

MEDICAL STAFF

Policy and Procedure Manual

***Adopted (05.01.2013); Revised June 12, 2013; December 16, 2013; October 8, 2014; December 10, 2014; March 11, 2015; June 10, 2015; June 7, 2016; September 25, 2017; August 28, 2019***

***Policies and Procedures Revised while contained in the JMMC Medical Staff Bylaws, Rules and Regulations (February 2012, July 11, 2012, July 13, 2012, December 5, 2012, February 6, 2013)***

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE: MEDICAL STAFF POLICY #1**  **MEDICAL RECORD SIGNATURES** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

The medical record may be authenticated by the attending physician. Certain conditions may apply that may not allow this to happen.

1. Group Practice: A letter written by the group stating that each associate may sign the charts of the group’s patients. This letter must be signed by each member of the group. This letter will be maintained in a file in the medical records office.
2. MD/DO Death or Indefinite Leave:
3. The Medical Executive Committee may close the file of a patient without the physician-of-record signature. There must be a letter placed in each patient’s medical record which has been closed stating the reason for the action taken.
4. The Medical Executive Committee may delegate the Medical Director or specialty representative on the Medical Executive Committee to sign the open medical records.
5. If extended medical leave of absence then the Medical Executive Committee may delegate the Medical Director or specialty representative on the Medical Executive Committee to sign the open medical records.
6. MD/DO On Temporary Leave: The open medical records may be filed until the physician returns from a short-term leave. A list of all outstanding medical records is to be maintained, and a letter placed in each file stating the reason for the chart being incomplete. When the physician returns from leave all of the listed outstanding charts will be pulled and completed by the returning physician.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE: MEDICAL STAFF POLICY #2**  **MEDICAL STAFF CRITERIA FOR SELECTION OF REFERRAL SOURCES** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

This policy provides that all referral sources from Johnson Memorial Hospital, where there are written agreements, represent that they meet the following criteria unless exceptions are noted. These include but are not limited to:

1. State licensure
2. Appropriate liability insurance

Referral facilities include but are not limited to other acute-care hospitals, sub-acute care facilities, long-term care units, surgery centers, and rehabilitation centers.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE: MEDICAL STAFF POLICY #3**  **NOMINATIONS FOR ELECTIVE OFFICES (PRESIDENT & VICE PRESIDENT)** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

At least sixty days prior to the Administrative Affairs Committee being convened for the purpose of selecting a slate of officers, a memo will be sent from the Chairman of the Committee (Vice President of the Medical Staff) to the Active Staff members, that the Administrative Affairs Committee is accepting names of those individuals who would be willing to serve as a Medical Staff Officer. These names should be provided to the Chairman for consideration by the Committee.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE: MEDICAL STAFF POLICY #4**  **RETENTION OF MEDICAL STAFF MATERIALS INCLUDING MINUTES, BYLAWS, AND CREDENTIALING FILES** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

Pending or Threatened Claims or Suits: As a general rule, if a claim has been made against the Hospital or Medical Staff, or a suit is pending or threatened, all relevant documents should be retained.

Minutes of Meetings of the Medical Staff: Minutes of the Medical Staff should be retained indefinitely. They are considered to be an important and valuable source of information.

Retention of Medical Staff Bylaws: The various versions of the Medical Staff Bylaws are critical to determining how the Medical Staff has functioned, and what rules and regulations were in place at any given time. At least one copy of each version of the Bylaws and Rules and Regulations should be retained permanently.

Minutes of the Committees of the Medical Staff: With the exception of the Medical Executive Committee and Credentials Committee, minutes of all committees of the Medical Staff should be retained for at least seven years. The Medical Executive Committee and Credentials Committee minutes should be retained for a period of at least 25 years or indefinitely.

Former Medical Staff Members Files: All credentialing records should be maintained for seven years following termination or resignation from the Medical Staff. In the case of a member of the Medical Staff who was removed from the staff, or whose clinical privileges were challenged, limited, or removed, these documents should be retained for whichever of the two following periods is longer: 1) ten years; or 2) seven years after the Member no longer is on the Medical Staff.

Files Pertaining to Physicians Currently on Staff: Credentialing files, including supporting documentation, should be maintained for each physician on the Medical Staff. Complete files should be maintained on current Medical Staff members for at least seven years.

Proceedings of Hearings: If a Medical Staff member challenged a credentialing decision, and a hearing was held in accordance with the provisions of the Medical Staff Bylaws, the entire record of the proceeding be retained for whichever of the two following periods is longer: 1) ten years; or 2) seven years after the member no longer is on the Medical Staff.

Correspondence and Other Formal Records of the Medical Staff Office: All of these documents should be retained for a period of seven years.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE: MEDICAL STAFF POLICY #5**  **DISPUTES REGARDING ON CALL COVERAGE WITHIN A SECTION** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

Issues pertaining to division of call amongst all specialties will attempt to be resolved by each section. If a resolution by the respective section cannot be reached, the issue would be referred to the respective Department. If a resolution cannot be reached by the Department, the issue would be referred to the Medical Executive Committee for review and final determination. Each case would be reviewed on a specialty by specialty basis. The Medical Executive Committee would review requests for appeal to any final determination at any time.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE: MEDICAL STAFF POLICY #6**  **ORGANIZED HEALTH CARE ARRANGEMENT; JOINT NOTICE OF PRIVACYPRACTICES; HIPAA PRIVACY AND SECURITY POLICIES AND PROCEDURES** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:**  **April 14, 2003** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

A. Each member of the Medical Staff, as a condition of membership, agrees to comply with the current version of the Joint Notice of Privacy Practices. In signing the membership application and reapplications and accepting Medical Staff membership, each member of the Medical Staff has already agreed to comply with applicable Hospital policies and procedures, which include the Hospital’s HIPAA Privacy and Security Policies and Procedures.

B. The Hospital and its Medical Staff constitute an Organized Health Care Arrangement (OHCA) under the Health Insurance Portability and Accountability Act (HIPAA), and therefore can share Protected Health Information (PHI) at the Hospital in accordance with the Hospital’s Policies and Procedures. An OHCA exists because the Hospital and Medical Staff provide services in the Hospital, which is a clinically integrated care setting in which patients typically receive health care from more than one provider, such as from the Hospital and from the member of the Medical Staff.

C. The Hospital and the Medical Staff have issued a “Joint Notice of Privacy Practices” to Hospital patients in accordance with the HIPAA Privacy Regulations.

D. This policy applies to each facility campus, satellite clinic and office and each facility Medical Staff within Johnson Memorial Hospital.

E. This policy is effective as of April 14, 2003.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE: MEDICAL STAFF POLICY #7**  **MEDICAL STAFF LEADERSHIP STIPENDS** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

**PURPOSE:** To stipend (6) six Medical Staff leaders of the Johnson Memorial Hospital Medical Staff as follows: *Medical Staff President; Medical Staff Vice President; Chair, Department of Family Medicine and Pediatrics; Chair, Department of Medicine; Chair, Department of Surgery; and Chair, Credentials Committee.* The stipends will be funded half by Johnson Memorial Hospital and half by the Johnson Memorial Hospital Medical Staff.

**SCOPE:** Stipends will be remunerated as follows, on the first day of each month.

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|  | **ANNUAL STIPEND** | **PER MONTH** |
| President, Medical Staff | $ 30,000 | $ 2,500 |
| Vice President, Medical Staff | $ 15,000 | $ 1,250 |
| Chairperson, Credentials Committee | $ 2,500 | $ 208.33 |
| Chairperson, Family Medicine and Pediatrics | $ 4,000 | $ 333.33 |
| Chairperson, Medicine | $ 5,000 | $ 416.66 |
| Chairperson, Surgery | $ 5,000 | $ 416.66 |
|  | $ 61,500 |  |

**POLICY:**

Each individual receiving a stipend is responsible for fulfilling the duties and responsibilities outlined in their respective job descriptions *(attached).*

The stipend for each individual receiving a stipend will be withheld for the following infractions:

## Unexcused absences for more than two meetings in one year

## Are more than two (2) months in arrears with meeting minutes

Additionally, in the event that any of the six individuals receiving a stipend dies, resigns, takes a leave of absence, loses his Medical Staff membership, or loses his license to practice medicine in the State of Connecticut, such individual shall be deemed to have been removed from office and their stipend will be revoked.

In the event that any of these individuals becomes disabled and incapable of fulfilling the requirements of his/her office, or is convicted of a crime reflecting negatively on the character of the individual such as a morals crime or a crime relating to the improper practice of medicine, or has been subject to disciplinary action by the Medical Staff or the Connecticut Department of Public Health, as a result of a matter deemed to be serious and to reflect negatively on the character or ability of the individual, then the Medical Staff by majority vote of all voting members may remove such individual and their stipend will be revoked.

# JOB DESCRIPTION

# MEDICAL STAFF PRESIDENT

The President shall serve as the Chief Medical Officer of the Hospital and as the principal elective official of the Staff shall be considered Chief of Staff, and shall be furnished with work space within the Hospital and clerical assistance, as needed. Duties are as follows:

1. Preside at the Annual and all special meetings of the Staff;
2. Call special meetings of the Staff;
3. Be Chairperson of the Medical Executive Committee;
4. Direct the organizational functions of the Medical Staff in accordance with the terms of the Medical Staff, its Bylaws, Rules and Regulations and Medical Staff Policies;
5. Implement sanctions where these are indicated and assure Medical Staff compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
6. Be responsible for the functioning of the clinical organizations of the Staff, keeping or causing to keep careful supervision over the clinical work in all Departments;
7. Serve as a member of the Quality Committee of the Board and as an ex‑officio member without vote of all other staff committees as necessary;
8. Be empowered in matters deemed most urgent, to act on behalf of the Medical Executive Committee in response to a request or petition from the Board , the President of the Hospital, a Departmental Chairperson or an external agency. Such action by the President shall be reported by him to the Medical Executive Committee at its next meeting, when it shall be presented for review or approval. Modification or verification of this action shall require majority vote of the Medical Executive Committee;
9. Be empowered to grant temporary privileges as described in the Medical Staff Bylaws;
10. Represent the Staff at meetings and functions with such representation as proper or requested;
11. Principal point of contact and liaison with the President of the Hospital and the Board.

