OhioHealth

CREDENTIALING APPLICATION: CURRENT OHIOHEALTH ALLIED HEALTH PROFESSIONAL (AHP)

Application Process

This application is for any Allied Health Professional (AHP) currently on an OhioHealth Hospital medical staff who wishes to add additional OhioHealth hospital(s). OhioHealth Credentialing Service (OHCS) will be your main contact for information regarding the non-hospital specific portion of your application. In addition to the requirements of this application, you may be asked to provide additional information in order to complete the credentialing process.

There are three (3) parts of the credentialing process which you must complete in their entirety.

1. **CAQH Application:** Located at https://proview/caqh.org
2. **OhioHealth Supplemental Documents:** Return completed documents:
   Email: OhioHealthCredentialing@ohiohealth.com
   Fax: 614-566-0401
3. **Hospital-Specific Documents/Information:** Provided by hospital(s) upon receipt of application

OHCS will review your CAQH Application and OhioHealth Supplemental Documents. When these items are determined to be complete, your application will be released to each hospital to which you are applying. Each hospital will process your application concurrently with OHCS and will provide the Hospital-Specific Documents/Information required to complete your credentialing at that campus.

Application Fee

Application fee must be received in order for your application to be processed for any of the OhioHealth hospitals. Please note, this is a one-time non-refundable fee. Fees listed below effective 7/1/2024.

Fee for 1 entity – $625	Fee for 6 entities – $1200	Fee for 11 entities - $1775
Fee for 2 entities – $740	Fee for 7 entities – $1315	Fee for 12 entities - $1890
Fee for 3 entities – $855	Fee for 8 entities - $1430	Fee for 13 entities - $2005
Fee for 4 entities – $970	Fee for 9 entities - $1545	
Fee for 5 entities – $1085	Fee for 10 entities - $1660	

Credit card payments can be processed at https://ohiohealthcrede.securepayments.cardpointe.com/pay
If you have questions or require other payment options, please call 614-566-0010 or 1-800-455-4460.

OhioHealth Credentialing Contact List

OHCS: (800) 455-4460
(614) 566- 0010
Berger Hospital: (740) 420-8361
Doctors Hospital: (614) 544-2236
Dublin Methodist Hospital: (614) 544-8040
Grady Memorial Hospital: (740) 615-1045
Grant Medical Center: (614) 566-9346
**Grant Medical Center includes Pickerington Methodist Hospital & Grove City Methodist Hospital*
Hardin Memorial Hospital: (740) 383-8659
Mansfield Hospital: (419) 526-8581
Marion General Hospital: (740) 383-8665
O'Bleness Hospital: (740) 592-9492
Riverside Methodist Hospital: (614) 566-5052
Shelby Hospital: (419) 526-8581
Southeastern Medical Center: (740) 439-8103
Van Wert Hospital: (419) 238-8627

PLEASE NOTE: It is ultimately your responsibility to provide all required documentation so that it can be verified. Your application will remain pending until all required information is received.

CREDENTIALING APPLICATION: CURRENT OHIOHEALTH AHP
OhioHealth Supplemental Documents

AHP Applicant Checklist

This checklist should be utilized as a tool for completing the application. The documents listed below are considered to be, in their entirety, your credentialing application. Please note that your application will not be considered or processed until all of these documents are completed, as instructed, and received.

☐ **CAQH on-line application is complete:**

- The CAQH must be updated and re-attested within 4 weeks of your application to an additional OhioHealth facility being returned to OhioHealth. If you need assistance completing your CAQH application, contact CAQH at https://proview.caqh.org or call 888-599-1771.

