ZSFG JOINT CONFERENCE COMMITTEE MEETING

October 22, 2024

MEDICAL STAFF Report

Contents:

1. Chief of Staff Report: Radiology Service Report Deferred next month
2. Chief of Staff Action List
    a) Privilege List Summary of Changes: General Internal Medicine
    b) ZSFG Credentialing Manual-October 2024

ZSFG CHIEF OF STAFF ACTION ITEMS
Presented to the JCC-ZSFG October 22, 2024
October 2024 MEC Meetings

Clinical Service Rules and Regulations: Radiology Service Report deferred next month

Credentials Committee

- Delineation of Privileges List Summary of Changes: General Internal Medicine
- ZSFG Credentialing Manual-October 2024

Summary of Changes

Document Name:	Medicine General Internal Medicine 2021
Clinical Service:	General Internal Medicine
Date of last approval:	
Summary of SOP updates:	Addition of Privilege
Update #1:	**50.16 INSERTION OF INTRAUTERINE DEVICE** PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine and currently or previously (in the past 5 years) credentialed at another institution for this privilege OR completion of a training program (in the past 5 years) that included IUD insertion training OR completion of 5 supervised IUD insertions with a credentialed provider. PROCTORING: Direct observation of 2 insertions by a qualified provider. REAPPOINTMENT: Review of 2 cases.

ZSFG HOSPITAL & TRAUMA CENTER
Medical Staff Organization
Credentialing Manual

Office of Origin: Medical Staff Office (628) 206-2342

I. PURPOSE:

Zuckerberg San Francisco General Hospital (ZSFG) and Clinics ensure that licensed health care providers meet the minimum credentials standards for Medical Staff or Affiliate Staff membership. This Credentialing Manual (with accompanying policies and procedures) and the Appendix, will be reviewed and approved each year by the ZSFG Credentials Committee and Medical Executive Committee.

II. REFERENCES:

- Medical Staff Bylaws, Rules and Regulations
- Joint Commission Medical Staff Standards
- NCQA Credentialing Standards
- CMS Conditions of Participation
- Committee on Interdisciplinary Practice (CIDP) Policy and Procedures

III. DEFINITIONS:

Practitioner: Any currently licensed physician (M.D. or D.O.), dentist, clinical psychologist, or podiatrist, unless otherwise expressly limited.

Affiliate Health Professional: Categories include the following clinical professionals with standardized procedures: Advanced practice registered nurses (NP – nurse practitioner, CNM – certified nurse midwife, or CRNA – certified registered nurse anesthetist), PA – physician assistant, Pharm-D, Optometrists, Genetic Counselor, Acupuncturist and other categories as approved by the Governing Body.

Provider: For purposes of this document, provider means practitioners and affiliates.

Complete Application:
A complete application, at the point that verifications are finished, means the following:

- all information was verified and any missing information is explained or accounted for;
- all gaps in time of three months or more are accounted for;
- any discrepancies between information provided by the applicant and the information verified by ZSFG have been resolved.

IV. POLICY:

A. The Medical Staff Office conducts credentialing with confidentiality for all clinical venues within ZSFG and will only delegate credentialing to any outside entities if

needed. Credentialing is performed prior to appointment and reappointment to the ZSFG Medical Staff.

B. Each provider has a confidential credentials file, which contains verification documents. For Medical Staff members, the credentials file includes quality information as described in Appendix A. These files are re-verified at least every two (2) years. Expirable documents are updated on an ongoing basis. All required verifications must be no more than 180 days old at the time of Governing Body review.

C. Credential files are treated as confidential and are kept within file cabinets with access by Medical Staff Office personnel only. These files are protected from discovery pursuant to Evidence Code Section 1156, et seq. Documents in these files may not be reproduced or distributed, except as permitted pursuant to State Law, including Section 1156, et seq.

1. The credentials file may be reviewed by contracting health plan representatives (pursuant to delegated credentialing agreements), except that information determined to be confidential.

   A provider has the right to review the items in their credentials file, except the following elements: National Practitioner Databank Reports and Letters of Reference. The provider may submit a signed addendum offering additional information about documents, indicators or events included in the credentials file.

2. The quality information may be reviewed by contracting health plan representatives for the following elements: malpractice claims history, disciplinary actions by hospitals, managed care organizations or State Medical Boards and outcomes of those actions. Other quality items are subject to review pursuant to delegated quality agreements or the National Commission on Quality Assurance (NCQA) credentialing standards.

   A provider has the right to review the items in their quality file, except letters of reference or documents related to peer review activities. The provider may submit a signed addendum offering additional information about documents, indicators or events included in the quality file.

D. Provider Rights to obtain Status of Application
Upon request, providers will be notified of the status of their application during the credentialing process.

E. Provider Rights to Amend Application
The provider attests that all information submitted for the credentialing process is accurate and agrees to immediately report any changes in information. If any submitted items differ substantially from documentation disclosed throughout the verification process, the provider will be asked (via phone, letter or email) to resolve this discrepancy. The provider will be given opportunity to resolve the discrepancies, with

response to the Credentials Committee Chair. Any attempts to intentionally hide or misrepresent information are addressed during the Credentials Committee review.

F. Notification of Provider Rights: Pursuant to the Medical Staff Bylaws, providers are notified of their rights to:
- review information submitted to support their credentialing application;
- correct erroneous information; and
- be informed of the status of their application upon request.

G. Erroneous Information: The applicant for appointment, reappointment, and/or clinical privileges will be notified by credentialing staff of any conflicting information found in the provider's application and/or any supporting documentation.
Notice will occur by telephone or written request within 10 days of discovery, and will be documented in the provider's credentials file.
- The provider will have 30 days to reconcile and return the application and/or supporting documentation to the credentialing staff
- Acceptable format will be the corrected and signed credentialing application and, as applicable, a written and signed explanation for any discrepancies in the original application
- The Credentials Committee or Credentials Committee Chair will receive a report of any corrected information submitted by the provider.
- The documentation provided by the applicant and any other related documents will be placed in the provider's credentials file along with notation as to the date received.

H. Upon delegation of credentialing activities, audits may be performed by health plan representatives and other payers, based upon the following guidelines:
1. Audits must be scheduled in advance at a time mutually agreed upon by ZSFG and the auditing entity.
2. Selected documents regarding peer review may not be subject to auditing.
3. Auditors may not photocopy or remove documents.

If credentialing is not delegated, the health plan/payer is responsible for credentialing providers for their health plan.