# JOB DESCRIPTION

# VICE PRESIDENT, MEDICAL STAFF

The Vice President shall be elected at the Annual Meeting of the Medical Staff for a term of one (1) year and may be re-elected for one additional term. The Vice President shall:

1. Succeed to the presidency in the event of an unexpired term of that office and shall subsequently be eligible for election and reelection as described above;
2. Assume the presidency at the conclusion of the current President’s term;
3. Act upon designation by the President or notification by the Chairman of the Medical Executive Committee in case of illness or absence from the community by the President;
4. Be responsible for the bi‑annual review of the Medical Staff Bylaws and the revision function of the Medical Staff Bylaws by serving as Chairperson of the Administrative Affairs Committee;
5. Be a member of the Medical Executive Committee;
6. Collect the authorized dues of the Medical Staff and properly disburse authorized monies from the Staff Treasury. Present a financial report at the Annual Meeting;

Pertaining to the disbursement of Medical Staff funds, proposed expenses of $500 or less may be approved by the President of the Medical Staff or the Vice President of the Medical Staff. Proposed expenses in the amount of $500 to $2,000 must be presented as an agenda item and voted on by the Medical Executive Committee. Proposed expenses greater the $2,000 must be presented as an agenda item and voted on at a Quarterly Staff meeting.

The final bill on all disbursements over $2,000, when the first request was just an estimate, must also be reviewed by the Medical Executive Committee and Quarterly Staff.

1. Perform such additional duties as are assigned to him by the President of the Medical Staff or the Medical Executive Committee.

# JOB DESCRIPTION

# CHAIRPERSON, CREDENTIALS COMMITTEE

The Chairperson of the Credentials Committee shall be a member of the Active Staff and shall be certified by an appropriate specialty board. The Chairperson of the Credentials Committee shall perform the following duties:

1. Preside at all meetings of the Credentials Committee;
2. Call special meetings of the Credentials Committee;
3. Directs organizational functions of the Credentials Committee to include oversight of the applicant credentialing process;
4. Shall be responsible for the Credentials Committee’s investigation of the credentials of all applicants for admission to the Medical Staff in conformity with the procedure for Staff appointments provided for in Article III, Section 4 of these Bylaws; shall review all information regarding the competence of Staff members and as a result of such reviews shall make recommendations for the granting of privileges, reappointments, and assignment of members to various Departments;
5. Shall be responsible for advising the Medical Executive Committee on means for determining the status of physical and mental health of each member of the Staff with specific relation to reappointment and renewal of privileges;
6. Shall be responsible for maintaining a permanent record of the Credentials Committee’s proceedings and actions; and ensuring that all meetings of the Credentials Committee shall be conducted as peer review sessions. The record of such sessions shall be marked “PEER REVIEW”.

# JOB DESCRIPTION

# DEPARTMENT CHAIRPERSON

* Chairpersons of the Departments will be elected by their respective Departments at their Annual Meeting, and will be recommended to the Board for approval. They will supervise the quality of care provided within their Department at the Hospital. Such Chairpersons shall be recognized by their peers as holding qualities of professional abilities and leadership which will assure both the Medical Staff and the Board of competent supervision. In the event that there is not an Active Staff member who is eligible to fulfill this role, while continuing the search, an Interim Chairperson may be selected to fill in temporarily. The expectation would be as soon as a suitable candidate is found within the Active Medical Staff; that candidate would assume the role of Department Chairperson.
* Each Department Chairperson shall be a member of the Active Staff, shall be certified by an appropriate specialty board, with demonstrated ability in at least one of the clinical areas covered by the Department.

Any member of the Medical Staff who has served Johnson Memorial Hospital in the past or is currently serving in the capacity of Chairperson of a Department and/or Section shall be allowed to hold either or both positions in the future independent of their Board Certification status.

* Each Department Chairperson unless otherwise ineligible will be a voting member of the Medical Executive Committee.
* A Department Chairperson shall serve a one‑year term commencing on his/her appointment. The number of years is consistent with the rules governing MEC membership.
* The Medical Executive Committee, or a 50% plus one or a majority vote of the Department members eligible to vote on departmental matters, may recommend removal of a Departmental Chairperson;
* Duties:

1. Shall conduct no less than the required meetings annually of his/her Department, as listed in Article Eight Section 8.3-1 and be accountable to the Medical Executive Committee and to the President of the Medical Staff for all professional and administrative activities within his/her Department; particularly for the quality of patient care rendered by the members of his/her Department;
2. Shall be responsible for the effective conduct of all clinically related activities of the Department;
3. Shall develop in conjunction with his/her Department all administrative related activities of the Department and shall administer them unless otherwise provided for by the Hospital;
4. Shall give guidance on the overall medical policies of the Hospital, making specific recommendations and suggestions regarding his/her own Department;
5. Shall maintain continuing review of the professional performance of all practitioners with clinical privileges and of all Advanced Practice Professionals with specified services in his/her Department and report regularly thereon to the Medical Executive Committee;
6. Shall transmit to the appropriate authorities his/her Department's recommendation concerning appointments and classification, reappointment, delineation of clinical privileges or specified services, or corrective action with respect to practitioners in his/her Department;
7. Shall enforce the Hospital and Medical Staff Bylaws, Rules and Regulations within his/her Department;
8. Implement within his/her Department actions taken by the Medical Executive Committee and by the Board;
9. Perform other such duties commensurate with his/her office as may from time to time be reasonably requested by the Medical Executive Committee, by the President of the Hospital, or by the Board;
10. Shall be responsible for recommending criteria for clinical privileges in the Department to the Credentials Committee;
11. Shall recommend privileges for all members of the Department;
12. Shall recommend all off site services using Medical Staff approved criteria;
13. Shall develop annual quality improvement goals for his/her Department.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE: MEDICAL STAFF POLICY #8**  **MEDICAL STAFF CODE OF CONDUCT** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:**  **October 27, 2009** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #: 4** |

**STANDARD:** Effective October 2013, the Joint Commission Leadership Standard (LD.03.01.01), Elements of Performance 4 and 5, require that hospitals have a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety; and that Leaders create and implement a process for managing behaviors that undermine a culture of safety.

**PURPOSE:** The objective of this Policy is to encourage a safe, cooperative, and professional healthcare environment that promotes high quality patient care in a safe environment. Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. Thus, all Members of the Medical Staff are required to treat each other and all other individuals who are associated with, or who come to, all the facilities of the Johnson Memorial Hospital (the “JMH”) with courtesy, respect, and dignity. If a member of the Medical Staff fails to conduct himself or herself in a civil, professional, and cooperative manner, that matter shall be addressed in accordance with the following Code of Conduct Policy.

**POLICY:**

## Conduct which disrupts JMH operations, affects the ability of other members of the Medical Staff or JMH personnel to do their jobs, creates a hostile work environment, or impacts the community's confidence in JMH's or the Medical Staff's ability to provide quality patient care will not be tolerated. Specific examples of unacceptable behavior are:

1. Conduct that reasonably could be considered sexual or racial harassment;

2. Verbal or physical attacks, or rude or threatening behavior, e.g., throwing objects, destruction of property;

3. Use of loud or profane language;

4. Written or oral statements that constitute intentional expression of falsehoods, or constitute deliberately disparaging statements made with reckless disregard for their truth or the reputation or feelings of others, including comments or illustrations in medical records or other official documents that impugn the care provided by others;

5. Inappropriate physical contact with another individual on the Corporation premises; and

6. Disruptive acceptance, of Medical Staff or departmental assignments.

This Code of Conduct Policy is not in any way intended to interfere with the right of a member of the Medical Staff to:

1. Express opinions freely and to support positions, whether or not they are in agreement with other staff members; and/or

2. Engage in honest differences of opinion with respect to diagnosis and treatment or basic program developments that are debated in appropriate forums.

The following shall constitute the appropriate process for reporting, reviewing and addressing disruptive conduct:

1. Reporting of inappropriate conduct may be accepted from any source, including a member of the Medical Staff, JMH employees, or a patient or visitor who observes, or is subjected to, inappropriate conduct by a practitioner. The individual making the report should be reassured that he or she will not be subject to retaliation.

2. The individual who reports an incident shall be requested to document the incident in a written or electronic report. If he/she feels uncomfortable reporting the incident by themselves, he/she may do so in conjunction with a supervisor or other JMH representative.

3. The report should include a brief description of the incident, the time and location of the incident, and the parties involved, and shall be forwarded to the Chief Medical Officer (the “CMO”) and the President of the Medical Staff (the “PMS”).

4. The CMO shall follow up with the individual who made the report by informing him/her that the matter is being reviewed, thanking him/her for reporting the matter and instructing him/her to report any further incidents of inappropriate conduct. The individual should also be informed the matter must be strictly confidential and should not be discussed with anyone not directly involved in the investigation. Once the review is complete, the individual reporting the incident shall be informed of the outcome of the review by the CMO or his/her designee.

5. The PMS and CMO shall promptly review the matter. If they determine that an incident violating this Policy implicating this Policy has likely occurred, the Clinical Department Chair (the “CDC”) for that individual under review will be informed. The CDC, PMS, and CMO will then meet with the member who is the subject of the report. The identity of the person who made the report will generally not be disclosed to the member unless the CDC, PMS and the CMO determine that it is appropriate to do so.

6. If they conclude that there does not appear to have been a violation of this Policy, the matter shall be closed.

7. If the CDC, PMS and the CMO conclude that there does appear to have been a violation of the Policy, the following procedure shall apply:

a. If the incident is the member's first violation, the CDC, PMS and CMO shall meet with the member and address the matter. If the member disagrees with the conclusion that the incident constitutes a violation, the member may ask that the matter be referred to the full Medical Executive Committee (the “MEC”) for review.

b. If the incident is the member's second violation, the CDC, PMS and CMO shall refer the matter to the MEC for review.

8. The goal of these efforts is to arrive at a voluntary response by the member to resolve the concerns that have been raised. However, this does not preclude action if a single incident of inappropriate conduct is so unacceptable that immediate action is required, e.g., summary suspension or immediate referral to the MEC. If this occurs, the member has full recourse to appeal the decision as defined in the Fair Hearing Plan of the Medical Staff Bylaws.

9. If the PMS or CDC is the subject of the alleged violation of the Policy, he/she shall recuse himself/herself from the review and the Vice President of the Medical Staff shall assume the duties otherwise assigned to that individual under this Policy. If the CMO is the subject of the alleged violation of the Policy, he/she shall recuse himself/herself from the review and the President of the Hospital, or his/her designee, shall assume the duties otherwise assigned to that individual under this Policy.

