From Document Retention Through Credentialing

Knowing what to keep and for how long

Amy Lewis
Brad Clark
Sue Middleton

Objectives

- Review state regulations for record retention
- Gain a legal perspective on resident files
- Walk through the process of saving ERAS applications
- Distinguish between the different types of credentialing
- Take a closer look at the credentialing process

Group Activity

All Tables

Table Exercise

- As a group at your table, list as many items as you can think of that you maintain in a resident’s file

Legal Perspective

Amy Lewis

Records Retention

- State Retention Schedules (With Reference Tables)
  - GS-1: General Records
    - http://dos.myflorida.com/media/698312/gs1-sl-2017-final.pdf
  - GS-5: Public Universities
    - http://dos.myflorida.com/media/693588/gs05.pdf

Other Considerations

- Contracts
- Public Records Law – exemptions limited
- Audits – 3 fiscal years – Plus
- Litigation – Litigation Hold – 7 Years
- Public Records Requests – 30 Days
- Accreditation
- State and Federal Law
- Protected Health Information
- USF Policy 5-012: Records Retention and Disposition

Key Points

- State retention schedule is the minimum

  Maintain records for longer period otherwise mandated

  - Records Disposition

- Electronic Records
  - Maintain date/routing information
  - Retain in native format for litigation

Applications

- Denied – 5 Fiscal Years from Application
- Admitted – 5 Anniversary Years from Separation
- Appeals – 5 Fiscal Years from Final Decision

Discipline

- Major – 5 Anniversary Years – Final
- Minor – 3 Anniversary Years – Final
- None – 60 Days – Final
- Counseling – 1 Anniversary Year – Final
- Grievance – 3 Fiscal Years – Final

Education

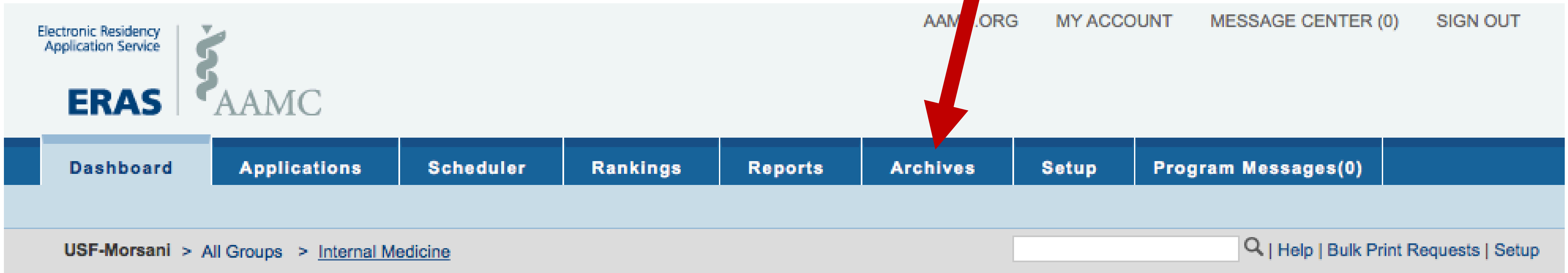
- Permanent Academic File – defined
- Support Documents – 5 Anniversary Years
- Transcript Release – 4 Anniversary Years

ERAS Applications

Brad Clark

Archiving ERAS Applications

On the main page, click "Archives"



ERAS | AAMC

Dashboard | Applications | Scheduler | Rankings | Reports | Archives | Setup | Program Messages(0)

USF-Morsani> All Groups > Internal Medicine | Help | Bulk Print Requests

Custom archive options are not available at this time but previously generated files are still available. Click Download next to the file you wish to open.

