

Department:	Administration Department
Document No:	RMC- HR - 004
Issue Date:	01/06/2008
Revision Date:	01/06/2021
Next Review Date:	01/06/2023

CREDENTIALING AND PRIVILEGING POLICY

1. PURPOSE:

- 1.1. This policy pertains to the procedures regarding credentialing of physicians.
- 1.2. To ensure that physicians appointed to serve our patients will meet uniform standards of education, specific training and experience, current competence and ability to perform the privileges assigned to them
- 1.3. To ensure that qualified practitioners perform patient care services and the only do so under conditions specified by the facility.
- 1.4. To ensure delivery of high quality, safe patient care within the facility.
- 1.5. To ensure the availability of required resources in the medical center to enable the physicians to practice their privileges.
- 1.6. To assist RMC in determining the competency of new practitioners, who seek additional privileges. To enable them to perform new or rarely, performed procedures.
- 1.7. To enable staff to practice a health care in the UAE, that is legally consistent with their professional qualifications.

2. POLICY STATEMENT:

- 2.1. The medical staff members are accepted in RMC only after issuing of license to practice by the health regulation authority.
- 2.2. All physicians with DOH license shall be eligible to apply for privileges based on their credentials, and within the scope of the facility.
- 2.3. A new physician credential file will be granted with temporary privileges for a period of three (3) months from the joining date. The final granted privileges will then be provided after the review of practice in lieu with temporary privileges.
- 2.4. A physician credential file will be reviewed every two (2) years after obtaining the final privileges.
- 2.5. The process of review shall be initiated by human resources department on submission of upgrading documents, appeal request or during renewal at least once in 2 years.
- 2.6. The PSV (Primary Source Verification) for all physicians is done by Dataflow. The new staffs are recruited only after issuing the license for practicing after the PSV report.
- 2.7. The process of granting privileges to new staff should be completed at the time of the staff's appointment to the facility.
- 2.8. All RMC practitioners, will be credentialed and privileged as defined in this policy. The pertinent requirements of the Department of Health (DOH), Joint Commission International (JCIA) and other relevant standards will be used to define the credentialing processes.
- 2.9. The process is applicable for all the practitioners including visiting, community medical staff members.
- 2.10. Credentialing and Privileging must be completed PRIOR to initial appointment, except as identified in this policy as Temporary Appointments; employment commitments shall not be made until the credentialing process is completed.

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- 2.11. A request for change in clinical privileges will be processed to the credential and privilege committee (CPC-Adhoc Clinic Advisory Committee Biannual) through the applicant or his/her HOD with all attached certifications, credentials and recommendations.
- 2.12. Upon initial appointment a temporary privilege is granted based on Evidence of competence, current and relevant DOH licensure, education and/or training, and experience presented to the credentialing and privileging committee
- 2.13. RMC shall adopt credentialing and privileging policy to ensure objectivity in delineating clinical privileges of medical staff based on their verified credentials.
- 2.14. On initial appointment the verified credentials and privileges shall be placed in each medical staff personnel file by the human resources department. The file should be kept enduring the confidentiality integrity.
- 2.15. On renewal of Credentialing & privileging, the data and information used for review of medical staff credentials and privileges are based on the annual performance review of medical staffs which includes:
- 2.15.1. Patient care
 - 2.15.2. Medical and clinical knowledge
 - 2.15.3. Practice based learning and improvement
 - 2.15.4. Interpersonal communication skills
 - 2.15.5. Professionalism and System based practices
- 2.16. Visiting physicians shall have their credentials verified by the facility and shall be granted temporary privileges.
- 2.17. Scope of this policy covers all practicing Physicians and Dentists.
- 2.18. The department heads shall monitor for the compliance with the services provided and with permitted privileges and report if any variance noticed.

2.19. The DOH Credentialing Elements:

Credential	Source	Method	Periodicity
DOH License	DOH	From HR online system in DOH	Once in 2 years
Home Country License	Home Country	From the employee	Upon application
Postgraduate Training	Home Country	From the employee	Upon application
Board Certificate	Specialty Certificate	From the employee	Upon application
Malpractice Insurance	HR	Copy of insurance binder/certificate	Upon application , re-appointment and expiration date
Clinical Privileges	Credentialing	Request from the CPC form	Upon application and re-appointment



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Credential	Source	Method	Periodicity
Work History Gaps	Application	Direct query with source / explanation from applicant	Upon application

3. SCOPE:

- 1.1 The scope of this policy will cover Human Resource Department
- 1.2 Clinic Advisory committee Adhoc-Credentialing and Privileging Committee "CPC"
- 1.3 All Physicians (Full Time and Part Time)

4. TARGET AUDIENCE:

- 4.1. All Physicians (Full Time and Part Time)
- 4.2. Outsource physicians of RMC
- 4.3. Part Time and Full Time physicians