10. The alleged violation documentation, and a report of the final disposition, shall be filed in the affected practitioner’s confidential peer review file, but will be considered as a part of the reappointment process.

11. This Policy does not prevent any individual from pursuing a matter through a venue other than the Medical Staff Bylaws, e.g., a referral to the Physician Health Program of the Connecticut State Medical Society, or a complaint filed with the appropriate local County Medical Association, or the Department of Public Health of the State of Connecticut.

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| Origination: *10/27/2009* | Revision Date(s): 1/13/2011, 10/21/2011; 10/03/2014 |
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| Peer Review Policies |
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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **PHYSICIAN QUALITY IMPROVEMENT COMMITTEE (PQIC) CHARTER** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

## Goal

To establish a centralized, multispecialty approach for the medical staff to evaluate practitioner performance and ensure patient safety on an individual and aggregate level and help create a positive culture for peer review.

## Scope

* The PQIC will be responsible for measuring and evaluating all areas of practitioner competency for care provided at Johnson Memorial Hospital and its facilities under the responsibilities of the medical staff unless otherwise indicated in this charter
* Although the PQIC will be a source of competency data, credentialing and privileging decisions are the responsibility of the department chairs, the credentials committee, and the MEC
* Performance measurement and evaluation for hospital systems and processes are the responsibility of the appropriate hospital committee or department

## Responsibilities

The primary responsibilities of the PQIC and/or their designee are:

* Measurement system management
* Evaluation of practitioner performance, including, but not exclusive to OPPE and other quality metrics
* Improvement opportunity accountability (FPPE monitoring, follow-up, and reporting to the MEC and/or the CMO)
* Oversight of other medical staff practitioner performance evaluation committees
* Review serious safety events and unexpected patient outcomes

These responsibilities and specific medical staff quality functions outside the PQIC scope are described in detail in the following sections.

### **1. Measurement system management**

* The PQIC, in collaboration with the Chairpersons of the Medical Staff Departments, shall have the authority to develop and implement specialty-specific indicators with MEC approval. .
* If data from subspecialty databases supported by the hospital exist, it shall be shared with the PQIC based on MEC-approved indicators.
* If such subspecialty databases supported by the hospital do not exist, then the PQIC or its designee can, on a specialty-by-specialty basis, utilize data from non-hospital databases. In the event such data is used in the quality program, the data provided, as well as the system from where the data is collected and stored shall be considered confidential.
* As needed, approve requests for additions or deletions to medical staff indicators, criteria, or targets.
* Design and/or approve focused studies when necessary to further analyze practitioner performance.
* In coordination with the credentials committee, define the appropriate content and format for practitioner performance feedback reports and reappointment profiles as approved by the MEC.

### **2. Evaluation of practitioner performance**

#### **A. Evaluation of individual cases**

* Perform practitioner reviews of all cases identified in the screening process; Make determinations regarding individual practitioner performance based on individual or multiple case reviews, as well as validated perception-based rule indicators
* Perform focused practice evaluation studies when necessary to further define whether an improvement opportunity exists
* Identify potential hospital systems, medical staff opportunities or nursing practice opportunities for improvement

### **3. Improvement opportunity accountability**

* The role of the PQIC is to ensure that when potential improvement opportunities are identified via case review or evaluation of rule or rate data, the appropriate individuals are notified of the potential issues and either further evaluation is performed or a reasonable improvement plan is developed. This will be accomplished through the process described in the OPPE/FPPE policy and is included in this binder.

### **4. Oversight of other medical staff practitioner performance evaluation committees**

* Some medical staff departments or committees may continue to evaluate practitioner performance as a quality control mechanism or for educational purposes. Such discussions will be considered part of the medical staff quality function and are protected from discovery as long as the appropriate policies and procedures of the PQIC are followed.

#### **Membership**

**PQIC composition**

The PQIC will be composed of the following members:

* The President of the Medical Staff (Chair of the Committee)
* The Vice President of the Medical Staff
* The Chair of the Department of Surgery
* The Chair of the Department of Medicine
* The Chair of the Department of Emergency Medicine
* The Chair of any additional Department or Subsection, appointed by the Medical Staff President or his designee

Additional medical staff members may be asked to participate on an ad hoc basis.

**Ex officio members**

The Chief Medical Officer shall serve ex-officio without vote. A member of the JMH QI team may also serve as ex-officio without vote. Their attendance is not required.

**Appointment and terms**

Appointment and term is based upon the appointment and term of each Chairperson.

The PQIC chair will be the President of the Medical Staff.

**Member responsibilities**

PQIC members will be expected to attend at least two-thirds (2/3) of the scheduled PQIC meetings over a twelve (12)-month period and perform assigned case reviews according to PQIC policies to maintain membership. If a member fails to fulfill his or her responsibilities, the member will be replaced by the President of Medical Staff. The MEC shall discuss replacing the Chairperson based upon his/her failure to perform the required duties. PQIC members will be expected to participate in appropriate educational programs provided by the hospital or medical staff to increase their knowledge and skills in performing PQIC responsibilities.

If a member of the medical staff who is not a PQIC member is requested to perform a case review, it is that individual’s responsibility to perform that review in a timely manner according to PQIC policies.

#### **Meetings**

The PQIC will meet monthly as needed. A quorum for purposes of making final determinations or recommendations for individual case reviews or improvement opportunities based on aggregate data will require the presence of fifty percent (50%) of the voting PQIC members at a regularly scheduled meeting. A majority will consist of a majority of voting PQIC members present.

#### **PQIC oversight**

The PQIC reports to the MEC. No changes can be made to the PQIC charter and policies without MEC approval. The PQIC chair will provide a report to the MEC for each PQIC meeting.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **MEDICAL STAFF COMPETENCY EXPECTATIONS AND IMPLEMENTATION** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

## Expectations of attending practitioners granted privileges at Johnson Memorial Hospital

Outlined here are the expectations that practitioners have of each other as members of our medical staff. These expectations reflect current medical staff bylaws, policies and procedures, and organizational policies to bring together the most important issues found in the documents and key concepts reflecting our medical staff’s culture and vision. Although these expectations provide a guide for the medical staff in selecting measures of practitioner competency, not every expectation will be directly measured.

**Patient care:** Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and at the end of life as evidenced by the following:

* Provide effective patient care that consistently meets or exceeds medical staff or appropriate external standards of care (best practices) as defined by comparative outcome data, medical literature, and results of peer review activities
* Plan and provide appropriate patient management based on accurate patient information, patient preferences, current indications, and available scientific evidence, using sound clinical judgment
* Ensure that each patient is evaluated by a practitioner as defined in the bylaws, rules, and regulations, and document findings in the medical record at that time
* Demonstrate caring and respectful behavior when interacting with patients and their families
* Provide patient comfort by managing acute and chronic pain according to medically appropriate standards
* Counsel and educate patients and their families
* Cooperate with hospital efforts to implement methods to systematically enhance disease prevention
* If applicable, supervise residents, students, and allied health professionals to ensure that patients receive the highest quality of care

**Medical knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others as evidenced by the following:

* Use evidence-based guidelines when available, as recommended by the appropriate specialty, in selecting the most effective and appropriate approaches to diagnosis and treatment
* Maintain ongoing medical education and board certification as appropriate for each specialty
* Demonstrate appropriate technical skills and medical knowledge

**Interpersonal and communication skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain respectful, professional relationships with patients, families, and all other members of healthcare teams as evidenced by the following:

* Communicate effectively with practitioners, other caregivers, patients, and families to ensure accurate transfer of information through appropriate oral and written methods according to hospital policies
* Request inpatient consultations by providing adequate communication with the consultant including a clear reason for consultation and direct practitioner-to-practitioner contact for urgent or emergent requests
* Maintain medical records consistent with the medical staff bylaws, rules, regulations, and policies and generally acceptable good clinical practice
* Work effectively with others as a member of the healthcare team
* Maintain patient satisfaction with practitioner care

**Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society as evidenced by the following:

* Act in a professional, respectful manner at all times and adhere to the medical staff code of conduct
* Respond promptly to requests for patient care needs
* Address disagreements in a constructive, respectful manner away from patients or noninvolved caregivers
* Participate in emergency call as defined in the bylaws, rules, and regulations
* Follow ethical principles pertaining to the provision or withholding of clinical care, confidentiality of patient information, informed consent, and discussion of unanticipated adverse outcomes
* Utilize sensitivity and responsiveness to culture, age, gender, and disabilities for patients and staff members
* Make positive contributions to the medical staff by participating actively in medical staff functions, by serving when requested, and by responding in a timely manner when input is requested

**Systems-based practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare as evidenced by the following:

* Comply with hospital efforts and policies to maintain a patient safety culture, reduce medical errors, and meet National Patient Safety Goals
* Follow nationally recognized recommendations regarding infection control procedures and precautions when participating in patient care
* Ensure timely and continuous care of patients by clear identification of covering practitioners and by availability through appropriate and timely electronic communication systems
* Provide quality patient care that is cost-effective by cooperating with efforts to appropriately manage the use of valuable patient care resources
* Cooperate with guidelines for appropriate hospital admission, level of care transfer, and timely discharge to outpatient management when medically appropriate

A copy of this policy will be included with all initial appointment and reappointment paperwork.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **MEDICAL STAFF PEER REVIEW** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

## Goals

* Create a culture with a positive approach to peer review by recognizing practitioner excellence, as well as identifying improvement opportunities
* Promote efficient use of practitioner and quality staff resources
* Support medical staff education goals to improve patient care
* Provide a link with the hospital performance improvement structure to ensure responsiveness to system improvement opportunities identified by the medical staff
* Ensure that the process for peer review is clearly defined, fair, defensible, timely, and useful

## Definitions

**Peer review:** The evaluation of an individual practitioner’s professional performance for all relevant competency categories using multiple sources of data (when available) and the identification of opportunities to improve care, if any. Through this process, practitioners receive feedback for potential personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice in all practitioner competencies. During this process, the practitioner is not considered to be “under investigation” for the purposes of reporting requirements under the Healthcare Quality Improvement Act.