V. PROCEDURE

A. Initial Appointments

1. The following information is required to begin the Initial Appointment process:
   - Request from Department
   - Applicant Name
   - Curriculum Vitae/Resume including all professional work history
   - Faculty Appointment (if applicable)
   - Requested Privileges/Protocols (Standardized Procedures), when applicable
   - Requested Start Date for Temporary Privileges/Credentials only

- ID attestation per Joint Commission guidelines

2. Providers must complete the following items:
   - Application for Medical Staff or Affiliate Staff appointment including Confidentiality Statement and Consent to Release Information, Privileges, or for Affiliate, Standardized Procedures.
   - Agreement to abide by the Medical Staff Bylaws, Rules and Regulations
   - Health Plan Attestation form (as applicable)
   - Environmental Safety form

3. In addition to returning the above documents, providers also must submit any relevant licensure/certificates as applicable to the requested privileges or clinical activity, including but not limited to:
   - Copy of California License(s) (an on-line query is acceptable)
   - Copy of DEA Certificate and/or Furnishing certificate as appropriate (a query is acceptable)
   - Evidence of Current Malpractice Coverage, if applicable
   - Fluoroscopy Certificate as appropriate
   - Current Photo
   - CPR, BLS/ACLS, PALS, NALS, if applicable
   - Current Curriculum Vitae (CV)

4. The Medical Staff Office reviews the documents as follows:
   a. All items on the application form, which includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status.
   b. Applicant's signature is present and dated on all forms. The applicant must have signed the application and request for clinical privileges. The applicant confirms the correctness and completeness of the application.
   c. Clinical venues are specified and appropriate.
   d. Complete addresses, phone and fax numbers as listed for:
      - Medical school, Internships, Residencies, Fellowships;
      - Hospitals and affiliations;
      - Peer references; and
      - Malpractice insurance company(ies)
   e. Privileging forms or Standardized Procedures are completed as appropriate.
   f. Continuing Medical Education (CME) materials document any courses relevant to specific privileges requested.
   g. California License(s), DEA Certificate, and Fluoroscopy Certificate are current.

5. Verification of information begins as soon as the application appears complete and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification.

Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

Verification of provider enrollment screening in the Medicaid Fee-For-Service program.

Completion of the Medi-Cal related acknowledgements for health plan specific trainings are required to begin within 10 working days of a new provider becoming active, and may be completed up to 180 days prior to the new being activated/approved.

6. File Triaging:
   Once all of the information is gathered, the applicant's file is triaged by the Medical Staff Office and flagged for potentially adverse information to be carefully evaluated during the Credentials Committee review.

7. Temporary Privileges for Initial Appointments:
   For Initial Appointments involving clinical urgency, a Service Chief may request temporary privileges up to 120 days. Request for Temporary Privileges/Credentials must be approved by the CEO (or authorized designee) on the recommendation of the Chief of Staff (or authorized designee).

   Actions on temporary privileges/credentials are updated in the Medical Staff Office database upon approval and appropriate areas are notified. The Medical Staff Office database updates the applicant's status and privileges/protocols are displayed on intranet websites for inquiry by the applicant or other Medical Center staff. Notification is forwarded to the applicant within 10 days of the decision on the request for temporary privileges.

8. Applicants must complete the credentialing process with privileges or standardized procedures (as appropriate) prior to the provision of patient care to ZSFG patients.

B. Reappointments

1. Reappointment Application Packet
   At least five (5) months prior to the end of the two (2) year appointment period, the provider is mailed an application for reappointment. Previously submitted information is queried to produce the reappointment application. The reappointment packet includes:
   - Preprinted Reappointment Application
   - Copy of current clinical privileges

2. The provider is required to return the application and supporting documents within thirty (30) days, and include the following:
   - Copy of current DEA Certificate as appropriate
   - Fluoroscopy Certificate as appropriate
   - CPR, BLS/ACLS, PALS, NALS, if applicable
   - Current CV

3. If the application is not returned within the designated time period, the provider and Department Chair will be notified for a delinquent reappointment and will receive a (15) day extension to complete the paperwork. Failure to submit a reappointment application at least 45 days before the expiration date of the current appointment may be deemed to be a voluntary resignation from the Medical Staff, and the provider will be submitted as "resigned" to the Credentials Committee.

   Practitioners/Affiliates who automatically resign shall be required to complete a reinstatement form to reapply for membership. Reinstatement shall be processed in a manner parallel to the reappointment process. Reinstatement application forms shall be accepted within one (1) month from the date the practitioner membership expires.

   All Practitioners/Affiliates whose membership has expired longer than one (1) month shall be required to complete the initial appointment process.

4. The Medical Staff Office reviews the documents as follows:
   a. All items on application form. This includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanations for any irregularities on certain questions about practice issues, legal matters and health status.
   b. Applicant's signature is present and dated on all forms. The applicant confirms the correctness and completeness of the application.
   c. Privileging forms and Standardized Procedures are completed as appropriate.
   d. Clinical venues are specified and appropriate.
   e. Completed addresses, phone and fax numbers as listed for:
      - Hospitals and affiliations
      - Peer references; and
      - Malpractice insurance company(ies)
   f. Continuing Medical Education (CME) materials document any courses relevant to specific privileges requested.
   g. California License(s) and applicable certificates (e.g. DEA, Fluoroscopy) are current.

5. Verification of Information
   Verification of information begins as soon as the application appears complete, and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification.

   Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

   Verification of provider enrollment screening in the Medicaid Fee-For-Service program

6. Reappointment Performance Improvement

The results of performance monitoring, evaluation, and identified opportunities to improve care and service are documented in this file. Data Summary sheets are collected and provided as evidence of the practitioner's current competence and suitability for medical staff membership.

7. Pre Credentials Committee Meeting
   A meeting shall be convened prior to the Credentials Committee meeting date which shall be attended by the Chair of the Credentials Committee and the credentialing staff in order to discuss files of concern and the agenda.

C. Evaluation And Approval Process

1. Clinical Services Evaluation Process
   If an issue is identified, the related documentation is flagged for the Service Chief to review. The complete file (including application, supportive documents, and privileges request form) is sent to the appropriate Service Chief for review and recommendation to the Credentials Committee. If the applicant's file was flagged, the reviewer must document sufficient review to support making a recommendation for appointment/reappointment.

   If the Service Chief is disinclined to make a favorable recommendation based on:
   - a perceived medical disciplinary cause or reason, indicating the potential for a provider's conduct to be detrimental to patient safety or to the delivery of patient care; or
   - perceived conduct or professional competence which affects or could adversely affect the health or welfare of a patient or patients, the Service Chief drafts a report to the Credentials Committee indicating concerns with the appointment/reappointment.