☐ **Application Fee**

☐ **Current copy of the Curriculum Vitae/Resume**

- Start and end dates for Education and Work History must be in **month/year** format

☐ **Gap in Timeline**

- For practitioners who have been on staff at an OhioHealth hospital(s) less than 5 years, any gaps in the practitioner's professional timeline that span greater than 3 months within the past 5 years require an explanation

☐ **Intended Practice Plan/Supervising/Collaborating Physician**

☐ **Criminal Background Disclosure**

** If you completed fingerprinting at the time of your initial credentialing at any OhioHealth Hospital or joined the Medical Staff prior to January 2009, your criminal background will be verified through the Employment Screening Associates (ESA) service. If you were credentialed at an OhioHealth Hospital after January 2009 and have not been fingerprinted, you will be required to obtain fingerprints in order to join another OhioHealth Hospital

☐ **Completed Provider Information Specific to Credentialing**

☐ **Conflict of Interest/Verification of Employment History/Malpractice Claims History**

☐ **Radiation Safety Questions**

☐ **Documentation of Professional References**

☐ **Signed/Dated Physician & Allied Health Professional Ethics and Compliance Program Information**

☐ **Standard Authorization, Attestation and Release**

CREDENTIALING APPLICATION: CURRENT OHIOHEALTH AHP
OhioHealth Supplemental Documents

INTENDED PRACTICE PLAN

*Please check (✓) each hospital where you are applying for privileges. List your primary Supervising/Collaborating physician and the detail how you will practice at **each** hospital.*

NOTE: Primary Supervising/Collaborating physician(s) must be a member of the Medical Staff with appropriate privileges at the hospital(s) where you are seeking privileges. It is your responsibility to update the Medical Staff Services Office if your primary Supervising/Collaborating physician(s) changes.

✓	HOSPITAL	PRIMARY SUPERVISING/COLLABORATING PHYSICIAN	INTENDED PRACTICE PLAN (e.g., Consultations, Rounding, etc.)
☐	Berger Hospital		
☐	Doctors Hospital		
☐	Dublin Methodist Hospital		
☐	Grady Memorial Hospital		
☐	Grant Medical Center (Includes Pickerington Methodist Hospital & Grove City Methodist Hospital)		
☐	Hardin Memorial Hospital		
☐	Mansfield Hospital		
☐	Marion General Hospital		
☐	O'Bleness Hospital		
☐	Riverside Methodist Hospital		
☐	Shelby Hospital		
☐	Southeastern Medical Center		
☐	Van Wert Hospital		

Name of Your Current Primary OhioHealth Hospital: _____

Practice Name: _____ Tax ID: _____
(Associated with this application)

Provider Information for the OhioHealth Clinical Directory

At the time of your initial appointment, you were asked to provide the following: email address, specialty, office phone number, office fax, pager type, pager vendor and your preferred method of contact from hospital staff for patient care purposes. If there have been any changes to this information, please go to https://clinicianportal.OhioHealth.com to update information as needed.

_____ _____ _____
Applicant Printed Name Applicant Signature Date

CREDENTIALING APPLICATION: CURRENT OHIOHEALTH AHP
OhioHealth Supplemental Documents

Criminal Background Disclosure

Have you ever been convicted of, plead guilty, no contest or nolo contendere to a misdemeanor or felony, other than a minor traffic violation? (Note: a DUI or DUI reduced to reckless operation is not considered a minor traffic violation.) Do not report any conviction that has been sealed, expunged, statutorily eradicated, annulled, impounded, erased, dismissed, dismissed under a first offender's law, pardoned by the Governor or which state law allows you to lawfully deny. This background check will identify information greater than 10 years. **Failure to disclose will add processing time.**

☐ No ☐ *Yes

***If yes, please explain below and include a separate sheet if necessary.**

_____

_____

NOTICE TO APPLICANTS

OhioHealth or affiliate including OHCS (collectively, "OhioHealth") may obtain information about you from a consumer reporting agency made in connection with your application for membership and/or privileges at an OhioHealth facility. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews. These reports may contain information including, but not limited to: verification of identification, and/or Social Security number; checks of criminal history; verification of employment; verification of education; credentials and/or licensures; sanctions/exclusions from Medicare/Medicaid and/or other information on your background or history in connection with your application for membership and/or privileges at an OhioHealth facility. Upon a written request made to OHCS, and within 5 days of the request, the name, address and phone number of the reporting agency and the nature and scope of the report will be disclosed to you. Before any adverse action is taken, based in whole or in part on the information contained in the report, you will be provided a copy of the report, the name, address and telephone number of the reporting agency, a summary of your rights under the Fair Credit Reporting Act, as well as additional information on your rights under the law.