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**Peer review body:** The committee designated by the Medical Executive Committee (MEC) to conduct the review of individual practitioner performance for the Medical Staff. The peer review body will be the Physician Quality Improvement Committee (PQIC) as described in the Medical Staff Bylaws unless otherwise designated for specific circumstances by the MEC. Members of the peer review body may render assessments of practitioner performance based on information provided by individual reviewers with appropriate subject matter expertise.

**Peer:** An individual practicing in the same profession who has the expertise to evaluate the subject matter under review. The level of subject matter expertise required will be determined on a case-by-case basis.

**Practitioner:** A Medical Staff member (MD, DO, DPM, DDS, and DMD) or a licensed independent practitioner (LIP).

**Peer review data:** Data sources may include case reviews and aggregate data based on review, rule, and rate indicators in comparison with generally recognized standards, benchmarks, and/or norms. The data may be objective or perception-based as appropriate for the competency under evaluation.

### **Conflict of interest:** A member of the Medical Staff requested to perform peer review may have a conflict of interest if he or she may not be able to render a fair and constructive opinion. An absolute conflict of interest would result if the practitioner is the provider under review or a first-degree relative or spouse.

Potential conflicts of interest would result if the practitioner is:

* Directly involved in the patient’s care but not related to the issues under review or a direct competitor, partner, or key referral source
* Involved in a perceived personal conflict with the practitioner under review

## Peer review procedures

### **Information management**

* All peer review information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws, regulations, and accreditation requirements pertaining to confidentiality and nondiscoverability.
* The involved practitioner will receive provider-specific feedback on a routine basis.
* The medical staff will use the provider-specific peer review results in making its recommendations to the hospital regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.
* Any written documents that the medical staff determines should be retained related to provider-specific peer review information will be kept by the hospital in a secure, locked file and/or an electronic equivalent. Provider-specific peer review information may include:
* Individual case review findings.
* Aggregate performance data for all of the general competencies measured for that practitioner.
* Any written correspondence with the practitioner deemed necessary regarding commendations, improvement opportunities, or corrective action and working notes of the peer review process. Any written or electronic documents related to the review process other than the final committee decisions shall be considered working notes of the committee and shall be destroyed after the committee decision has been made. Working notes include potential issues identified by the hospital staff, preliminary case ratings, questions, and notes of the practitioner reviewers.
* Peer review data will be retained for at least 5 years after the most recent reappointment of the provider. Information related to formal investigations and corrective actions will be retained for at least 5 years unless the issue reoccurs.
* Peer review information in a practitioner’s quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities. The Chief Medical Officer will ensure that only authorized individuals have access to individual provider quality files and that the files are reviewed under the supervision of the Medical Staff Services Coordinator or designee for the following individuals:
* The specific provider
* Members of the MEC and/or department chairs and credentials committee
* Chief Medical Officer, medical staff services professionals, quality director, and quality staff members supporting the peer review process
* Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g., The Joint Commission, HFAP, DNV, or state/federal regulatory bodies)
* Individuals with a legitimate purpose for access as determined by the hospital Board of Directors
* The hospital President for purposes of any potential professional review action as defined by the medical staff bylaws
* No copies of peer review documents will be created and distributed unless authorized by medical staff policy or bylaws, the MEC, or the board.

### **Internal peer review (IPR)**

**1. Circumstances:** IPR is conducted by the Medical Staff using its own members as the evaluation source of practitioner performance. The procedures for conducting IPR for an individual case and for aggregate performance measures are described shortly.

**2. Participants:** Participants in the review process will be selected according to the Medical Staff policies and procedures as described in the Medical Staff Competency Expectations and Implementation policy.

**3. Conflict of interest procedure:** It is the obligation of the reviewer to disclose to the peer review committee the potential conflict. It is the responsibility of the peer review body to determine on a case-by-case basis if a relative conflict is substantial enough to prevent the individual from participating.

* When a potential conflict is identified, the PQIC chair will be informed in advance and determine whether a substantial conflict exists
* When either an absolute or a substantial potential conflict is determined to exist, the individual may not participate in or be present during peer review body discussions or decisions other than to provide specific information requested as described in the peer review process

In the event of a conflict of interest or circumstances that would suggest a biased review beyond that previously described, the PQIC or the MEC will replace, appoint, or determine who will participate in the process so that bias does not interfere in the decision-making process.

### **External peer review (EPR)**

**1. Circumstances:** Circumstances for EPR may include, but are not limited to, the following:

* Lack of internal expertise: when no one on the Medical Staff has adequate expertise in the specialty under review, including new procedures or technology, or the only practitioners on the Medical Staff with that expertise are determined to have a significant conflict of interest
* Ambiguity: when dealing with vague or conflicting recommendations from internal reviewers or Medical Staff committees
* Legal concerns: when the Medical Staff needs confirmation of internal findings or an expert witness for potential litigation or fair hearing
* Credibility: when or if the Medical Staff or board needs to verify the overall credibility of the IPR process, typically as an audit of IPR findings
* Benchmarking: when an organization is concerned about the care provided by its physicians relative to best practices and wishes to better define its expectations and as future quality monitoring to determine whether improvement has been achieved
* Lack of internal resources: when the Medical Staff has the expertise but lacks sufficient time to perform EPR

In addition, the MEC or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies. EPR may also be initiated by the agreement of any two of the following three individuals: the President of the Hospital, the Medical Staff President, and the Chief Medical Officer. In the event an EPR is initiated using this latter mechanism, the MEC shall be notified within one business day of the decision for EPR.

**2. Authorization:** The need for EPR will be determined by any one of the following: the PQIC, the MEC, the Board of Directors, or by the agreement of any two of the following three individuals: the President of the Hospital, the Medical Staff President, and the Chief Medical Officer. No practitioner can require the hospital to obtain EPR if these determining bodies have not deemed it appropriate. The authorizing body will define how the external results will be evaluated and considered regarding the quality and appropriateness of care. This will be based on the nature of the review, the expertise of the reviewer, and the issues under review.

**3. Review:** Once the results of EPR are obtained, unless the reason for EPR was due to legal concerns or credibility, the report will first be reviewed by the PQIC at its next regularly scheduled meeting unless an expedited process is requested by the MEC, the CMO, the President of the Hospital, or the Board. As with IPR, the PQIC will determine whether any potential improvement opportunities are present. If improvement opportunities exist, they will be handled through the same mechanism as IPR unless the issue is already being addressed in the corrective action process. If EPR is requested through any of the noted mechanisms, for legal concerns or credibility, the requesting body will determine which body should perform the initial review of the report.

**4. Practitioner involvement:** The authorizing body will prospectively determine the nature of the involvement for the practitioner under review. Unless otherwise determined, as with IPR, the practitioner will not be made aware that EPR is being obtained unless issues with care are identified. If issues are identified, the practitioner will be given a copy of the report and an opportunity to provide input regarding its findings in the same time frames as for IPR prior to the committee’s final decision. The identity of the EPR reviewer will be withheld from the practitioner.

#### **Oversight and reporting**

The oversight of the peer review process is described in the PQIC Charter found in these policies.

#### **Statutory authority**

This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11101, et seq. and Connecticut General Statutes Sec. 19a-17(b). All minutes, reports, recommendations, communications, and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review–related activities. Documents, including minutes and case review materials, prepared in connection with this policy should be labeled consistent with the following language:

“Statement of confidentiality”

“Data, records, documents, and knowledge, including but not limited to minutes and case review materials, collected for or by individuals or committees assigned peer review functions are confidential, not public records, shall be used by the committee and committee members only in the exercise of proper functions of the committee, and are not available for court subpoena in accordance with Connecticut General Statutes Sec. 19a-17(b).

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)** | | |
| .  Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:**  **July 2012** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

**I POLICY:**

It is the policy of Johnson Memorial Hospital to conduct appropriate monitoring of the care delivered by its medical staff and to promote safety and high-quality health care for its patients. To comply with CMS regulations and Joint Commission standards, *MS.08.01.01 EP 1-9*, regarding focused professional practice evaluation (FPPE), a systematic process to evaluate and confirm the current competency of a practitioners’ performance will be defined. FPPE is the time-limited evaluation of a practitioner’s professional performance and competency through an objective and evidence-based process. FPPE is intended to assess practitioner competency in performing specific privileges. The Medical Staff will conduct focused professional practice evaluations, and use the results of such assessments to facilitate decisions whether to grant new privileges, or recommend other action upon a practitioners existing privilege(s).

**II APPLIES TO:**

All licensed independent practitioners (LIPs) initially requesting Medical Staff privilege(s); current Medical Staff members requesting new privileges; or practitioners with potential performance concerns as determined through OPPE, Peer Review or other triggers.

**III PROCEDURE:**

1. **General Physician Expectations & Competencies** 
   1. The Joint Commission and ACGME outline six general competencies that may be used as a framework for selecting measures of practitioner performance and for evaluating and assessing practitioner competency. These include:

Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

Medical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.

Practice Based Learning & Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

Interpersonal & communication skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain respectful, professional relationships with patients, families and other members of health care teams.

Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to professional development, ethical practice, and understanding to diversity and a responsible attitude towards their patients, their profession, and society.

Systems-based practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

* 1. As part of the FPPE process, the appropriate department or section Chair and/or their designee, will personally review performance expectations with the practitioner.
  2. All new appointees, existing Medical Staff members requesting new privileges, or practitioners undergoing a focused review of current privileges will review and sign a copy of the FPPE report to acknowledge receipt as part of their appointment or reappointment documents.