   After the Service Chief's recommendation, the file is prepared for the monthly Credentials Committee and the applicant is added to the next monthly Credentials Committee Summary Report.

2. Credentials Committee Evaluation Process
   The Credentials Committee reviews the Summary Report and Committee makes a recommendation for appointment/reappointment. File are reviewed in accordance with the File Triaging categories (see Appendix C). Applications deemed '*green'* do not require committee discussion and are approved on the consent agenda. Applications deemed '*yellow'* or *'red*' are discussed in detail by the Credentials Committee for review and recommendation. Applications requiring additional information/clarification may be tabled until sufficient information is gathered to support a recommendation. Discussion is documented in the committee meeting minutes ~~. This~~ The report with Credentials Committee recommendations is then sent to the Medical Executive Committee (MEC).

3. Medical Executive Committee and Governing Body Evaluation Process
   The Credentials Committee Summary Report is reviewed by the Medical Executive Committee, then the Joint Conference Committee, and then referred to the Health Commission as the Governing Body.

Actions on appointments/reappointments are updated in the Medical Staff Office database within 10 days of Governing Body approval. The Medical Staff Office database updates are displayed on intranet websites for inquiry by the applicant or other Medical Center staff. Notification of the Governing Body decision is forwarded to the applicant within 30 days.

4. Provider Enrollment
   Upon Governing Body approval, the Credentials Committee Summary Report is sent to the contracted Health Plans.

D. Visiting Privileges

1. In circumstances involving clinical necessity when clinical services require the services of a physician, dentist, podiatrist or clinical psychologist who is not a member of the Medical Staff, visiting privileges may be granted on a case by case basis.

2. The following information is required to begin the Visiting Privileges process:
   - Completed Application
   - Curriculum Vitae/Resume including all professional work history
   - Faculty Appointment (if applicable)
   - Service Chief Recommendation
   - Requested Privileges
   - Requested Start Date

3. Providers must complete the following items:
   - Visiting Application including Confidentiality Statement and Consent to Release Information and Privileges.
   - Review the Medical Staff Bylaws, Rules and Regulations

4. In addition to returning the above documents, providers must also submit any relevant licensure/certificates as applicable to the requested privileges or clinical activity, including but not limited to:
   - Copy of California License(s) (an on-line query is acceptable)
   - Copy of DEA Certificate and/or Furnishing certificate as appropriate (a query is acceptable)
   - Evidence of Current Malpractice Coverage
   - Fluoroscopy Certificate as appropriate
   - CPR, BLS/ACLS, PALS, NALS, if applicable
   - Current Curriculum Vitae (CV)

5. The Medical Staff Office reviews the documents as follows:
   - All items on the application form, which includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status.
   - Applicant's signature is present and dated on all forms. The applicant must have signed the application and request for clinical privileges.
   - Clinical urgency and venues are specified and appropriate.
   - Complete addresses, phone and fax numbers as listed for:

- Hospitals and affiliations;
- Peer references; and
- Malpractice insurance company(ies)

- Privileging forms are completed as appropriate.
- California License(s), DEA Certificate, and Fluoroscopy Certificate are current.

6. Verification of information begins as soon as the application appears complete and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Oral verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification, and how it was verified.

   Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

7. The Chief of Staff and the Executive Administrator (or authorized designees) may grant Visiting privileges for a specified period of time after the above information has been evaluated by the applicable service chief and he/she has made an affirmative recommendation.

E. Expirables/Ongoing Monitoring

Sanctions and expirables are monitored on a monthly basis as indicated in Appendix B - Verification Methods.

F. Resignations

The effective date of the resignation will be the last day of the month in which the provider states that he/she is resigning, or a date indicated by the Chief of Service, and can occur before the Governing Body date. Notice of resignation to the Medical Staff Office may be submitted by the resigning provider or by the Department Chief, or Chief's designee, provided that the resigning provider is copied on the notice.

H. Non-Discriminatory Credentialing and Recredentialing.

The Medical Staff Office monitors and prevents discriminatory credentialing through the following process:

i. Tracking and trending of reasons for denial and / or termination.

ii. Semi-annual audits of files in process for more than six (6) months

iii. The presence of a non-discrimination statement on the Statement of Confidentiality to be signed by members, staff and guests of the Credentials Committee on an annual basis.

iv. The presence of a non-discrimination statement on the Credentials Committee agenda.

v. Documents and / or information, submitted to the Credentials Committee for approval, denial or termination do not designate a practitioner's race, ethnic / national identify,

gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes. The Credentialing Committee members will sign a non-discrimination agreement that remains in effect during their term as a Committee member. The statement attests that all decisions made by the committee are based on the applicant's credentials and network participation criteria and not the applicant's age, gender, sexual orientation, race, ethnic/national identity, specialization or special services the applicant may provide.

The Medical Staff Office monitors complaints alleging discrimination. Results are reported to the Credentialing Committee bi-annually.

l. Queries: Verification of the following within 180 days of the Governing Body decision date:

- National Practitioner Data Bank (NPDB) (required for all applicants)
- The State Medical Board responsible for issuing the provider licensure
- Medi-Cal and Medicaid Suspended and Ineligible Provider Reports
- Medicare and Medicaid sanctions
- Office of Inspector General
- Board certification
- Work History
- Malpractice insurance coverage and professional liability claims history
- Attestation questions answered in the application

J. System Control Measures (CR 1C & D)

- The purpose of this section is to ensure compliance with the National Committee for Quality Assurance (NCQA) standards.

Part C – System Controls

1. How primary source verification information is received, dated and stored.	Credentialing applications are received via MD-Staff credentialing database. Supporting documentation such as primary source verifications (PSVs) are either uploaded into the MD-Staff credentialing database or queried directly through the database. All primary source verifications (PSVs) collected as part of the ZSFG credentialing process for initial and reappointment applications are reviewed by the ZSFG credentialing team. Primary source verifications (PSVs) include but are not limited to the following; State licensure, DEA, DEA-X, OIG, SAM/GSA, NPDB, AMA, NPI, Certifacts. PSVs are received or obtained by primary source websites, email, or verbally (over the phone): a. Primary Source Websites – Verifications from primary source websites will show the name of the source, the provider(s) being verified, the type of verification (license, certificate, etc.), and expiration date if applicable. b. Email – Verifications received by email will be from an approved source and verify a provider's name, type of information being verified, and relevant start/end/expiration dates if applicable. c. Verbal – Verifications from verbal sources are recorded electronically and will note the source, date of verification, type of

