plans for improvement
- Amend clinical privileges as necessary
  - Expansion
  - Limitation
  - A period of counseling and oversight
  - Other appropriate action
- Make informed decisions regarding reappointment.
- Recommend training and continuous education as needed

Performance & Competency evaluation

❑The outcomes of the medical staff performance evaluation and actions taken are documented in the physician’s credentials file

❑Data and information resulting from the medical staff performance review are used to continuously improve the quality and safety by :

- Studying and minimizing variances in the processes.
- Taking actions to avoid preventable medical errors and adverse events.
- Recommending equipment needed in specified areas.

Appeals

Hospitals must have a process in place for appeals against credentialing or privileging decisions

Credintialing & Privileging **Red Flags**

- Gaps / Missing dates
- Discripancies between applicant’s information & verification
- Previous adverse actions
- Drug & alcohol abuse
- Felony convictions
- Many lawsuits settlments
- Cancelled malpractice insurance
- Frequent job changes
- Suscpicious reference letters
- Altered documents

Continuous monitoring of privileges

- some hospitals conduct periodical performance evaluations,
- others do it routinely only to fulfill paperwork,
- while others do not do it at all.

➢ Based on this evaluation, the privileges and at times the credentials may be revisited to make sure they are rightfully granted and aligned with the professional practice.

Module 4

Types of Practitioners

All Practitioner Classified by the SCHS:

- Medical Physician.
- Non-physician practitioners who are licensed, certified or registered by the SCHS to practice independently (without direction or supervision), and treating patients such as (Nurse Practitioners, Nurse Midwives, Dentists).
- Telemedicine consultants interacting with patients
- Physical Therapists, Occupational Therapists, Speech and language therapists
- Behavioral healthcare practitioners (Psychiatrists and other physicians, Addiction medicine specialists, Doctoral or master's-level psychologists who are state certified or licensed,
- Social workers who are certified or licensed, or any other healthcare specialists, who are licensed, certified or registered by the SCHS independently.

Advanced Practice Professionals (APPs)

Credential and privilege grant for advanced practice professionals is based on the regulations and accreditation standards, as well as its bylaws.

Advanced Practice Clinicians – also known as Allied Health Professionals (AHPs) or Advanced Practice Professionals (APPs) typically include:

- Advanced Practice Registered Nurses
  - **Clinical Nurse Specialists**
  - **Nurse Practitioners**
  - **Certified Nurse Midwives**
- Psychologists

Module 5

Decision-making Criteria and Process

Decision-making criteria and process

Determines in advance what should be done.

A medical services manager would:

- Determine department objectives
- Set goals
- Formulate policies and procedures, programs, rules ar
- Schedule review and updates of governance documen

Decision-making criteria and process

Determines how work in a department will be accomplished.

A medical services manager would:

- Identify roles and responsibilities for staff
- Assign duties to staff
- Assign levels of supervision
- Coordinate activities and teams to achieve departmental goals

Decision-making criteria and process

- Credentialing and privilege decisions are based on the collection of information regarding an applicant’s qualifications, including education, training, licensure, malpractice and competence.

Decision-making criteria and process

- The Credentialing & Privileging Committee holds the responsibility for reviewing credentialing and privileging for each applicant.

- All licensed practitioners by the SCHS must be approved by the credentialing committee.

- When issues are found during the credentialing & Privileging processes, the reviews make the determination to approve or reject the practitioners' application.

- The chair of Credentialing & Privileging committee, has the authority to approve or disapprove practitioners' credentialing or re-credentialing files.

Decision-making criteria and process

- Only when the reason for the exception is in benefit of member care, or when the timeline for Committee review exceeds the established schedule, the Chair of Credentialing committee will review and provide final approval on all of the clean files approved by the CMO.

- All provisionally credentialed practitioners must complete a credentialing application.

- The Credentialing & Privileging Staff will complete primary source verification, and review malpractice claims and settlements from malpractice carriers prior to submitting recommendation for committee approval.