1. **Criteria/Triggers for FPPE**
   1. All new appointees, existing Medical Staff members requesting new privileges, or practitioners who do not meet the minimally acceptable levels of performance as determined through the OPPE process will be subject to a focused review.
   2. All practitioners whose volume of procedures/admissions are insufficient or below the threshold for meaningful data interpretation will be subject to a focused review.
   3. Thresholds for minimally acceptable levels of performance must be determined for the selected performance indicators.
   4. Thresholds must be defined by individual departments and/or sections, the Medical Staff Office, or the PQIC.
   5. If during the OPPE process potential concerns regarding practitioner performance are identified, the appropriate department or section Chair, Chief Medical Officer and/or the PQIC will facilitate decision to initiate a focused professional practice evaluation (FPPE).
   6. Potential concerns that may trigger FPPE include, but are not limited to, the following:

* Any single egregious case or sentinel event
* Significant deviation from accepted standards of practice
* Adverse or negative performance trends in comparison to peers and benchmarks
* Patient and Staff Complaints
* Other circumstances indicating that patient safety and quality may be compromised

1. **Selection of practitioner performance indicators** 
   1. Measures of practitioner performance may be selected to reflect the general competencies framework as described in this policy.
   2. Performance indicators specific to the requested or delineated privileges in question will be determined by individual departments and/or sections Chairs, the Chief Medical Officer, and/or the PQIC.
   3. Performance indicators may be reviewed, revised and changed by individual department or section Chairs, the Chief Medical Officer and the PQIC as deemed appropriate.
2. **Sources of Data** 
   1. Measures of practitioner performance for initially requested privileges and for quality and safety concerns will utilize appropriate screening criteria and multiple sources of data, as defined by the appropriate department or section Chair, the Medical Staff Office and/or the PQIC, including, but not limited to:

* MIDAS Reports
* Paragon Reports
* Internal and/or external Peer Review
* Patient Complaints
* Medical Record Suspensions
* Retrospective or Prospective Chart Review
* Prospective, Concurrent or Retrospective Proctoring
* Documented personal interaction with the practitioner
* Documented discussion(s) with other individuals interacting with the practitioner
* Monitoring clinical practice patterns
* Simulation

1. **Frequency of Data Collection** 
   1. The period for FPPE performance will be evaluated either by a set length of time, or by a set number of occurrences (i.e. activity oriented), or both, as determined by the appropriate department or section Chair.
   2. The duration of FPPE for new Medical Staff members initially requesting privileges, or current Medical Staff members requesting new privileges, will be determined by the appropriate department or section Chair, with a duration not to exceed 6 months.
   3. The duration of FPPE for current practitioners with identified potential safety and quality concerns will be determined by the appropriate department or section Chair, with a duration not to exceed 6 months.
   4. If minimum activity does not occur by the end of 6 months, or an insufficient number of cases have been presented for review, or the practitioner requires further review or his/her privileges, the department or section chair can recommend extending FPPE review period as deemed appropriate.
   5. Practitioner-specific FPPE reports will be generated by the Quality/Risk Management Department for completion by the appropriate department or section Chair, and the PQIC. Practitioner-specific FPPE reports will be performed by using the Medical Staff approved performance indicators, screening criteria and data sources.
2. **Monitoring of FPPE Data**
   1. At the end of the FPPE review period, the evaluation of FPPE performance data to recommend action or decision upon requested privileges will be the responsibility of the appropriate department or section Chair, the PQIC, and the Chief Medical Officer.
   2. If it is determined that no performance issue(s) exist at the end of the FPPE review period, then the practitioner will begin the OPPE process.
   3. Recommended action to resolve performance issues may include extended proctoring, necessary education, counseling, suspension or revocation of specific privileges.
   4. Recommendations for revising or revoking any initial, specific or existing privilege(s) will require final evaluation and approval by the Credentialing Committee and the MEC.
   5. Recommendations regarding the actions taken upon the practitioner’s privilege(s) and/or measures employed to resolve performance issues, will be communicated to the practitioner as required in the Medical Staff Bylaws.
3. **External Peer Review**
   1. External peer review may be solicited when a review would not be fair and objective. Indications include, but are not limited to:

Lack of internal expertise: when no one on the Medical Staff has adequate expertise in the specialty under review, including new procedure or technology, or the only practitioners of the Medical Staff with that expertise are determined to have a significant conflict of interest.

Lack of internal resources: when the Medical Staff has the expertise but lacks sufficient time to perform an External Peer Review

Ambiguity: when dealing with vague or conflicting recommendations from earlier reviews

Lack of credibility: when findings due to possible conflicts of interest or the overall credibility of the review process potentially affect prior reviews and conclusions.

Legal concerns: when the Medical Staff needs confirmation of internal findings or an expert witness for potential litigation or fair hearing.

Benchmarking: when an organization is concerned about the car provided by its physicians and external sources are needed to identify best practices or expectations to determine whether improvement has been achieved.

* 1. The need for External Peer Review will be determined by the PQIC, the MEC, the board of directors, or by the agreement of any two of the individuals of the following three individuals: the President of the Hospital, the Medical Staff President and the Chief Medical Officer.
  2. The MEC or governing board may require External Peer Review in any circumstances deemed appropriate by either of these bodies.
  3. The External Peer Review process will be in accordance to the policies and procedures set forth in the Medical Staff Bylaws.

1. **Documentation** 
   1. All FPPE activity, information and correspondence is privileged and confidential in accordance with Medical Staff and Hospital Bylaws, Johnson Memorial Hospital policies, and Federal and State laws, regulations and accreditation requirements pertaining to confidentiality and non-discoverability.
   2. The outcome of the FPPE will be documented and maintained in the practitioners credentials file.
   3. FPPE reports and data summaries will be stored in the practitioner’s quality file.

Date of Origination

07/2012

Revision Date: 07/2012

11/2012

1/2013

12/2013

5/2015

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:**  **July 2012** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

**I POLICY:**

It is the policy of Johnson Memorial Hospital to conduct appropriate monitoring of the care delivered by its medical staff and to promote safety and high-quality health care for its patients. To comply with CMS regulations and Joint Commission Standards, *MS.08.01.03 EP 1-3*, regarding ongoing professional practice evaluation (OPPE), an objective and evidence-based process will be clearly defined in order to continuously evaluate and monitor each practitioner’s performance. OPPE will be utilized to support decisions regarding the continuance, revision or revocation of existing privilege(s) prior to or at the time of a practitioner’s Medical Staff reappointment. OPPE is intended to: identify practitioner trends that may affect the quality of care and patient safety; identify improvement opportunities for patient care; identify performance improvement opportunities for practitioners; and to recognize practitioner excellence.

**II APPLIES TO:**

All licensed independent practitioners (LIPs) with granted Medical Staff membership and privilege(s) undergoing reappointment, but not currently undergoing focused professional practice evaluation.

**III PROCEDURE:**

1. **General Physician Expectations & Competencies** 
   1. The Joint Commission and ACGME outline six general competencies that may be used as a framework for selecting measures of practitioner performance and for evaluating and assessing practitioner competency. These include:

Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

Medical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.

Practice Based Learning & Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

Interpersonal & communication skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain respectful, professional relationships with patients, families and other members of health care teams.

Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to professional development, ethical practice, and understanding to diversity and a responsible attitude towards their patients, their profession, and society.

Systems-based practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

* 1. Medical Staff members undergoing reappointment will receive a copy of their OPPE reports with their reappointment documents.

1. **Selection of practitioner performance indicators** 
   1. Measures of practitioner performance may be selected to reflect the general competencies framework as described in this policy.
   2. Performance indicators will be determined by individual departments and/or sections, Medical Staff, and/or the PQIC.
   3. General and specialty-specific indicators may be reviewed, revised and changed by the appropriate department and/or section Chairs or committees, the Medical Staff and by the PQIC as deemed appropriate.
2. **Sources of Data** 
   1. Measures of practitioner performance will utilize appropriate screening criteria and multiple sources of data, as defined by the appropriate department or section Chair, the Medical Staff Office and the PQIC, including, but not limited to:

* Core Measures
* MIDAS Reports
* Medical Record Suspensions
* Patient Complaints
* Paragon Reports
* Periodic Chart Review and Audits
* HCAHPS
* Peer Review
  1. Data collected will not be limited to negative trends or outlier data.
  2. “Zero” data will be documented as either evidence of good performance or evidence that specific privileges are not being performed.

1. **Methods of Evaluation** 
   1. Thresholds for minimally acceptable levels of performance must be determined for the selected general and specialty-specific performance indicators.
   2. Thresholds must be defined by individual departments and/or sections, the Medical Staff Office, or the PQIC.
   3. Thresholds that fall outside the range of acceptable levels of performance could initiate a focused practice performance evaluation (FPPE). Additional triggers that may initiate FPPE, individual case review, or other peer review process include, but are not limited to, the following:

* Any single egregious case or sentinel event
* Significant deviation from accepted standards of practice
* Adverse or negative performance trends in comparison to peers and benchmarks
* Patient and Staff Complaints
  1. If during the OPPE process potential concerns regarding practitioner performance are identified, the appropriate department Chair, Medical Staff Office and the PQIC will facilitate decision as whether to initiate a focused professional practice evaluation (FPPE).

1. **Frequency of Data Collection** 
   1. Practitioner-specific OPPE reports will be generated bi-annually by the Quality/Risk Management Department for review by the appropriate department or section chair, and the Chief Medical Officer.
   2. Practitioner-specific OPPE reports will be performed by the Quality/Risk Management Department using the Medical Staff approved screening criteria and data sources.
   3. Practitioner-specific OPPE data will reflect a bi-annual collection period: January through June and July through December of each calendar year.
2. **Review of OPPE Data**
   1. The review of OPPE performance data to recommend a decision whether to maintain, revise or revoke any existing privilege(s) prior to or at the time of a practitioners Medical Staff reappointment will be the responsibility of the appropriate department or section Chair and the Chief Medical Officer.
   2. OPPE reports for the last two years will be presented to the Credentialing Committee for consideration at the time of a practitioners Medical Staff reappointment.
   3. Recommendations for revising or revoking any existing privilege(s) will require final evaluation and approval by the Credentialing Committee and the MEC.
   4. Recommendations regarding the actions taken on the practitioner’s privilege(s) will be communicated to the practitioner as required in the Medical Staff Bylaws.
3. **Documentation** 
   1. All OPPE activity, information and correspondence is privileged and confidential in accordance with Medical Staff and Hospital Bylaws, Johnson Memorial Hospital policies, and Federal and State laws, regulations and accreditation requirements pertaining to confidentiality and non-discoverability.
   2. Analyzed OPPE performance data and practitioner-specific feedback will be communicated to the individual practitioner as needed by the appropriate department or section chair, or by the Medical Staff Office.
   3. The outcome of each OPPE will be documented and maintained in the practitioners credentials file.
   4. OPPE reports and data summaries will be stored in the practitioners quality file on a routine basis.

Date of Origination

7/2012

Revision Dates: 7/2012

11/2012

1/2013

12/2013

5/2015

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| --- | --- | --- | --- |
| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **VALIDATION OF PERCEPTION-BASED RULE INDICATOR OCCURRENCES** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

## Purpose

Provide a fair method for validating occurrences regarding practitioner performance reported through the hospital occurrence reporting system that meet a rule indicator that is primarily based on perception information and is designated by the Medical Staff as requiring validation.