	verification, name of the individual verifying the information, their position and any relevant dates (certification, licensure, training, educations, etc.) PSVs are dated automatically via the MD-Staff credentialing database and the dates cannot be changed/modified. PSVs are stored in the MD-Staff Credentialing database hosted by the vendor.
2. How modified information is tracked and dated from its initial verification.	PSVs uploaded into the MD-Staff Credentialing database cannot be modified. The ZSFG credentialing team is oriented not to attempt to modify any type of PSV prior to upload within MD-Staff Credentialing database. If a verification contains discrepant information that requires additional clarification, the credentialing team may include additional information to supplement the original PSV. Supplemental information should include the credentialing team member's name and date additional information was obtained. For verbal verifications, a memo to the file (or email from the credentialing team member) is included in the credentialing database as PDF supplemental documentation to the original information verified. Uploaded supplemental documentation from the credentialing staff should indicate the reason that the team member is requiring additional clarification
3. Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate.	All users are authorized to review information. No users have ability to modify PSVs uploaded into MD-Staff. Authorized users are instructed to use good judgement and even consult a team member whenever a question arises regarding a need to remove/delete information in MD-Staff. The MD-Staff credentialing database has three levels of rights: A. **Administrator –**Access to system settings such as adding new users, removing users and assigning user rights. Full read/write access toe the MD-Staff credentialing database (modify & delete). B. **Standard user–** Full read/write access to MD-Staff credentialing database (modify & delete) C. **Read Only** – User may only view information and cannot modify system data. May not modify or delete. Authorized users are encouraged to check with their direct manager when a need to delete information presents itself. This includes instances when a PSV may need to be re-run for a provider's profile. **Examples of appropriate modifications to credentialing information include but are not limited to:** • Updates to expired licensure or other documents (*updating the database data fields to reflect current/accurate information*) • Changes/updates to education, training, or privileges when supporting

	PSVs are obtained • Correcting/rectifying any data entry errors • Addressing/identifying duplicative provider profiles • Documents uploaded to incorrectly (*e.g. wrong provider profile)* **Examples of inappropriate modifications to credentialing information include but are not limited to:** • Altering credentialing approval dates unsanctioned by the Joint Conference Committee (JCC) or prior to temporarily approval by the ZSFG clinical leadership while awaiting JCC final approval • Altering dates on verifications cannot be performed • Whited out of dates or signatures on hard copy documents • Unauthorized/inappropriate deletion of provider files or supporting documentation
4. The security controls in place to protect the information from unauthorized modification.	An excerpt from the City of San Francisco Employee Handbook is detailed below (pg 54 of the New Employee Handbook. **Work Site Security** To prevent and discourage unauthorized access to your work site, do not leave your office area unattended. Do not prop open doors or windows that are normally kept locked. Lock all office doors after business hours or when you leave. Prevent and discourage theft by securing your valuables. Work-site keys and passes may not be shared, may not be duplicated without permission and must be returned upon separation. Access to credentialing information is limited to authorized users only. Only authorized users are granted access to the MD-Staff credentialing database based on business need. Authorized users are required to complete Annual Compliance and Privacy Training (DPH) along with Cybersecurity Training to ensure safeguard of credentialing database information. Authorized users should: • Use strong passphrases containing unique combinations of uppercase letters, lowercase letters, numerals and symbols • Refrain from writing down passwords • Only use a unique password for any of their accounts, and not use a password more than once • Update/change their passwords periodically, including when appropriate such as when passwords may be compromised Authorized user's accounts are inactivated upon separation from the organization, and every 30 days from their last login. The MD-Staff credentialing database is only accessible via hospital intranet or VPN access. When the organization inactivates the user's active directory account, the user will no longer have a mechanism/pathway to log-in to MD-Staff for access to credentialing information.

5. The policies and procedures describe the organization's audit process for identifying and assessing risks and ensuring that specified policies and procedures are followed. At a minimum, the description includes: o the audit elements include: o methodology used; o including sampling; o individuals involved in the audit; and o audit frequency. ➢ Oversight of the department responsible for the audit.	Monitoring of our processes must occur at least annually. The audits of our process will be performed by a director in conjunction with selected members of the medical staff office team. The audits may include but are not limited to the following: 1. A description of the system functionality that prevents or disallows modifications of credentialing information. 2. If the CR system allows modifications only under specific circumstances, an annual process for identifying all changes to established policies within the past 12 months and then updating the system controls accordingly. 3. A review of automatic system alerts or flags for modifications or events in real time and a separate process for annually testing the performance of the system's automatic alerts or flags. Primary source documentation uploaded into our ECHO credentialing database cannot be modified. An annual review sampling 5% of active records or 50 files will be reviewed at random from our monthly health plan roster (provider universe) and conducted by department management/senior staff to ensure that the ECHO provider records are complete and possesses accurate information. When auditing is used as the method for monitoring, sampling using the "5% or 50 files" audit method, with a minimum of 10 credentialing files and 10 recredentialing files shall occur. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits will audit 100% of the credentialing and recredentialing files. Annual review of job roles and current user access to ensure system access is still appropriate for the role requirements. Monthly, quarterly, semiannual, or annual review of all modifications made to credentialing data to confirm accuracy and appropriateness using the electronic system's audit trail function reporting capability. Credentialing, privileging, and enrollment are paperless processes that have very limited paper documents due to requirements for wet signatures. For paper documents/files, leadership conducts periodic walk-throughs of the department to ensure confidential/sensitive documents are being handled and stored properly during and after business hours – i.e., in locked drawers/filing cabinets, not left on workstations, etc. Incorporate review of data modifications/changes/updates to credentialing data (both electronic and paper as applicable) into file Q&A process. Assess for accuracy, appropriateness, compliance with policies. Findings will be documented and stored in a network folder.