Module 6

Managing files that meet Criteria

Managing files that meet criteria

1. Credentials & Privileging files are treated as confidential and are kept with restricted access to the Credentialing & Privileging Staff, and Compliance Department.
2. Documents in these files may not be reproduced or distributed, except for confidential peer review.
3. Primary source verification is obtained and the provider file is updated.
4. The following documents will be current and maintained in the practitioner's file:
 - Current License.
 - Verification of education and training.
 - Verification of board certification.
 - Work history-including gap inquiry.

➢ In addition to the above listed, each file contains a signed and dated checklist that includes:
 - The source used.
 - The date of verification.
 - The signature or initials of the person who verified the information
 - The report date, if applicable

Managing files that meet criteria

Each file contains a signed and dated checklist that includes:
- The source used.
- The date of verification.
- The signature or initials of the person who verified the information
- The report date, if applicable

File Audits

- Help verify compliance with the requirements of bylaws, accrediting agencies, and regulations.
- Tools should include necessary documentation and completion within the required timeframe.
- Audit tools vary depending on the processes being audited.
- Must be in compliance with current accreditation standards.
- Audit for required timeframes, if applicable.

Database Audits

Best practices include:

- Run reports from credentialing database containing information.
- Compare data from credentialing database with information from credentials file.
- Look for missing data.
- Correct discrepancies.
- Run audits of who is accessing database to assure no breach in confidentiality.
- Utilize software capabilities to track errors and educate staff to increase accuracy.
- Develop a policy that includes how often you should perform these audits and who is responsible.

Module 7

Submitting Credentialing Application

Submitting Credentialing Application

1. Upon receipt of the credentialing application, the credentialing specialist verifies that the application is signed and dated.

2. Applications that are missing signature and date are returned to the practitioner or to the submitted department.

3. All applications must have signature; electronic signatures are not accepted.

4. The application should be typed or legibly printed in black or blue ink.

5. The documents must be completed and submitted along with the application

6. Before the credentialing decision, the practitioner must attest that the information on the application remains correct and complete application with the new attestation form when it requests the practitioner to update the attestation.

Submitting Credentialing Application

7. Credentialing application includes at minimum the following responses:

- When this statement is answered “yes” in the attestation, practitioners must submit in writing the reason for their inability to perform the essential functions of the position.

- The Credentialing Office will review the credentialing file, conduct further investigation, and will submit recommendations for next steps to the Committee.

- The Credentialing Chair makes the final decision in the credentialing process.

Module 8

Appealing Credentialing Decisions

Appealing credentialing decisions

“Appeal” means a request by a Licensed Independent Practitioner, to reconsider a Professional Competence or conduct decision that affects a Licensed Independent Practitioner, participation in the Health care facility.

- ❑ Providers have the right to appeal credentialing determinations with which they disagree.

- ❑ The process for appealing credentialing result is outlined in the credentialing notification letter.

Appealing credentialing decisions

- An appeal is a formal request by a practitioner to request reconsideration of any adverse action.
- A hearing is a formal proceeding at which evidence and argument are presented on the matter to a person or body having decision-making authority.
- The purpose of a hearing is to provide the opportunity for each side of a dispute, and particularly the person deprived of this or her membership or privileges, to present its position.

Appealing credentialing decisions

To comply with this policy, applicant responsibility is to: Follow the instructions outlined in the ineligibility letter to appeal an ineligibility determination.

- Credentialing office responsible to:

1. Notify the candidate in a timely manner of the determination that if He/ She do not meet credentialing criteria.

2. Consider any appeals submitted in accordance with the instructions outlined in the ineligibility notification letter.

Appealing credentialing decisions

- Practitioner appeal rights:

1. Health care organization uses objective evidence and patient-care considerations when deciding the course of action for practitioners who do not meet quality standards.

2. Health care organization must notify authorities as appropriate of practitioners' terminations or suspension.

3. Health care organization Notification to Authorities of Practitioner Disciplinary Actions describes the process for handling quality of care issues and related decisions.

Module 9

Credentialing of Non-Physician Medical Practitioners

Credentialing of non-physician medical practitioners (NPMP)

- If a NPMP accepts member assignment as a Primary Care Provider (PCP), medical care organizations and its delegated medical groups follows the full credentialing procedures.