Season Archive Request Status

Season	Print Job Name	Request Type	File	Status	User's Name	Requested Date	Generated Date
2017	All Applicants	PDF	Download	Completed	A ERAS-PDWS	08/16/2017 04:55 pm	08/16/2017 11:24 pm
2017	All Applicants	CSV	Download	Completed	A ERAS-PDWS	07/10/2017 11:26 am	07/10/2017 11:43 am
2016	All Applicants	PDF	Download	Completed	A ERAS-PDWS	08/12/2016 07:01 pm	08/12/2016 09:04 pm
2016	All Applicants	CSV	Download	Completed	A ERAS-PDWS	06/21/2016 02:41 pm	06/21/2016 03:00 pm
2015	All Applicants	PDF	Download	Completed	A ERAS-PDWS	08/20/2015 02:42 pm	08/20/2015 04:07 pm
2015	All Applicants	CSV	Download	Completed	A ERAS-PDWS	06/18/2015 02:29 am	06/18/2015 03:30 am

PDF will be a large ZIP file

CSV is spreadsheet

- Good for searching and filtering

Download both PDF and CSV

GME Credentialing

Sue Middleton

Types of Credentialing Requests

- Board of Medicine
  - Original
  - FCVS
- *Hospital*
  - *From Hospital*
  - *From credentialing company*
- Peer
  - These can be sneaky!

MEDICAL BOARD OF CALIFORNIA

Licensing Program

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

Check one: D U.S. or Canadian Medical School Graduate D International Medical School Graduate

MBC Use Only

Type or Print Legibly — APPLICANT NFORMATION

Personal Data D

NAME:	Last	First	Middle

Date of Birth (mm/dd/yyyy)	US.Social Security Number	Medical School of Graduation

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINNG NFORMATION

Training Information

ATIENTION PROGRAM DIRECTOR: Do not sign and date this fonn prior to the last day of any postgraduate trai ning year which will be used by the appli ca nt to qualify for licensure. Completon of this fonn will certify that the applicant referenced above has satisfactori ly completed a period of accredted postgraduate training at this facility and that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine n this state. *The completed form must be mailed directly from the program to the Board.*

Facility Name		D 0
Facilty Address		0 0
Specialty	ACGME 10-dlgit Program # http://www.acgme.org/adspubl c	D D
Begin Date (mm/dd/yyyy)	End Date (or anticipated completion date): / /	

UNUSUAL CIRCUMSTANCES

Question	Response	MBC
1. Did the applicant receive partial or no credit for any postgraduate training year?	0 Yes 0 No	0
2. Did the applicant ever take a leave of absence or break from his/her training?	0 Yes D No	D
3. Was the applicant ever terminated, dismissed or expelled?	0 Yes 0 No	0
4. Did the applcant ever resign?	0 Yes 0 No	0
5. Was the applicant ever placed on probation?	D Yes 0 No	0
6. Was the applicant ever disciplined or placed under nvestigation?	0 Yes 0 No	0
7. Were any incident reports regarding this applicant ever filed by nstructors?	0 Yes 0 No	0
8. Were any Imitations or special requirements placed upon the applcant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	0 Yes 0 No	0
9. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?	D Yes 0 No	0

Program Director: Please provide a signed and dated letter of explanation for any "yes" response to questions # 1-9. The explanation must be provided on program letterhead and mailed directly to the Board with the Form L3A-L3B.

L3A

GENERAL MEDICINE TRAINING REQUIREMENT

MBC Use Only

To qualify for licensure in California, applicants who are graduates of an international medical school must complete at least four months of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to licensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant had direct patient care responsibilities for at least four months in any particular specialty or sub-specialty area.

General Medicine D

10. Did the applicant named on the L3A form complete a minimum of four months of general medicine as part of the postgraduate training program accredited by the ACGME or the RCPSC?

D Yes D No

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

NOTE: The completed Form L3A-L3B must be mailed directly from the program to the Board to be acceptable.

The program director signing this form is formally certifying and documenting under penalty of perjury that the applicant received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to satisfactory performance. The program director is attesting to the fact that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

I hereby declare under penalty of perjury under the laws of the State of California that all of the information contained on these forms is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant named on the Form L3A, and the applicant was trained in an ACGME or RCPSC slotted program position.

Program Director's Signature & Date D

PRINTED NAME OF PROGRAM DIRECTOR

Email Address

SIGNATURE OF PROGRAM DIRECTOR

DATE

Phone Number

(Signature Stamp Is Not Acceptable)

Program Director's Signature D

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

NOTE: If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.