	Credentialing staff and anyone who has access to credentialing information is required to sign an annual confidentiality form. These forms will be stored in a Medical Staff Services folder.
Part D - Oversight	
1. Identify all modifications to credentialing and recredentialing information that did not meet the organizations policies/procedures for modifications as described in CR 1, Element C, Credentialing System Controls.	At a minimum, an annual monitoring report will be required to show compliance with our Credentialing System Controls policies, procedures shall be reported to the ZSFG MSO and AH Credentials Committee and Medical Executive Committee. The report will need to include: **a.** A review of all modifications that did not meet the policies and procedures i. Conduct a qualitative and quantitative analysis of all modifications that did not meet policies. ii. Actions taken to address any modifications that did not meet established policy. iii. Implement quarterly monitoring when there are elements that did not meet the policies and procedures and provide written documentation in a report of this review. **b.** The report shall include the person/role/title of the person performing the monitoring. **c.** The report shall include the person/role/title of the person who has oversight of the monitoring process if different from who performs monitoring.
2. Document and analyze all modifications that did not meet standards by doing a qualitative and quantitative analysis of all modifications.	**i. Credentialing System Controls Oversight Report** – this template will be included in the request for documents at the time of the annual oversight assessment. **ii. Monitoring and Reporting of Inappropriate Modifications** this template will be included in the request for documents at the time of the annual oversight assessment. ZSFG MSO would need to submit this report if inappropriate modifications were identified. MSS will continue to monitor the report until it demonstrates improvement for three consecutive quarters. If improvement isn't demonstrated for at least one finding, all quarterly reports will be submitted to the MSS Director.
3. Acting on all findings. (Not applicable if no findings above.)	Findings will be acted upon by the ZSFG MSO, if any are identified.

~~Approved by Credentials Committee – 2/5/2024~~
~~Approved by Credentials Committee – 5/1/2023~~
~~Approved by Credentials Committee – 12/5/2022~~

Commented [FJ(1]: Removing past approval dates from this area and they are at the end of the document, after all the appendices.

APPENDIX A - CREDENTIALS AND QUALITY FILES

A. CREDENTIALS FILE

(available for provider review)

The following documents are kept current and maintained in the Credentials file (as applicable):

1. Application for membership.
2. Delineation of privileges, recommended by the Service Chief in the service which privileges are being requested.
3. Current California State Medical (or other professional) License
4. Valid DEA certification, as applicable
5. Current X-ray Supervisor and Operator Certificate, as applicable
6. Verification of graduation from medical (or other professional) school and completion of residencies and fellowships
7. Verification of previous affiliations prior to SFGH Medical Staff appointment
8. Curriculum Vitae that includes a comprehensive work history
9. Evidence of current, adequate malpractice insurance
10. Professional liability claims history
11. Verification of Board Status Certification or Candidacy, as applicable
12. National Practitioner Data Bank Query Report (which includes Medicare and Medicaid Sanctions activity)
13. California Medical Board Status check for validation of license and sanction activity
14. Continuing Medical Education Compliance
15. Consent to release relevant information .
16. Copies of the Governing Body Approval letters confirming Medical Staff appointment and/or approved privileges
17. For Affiliate Staff only: CPR (BLS/ACLS) certification

B. QUALITY FILE

(not available for provider review)

The quality files contain the following historical and current documents (as applicable):

1. Any action taken as a result of a malpractice claim within the previous three (3) years.
2. Reports of disciplinary actions and the outcome of those actions.
3. Results of internal and health plan quality management review such as Peer Review, Surgical Case and Hospital Mortality Review, Transfusion Committee reviews, patient complaints, clinical activity reports, and other quality indicators.
4. State Medical Board reports on any state sanction activity (e.g. 805 reports).
5. Any supplemental information or documentation regarding quality of care including, but not limited to, letters of reference or service.
6. Letters of Reference that attests to clinical competence and ethical character of the applicant.

APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event				
			Initial Appointment	New Privileges	Reappoint-ment	Update as Expires	Visiting/ Temp Privileges
1.	**License to Practice in California** Includes information related to licensure sanctions monitored monthly	Website as available for the type of provider. If website that is considered prime source verification is not available, credentialer confirms in writing.	**X**	**X**	**X**	**X**	**X**
2.	**DEA Registration** Provider attests if DEA is not applicable to scope of practice.	Obtain on line verification. If website that is considered prime source verification is not available, credentialer confirms in writing.	**X**	**X**	**X**	**X**	**X**
3.	**Fluoroscopy Certificate** Provider attests if certificate is not applicable to scope of practice.	Obtain on line verification. If website that is considered prime source verification is not available, credentialer confirms in writing.	**X**	**X**	**X**	**X**	**X**

APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event				
			Initial Appointment	New Privileges	Reappoint-ment	Update as Expires	Visiting/ Temp Privileges
4.	**Medical School (Domestic Graduates) Or Other Professional Schools (non-physician applicants)**	May be obtained (in writing or orally) from the institution(s) where medical school/other professional school completed or the AMA or AOA profile service, as applicable.	**X**				
5.	**ECFMG (Foreign Graduates)** For physicians who enter USA-based internship/resi-dency programs.	www.ecfmg.org or in writing from ECFMG	**X**				
6.	**Internship/other professional training**	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	**X**				

APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event				
			Initial Appointment	New Privileges	Reappoint-ment	Update as Expires	Visiting/ Temp Privileges
7.	**Residency/other professional training**	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	**X**		**X** If any new training during the previous appointme n t period		
8.	**Fellowship/ other professional training**	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	**X**		**X** If any new training during the previous appointme n t period		
9.	**Board Certification or other professional certification or registration**	CertiFACTS, ABMS compendium, query of the ABMS database, AMA or AOA profile or confirmation (orally or in writing) directly from the certifying organization.	**X**	**X**	**X**	**X**	**X**

APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event				
			Initial Appointment	New Privileges	Reappoint-ment	Update as Expires	Visiting/ Temp Privileges
10.	**Healthcare Organization Affiliations**	Confirm in writing or by telephone with affiliation. Confirm dates of affiliation, scope of privileges, restrictions and any disciplinary actions taken during the affiliation. If verification of an affiliation is not obtained after two requests (including a phone call to the facility), this will be noted in the file and the file may then move through the evaluation process without verification of the affiliation.	**X** Verify all affiliations within the last five years after Medical/ Professional School	**X** Verify as necessary to obtain information related to competenc y	**X** Verify current affiliation(s		**X** Verify current affiliation
11.	**Work History (Looking for gaps in training and work history)**	Applicant provides information on application form or curriculum vitae. Additional investigation occurs for 3 months month gaps in work history. Gaps will be documented in the file.	**X** Verify all affiliations within the last five years after Medical/ Professional School				**X** Temps: the last five years Visiting: current affiliation

APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event				
			Initial Appointment	New Privileges	Reappoint-ment	Update as Expires	Visiting/ Temp Privileges
12.	**Professional Liability Insurance**	Obtain information related to coverage and amounts of coverage directly with carrier. Minimum insurance: $1/million per claim and $3/million annual aggregate coverage.	X		X		X
13.	**Professional Liability Claims History:**	Applicant provides information about current and past claims, settlements and judgments; AND write to current carrier; AND request NPDB report.	X	X	X		X
14.	**Continuing Medical Education**	License attestation					
15.	**National Practitioner Data Bank (NPDB)**	Query	X	X	X		X