- Credentialing requirements listed below:

  - Verification time limit: must be in effect at the time of the decision.
  - NPMPs hold a current license.
  - Nurse Practitioner: Nursing License
  - Certified Nurse Midwife: Registered Nursing License, Nurse Midwife certification.
  - Clinical Nurse Specialist: Registered Nursing
  - Physician Assistant: Physician Assistant license.

Module 10

Confidentiality Agreement

Confidentiality agreement

The Health care organizations must have a legal and ethical responsibility to safeguard the privacy of all members and Providers, and to protect the confidentiality of their health and other information

Confidentiality agreement

Physicians and Health care providers, must fill and signee a confidentiality agreement, and need to be filled as following: (I agree that)

- I will not intentionally or unintentionally disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. Should I have any doubts as to whether information is Confidential Information or not, I seek clarification from the Chair of (Health Organization Name), or the Chief Executive Officer.

- I will not access or view any Confidential Information other than that required for my duties on (Health Organization Name).

Confidentiality agreement

- I agree to abide by all laws, rules and regulations protecting the confidentiality of the Confidential Information.

- Upon termination of my participation on (Health Organization Name), I will immediately destroy or return any documents or other media containing Confidential Information to (Health Organization Name).

- I understand that violation of this Agreement may result in termination of my participation on (Health Organization Name), as well as potential legal liability.

Module 11

Credentialing and Primary Source Verification

Credentialing and privileging processes are both interdependent

In KSA, The credentialing of healthcare practitioners is centralized in the Saudi Commission for Health Specialties (SCHS).

➢Two main courses for credentialing

- Credentialing of Saudi healthcare practitioners with local qualifications.
- Credentialing of expatriates and Saudi healthcare practitioners with overseas qualifications.

Credentialing and privileging processes are both interdependent

Fig. 1 - SCHS credentialing process for Saudi medical staff with local qualifications

Primary Source Verification (PSV)

1. No Dataflow Group Primary Source Verification (PSV) is required for KSA credentials issued from the country.

2. Dataflow Group verification applies only for foreign credentials even for Saudi clinicians.

3. Others who are exempt from PSV include Saudis who have undertaken an equivalency from the Ministry of Higher Education (unless required by their facility), as well as non-Saudis who were born in KSA or graduated from KSA high schools who do not need to submit/verify their experience when registering with the SCHS.

Primary Source Verification (PSV)

1. The SCHS applies PSV for the following components only:
   a) education qualification.
   b) Last one year of experience.

1. The SCHS is currently addressing overseas applicants through the Mumaris system, which allows applicants to begin their registration and PSV processes from their home countries before arriving to KSA.

Primary Source Verification (PSV)

- Currently, universities under the Ministry of Higher Education do not mandate SCHS registration for promotions, therefore the rule is faculty staff do not acquire the SCHS license unless required by the private hospital they practice within.

- Implementing PSV globally across the board for all applicants through a unified process of verification for all types of healthcare professionals will result in a healthier and more competent workforce.

- The addition of components to the verification process such as increasing the number of years' experience, health license, logbook and Certificates of Good Standing will ensure the standard of expertise.

Primary Source Verification (PSV)

1. Expatriate healthcare practioner undergoes the interview in their home country or virtually via Skype or telephone - with initial verification of the credentials and training by committees or commissioners in the home country of the interviewee or in KSA sent via email, usually either directly by the applicant or by a broker agency (recruiting company).

2. Upon initial acceptance, a job offer will be shared with the applicant. The signing of this contract by both parties is considered preliminary credentilaing.

3.
   - Cultural attaché and consulate authenticate the certificates.
   - In certain instances, the applicant is simultaneously requested to undergo Primary Source Verification through the DataFlow Group and/or undergo the Prometric or Pearson VUE exams within their specialty while still in theeir home country. However, this is not mandatory by all healthcare sectors in KSA.