5. RESPONSIBILITY:

Responsibility	Procedure
Human Resource Department / Head of the concerned Department	Credentials and other details presented in the Curriculum Vitae of the applicant are screened. If the details are found to be appropriate to the position that the candidate has applied for, the applicant will be interviewed.
Licensing Dept./ Human Resource department	After the initial approval, the verification of credentials is carried out from its primary source
Concerned Medical Staff	Upon appointment to the facility, the applicant requests from the Head of the Department for Clinical privileges.
Concerned Medical Staff	The credential of the medical staff is reviewed in order to delineate privileges. Further specific credentials are requested (if required) in order to support the medical staffs application for certain privileges.
Authorized Approving Personnel	The documents validating the requested privileges are reviewed. If approved, the decision on privileges is forwarded to the Concerned Head of Departments.
	The approval is communicated to the concerned Medical Staff who has applied for the privileges. The approved privileges of the medical staff are communicated to the Medical Director. Concerned staff receives privileges and acknowledge the same. A copy of the privileges is handed over to the HR and copy should be kept in personal file.

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Concerned Department	Head of	Application for new /addition of privileges is submitted. Provision of the necessary documents to support the request demonstrating compliance with the required criteria (e.g. evidence of certification, log of new procedures performed etc.) and resolution of any inconsistencies/doubt. The application is reviewed and appropriate verifications are obtained.
Concerned Department	Head of	An appraisal is carried out for the Medical Staff's professional judgment, clinical skills and ability to function. If satisfactory, the approval report is forwarded to Authorized Approving Personnel for further necessary action.
Medical Director		Re-credentialing and re-privileging: Once every 2 years the CPC will review the physician's OPPE data for 2 years and recommend re-granting of current privilege(s), withdrawal of current privilege(s) or granting of new privilege(s) if the physician provides new evidence of training and or competence to perform the requested new medical treatment and/or procedure based on the on-going physician performance evaluation results. Renewal of the Privileges of the medical staff that is due for renewal and Appropriate delineation of clinical privileges is sent 7 days prior to expiry of approved clinical privileges.
Concerned Department	Head of	On-going Professional Practice Evaluation (OPPE): The Quality coordinators of each department will gather clinical performance data for each individual physician which is called OPPE. The OPPE is done every six months to evaluate the performance of the physician. This OPPE is reviewed by the Medical Director. The OPPE evaluates the physician on: • Behaviors • Professionalism • Medical and Clinical Knowledge Whenever possible, Clinical results and other data and information available on medical staff members are reviewed with objective and evidence-based information, as available. Whenever the performance of the physician is not satisfactory, appropriate actions are taken like counselling, training/education, degrading privileges etc. and documented in the OPPE form.

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6. PROCEDURE:

- 6.1. The credential element of qualifications shall be authenticated according to the governing rules and regulations of the country of origin (for expatriates); and the UAE Embassy where the candidates originate.
- 6.2. Experience Certificates from previous employers must be issued from the HR department.
- 6.3. Authenticated Practitioner's License should be from the country of origin or qualification obtained.
- 6.4. The original documents should be submitted to HR when asked for to complete joining formalities.
- 6.5. HR department is responsible to check all required documents by verifying with Primary Source Verification Report issued by Data Flow under Department of Health (DOH).
- 6.6. Credentialing and Privileging of physicians who provide patient care services on the premises of the facility but are not employees or members of the clinical staff:
 - 6.6.1. The facility leadership shall ensure that independent practitioners not employed by the facility have the right credentials for the services provided to the facility's patients.
 - 6.6.2. When the facility contracts the services from physicians and dentists outside their facility or when the facility arranges for them to come into the facility to provide services or located outside the facility region or the UAE.
 - 6.6.3. If the services provided determine the care choice or course of care for the patient, the practitioner must proceed through the credentialing and privileging processes of RMC.
 - 6.6.4. RMC leadership shall determine those services that will be provided by independent practitioners outside the facility.
 - 6.6.5. All diagnostic, consultative, and treatment services provided by independent practitioners outside the facility shall be privileged by RMC to provide such services.
 - 6.6.6. Independent practitioners who provide patient care services on the premises of the facility but are not employees or members of the clinical staff are credentialed and privileged as per RMC credentialing and privileging procedure.
 - 6.6.7. The quality of services by independent practitioners outside the facility is monitored as a component of the RMC's quality improvement program as per RMC's On-going Professional Practice Evaluation Policy"
 - 6.6.8. Initial approval of credentials to be granted to visiting physicians shall be approved by the CPC.
- 6.7. The Human Resources Department must ensure that the approved temporary privileges are communicated to the concerned visiting physicians and departments.