APPENDIX B – VERIFICATION METHODS

Number	Credentialing Item	Method of Verification	Credentialing Event				
			Initial Appointment	New Privileges	Reappoint-ment	Update as Expires	Visiting/ Temp Privileges
16.	**Medicare Sanctions**	OIG Sanction Report	**X**	**X**	**X**	**Monthly**	**X**
17.	**Peer/Professional References/ Recommendations** Peer means an individual in the same professional discipline (same type of license) or MD for Affiliated Staff as appropriate.	Peer references must be from individuals who have recently worked with the applicant, have directly observed his or her professional performance over a reasonable period of time, and who can and will provide reliable information regarding current clinical ability, ethical character, health status and ability to work with others. If the applicant has recently completed professional training (resident, fellowship, etc.), a reference from the program director must be requested and references from supervising Attending physicians, rather than co-residents, must be obtained.	**X** Obtain 3 Peer References, with at least one from each professional position held in the last two years	**X** As necessary to obtain confirmation of clinical competency	**X** Obtain 2 Peer References; If Courtesy appt. with no data summary sheet, one reference must be from a Supervisor at external primary hospital		**X** One peer reference

APPENDIX B – VERIFICATION METHODS

18.	**Social Security Death Master File verification** Verification of the SSDMF from NTIS via MD-Staff is required for all initial applicants and then to be verified on an ongoing monthly basis for all actively credentialed providers	Verification of the SSDMF is conducted through the MD-Staff credentialing database and	**X**			**Monthly**	**X**
19.	**SAM (GSA/EPLS)**	System for Award Management	**X**		**X**	**Monthly**	**X**
20.	**CA DHCS (S&I)**	California Department of HealthCare Services; Sanctions and Ineligible List	**X**		**X**	**Monthly**	**X**

APPENDIX C – FILE TRIAGING CATEGORIES

Triaging Category	Initial Appointment	Reappointment
Green	No issues have been identified with the provider's application, and the file meets the following criteria: • Satisfactory References • No record of malpractice payment or current pending claims • No disciplinary actions • No licensure restrictions • No unexplained time gaps in work history • Current licensure • No problems verifying information • No indication of investigations or potential problems Information is returned in a timely manner and contains nothing that suggests the practitioner is anything but highly qualified	No issues have been identified with the provider's reappointment, and the file meets the following criteria: • Satisfactory References • No record of malpractice payments since the last appointment or current pending claims • No disciplinary actions • No licensure restrictions • Current licenses • No problems verifying information • No indications of investigations or potential problems • Information is returned in a timely manner and contains nothing that suggests the practitioner is anything by highly qualified • Applicant is not requesting new privileges • Applicant is not requesting a status change • Applicant meets all criteria for privileges requested • Activity levels are appropriate • CME relates to privilege requests • QA data includes no Peer Review or Quality of Care issues • No health problems identified
Yellow	The provider's file may include questionable information, such as: • Peer references and prior affiliations indicate potential problems. • malpractice claims • Criteria for Privileges requested is not met. • International Medical Graduate	The provider's file may include questionable information, such as: • Peer references and prior affiliations indicate potential problems. • malpractice claims in past 3 years • Health problem identified which will likely have impact on exercise of clinical privileges or standardized procedures. • Lack of clinical activity or difficulty in obtaining monitoring reports

Red	The provider's file shows potentially adverse information, including: • Unsatisfactory peer references or prior affiliations • Disciplinary actions or reports filed by any verification organization (NPDB, Federations, MBC, Medicare Sanctions, AMA) • Clinical privileges revoked, diminished or altered by another Healthcare organization • Any existing information shows a quality of care or competency issue	The provider's file shows potentially adverse information, including: • Disciplinary actions or reports filed by any verification organization (NPDB, Federations, MBC, Medicare Sanctions, AMA) • Clinical privileges revoked, diminished or altered by another Healthcare organization • New privileges requested outside of normal scope of specialty • Any existing information shows a quality of care or competency issue

APPENDIX D – SOURCES OF PERFORMANCE IMPROVEMENT DATA
When available, information from these sources is integrated into the credentialing process:

1. **Patient Complaints and Grievances:** Significant issues are forwarded to Quality Improvement and/or Risk Management for further analysis with communication to the Service Chief. If the Service Chief determines immediate action is required, the Chief of the Medical Staff is notified and initiates appropriate resolution.

2. **Clinical Activity Reports:** For monthly reappointment cycles, physician volume statistics and comparative data are gathered by the Medical Staff Office. Providers with no clinical activity may provide supporting information for consideration by the Service Chief to ensure appropriate recommendation of membership/privileges.

3. **Quality Measures:** Physician specific quality data identified for Credentials Committee review as appropriate.

4. **Peer Review:** Individualized profiling information is assessed by the Service Chief.

5. **Medical Record Delinquencies**: The Service Chief reviews and notates as appropriate.

6. **Risk Management/Malpractice Claims:** Risk Management entities report UC Regents and San Francisco City and County claims history. Providers are obligated to disclose past and pending liability actions and provide further details regarding these actions, including specific discussion with the Service/Division Chief. Claims histories also are requested from external professional liability insurance companies, as applicable. Providers with one or more claims are flagged for review by the Service Chief and the Credentials Committee.

7. **Suspensions/Sanctions**: Physicians may be suspended for non-compliance with policies as outlined in the Medical Staff Bylaws, and for infractions, such as a license revocation or other action by the Medical Board or Governing Body (please see the Medical Staff Bylaws for further information). These suspensions are monitored by the Medical Staff Office and identified for Service Chief and Credentials Committee review.

8. **Reporting of Adverse Action to Authorities and Contracted Health Plans**: Adverse action that has been taken against a practitioner which falls under the reporting guidelines for state and federal agencies will be reported as appropriate to the National Practitioner Data Bank, the California Medical or Nursing Board, to the SFDPH Office of Managed Care and to contracted Health Plans. (refer to the ZSFG Medical Staff Bylaws for activities or professional conduct that constitutes a request for investigation).

9. **Service Quality Indicators:** Each clinical service establishes and monitors quality indicators. The Service Chief considers applicable indicators when recommending appropriate membership/privileges and indicates any issues for Credentials Committee consideration. **Provider Directories**: All information required to be published in the practitioner directories of managed healthcare plans per the contractual agreement will be consistent with the information required for the credentialing process.