4. Applicant arrives to KSA.

5. Most of the time, in order to issue a residency, the hospital (especially the Ministry of Health) has to apply for a provisonal license in the SCHS for 6 months. Usually, the ranking in the provisional license is downgraded until the credentailing process is complete (i.e. Consultant will provisonally be a Specialist Registrar).

6. The credentailing process is complete. In some cases, this may take over 6 months.

Fig. 2 - SCHS credentialing process for expatriate healthcare workforce in KSA

Stakeholders for Credentialing and Privileging in KSA

Stakeholder	Role(s)
Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI)	Accreditation of healthcare institutions
Saudi Commission for Health Specialties (SCHS)	Licensure of healthcare workforce
Ministry of Health (MoH)	Regulator and key provider of healthcare services
Hospitals and Medical Services	

Stakeholders for Credentialing and Privileging in KSA

Stakeholder	Role(s)
MoH	Healthcare Providers Healthcare Workforce
Medical Cities, MoH	
University Hospital	Healthcare Workforce
Military Medical Affairs	
Saudi Arabian National Guard - Health Affairs	
Royal Commission Medical Affairs	
Security Forces Medical Affairs	
University Hospitals	Recruiters
King Faisal Hospital& Research Center	
Private Sector	
Johns Hopkins - Aramco	
KSA Airlines Medical Services	
Ministry of Foreign Affairs (MoFA) - in coordination with the Ministry of Education (MoE) and Ministry of Labor (MoL).	Development of the 'Shamel' platform to verify the healthcare workforce and other regulated professions online

Stakeholders for Credentialing and Privileging in KSA

Stakeholder	Role(s)
MoFA headquarter	Verification of expatriate and Saudi healthcare workforces with overseas qualifications
Saudi consulates abroad - MoFA	
Cultural attaches abroad - Ministry of Higher Education (MoHE)	
Ministry of Labor (MoL)	Workforce regulator
Saudi Medical Societies / Associations	Privileging guidelines and job descriptions
Council of Cooperative Health Insurance (CCHI)	Payment regulator

Responsibilities

Responsibilities

1. **Director of the health facility and the medical director:** The director of the health facility is primarily responsible for setting up a program for accreditation of privileges.

❖ The medical field is within the authority delegated and stipulated in the rules and regulations of the Saudi Commission for Health Specialties. And it is considered the medical director is responsible for making the final decision reliable.

2. **Medical Privileges and Accreditation Committee:** The committee is responsible for reviewing credentials for professional competence and status health care for all applicants for granting medical privilege eligibility, and verifying that all applicants are provided with Medical privileges, with a copy of the health laws and regulations, with a declaration of compliance

Responsibilities

3. Head of Department: The head of the department is responsible for receiving all requests to obtain the appropriate medical privilege for doctors Who supervises them and review all supporting documents to be submitted to the Medical Privileges and Accreditation Committee. And must The head of the department ensures that doctors practice according to the scope of powers granted to them by the Privileges Committee classification levels.

4. **The department head** may assign any practitioner within his department who is suitable (in terms of classification and privileges) to evaluate New practitioners requesting new benefits or evaluating existing benefits.

- As for if the required privileges are outside it Regarding the scope of the resident or department head, the practitioner's privileges must be evaluated by another medical institution that has the same status Practitioner’s academic level. Privilege applicants and privilege categories

Responsibilities

5. Applicant: The medical internship application form must be submitted with supporting documents for pre-employment verification And during the recruitment process, as required and the applicant must adhere to health regulations and regulations. Make sure of the following if submitting the application:

- ❖ It is a basic human resource requirement for any employee who joins the facility, whether on a clinical or non-clinical position. clinical. Our employees must certify compliance with medical privileges granted to them by the Accreditation Privileges Committee medical

Responsibilities

6. **Human Resources Manager:** The Human Resources Manager acts as a technical advisor to the committee and reviews all documents for compliance, legal and regulatory requirements.

7. **Department of a competent authority to follow up the work of accrediting medical privileges:** This department or this entity is responsible for Follow up on all requests for obtaining medical privileges and monitor the process of accreditation and medical privileges that take place in the facility through the Medical Accreditation and Privileges Committee

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