Notary Signature & Seal D

Hospital Seal D

SIGNATURE OF PROGRAM DIRECTOR:

(Please sign full name in presence of notary)

State of

County of -

Subscribed and sworn to (or affirmed) before me on this day of , 20

NOTE: The completed form must be mailed directly from the program to the Board to be acceptable.

by, - proved to me on the basis of satisfactory evidence

Updated August 2017

USF HEALTH
Making Life Better

Cover Letter 2

VERIFICATION OF GRADUATE MEDICAL EDUCATION & TRAINING
CONFIDENTIAL AND PRIVILEGED
PEER REVIEW DOCUMENT

Today's Date

Re:
Trainee's Name
DOB or NPI #
Residency or Fellowship Program Name
Training Dates 1
Training Dates 2

Hospital or credentialing organization
Department/Program (if applicable)
Organization
Hospital or credentialing organization Address 1
Hospital or credentialing organization Address 2
Hospital or credentialing organization City, State, Zip

Dear Hospital or credentialing organization :

The above-referenced physician trained at this institution in this program and during the dates referenced above. The enclosed Verification of Graduate Medical Education Training Form summarizes this individual's performance during that period of training.

This form:

☐ was completed at the time the trainee left the program,

or

☐ was completed by the current program director, based on a review of the trainee's file, after the trainee had left the program, and is sent to you upon receipt of a signed authorization and release form by the former trainee.

This cover letter attests that the enclosed information contains a complete and accurate summary of the trainee's performance in this program. We are unable to provide information about training or practice after completion of this program, and trust that you will obtain that information from the appropriate programs/institutions.

Sincerely,

Program Director Name
Program Director's Title
Organization
Address 1
Address 2
City, State, Zip

Enclosures: (i) Verification of Graduate Medical Education & Training Form

VERIFICATION OF GRADUATE MEDICAL EDUCATION & TRAINING

Section I: Verification of training and performance during training
(To be completed for EACH trainee)

Trainee's Full Name:	DOB:	NPI:

Program Specialty or Subspecialty:

☐Preliminary Program: . Date From/To: – .
☐Core Residency Program: . Date From/To: – .
☐Fellowship Program: . Date From/To: – .

Training Program Accreditation: ☐ ACGME ☐ AOA ☐Other

If marked "other," please indicate accreditation type or list "none:"

Program ID #:

Did the above-named trainee successfully complete the training program which she/he entered?
☐ Yes ☐ No

In addition to completion of full specialty training, completion of a transitional year or a planned preliminary year(s) would constitute completion of a program.

(If NO, please provide an explanation in the "Additional Comments" section below or enclose a separate document.)

Was the trainee subject to any of the following during training?

(i)	Conditions or restrictions beyond those generally associated with the training regimen at your facility;	☐Yes	☐ No
(ii)	Involuntary leave of absence;	☐ Yes	☐ No
(iii)	Suspension;	☐ Yes	☐ No
(iv)	Non-promotion/non-renewal;	☐ Yes	☐ No
(v)	Dismissal; or	☐ Yes	☐ No
(vi)	Resignation.	☐ Yes	☐ No

(If YES to any of the above, please provide an explanation in the "Additional Comments" section below or enclose a separate document.)

Upon completion of the training program, the individual was deemed to have demonstrated sufficient competence in the specialty/subspecialty to enter practice without direct supervision.

☐ Yes ☐ No ☐ N/A

(If NO, please provide an explanation in the "Additional Comments" section below or enclose a separate document.)

Did the program endorse this trainee as meeting the qualifications necessary for admission to the specialty's board certification examination? ☐ Yes ☐ No ☐ N/A

If NO, indicate the reason(s):

☐ This trainee was a preliminary resident.

☐ Trainee was not eligible for certification.

☐ Trainee involuntarily or voluntarily left this program before completion. *

☐ No certification is available for this subspecialty.