APPENDIX F - Ongoing Professional Practice Evaluation (OPPE) Procedure

I. PURPOSE

Ongoing Professional Practice Evaluation (OPPE) is designed to support quality patient care activities and can identify outliers related to clinical performance at Zuckerberg San Francisco General Hospital (ZSFG). OPPE is intended to ensure consistency and to foster a more efficient evidenced-based privilege renewal process. The OPPE process focuses on the collection of practitioner-specific, professional practice data related to clinical activities of Medical Staff and Affiliated Medical Staff practitioners at ZSFG. OPPE improves the delivery of quality patient care and is conducted regularly, in accordance with The Joint Commission Medical Staff Standard MS.08.01.03. ZSFG Chiefs (or their designees) are expected to review the data metrics and sign-off the data. When necessary, intervention by the organized medical staff may be required, including but not limited to development and implementation of a Focused Professional Practice Evaluation (FPPE) to address practice that is considered marginal or unacceptable.

II. PROCEDURE

The ZSFG Medical Staff Services Department is required to coordinate the collection, validation, and assessment of practitioner-specific, professional practice data that is relevant to the clinical practices approved by the ZSFG organized medical staff. Continuous monitoring of practitioner's clinical competence metrics will support the ZSFG organized medical staff in the provision of high-quality, safe patient care that is compassionate, appropriate, and effective.

Each practitioner's professional practice metrics will be reviewed by each service Chief or their designee(s) in keeping with the goal of providing high-quality and safe patient care and in accordance with The Joint Commission Standard MS.08.01.03. The practitioner's professional practice evaluation will be documented in the Professional Performance (OPPE) by the Medical Staff Services Department and the timeframe for review of the data cannot exceed 12 months. Management of OPPE is the responsibility of the Medical Staff Services Department. Practitioner's Ongoing professional practice data (OPPE) is privileged, facility specific information protected by California Evidence Codes 1156 and 1157.

Categories of metrics may include the following groups, in accordance with the Accreditation Council for Graduate Medical Education (ACGME) core competencies: Patient Care, Medical/Clinical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems-Based Practice. Examples of individual metrics may specifically include data from:

- Administrative Activity
- Case Characteristics and Volume
- Core Competencies
- Inpatient Utilization
- Outpatient Utilization
- Patient Safety and Quality
- Patient Satisfaction
- Patient Relations
- Risk Management

A. DEFINITIONS

Chief of Service– Physician with the ultimate responsibility to review and sign-off on the professional practice information of each practitioner in his/her department. If needed, the Chief of Service may designate a faculty member to review and sign-off on records.

Credentials Committee – The ZSFG Medical Staff Committee is responsible for recommending appointments and reappointments to the Medical Staff, delineation of staff privileges, and application of corrective actions where indicated.

Designee – Physician leader identified by the Service Chief to review a set of practitioners.

OPPE – the Ongoing Professional Performance Evaluation system is designed to aggregate practitioner-specific data from a variety of sources and display this information on a secure password protected website.

All the information is stored on the city's secure network under ZSFG IT Security Policy.

Practitioner – Member of the ZSFG Medical Staff or Affiliate Medical Staff

B. CONFIDENTIALITY

Professional practice evaluation information is privileged and confidential in accordance with ZSFG Medical Staff Bylaws and California state evidence codes (including 1157) pertaining to confidentiality and non-discoverability.

All staff, committee members, and other practitioners involved in review and evaluation of performance will hold information in strict confidence, make no voluntary disclosures of such information, and agree to complete a confidentiality acknowledgement related to their handling of Professional Practice Evaluation information under this procedure.

A confidentiality acknowledgment will be completed at initial participation and at least every two years thereafter.

Security practices must be maintained to protect the integrity and confidentiality of OPPE at ZSFG. As OPPE reports are facility-specific, the information contained within are considered proprietary and thus only intended to be viewed by those directly involved in the OPPE process at ZSFG.

OPPE data may be directly shared with other facilities outside of ZSFG (1) Upon special request to the current Chief of Staff, or (2) as requested by another facility under a current, executed Memorandum of Understanding or Peer Review Sharing Agreement.

C. CONFLICTS OF INTEREST

A medical staff member asked to perform professional practice evaluation may have a conflict of interest if they might not be able to render an unbiased evaluation due to:

- Involvement in the patient's care
- Relationship to patient or patient family
- Relationship with the involved practitioners as a partner or direct competitor

It is the responsibility of the reviewer to disclose potential conflicts.

It is the responsibility of the Credentials Committee to determine whether a conflict would prevent the individual from participating and the extent of that participation if allowed.

Individuals determined to have a conflict may be present during group discussion (if approved by Credentials Committee) but are required to recuse themselves prior to final deliberation and vote.

III. PROCEDURE

The OPPE will be updated with the latest available data every 12 months focusing on collection of metrics between July 1 and June 30 each year. Departmental OPPE data is coordinated between each clinical service and the ZSFG Medical Staff Services Team as detailed within the timeline table in the section below. Internal (ZSFG defined) benchmark data will be provided by the clinical services for specified metrics with each clinical service. Each clinical service will be responsible to review and validate the OPPE data for providers within their service.

Submission of OPPE data related to the clinical practice of each service Chief shall be reviewed/validated by someone other than the service Chief such as a senior faculty member in the department with the same clinical privileges.

A. TIMING & RECURRING SCHEDULE

The calendar below outlines the timeframes that the various parts of OPPE are carried out each cycle:

MONTH	DESCRIPTION	RESPONSIBLE PARTIES
July	1. On July 1st, run retrospective master roster of credentialed providers from the credentialing database which lists provider holding an appointment/privileges through the ZSFG Medical Staff during the previous July 1 thru June 30 OPPE cycle. 2. Run the Board Certification Issues Report & the Suspensions Report from MD-STAFF for the previous July 1 thru June 30 OPPE cycle. 3. Obtain copy of the Hydra ZSFG Compliance Report from Dean's Office 4. Sort/edit the roster to create department-specific list of providers. 5. Sort/edit the roster again to identify providers with privileges in the department but whose home department is elsewhere. These are referred to as the "add-on" providers for the department for purposes of OPPE. They are listed at the end of each department's OPPE spreadsheet. 6. Reconcile the provider count against the original master roster to assure quality with no names overlooked throughout the data sorting process. 7. Copy the finalized department-specific OPPE spreadsheets as templates from the previous OPPE cycle. This involves deleting the provider names/metric data/comments, add/delete/revise metrics as directed by notes from Chiefs/approved by Chair, Credentials Committee to create the OPPE spreadsheets for the current OPPE cycle. 8. Copy/paste the provider names, including the "add-on" providers, from the department sections of the final edited master roster to the department-specific spreadsheet templates. (**Note:** *Totaled 47 spreadsheets for 30 OPPE departments last OPPE cycle.)* 9. Update/revise the instructions for completing the OPPE spreadsheet. 10. Update the Chief/Credentials Committee annual OPPE email language directed to Chiefs & designees. Save a copy to Outlook drafts folder. 11. Obtain note closure report data from IT/OPPE workgroup. 12. Add board certification, license, & note closure data to the OPPE spreadsheet templates	OPPE Coordinator/ MSSO Chief, Creds Committee with OPPE IT workgroup UCSF Deans Office
August	1. Complete any remaining steps from July list. 2. Aim towards a mid-August target for issuing OPPE lists to Chiefs & designees. 3. Use the department-specific annual OPPE email language indicating the due-date deadline within 60 days. Attach a copy of the department-specific OPPE spreadsheets along with a copy of the instructions for completion. 4. Repeat step #3 for each department or clinical service specialty. 5. Create a Tracking Log of Spreadsheets Returned by Due Date & Finalized which lists the departments or clinical service specialties who have received the OPPE email outreach requests. Use this log to track the response and versions returned.	OPPE Coordinator/ MSSO