## Procedure

The occurrence report and initial investigation commences procedure includes the following:

1. Occurrences involving practitioner performance will be entered into an appropriate database for tracking and screened by quality manager to determine whether the occurrence meets a medical staff rule indicator.
2. The occurrence report must include sufficient information of the reporting individual or his or her supervisor so that the appropriate individual (e.g., risk manager, quality director, peer review coordinator) can contact the individual to get preliminary information to validate the event. Events without the necessary information for follow-up will not be investigated further and will be closed as “unable to validate.”
3. The appropriate individual will contact the individual reporting the occurrence, or the appropriate supervisor, and additional individuals who can provide necessary information to validate the occurrence.

* If the event appears to be potentially valid, the appropriate individual will contact the practitioner involved to obtain the provider’s perspective on the event without disclosing the name of the individual reporting the event

## Physician leader validation decision

1. The appropriate individual will then provide the information obtained from all parties to a physician leader to determine whether the incident is valid. A physician leader may include a Department Chair, a MEC member, or the Chief Medical Officer.

## Communication and tracking

1. If the occurrence is not determined to be valid, the occurrence will be retained in the system but no rule indicator communication will be issued to the practitioner. The practitioner will receive verbal communication from the appropriate individual that the occurrence was not validated.

1. If an individual event is considered serious in nature, additional follow-up may be required by the PQIC per the appropriate Medical Staff policy.

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| --- | --- | --- | --- |
| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **IMPAIRED PRACTITIONER (POLICY ON PRACTITIONER HEALTH)** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

The American Medical Association defines the impaired provider as "one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol." This policy is intended to provide some overall guidance and direction when confronted with a potentially impaired provider.

Specific needs and varying circumstances preclude a single inflexible mechanism for dealing with all impaired providers. The number of incidents with the provider, for example, and their seriousness may dictate a different response by the hospital. If the "evaluation" suggested in this policy is carried out, the individuals conducting the evaluation may vary depending upon personalities and circumstances. Moreover, the risk of patient harm must be of paramount concern and immediate action may be necessary. There can be no one policy to cover all situations.

One exception to this policy is impairment due to age and irreversible medical illness or other factors not subject to rehabilitation. In such cases, the sections of the policy dealing with rehabilitation and reinstatement of the provider are not applicable.

When dealing with any issue relating to a provider's illness or disability, keep in mind the state reporting statutes and the application of the Americans with Disabilities Act. These procedures should, under any interpretation of the Act, be legally appropriate. As in all matters with significant legal implications, however, legal counsel should be consulted.

## State of Connecticut Reporting Statutes

The Connecticut Department of Public Health (“DPH”) requires (Conn. Gen. Stat. Sec. 20-13d) that DPH be notified by “The state society or any county society or any physician or hospital shall within thirty days” report a provider or physician who “is or may be unable to practice medicine with reasonable skill or safety for any reasons listed in section 20-13c. (C.G.S. Sec. 20-13d(1).)  Alternatively, the reporting individual or body may contact HAVEN and refer the physician to the program in lieu of filing a complaint with DPH (Conn. Gen. Stat. 19a-12a).  A referral made by the Hospital to the HAVEN program is deemed to satisfy the reporting obligation.  (C.G.S. Sec. 19a-12a(j)(1).)

*Note:* The President of the Hospital plays a significant role in this process in conjunction with medical staff leadership because an impaired provider is a hospital concern as well as a medical staff problem.

## Report and evaluation

If any individual has a reasonable suspicion that a provider appointed to the medical staff is impaired, the following steps should be taken:

1. A written report is given to the President of the Medical Staff and/or the Chief Medical Officer (CMO), and/or the President of the Hospital. The report includes a description of the incident(s) that led to the belief that the provider may be impaired. The report must be factual. The individual making the report does not need to have proof of the impairment but must state the facts leading to the suspicions.
2. If, after discussing the incident(s) with the individual who filed the report, the President of the Medical Staff and/or the CMO and/or the President of the Hospital believes there is enough information to warrant an evaluation, one of the three will direct that an evaluation beinstituted and a report be rendered by one of the following:

* The President of the Medical Staff
* An ad hoc committee is convened at the request of Medical Executive Committee (MEC) which may be comprised of multidisciplinary representatives of the Medical Staff, according to the potential problem(s) to be addressed. This committee would not be asked to recommend any action but would gather information to facilitate the MEC’s determination of the scope of the problem
* An outside consultant such as the HAVEN program
* Another individual(s) appropriate under the circumstances

3. According to the results of the report, one of the following actions will be taken by the MEC:

* If the evaluation reveals that there is no merit to the report, the report is destroyed
* If the evaluation reveals that there may be some merit to the report but not enough to warrantimmediate action, the report is included in a confidential portion of the provider's file and the provider's activities and practice are monitored until it can be established that there is, or is not, an impairment problem
* If, after the evaluation, it is found that sufficient evidence exists that the provider is impaired, the Medical Staff President, CMO, or President of the Hospital personally meets with that provider or designates another appropriate individual to do so:
* The provider is told that the results of an evaluation indicate that the provider suffers from an impairment that affects his or her ability to practice safely. The provider is not told who filed the report and does not need to be told the specific incidents contained in the report.
* Depending upon the severity of the problem and the nature of the impairment, the medical staff has the following options:
  + Require the provider to undertake a rehabilitation program as a condition of continued appointment and clinical privileges
  + Impose appropriate restrictions on the provider's practice
* Depending upon the severity of the problem and the nature of the impairment, the Medical Staff President and/or the CMO and/or the President of the Hospital or a designee of one of these individuals is required to do one of the following:
  + Report the individual to the Connecticut State Department of Health, pursuant to Conn. Gen. Stat. Sec. 20-13d.
  + Report the individual to the HAVEN program, fulfilling the reporting obligation pursuant to Conn. Gen. Stat. Sec. 20-13d.

1. The original report and a description of the actions taken by the MEC are included in the provider's file.
2. The Medical Staff, and/or Medical Staff President, and/or CMO and/or President of the Hospital may elect to seek the advice of legal counsel to determine whether any conduct must be reported to law enforcement authorities or other government agencies and what further steps must be taken.
3. The President of the Medical Staff, CMO, or President of the Hospital informs the individual who filed the report that follow‑up action was taken.
4. Throughout this process, all parties should avoid speculation, conclusions, gossip, and any discussions of this matter with anyone outside those described in this procedure.

## Rehabilitation

Hospital and Medical Staff leadership assist the provider in locating a suitable rehabilitation program when relevant. A provider may not be reinstated until the medical staff is satisfied that the provider has successfully completed a rehabilitation program in which the Medical Staff has confidence.

## Reinstatement

1. Upon sufficient proof that a provider who has been found to be suffering an impairment has successfully completed a rehabilitation program, the Medical Staff, in its discretion, may consider that provider for reinstatement to the Medical Staff.
2. In considering an impaired provider for reinstatement, the Hospital and its Medical Staff leadership must consider patient care interests as paramount.
3. The Medical Staff must first obtain a letter from the director of the rehabilitation program where the provider was treated. The provider must authorize the release of this information. This letter must address the following information:

* Whether the provider is participating in the program
* Whether the provider is in compliance with all of the terms of the program
* Whether the provider attends AA or other support meetings regularly (if appropriate)
* To what extent the provider's behavior and conduct are monitored
* Whether, in the opinion of those providing treatment, the provider is rehabilitated
* Whether an after-care program has been recommended to the provider, and, if so, a description of the after-care program
* Whether, in his or her opinion, the provider is capable of resuming medical practice and providing continuous, competent care to patients

1. The provider must inform the Medical Staff of the name and address of his or her primary care provider (PCP) (or other designated physician after-care provider), and must authorize that provider to share information of condition and treatment with the medical staff. The Medical Staff has the right to require an opinion from other provider consultants of its choice.
2. From the PCP (or other designated physician after-care provider) the Medical Staff needs to know the precise nature of the provider's condition and the course of treatment, as well as the answers to the questions posed in reinstatement step 3.
3. Assuming all of the information received indicates that the provider is rehabilitated and capable of resuming care of patients, the Medical Staff must take the following additional precautions when restoring clinical privileges:

* The provider must identify one (1) provider who is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability
* The provider is required to obtain periodic reports for the Medical Staff from his or her PCP (or other designated physician after-care provider)—for a period of time specified by any two of the following: the President of the Medical Staff, the CMO or President of the Hospital— stating that the provider is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the hospital is not impaired.

1. The provider's exercise of clinical privileges in the hospital is monitored by the MEC or by a provider appointed by the MEC. The nature of that monitoring is determined by the MEC after its review of all of the circumstances.
2. The provider must agree to submit to an alcohol or drug screening test (if appropriate to the impairment) at the request of a member of hospital management, a provider, or a nurse who suspects that the provider may be under the influence of drugs or alcohol.
3. All requests for information concerning the impaired provider are forwarded to the Medical Staff President and/or CMO and/or President of the Hospital for response.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **CONFIDENTIALITY POLICY** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

## General statement

Medical Staff members, Hospital employees, and Board members are expected to maintain confidentiality of all information and discussion occurring during meetings of the Medical Staff, Hospital, and Board when dealing with issues of peer review (peer review, credentialing, and corrective action) and with confidential hospital information.

## Confidentiality of information

To the fullest extent permitted by law, the following shall be kept confidential: information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or Medical Staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided; evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; or determinations that healthcare services were indicated or performed in compliance with an applicable standard of care. Such confidentiality shall also extend to information provided by third parties.

The following information is also considered confidential: hospital financial information, unless deemed appropriate for sharing; hospital strategic planning information, unless deemed appropriate for sharing; and individual votes on any of the above matters.

## Covered activities

The confidentiality and immunity provided by this policy apply to all information or disclosures performed or made in connection with this or any other healthcare facility or organizational activities concerning, but not limited to:

* Applications for appointment/affiliation, clinical privileges, or specified services
* Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services
* Corrective or disciplinary actions
* Hearings and appellate reviews
* Quality assessment and performance improvement/peer review activities
* Utilization review and improvement activities
* Claims reviews
* Risk management and liability prevention activities
* Other hospital, committee, department, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct
* Hospital strategic plans, financial performance, quality performance or adverse occurrences, and events in the hospital

## Acknowledgement of the confidentiality policy

On initial appointment, all medical staff leaders and medical staff members, hospital employees with access to the above information, and board members will sign a statement acknowledging that they have read and will abide by the confidentiality policy. If serving on committees pertaining to the covered activities stated in this policy, one will abide by the confidentiality policy.