☐ Other. *

**Please provide an explanation in the "Additional Comments" section below or enclose a separate document.*

Section II: Additional Comments
Please utilize this comment area to provide additional information in response to any of the questions noted above on this form. *(If additional space is needed, please enclose a separate document.)*

Section III: Attestation
The information provided on this form is based on review of available training records and evaluations. Signature: Printed Name: GME Title: Professional Credentials: Phone Number: Email:

In an effort to improve and streamline the credentialing process, the Accreditation Council for Graduate Medical Education (ACGME), American Hospital Association (AHA), National Association Medical Staff Services (NAMSS), and Organization of Program Directors Associations (OPDA) have collaborated to create a standardized "Verification of Graduate Medical Education Training (VGMET)" form designed to be completed once at the completion of training (or at the first opportunity thereafter when the program is asked to complete a verification/credentialing form).This VGMET is then time-stamped and inserted in the trainee's file. This time-stamped form, along with a cover letter from the current program director or institutional official, serves as the program's verification of training. The form will not include detailed lists of current procedural or technical competencies.

NOTE: THE VGMET FORM IS NOT INTENDED TO MEET REQUIREMENTS FOR LICENSURE. PLEASE USE THIS SUPPLIED FORM FROM THE FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS) FOR LICENSURE PURPOSES. THIS CAN BE USED WHETHER THE PHYSICIAN IS USING FCVS OR IS SEEKING LICENSURE INDEPENDENTLY.

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MEDICAL STAFF SERVICES – MP 38
t 407.841.5139 • f 407.841.5255
OrlandoHealth.com

Peer Reference Questionnaire:

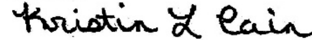
date:	August 28, 2017	*from::*	Kristin Cain
to:		*telephone:*	407.841.5139
fax:	(813) 558-9421	*fax:*	(321) 843-1741

To Whom It May Concern:

The above referenced applicant has applied for membership and clinical privileges at Orlando Health. In order to process I ______ application for appointment, information regarding his/her clinical performance is requested. Please find attached a Peer Reference Questionnaire and a signed release form from the applicant.

Please, specifically indicate anything that would warrant exercising caution in granting clinical privileges to Dr. Cooke. If you would like to discuss matters relative to ; application personally, please feel free to contact me at 407-841-5139. I would certainly be happy to speak with you.Thank you for your time and assistance in providing the requested information at your earliest response.

Sincerely,



Kristin Cain, Credentialing Specialist

CONFIDENTIALITY NOTICE: The information contained in this transmission may be privileged and confidential under Florida law. This transmission may also contain material protected by Federal privacy regulations or attorney-client, work product or other privileges. It is intended solely for the use of the addressee(s) named above. If you are not an intended recipient, any review, use or distribution of this information is strictly prohibited. If you have received this confidential communication in error, notify the sender immediately by telephone and return the original of this transmission to the U.S. Mail at the address shown. If this transmission concerns a contract matter, be advised that no employee or agent is authorized to conclude any binding agreement on behalf of Orlando Health without express written confirmation by an officer of the corporation.

Please return completed and signed form via fax to (321) 843-1741, Attention Kristin Cain

RELATIONSHIP TO APPLICANT

1. During what time frame did you directly observe the applicant's practice of medicine?

   ____

   From (mm/yr) To (mm/yr)

2. What settings have you observed the applicant? ☐Office ☐Training Program ☐Hospital

   ☐ Other: ______________________________

3. With what frequency did you observe the applicant? ☐Daily ☐ Monthly ☐Weekly

   ☐Other: ______________________________

4. Please state the name of the Organization & your Title during the time you observed the applicant:
   ______________________________; please also state the applicant's Title or Position during the time: ______________________________.

5. Have you been or are you related to the applicant as family or through a professional

   ☐association? Yes, please state relationship: ______________________ ☐No

DennisLedford

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PROFESSIONAL COMPETENCY: Please rate the following:
(**EX**: Excellent; **GD**: Good; **AV**: Average; **BA**: Below Average; **NI**: No Information)
If you do not have adequate knowledge please indicate NI and provide an explanation in the space provided.