September	1. Complete outreach to any remaining departments regarding remaining steps from August. 2. Send out reminders as 6 weeks, 4 weeks, and 2 weeks to services that have not responded. 3. Review/return spreadsheets back to Chiefs/designees with replies/requests for clarification/comments /finalization with cc to Chair/Creds Committee & Manager/MSSO 4. Update Tracking Log of M&U OPPE Evals as indicated by reviews	OPPE Coordinator /MSSO Chair/Creds Committee Manager/ MSSO
October - November	1. Update & issue the Tracking Log of Spreadsheets Returned by Due Date & Finalized biweekly to Chair/Credentials Committee for his updates to Creds Committee, MEC, etc. 2. Continue spreadsheet reviews/replies/requests for clarification/comments/ working towards finalization for all clinical services remaining. 3. Continue updating Tracking Log of M&U OPPE Evals as indicated by reviews.	OPPE Coordinator /MSSO Chair/Creds Committee
December	1. Finalize any remailing reviews of departments or clinical service specialties OPPEs spreadsheets. 2. Finalize the Tracking Log of M&U OPPE Evals 3. Finalize the Tracking Log of Spreadsheets Returned by Due Date & Finalized	OPPE Coordinator / MSSO
January	1. When all spreadsheet reviews are finalized, meet with Credentials Committee Chair to review all marginal & unacceptable OPPE ratings identified. 2. Ensure that each marginal & unacceptable has commentary and has been appropriately addressed.	OPPE Coordinator /MSSO
May - June	1. Prepare Prep file folders and structure on T Drive for the next cycle of OPPE	OPPE Coordinator /MSSO

B. Marginal and Unacceptable OPPE Evals:

1. During the review of the annual department OPPE spreadsheets, the Medical Staff Services Coordinator updates the Tracking Log of Marginal & Unacceptable OPPE Evals by department/provider and advises the respective Service Chief regarding providers whose OPPE evals may trigger a Focused Professional Practice Evaluation (FPPE) based on the following frequency thresholds:
    a. Two (2) consecutive Unacceptable (U) evals for the same OPPE metric, OR
    b. Three (3) consecutive Marginal (M) evals for the same OPPE metric, OR
    c. One (1) Unacceptable and two (2) Marginal evals consecutively for the same OPPE metric
2. Marginal and Unacceptable OPPE ratings require the Chief to enter a comment in the COMMENTS column of the department's OPPE spreadsheet for providers whose data for any OPPE metric falls within the Marginal or Unacceptable threshold range for the metric. The Service Chief will consult with the Chair/Credentials Committee regarding the need for a for-cause FPPE plan.
3. The Chief or designee will discuss any Marginal or Unacceptable OPPE evals with the provider. The Medical Staff Services Coordinator will confirm and document through use of a DocuSign form signed by both the service chief and subject provider.
4. Following completion of the annual OPPE spreadsheet reviews and finalization, the OPPE Coordinator and the Chair of the Credentials Committee meet to review the Tracking Log of M&U OPPE Evals to

ensure that all have been reported to/addressed by the Chief.

C. RESPONSIBILITIES

1. **Service Chief's Responsibilities:**
   a. Review, validate each practitioner's OPPE data within 60 days of posting by the ZSFG Medical Staff Services Department.
   b. Comment on performance metrics that have not met the established thresholds or address identified clinical practice irregularities.
   c. Sign-off on the data provided for each practitioner within the department, per OPPE review period.
   d. Forward identified concerns or clinical practice irregularities to the ZSFG Medical Staff Services Department immediately, for further review by the ZSFG Credentials Committee.
   e. May opt to assign a designee with the primary responsibility to review practitioners within the department. The Chair must keep the Medical Staff Services Department advised of any changes or updates.
   f. Arrange for appropriate coverage to review OPPE data performance metrics reports during periods of planned absences.
2. **Practitioner**
   a. May request to review their OPPE data.
   b. May add supplemental information/comments for the Service Chief or designee to review as part of periodic validation and sign-off of the OPPE metrics.
   c. May communicate with Service Chief or designee regarding any concerns regarding the content of the OPPE data.

D. OVERISGHT & DATA RETENTION

1. The Medical Staff Services Department will be notified by the Chief or designee upon completion of the annual review/sign-off of OPPE clinical practice metrics. The Medical Staff Services Department will retain electronic copies of the individual practitioner's data for inclusion in the credentials file to be reviewed by the Credentials Committee as part of each provider's credentialing reappointment.

E. PROCEDURE REVIEW AND REVISION

The Ongoing Practitioner Practice Evaluation Procedure will be reviewed on an annual basis. Compliance with The Joint Commission and functionality will be evaluated as well as the continued relevance of the indicators chosen.

Appropriate revisions will be recommended by the Medical Executive Committee and/or the Credentials Committee.

REVIEWED & APPROVED BY:

Medical Executive Committee	4 /30/2024

POLICY & PROCEDURE WITH ALL APPENDICIES (A, B, C, D, F)

Reviewed for approval: *October 2024*

Approved by Medical Executive Committee – April 30, 2024
Approved by Credentials Committee – February 5, 2024
Approved by Credentials Committee - December 5, 2022
Approved by Medical Executive Committee – December 16, 2021
Approved by Credentials Committee – December 6, 2021
Approved by JCC – October 22, 2019
Approved by Medical Executive Committee – October 17, 2019
Approved by Credentials Committee – October 8, 2019