## Noncompliance with this policy

Whenever a breach of confidentiality is validated, corrective action will be considered by the Medical Executive Committee, the President of the Hospital, or the Board accordingly.



**Credentialing Policies and Procedures**

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Content of Medical Staff Credentials File** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

## Objective

To define the required minimal content of the Medical Staff credentials files.

## Policy

The Medical Staff of Johnson Memorial Hospital (JMH) recognizes that it is important to maintain Medical Staff credentials files for medical, regulatory, legal, and policy reasons. The credentials documents should be categorized and maintained as follows:

## Initial Appointment

### **Application**

* The completed, signed application
* Practitioner Identity Attestation Form
* Curriculum vitae
* Medical Staff Release Form
* Signed copy of State of Connecticut Medical License
* Copy of State of Connecticut Controlled Substance Registration for Practitioner (if applicable)
* Copy of Federal DEA Certificate with Connecticut Address (if applicable)
* Copy of Board Certification Certificate
* Current Certificate of Insurance
* Verification of Professional Liability Insurance Form
* Signed State of Connecticut Consent for Release of Confidential Records Form
* Copy of any Diplomas or Certifications regarding Education/Training
* Delineation of Privilege Form
* Medicare Acknowledgement Statement
* Statement of Confidentiality Form
* JMH Credo
* Application Fee (if applicable)

### **Data gathering**

* Letter[[1]](#footnote-1) to applicant requesting additional information to complete application (if any)
* Initial application processing checklist (included in electronic credentialing software program)
* Letter requesting verification of insurance (optional)
* Information from all prior and current insurance carriers regarding claims, suits, and settlements during the past ten (10) years or since beginning practice if less than ten (10) years
* Verification correspondence of education
* Verification correspondence of training
* Verification correspondence of affiliation/practice at other healthcare facilities
* Peer reference questionnaires
* Verification of current and past licensures
* Verification of board certification status
* d)
* AMA Physician Masterfile Profile or equivalent
* Verification of National Practitioner Data Bank (NPDB)
* Government-issued photo ID with verification that this is the applicant
* Evidence of malpractice coverage

### **Document review**

* Interview letter
* Department chairperson approval for appointment
* Credentials Committee approval for appointment
* Correspondence related to temporary privileges, both to and from the applicant (if applicable)
* Letter to applicant regarding approval, deferral, denial, or modification of the appointment
* Documentation that the applicant was oriented to Medical Staff Bylaws, Rules, and Regulations (all practitioners have access to these via JMH’s website)
* Documentation regarding Focused Professional Practice Evaluation (FPPE) when complete
* Provisional status report and related documents (if applicable)

## Reappointment

### **Application**

* Reappointment application
* Privilege request form(s)
* Evidence of continuing medical education (if required)

### **Data gathering**

* Letter requesting information on licensure, other practice settings, references from peers, etc. (optional)
* Verification correspondence of additional training (if applicable)
* Verification correspondence of affiliation/practice at other healthcare facilities
* Peer reference questionnaires
* Verification of current licensure
* Verification of current and past licensures
* NPDB query and response
* Verification of board certification status
* Evidence of malpractice coverage
* Attendance records at Medical Staff, section, or committee meetings (for reappointment of Active Medical Staff and Advanced Practice Professional Active Staff)
* Monitoring form(s) (if used)
* Performance improvement reports/profiles. e.g. OPPE reports
* Related performance improvement documents (e.g., incident reports, complaints, documentation relative to the individual’s performance during the previous reappointment cycle, records of discussion, disciplinary reports)

### **Document review**

* Reappointment assessment/recommendation(s)
* Credentials committee documentation
* Letter to applicant regarding approval, deferral, denial, or modification of the reappointment/clinical privileges

*Other documents may be maintained in the Medical Staff member’s individual credentials file or adjacent to the individual’s credentials file as the organization determines appropriate and as applicable state statutes prescribe.*

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Credentials File: Content, Access, Control and Retention** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

## Policy

A credentials file[[2]](#footnote-2) shall be maintained for each applicant for Medical Staff membership and/or privileges. These files are confidential and shall be secured in the Medical Staff Office under the direct control of the responsible party in the Medical Staff Office.

## File content

The credentials file must include the following components:

### **Correspondence**

Correspondence includes, but is not limited to:

* Documentation to and from the applicant related to the application, verification, and review/approval processes.
* Documentation related directly to the applicant’s competence, including OPPE and FPPE, and the categories of medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.
* Documentation to the practitioner related to clinical performance. Letters of complaint or incident reports relating to the practitioner may be, but are not automatically filed in the practitioner’s file. They are handled in accordance with Hospital policy and referred through appropriate channels. However, if such items result in correspondence to the practitioner and/or corrective action, the resultant correspondence/notification to the practitioner shall become a permanent part of the file.

***Note:*** Any communication with legal counsel concerning content of a credentials file should be maintained separately to preserve attorney-client privileges.

### **Demographics**

Demographics include:

* Profiles from database
* Original application
* Curriculum vitae or equivalent
* Consent forms

**Reappointment/Reappraisal**

Reappointment/reappraisal includes:

* Correspondence related to the reappointment verification and review/approval processes
* Profiles of performance from the process of monitoring the delivery of patient care and professional conduct

### **Clinical privileges**

Clinical privileges include:

* Application for clinical privileges and any correspondence and supporting documentation related to the delineation of privileges request, verification, and review/approval processes

### **Certificates**

Certificates include:

* Professional liability insurance, federal controlled substance registration, state controlled substance registration (if applicable), state licensure, and pertinent certificates of continuing medical education per medical staff member preference and professional certification e.g. board certificates

### **Verification process**

The verification process for the initial application includes:

* The request and response for each element of the verification process, as well as unsolicited letters of reference or memos documenting information

### **Corrective action**

Corrective action includes:

* Documentation of corrective action taken by the Hospital
* Documentation of any disciplinary action taken by outside agencies or other hospitals

## Control

* Hard copy files shall be controlled by the Medical Staff Office.
* Electronic files shall be controlled by the limited assignment of individual user ID’s and passwords, assigned by the CMO and/or his or her designee.

## Retention

* Credentials files shall be retained for a period of ten years.
* Active hard copy files shall be maintained in the Medical Staff Office. Active electronic files are available on-line through a user ID and password secured system, accessible from any computer with an internet connection. Inactive hard copy files shall be archived in accordance with the hospital’s procedures for archival of documents. Inactive electronic files shall be retained within the system indefinitely.

Copies of Certificates

|  |  |
| --- | --- |
| **Item** | **Retention** |
| License | Current only |
| State controlled substance registration | Current only |
| Federal controlled substance registration | Permanent |
| Professional liability insurance | Hospital decides |
| Professional certificates | Permanent |
| External continuing medical education (not supporting clinical privilege requests) | Until logged/summarized |

Work Papers

|  |  |
| --- | --- |
| **Item** | **Retention** |
| Tracking forms | Until final action by Board |
| Memos/correspondence to facilitate the verification process | Until final action by Board |

Verification Process

|  |  |
| --- | --- |
| **Item** | **Retention** |
| Cover letters to request verification | Upon response |
| if no response | Permanent with note indicating reason |
| Query to and response from National Practitioner Data Bank | Permanent |
| Lists from state licensing board providing verification of licensure and state-controlled registration | Ten (10) years |
| Related information which supports the initial application, initial period of focused professional practice evaluation, interim request for changes in privileges and/or status, reappraisal/reappointment, and temporary privileges | Permanent |

Requests for References from Other Hospitals

|  |  |
| --- | --- |
| **Item** | **Retention** |
| Letter/release form/response | Permanent, if hard copy available |
|  |  |

Correspondence to/from Applicant/Member/Affiliate

|  |  |
| --- | --- |
| **Item** | **Retention** |
| Memos/letters to notify individual of information required | Upon receipt of information |
| If information not received, follow-up, initial request(s), and results of adverse action | Permanent |
| Requests from practitioner | Permanent |
| Formal notifications regarding appointments and/or clinical privileges | Hospital decides |
| Formal notifications of administrative issues to an appointment (e.g., committee appointments, medical record suspensions) | Permanent |
| Addendum to the credentials file by the practitioner | Permanent |

Miscellaneous Items

|  |  |
| --- | --- |
| **Item** | **Retention** |
| Privilege forms | Permanent |
| Reappointment summary forms | Permanent |
| Consent forms | Permanent |

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Credentials Information Verification** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

## Credentials information

Upon receipt of a completed application, the Medical Staff Office, in coordination with our regional health ministry, will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization. When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source.