** If you completed fingerprinting at the time of your initial credentialing at any OhioHealth Hospital or joined the Medical Staff prior to January 2009, your criminal background will be verified through the Employment Screening Associates (ESA) service. If you were credentialed at an OhioHealth Hospital after January 2009 and have not been fingerprinted, you will be required to obtain fingerprints in order to join another OhioHealth hospital.

_____	_____	_____
Applicant Printed Name	Applicant Signature	Date

CREDENTIALING APPLICATION: CURRENT OHIOHEALTH AHP

OhioHealth Supplemental Documents

Provider Information Specific to Credentialing

Please provide the following information so that we can ensure our records are up to date:

Provider Home Address: _____

Provider Cell Phone Number: (____) _____

Provider Email Address: _____

Provider CAQH Number: _____

Conflict of Interest

The following two questions must be answered by all applicants:

1) Do you hold a direct or indirect ownership interest in an inpatient hospital located within the state of Ohio? (For purposes of this question, "indirect ownership" means that another person or entity may own the interest but you will receive a benefit from it, e.g., ownership by a spouse, employer, pension program or beneficial trust).

☐ No ☐ *Yes

*If yes, please explain: _____

_____

2) **If the answer to question 1 is "no":** are you in a profit-sharing arrangement with a person or entity that holds a direct or indirect ownership interest in an inpatient hospital located within the state of Ohio?

☐ No ☐ *Yes

*If yes, please explain: _____

_____

Verification of Employment History

Have you ever been subject to any disciplinary action by an employer including but not limited to termination or non-renewal of a contract for cause?

☐ No ☐ *Yes

*If yes, please provide specific details: _____

_____

Please make sure that your CAQH application documents all employment for the past five (5) years or since your graduation from professional school, whichever is less. Please note that you only need to provide employment information for jobs in which you functioned in a clinical capacity.

Malpractice Claims History

NOTICE TO APPLICANTS

You must provide documentation of all pending and/or settled malpractice claims against you within the last 10 years. This information, including any malpractice claims since your last appointment/reappointment, MUST be listed on your CAQH Application.

_____ _____ _____

Applicant Printed Name Applicant Signature Date

Radiation Safety

1. **Will you be present in an area where fluoroscopy is used?** ○ Yes ○ No
   (e.g. surgery, cath lab, endoscopy, electrophysiology lab, radiology)
   If "yes", Ohio Department of Health regulations require that you fulfill education requirements regarding radiationsafety. You will be assigned two courses on OhioHealth University that must be completed before you are present in an area where fluoroscopy is used. This is a one-time requirement for those who are new to OhioHealth or have taken on a new role working in a restricted area where ionizing radiation is used.
2. **Do you plan to personally operate* fluoroscopic equipment**? ○ Yes ○ No
   If yes, check all that apply: ☐ Mini C-Arm ☐ C-Arm ☐ O-Arm ☐ Angiographic fluoro ☐ Other fluoro
   If "yes", Ohio Department of Health regulations require that you complete site-specific equipment competency documentation. You will be required to meet with the manager of the department who owns the fluoroscopic equipment to have this completed before you begin operating fluoroscopic equipment. You will receive an email notifying you of the manager to contact based on the equipment you wish to operate. This is a one-time requirement for those who are new to OhioHealth or have taken on a new role working in a restricted area whereionizing radiation is used.

** "Operate" means using the x-ray controls directly, including stepping on the pedal to generate x-rays, operating the controls to change views or otherwise manipulating the x-ray unit. It does not mean ordering fluoroscopic procedures, directing a rad tech tooperate a fluoroscope or reviewing fluoroscopic images.*

_____	_____	_____
Applicant Printed Name	Applicant Signature	Date

OhioHealth

APPLICATION FOR INITIAL CREDENTIALING
Current OhioHealth Allied Health Professionals

Instructions for Submitting Five (5) Professional References

At the time of your initial appointment, you were asked to supply the names of 5 professional references. While we recognize this was done during the initial application process, The Joint Commission requires us to prove current clinical competence and professionalism. We believe that professional references are a valuable assessment of professional performance and therefore we require new, up-to-date references when applying to an additional OhioHealth Hospital.