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- 6.8. HR Department will initiate a privilege form for all new joining practitioners; the applicant will apply his/her request using this form with attached credentials to the credentialing and privileging committee.
- 6.9. The Head of Department (HOD) related to the request may be asked to review the individual applicant's file and add his or her recommendation. This recommendation includes information about the applicant's clinical abilities as well as the ability to continue carrying out the clinical privileges requested. The HOD then forwards the same to the medical director and the information will be forwarded to the (CPC). The Privilege and Credentials Committee discuss the request and take appropriate decision to approve or deny the requested privileges.
- 6.10. The (CPC) reviews the practitioner's request for the privilege renewal or granting a new privilege. This review shall be done every two (2) years.
- 6.11. On occasion, a practitioner is denied clinical privileges when it is proved inappropriate according to competence and professional licensing.
- 6.12. If or when a physician refuses or does not practice a particular privilege for a period of 1 year, the CPC committee has a right to remove the respected privilege from the physician at any given time; the CPC also has the right to under-privilege a physician if the physician has undergone the below:
- 6.12.1. Patient Complication(s)
 - 6.12.2. DOH investigation(s)
 - 6.12.3. Suspension
 - 6.12.4. Sentinel Event(s)
- 6.13. Addition of privileges can be requested by any clinician at any time.
- 6.14. CPC committee may meet accordingly to approve any intermittent request/new joiners.
- 6.15. RMC policy is to review all staff members privileging every two years unless required earlier.

7. DEFINITIONS AND ABBREVIATIONS:

7.1	Appeal	Process whereby a formal request to review or rule against a decision is made. This will include any practitioner whose request for privileges has been denied, withheld or granted in a different format that has been requested.
7.2	Approved privilege	Defined privileges approved on the same credentialing and privileging application form is valid for the time period of two (2) years. The medical staff shall apply for renewal of the privileges within every two years.
7.3	Authorized approved personnel	Credentialing and privileging committee.

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7.4	Core privileges	Refers to generic activities that are done by the medical staff such as admission, attending patients, obtaining history and physical examination, prescribing medications. Although there are department specific privileges, they are similar in many departments. The authorized approving personnel will identify the core privileges.
7.5	Core credentials	Evidence of competence, current and relevant licensure, education and/or training, and experience.
7.6	Credentialing	Refers to the systematic process of screening and evaluating qualifications and other credentials, including licensure, required education, relevant training and experience, current competence and health status.
7.7	Licensure	Refers to the official or legal permission to practice in an occupation, as evidenced by documentation issued by DOH in the form of a license and/or registration.
7.8	Medical staff	Any individual permitted by law and the organization to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.
7.9	Privilege	Refers to clinical services a medical staff is qualified to perform.
7.10	Clinical Privileging	is defined as the process by which a licensed practitioner is permitted by the facility to practice independently, to provide medical or other patient care services within the scope of their license, based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure.
7.11	Privileging	is the process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization, based on evaluation of the individual's credential and performance.
7.12	Re-credentialing and re-privileging:	Once every 2 years the CPC will review the physician's OPPE data for 2 years and recommend re-granting of

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		current privilege(s), withdrawal of current privilege(s) or granting of new privilege(s) if the physician provides new evidence of training and or competence to perform the requested new medical treatment and/or procedure based on the on-going physician performance evaluation results. Renewal of the Privileges of the medical staff that is due for renewal and Appropriate delineation of clinical privileges is sent 7 days prior to expiry of approved clinical privileges.
7.13	Independent Practitioners	is any individual permitted by DOH, to provide patient care services independently; i.e., without supervision or direction, within the scope of the individual's license and in accordance with individually granted clinical privileges.
7.14	Under Privileging	Action of removing a privilege which has already been granted, when required.
7.15	RMC	Al Reyada Medical Centre
7.16	HRD	Human Resource Department
7.17	HOD	Head of the Department
7.17	CPC	Credentialing and Privileging Committee
7.18	PSV	Primary Source Verification

8. DISTRIBUTION LIST:

On shareholder Policies HR

9. SPECIAL INSTRUCTIONS:

9.1. Not applicable

10. CROSS REFERENCE, RELATED LEGISLATION, FORMS, POLICY & DOCUMENTS:

- 10.1. Joint Commission International Accreditation for Ambulatory Care, Fourth Edition 2019. Joint Commission Resources; SQE 1 & 2
- 10.2. Hospital Standards, Health Authority-Abu Dhabi, 2008
- 10.3. Abu Dhabi – Healthcare Information and Cyber Security Standards, Department of Health, Version 0.9, 2019;
- 10.4. Policy for Quality and Patient Safety January 2017

11. KEY RESULT AREAS:

- 11.1. The procedure is fully implemented if there are nil incidences of non-compliance with this policy.

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Version	Revision Date	Description of Amendments	All pages
01	01/06/2021	New policy	All pages

13. APPENDIX:

- 13.1. Credentialing and Privileging Form (All departments)
- 13.2. OPPE Form

14. APPROVAL SHEET:

Document Developed & Reviewed By:			
HR Supervisor	Mr. Syed Alquama Zulquarnain		01/06/2021
	Name	Signature	Date
Document Developed & Reviewed By:			
Asst. Manager Quality/ Chief Compliance Officer	Ms. Dhanya Thankappen		01/06/2021
	Name	Signature	Date
Document Approved By:			
Medical Director	Dr. Lubna H. E. Elshaer		01/06/2021
	Name	Signature	Date