1. Patient Care: Technical and Clinical Skills and Clinical Judgment	**EX**	**GD**	**AV**	**BA**	**NI**
Communicates Effectively, Compassionately, and Respectively with patients and their families.					
Gathers essential and accurate information about his/her patients					
Makes informed diagnostic and therapeutic decisions based on patient information and preferences, scientific evidence, and clinical judgment.					
Uses information technology to support patient care decisions and education					
Effectively develops and carries out patient mgt plan, including obtaining appropriate consults when needed.					
Provides care aimed at preventing health problems or maintaining health.					
Demonstrates competence in performing all procedures for his/her specialty					
Works effectively with all members of the healthcare team, including those from other disciplines, to provide patient-focused care					
Effectively counsels and educates his/her patients and their families					
2. Medical Knowledge, Learning, and Improvement	**EX**	**GD**	**AV**	**BA**	**NI**
Demonstrates knowledge of basic and discipline-specific medicine					
Demonstrates an investigatory and analytic approach to clinical situations					
Locates, appraises, and understands evidence (labs, clinical research, patient demographics) and effectively applies this knowledge for his/her patients					
Evaluates his/her patient care practices and makes improvements as needed.					
Is proactive in increasing his/her own knowledge base and in facilitating learning in other healthcare professionals.					
3. Interpersonal and Communication Skills	**EX**	**GD**	**AV**	**BA**	**NI**
Creates and sustains a therapeutic and ethical relationship with patients					
Effectiveness of nonverbal, listening, explanatory, questioning, and writing skills					
Provides appropriate and concise written and verbal skills to allow for continuity of care.					
4. Professionalism	**EX**	**GD**	**AV**	**BA**	**NI**
Responsiveness, accountable, and committed to patients and profession					
Demonstrates respect, compassion, and integrity					
Demonstrates ethical principles: provision or withholding of clinical care, patient confidentiality, informed consent, and business practices					
Demonstrates sensitivity and responsiveness to patient/coworkers culture, age, gender, disabilities					

Please add any additional comments or information regarding a NI listed above:

____

____

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1. The above responses are based on: ☐ Close personal observations ☐ General impressions
   ☐ Supervisor/Manager evaluations ☐ Other: ____________________
2. Are you aware of any health impairments, including drug addictions, substance dependence, or alcohol abuse, which would affect the applicant's ability to fully perform his/her professional and staff duties? ☐ Yes ☐ No
3. Recognizing that medical staff privileges are based upon providing high quality medical care; can you recommend this applicant's professional staff privileges at this hospital? ☐ Yes ☐ No
4. Please add any additional comments, information, recommendations you may consider relevant to our granting appointment/affiliation/specific clinical privileges/services to applicant:
   ____
   ____

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PHYSICIAN:

CLINICAL COMPETENCY AND TRAINING

The above referenced applicant has expressed an interest in performing the procedures listed below. Your assistance is appreciated in documenting his/her training and clinical competency:

Procedure	Recommended	Not Recommended*	Unknown*
Allergy & Immunology-CORE Pulmonary Function Test Interpretation Penicillin Desensitization Skin Testing including Scratch, Prick, or Intradermal Technique.	☐	☐	☐

V. REFERENCE PROVIDED BY: *Please PRINT information requested below.*

Name:		**Specialty:**	
Professional Position:			
Name of Institution:			
Address:			
Phone:		**Fax:**	

Please Sign: *Date Signed:*

Return to:

Orlando Health; Medical Staff Services, MP38; 1414 Kuhl Ave, Orlando, FL 32806 407-841-5139
Fax: 407-841-5255

*Should you select "Not Recommended" or "Unknown" regarding the requested privileges, please provide a brief description as to why.

DennisLedford

Processing

- Board of Medicine
  - We do not charge for these
  - They must be reviewed by GME prior to returning
- Hospital
  - Processed and often completed by GME
  - Change in AHA for now to have PD often sign
  - Signature is still an option
- Peer
  - No charge required-optional
  - Do not need to go through GME…UNLESS PD COMMENT REQUIRED!

Questions?