Please note that all references must have observed your clinical practice as an Allied Health Professional within the past 3 years and be able to attest to your current clinical competence.
NOTE: Friends and/or relatives cannot be used as references.

Please adhere to the following criteria when submitting the names of your five (5) professional references.

REQUIRED REFERENCES
• **Primary Supervising/Collaborating Physician** –You are required to submit the name of your primary supervising or collaborating physician from your primary OhioHealth hospital at which you currently have clinical privileges. • **Previous Supervising/Collaborating Physician –** If you have changed practices or employers within the past three years, you are required to submit the name of a supervising/collaborating physician from **each** of your previous practices or employers. • **Program Director** – This is a required reference **if** you completed classroom or online training within the **past twelve (12) months**. • **Preceptor** – This is a required reference **if** you graduated from an online training program within the **past twelve (12) months**.
OTHER ACCEPTABLE REFERENCES **(IN ADDITION TO REQUIRED REFERENCES)**
• **Peer** - A provider who holds the same license (ex. Certified Nurse Practitioner for Certified Nurse Practitioner, Physician Assistant for a Physician Assistant, etc.) as you and who works in the same discipline (has similar privileges) with knowledge about the quality of your performance. NOTE: A registered nurse (RN) is **not** an acceptable peer. • **Preceptor**

OhioHealth

APPLICATION FOR INITIAL CREDENTIALING
Current OhioHealth Allied Health Professionals

Documentation of Five (5) Professional References

All information must be completed on this form; a separate page ***will not*** *be accepted. Peer references are sent electronically so a current email address for each reference will be required.* ***Please be aware that if this information is not legible, your application will be deemed incomplete.***

Reference #1 (REQUIRED REFERENCE)

First Name:	**Last Name:**	**Degree:**
Phone:	**Email Address:**	
This reference is my (Choose 1): ☐ Primary Supervising/Collaborating Physician ☐ Previous Supervising/Collaborating Physician ☐ Program Director	☐ Preceptor ☐ Peer	**Name of Institution:** ***(where you practiced with this reference)***

Reference #2

First Name:	**Last Name:**	**Degree:**
Phone:	**Email Address:**	
This reference is my (Choose 1): ☐ Current Supervising/Collaborating Physician ☐ Previous Supervising/Collaborating Physician ☐ Program Director	☐ Preceptor ☐ Peer	**Name of Institution:** ***(where you practiced with this reference)***

Reference #3

First Name:	**Last Name:**	**Degree:**
Phone:	**Email Address:**	
This reference is my (Choose 1): ☐ Current Supervising/Collaborating Physician ☐ Previous Supervising/Collaborating Physician ☐ Program Director	☐ Preceptor ☐ Peer	**Name of Institution:** ***(where you practiced with this reference)***

Reference #4

First Name:	**Last Name:**	**Degree:**
Phone:	**Email Address:**	
This reference is my (Choose 1): ☐ Current Supervising/Collaborating Physician ☐ Previous Supervising/Collaborating Physician ☐ Program Director	☐ Preceptor ☐ Peer	**Name of Institution:** ***(where you practiced with this reference)***

Reference #5

First Name:	**Last Name:**	**Degree:**
Phone:	**Email Address:**	
This reference is my (Choose 1): ☐ Current Supervising/Collaborating Physician ☐ Previous Supervising/Collaborating Physician ☐ Program Director	☐ Preceptor ☐ Peer	**Name of Institution:** ***(where you practiced with this reference)***

_____ _____ _____

Applicant Printed Name Applicant Signature Date

APPLICATION FOR INITIAL CREDENTIALING
Current OhioHealth Allied Health Professionals

Physician and Allied Health Professional Ethics and Compliance Program Information

Background

OhioHealth Hospitals (Berger Hospital, Doctors Hospital, Dublin Methodist Hospital, Grady Memorial Hospital, Grant Medical Center, Hardin Memorial Hospital, Mansfield Hospital, Marion General Hospital, O'Bleness Hospital, Riverside Methodist Hospital, Shelby Hospital, Southeastern Medical Center and Van Wert Hospital) are committed to conducting business and providing patient care in accordance with high ethical standards and compliance with applicable laws. To that end OhioHealth has created a corporate Ethics and Compliance Officeand a Compliance Program.

Physicians and Allied Health Professionals associated with any OhioHealth Hospital are expected to support this Program by being knowledgeable about the Program and the regulatory requirements affecting hospital operations. Requirements vary depending upon theemployment relationship of the Physician or the Allied Health Professional with the Hospital.

Ethics and compliance violations may be grounds for corrective action under the Medical Staff Bylaws or termination of employment in accordance with the terms of the employment contract.

To learn more about OhioHealth's Ethics and Compliance Program please visit the OhioHealth eSource at https://ohesource.ohiohealth.com/departments/EthicsCompliance/GeneralCompliance/Pages/default.aspx

Reporting

Any Physician or Allied Health Professional who believes an ethics or compliance violation has occurred or is occurring within the Hospital shall report his or her concern. The report may be made to the Vice President of Medical Affairs, President of the Medical Staff or the Corporate Ethics and Compliance Office using any of the methods listed below.

- Ethics and Compliance Office: (614) 544.4200.
- OhioHealth Ethics and Compliance Hotline: (866) 411.6181.
- Emailing details to: CompliancePrivacy@OhioHealth.com.
- Submitting a report through OhioHealth's online reporting tool at www.MyComplianceReport.com using access code: OHH.

Ethics and Compliance Attestation Form

During the initial application process all Physicians and Allied Health Professionals must sign and return the Ethics and Compliance Attestation. This attestation must also be signed and returned at each reappointment. This Attestation has been approved by the Quality of Care Committee of the OhioHealth Board, and the purpose of the Attestation is to establish linkage to the Hospital's Ethics and Compliance Program and to set educational standards.

My signature below indicates that:

I have received the Physician and Allied Health Professional Ethics and Compliance Information describing the OhioHealth Ethics and Compliance Program, and at initial appointment, I received a copy of the OhioHealth Code of Conduct. I understand that these documents represent the manner in which the OhioHealth Board of Directors expects business to be conducted within the organization. I have received the OhioHealth Ethics and Compliance office phone number and the Ethics and Compliance Hotline number where issues can be reported. I also agree to report any ethics or compliance violation I believe has occurred or is occurring within the organization.

_____	_____	_____
Applicant Printed Name	Applicant Signature	Date

OhioHealth

APPLICATION FOR INITIAL CREDENTIALING
Current OhioHealth Allied Health Professionals
Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

3094

OhioHealth

APPLICATION FOR INITIAL CREDENTIALING
Current OhioHealth Allied Health Professionals

INFORMATIONAL ONLY

Notification of Practitioner Rights

- Practitioners have the right to be informed of the status of their credentialing or reappointment application uponrequest.
- Practitioners have the right to review information obtained and used for purposes of credentials evaluation with the exception of professional references and/or any other type of information that is deemed to be privileged and confidentialand/or is protected under Ohio peer review statute.
- Practitioners have the right to correct information collected from outside sources that is erroneous. Corrections to erroneous information must be made in writing and sent to OHCS within fifteen days of notification that erroneousinformation has been received.
- Practitioners have the right to copy only documents in their file which they have submitted with regard to theirapplication.
- Practitioners have the right to be credentialed in a non-discriminatory manner based upon race, gender, nationality,origin, or religion.

Sharing Privileged Provider Information

By submitting an application for appointment/reappointment and/or clinical privileges or by maintaining an appointment and/or clinical privileges at an OhioHealth hospital, the Provider agrees and recognizes, consistent with such OhioHealth hospital's medical staff bylaws or other OhioHealth system- or hospital-related documents, that Privileged Provider Information (as defined below) related to the Provider will (i) be available to each OhioHealth hospital at which the Provider currently has an appointment and/or privileges; (ii) be available to each OhioHealth hospital to which the Provider is applying for appointment/reappointment and/or privileges; and (iii) be otherwise shared between such OhioHealth hospitals, on an as-needed basis, regardless of whether the Provider has signed a separate consent or authorization related to the information. For purposes of this statement, 'Privileged Provider Information' means all information from professional review activities within the purview of applicable federal and state statutes governing the confidentiality and privilege that flow to professional review documents including, but not limited to, all information related to the credentialing of providers and information related to the quality of care provided by a provider and/or hospital.

Allied Health Practitioner Delineation of Privileges

What is a Delineation of Privilege (DOP)?
A formal document that contains a list of privileges that an Advanced Practice Provider has been approved to perform when seeing patients in the hospital.

Types of DOPs
APRNs (CNP, CNS, CNM, CRNA) and PA-Cs all have DOPs. CNP, CNS, and PA-C DOPs have been standardized throughout the OhioHealth system. CNM and CRNA DOPs will be standardized in the future but are not currently standardized. There are general DOPs and specialty specific DOPs (e.g., Trauma/Critical Care APRN DOP, Cardiovascular PA-C DOP etc.). If a specialty specific DOP does not exist (e.g., Oncology, Infectious Disease, Gastroenterology, etc.) those providers will utilize the general DOP.

Initial DOP Completion
During the onboarding process, the APP will complete the DOP in collaboration with the APP's primary collaborating physician. General privileges and, if applicable, Category I or Category II privileges specific to the APP's area of practice are selected. For any Category II privileges, the need for proctoring is identified on the DOP. Proctoring can only be performed after the privileges have been granted.

CONTINUED: Allied Health Practitioner Delineation of Privileges

While privileges are standardized across the system providers at a particular hospital should only select privileges they plan to exercise at their hospital, (i.e., neurocritical care is not available at all hospitals). A separate DOP must be completed for each OhioHealth hospital in which you plan to provide patient care.

Category I versus Category II Privileges
Category I privileges are basic clinical activities within a specialty that any appropriately trained provider should be competent to perform. Category I privileges do not require proctoring, nor do they require a certain number to be performed annually to maintain competence. This would include things such as minor suturing, drain removal, foley insertion, etc.

Category II privileges are more specialized and require significant education, proctoring, possibly an OhioHealth Learning Management System (LMS), or another online course, or an in-person course. Category II privileges typically have volume requirements and need to be performed with some frequency in order to maintain competence. Examples include intubation, surgical first assisting, line placement, ICP monitor placement, etc. **Category II privileges may only be requested by an APP if those privileges mirror those of their collaborating physician.**

Expectations
The APP is responsible for keeping track of the completion of any proctoring requirements, using the proctoring reporting forms, and turning the forms in to the hospital's medical staff office once the identified number have been completed. The APP must also continue to keep a record of any Category II privileges exercised. These logs will be evaluated as part of Ongoing Professional Performance Evaluation (OPPE).

How are changes made to a DOP?
When there is a need for a correction, addition, or deletion to a DOP, the request must be submitted to the Allied Health Practitioner System DOP committee. This committee is charged with standardizing, where possible APP privileges throughout the OhioHealth system.

APPs or physicians who wish to make a change to an existing DOP or create a new DOP, should reach out to Paige Ford in the Medical Staff Office at Riverside to request the DOP change form. The change should be described and, if new, identified as Category I or Category II, and the training pathway described. The request should be reviewed by stakeholders including specialties that would have providers performing the requested privilege. Those stakeholders who have vetted the change must be listed on the request form. The completed form is then sent to Paige who will place the request on the Allied Health Practitioner System DOP Committee's agenda.

The requestor will be notified of the request being added to the agenda and invited to attend the meeting. They will need to be available for questions from the committee. The committee meets the 2nd Thursday of each month at 1pm, in person (not currently) and by Webex. Once committee approval is obtained, the change is sent to each impacted hospitals' Medical Executive Committee (MEC) and then to Quality of Care Committee (QCC) for final approval.