Information to be primary-source verified, as mandated by The Joint Commission, includes the following:

* Licensure status in the state; in addition, the Medical Staff Office will primary-source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration
* Information from the medical school(s)
* Information from professional training programs, including residency and fellowship programs
* Documentation of the applicant’s past clinical work experience (as an assessment of current competence)
* Information from the National Practitioner Data Bank (NPDB); in addition, the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested
* Photo ID confirmation that the applicant is the same person as identified in the credentialing documents by viewing one of the following: a valid picture ID issued by a state or federal agency (e.g., driver’s license or passport), or a current picture hospital ID card
* Information from the American Medical Association or American Osteopathic Association Physician Profile, Federation of State Medical Board, Office of Inspector General List of Excluded Individuals/Entities, and/or Fraud and Abuse Control Information System
* Licensure status in all current or past states of licensure upon initial appointment
* Licensure status in all current states of licensure for each reappointment cycle
* Board certification, if required by the Medical Staff Bylaws, Rules and Regulations
* Malpractice coverage, if required by the Medical Staff Bylaws, Rules and Regulations
* Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments (if any) during the past ten (10) years upon initial appointment and during the past two (2) years for each reappointment cycle
* Other information about adverse credentialing and privileging decisions
* The provider’s OPPE results from twelve (12) to twenty-four (24) months for each reappointment cycle

*In addition, the Medical Staff Office may collect other relevant additional information from primary sources, which may include:*

* Information from any other sources relevant to the qualifications of the applicant to serve on the Medical Staff and/or hold privileges
* Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available

It is only when the information has been obtained that the applicant’s file will be considered verified and complete and eligible for evaluation.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Delineating Clinical Privileges and New Technology** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

## Procedure for developing privilege criteria

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Whenever a privileging question arises[[3]](#footnote-3) for which there is no policy or privileging criteria, the Credentials Committee will follow these steps to coordinate the development of a policy and applicable criteria:

1. If the issue pertains to the use of new technology or a new treatment protocol, first put the burden on the interested practitioner to provide information about the device, technology, or protocol. The practitioner should be requested to provide a full briefing concerning the new technique or procedure. This briefing should include information concerning the development of the new technology, the names of other hospitals in which it is used, any peer-reviewed research demonstrating the risks and benefits of this technology, any product literature or educational syllabus addressing the technology, and the names of any residency training directors or other training personnel responsible for providing training in this area. Any certificates or certification letter for having attended such training shall be provided as part of the application.
2. The Credentials Committee will review the issue and will determine whether the technology will be permitted within the institution at all. When making this determination, the Credentials Committee should discuss the institution's current plan of care, whether the new technology/procedure is of proven clinical efficacy, safety, and effectiveness, including the evidence upon which efficacy and safety is based, and whether the new procedure/technology carries a greater risk than existing conventional therapy. *Remember, the first question which must be answered is, "Should this technology be permitted at all?” If the answer is no, there is no credentialing issue.*
3. The proposed change in delineation of privileges will then be submitted to the Medical Executive Committee (MEC) for final review and recommendation to the Board.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Credentialing: Burden on the Applicant** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

## Policy

Each individual practitioner who either applies for or maintains Medical Staff membership and/or privileges has the sole burden of providing evidence that demonstrates, in the sole discretion of the Hospital, that he or she meets the Hospital’s established criteria for membership and/or privileges. This policy applies at the time of initial appointment, reappointment, application for clinical privileges, employment, or anytime during a practitioner’s affiliation with the institution.

## Procedure

In order to fulfill this responsibility, the practitioner has the sole burden of producing any information requested by the Hospital or its authorized representatives that is reasonably necessary, in the sole discretion of the Hospital, to evaluate whether the practitioner meets the criteria for Medical Staff membership and/or privileges.

If there is an undue delay in obtaining such required information or if the Hospital requires clarification of such information, the Medical Staff Office will request the applicant’s assistance. Under these circumstances, the Medical Staff may modify its usual and customary time periods for processing the application or reapplication. The Hospital has sole discretion for determining what comprises an adequate response.

If, during the process of initial application, reapplication, or request for additional clinical privileges, the applicant fails to respond adequately within thirty (30) days to a request for information or assistance, the Hospital will deem the application, reapplication, or request for additional clinical privileges as being withdrawn voluntarily. The result of the withdrawal is automatic termination of the application or reapplication process. The Hospital will not consider the termination an adverse action. Therefore, the applicant or reapplicant is not entitled to a fair hearing or appeal consistent with the Medical Staff’s fair hearing plan. The Hospital will not report the action to any external agency.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Initial Medical Staff Appointment** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

Potential applicants may request application materials for membership and/or clinical privileges as follows:

* Direct (personally or via an authorized representative) contact with the Medical Staff Office, in person, by phone or email
* Via a request from:
  + - * Department chairs
      * Clinical service chiefs
      * Chief Medical Officer
      * Recruitment office
      * President of the Hospital
      * Other

All requests for applications to the Medical Staff and requests for clinical privileges will be forwarded to the Medical Staff Office. After the Medical Staff Office receives an application request via its online credentialing system, it will electronically send an application package with a cover letter to the potential applicant. Alternatively, hardcopy applications will be used at the sole discretion of the Medical Staff Office.

The process of a request is as follows:

* The applicants name and email address are provided to the Medical Staff Office.
* The Medical Staff Office will send an application or an email to the applicant. A link to the credentialing website may be offered.
* The applicant will set up their initial account by providing (online):
  + Their email address
  + Choosing a password
  + First and Last Name
  + Their NPI number
  + Their specialty
* Once received by the Medical Staff Office, the Medical Staff Office will approve the request for application and assign a Delineation of Privileges for the requested specialty.
* The applicant will receive notification of their active application.
* The applicant completes the application.

*Note*: Applications will not be sent to practitioners in those specialties in which privileges have not been developed, in which services are not offered at the Hospital, or for which there is an exclusive contract arrangement and the potential applicant is not a part of the group holding the exclusive contract. The Hospital will accept and process applications for only those applicants who can demonstrate that they can fulfill the eligibility qualifications for membership and criteria for specific privileges requested as outlined in the Medical Staff Bylaws, Rules and Regulations; accessory documents; and applicable clinical privilege forms.

The application package shall include the following:

* A detailed list of requirements for completing the application
* An application
* Applicable privilege request form(s) and criteria for privileges
* Delineation of Privilege Form
* Attestation and release statements
* Release of Liability Statement
* Practitioner Identity Attestation Form
* Medical Staff Release Form
* State of Connecticut Consent for Release of Confidential Records Form
* Medicare Acknowledgement Statement
* Statement of Confidentiality Statement
* Other required documents (organization-specific)
* JMH Credo

In addition, the Medical Staff Office shall provide (or make available) to the applicant an overview of the Medical Staff Bylaws, Rules and Regulations or a complete set of Medical Staff Bylaws, Rules and Regulations.

The Medical Staff Office will initiate a credentials file for each individual requesting Medical Staff membership or clinical privileges.

The completed application should be legible and on the form designated by the Credentials Committee and approved by the Board.

## Conditions of appointment

In signing the application, the applicant:

* Attests to the accuracy and completeness of all information on the application and any accompanying documents and agrees that any inaccuracy, by omission or commission, is grounds for terminating the application process.
* Signifies his or her willingness to appear for interviews regarding his or her application, peer review, and hospital quality improvement activities.
* Authorizes Hospital and Medical Staff representatives to consult with prior and current associates and with others who might have information bearing on his or her professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges he or she requests.
* Consents to Hospital and Medical Staff representatives’ inspection of all records and documents that might be material to an evaluation of his or her professional qualifications and competence to carry out the clinical privileges requested, physical and mental health status,[[4]](#footnote-4) and professional and ethical qualifications, including, but not exclusive to current and past OPPE and/or FPPE reports, surgical case logs, and other quality data.
* Releases from liability—to the fullest extent permitted by law—any and all Hospital representatives for acts they perform and statements they make in connection with evaluation of his or her application, credentials, and qualifications.
* Releases from liability all individuals and organizations that provide information to the Hospital or the Medical Staff, including release to Hospital representatives of otherwise privileged or confidential information concerning the applicant’s background, experience, competence, professional ethics, character, physical and mental health, emotional stability, utilization practice patterns, and other qualifications for staff appointment and clinical privileges.
* Authorizes and consents to Hospital representatives providing other hospitals and licensing boards with any information relevant to such matters that the Hospital may have concerning him or her, and releases Hospital representatives from liability for so doing.
* Signifies that he or she has read the current Medical Staff Bylaws, Rules and Regulations and associated manuals and policies and procedures and agrees to abide by their provisions in regard to his or her application for appointment to the Medical Staff.
* Agrees to abide by and sign the JMH Credo.
* Agrees to provide to the Medical Staff Office updated information requested on the original application and subsequent reapplications or privilege request forms, including the following:

\* Hospital appointments

\* Challenges to any licensure or registration

\* Voluntary or involuntary relinquishment, termination, limitation, reduction, or loss of Medical Staff membership or clinical privileges, or licensure status

\* Involvement in liability claims or license/DEA sanctions (including both current and pending investigations and challenges)

\* Any removal from a managed care organization’s provider panel for quality-of-care reasons or unprofessional conduct

\* Information (in the form of a statement) that no health problems exist that could affect his or her ability to perform the privileges requested

\* Loss of employment from a group practice or hospital.

* Agrees to disclose any successful or currently pending challenges to licensure or registration or voluntary or involuntary relinquishment of such licensure or registration to the Medical Staff Office or President of the Hospital.
* Agrees to disclose voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, suspension, or loss of clinical privileges at another institution.
* Agrees to disclose any current clinical charges pending, and any past charges and convictions of misdemeanors or felonies.

For the purposes of this provision, the term H*ospital representatives* include the following entities:

* The Board, its Directors, and Committees
* The President of the Hospital or his or her designee
* The Chief Medical Officer
* The Medical Staff organization and all Medical Staff appointees
* Clinical units and committees that have responsibility for collecting and evaluating the applicant’s credentials or acting upon his or her application
* Any authorized representative of any of the aforementioned

## Procedure for processing applicants for initial staff appointment

The applicant must provide the following information necessary to complete the application:

* A legible, completed, and signed application form and request for privileges
* A copy of current DEA certificate and state controlled substances registration, if applicable
* A copy of the face sheet of the current professional liability insurance policy or certificate of insurance
* Names and addresses of three (3) professional references that have recently worked with the applicant and have directly observed his or her professional performance recently. At least one (1) reference must be an individual practicing in a field similar to that of the applicant. Only one (1) reference may be a partner of the applicant. The Hospital will directly contact the references and request information regarding current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and ability to perform (health status).

If the Medical Staff Office does not receive all of the aforementioned information within thirty (30) days of receipt of the application, the Hospital may consider the application incomplete, and the Medical Staff Office may suspend further processing. The Hospital may send reminder notices in writing (via either/or email, fax, or hardcopy) to the applicant after the Medical Staff Office receives the application, noting missing items or information.

The Medical Staff Office will then verify the application’s contents and collect additional information as follows:

* Information from all prior and current insurance carriers concerning claims, suits, and settlements (if any) during the past ten (10) years
* At least three (3) clinical peer reference questionnaires
* Verified documentation of the applicant’s past clinical work experience from [all/the past ten (10) years] practice settings
* Verification of healthcare licensure status for all current and past states of licensure
* Information from the American Medical Association Physician Masterfile
* Information from the Federation of State Medical Boards, if applicable
* Verification of completion of medical, osteopathic, dental, or podiatric school, and residency and fellowship programs
* Verification of all medical, osteopathic, dental, or podiatric school, and residency and fellowship programs ever begun
* Information from the National Practitioner Data Bank (NPDB)
* Information from a background check (in accordance with Hospital policy)
* Information from the Office of Inspector General [and Excluded Parties List System] relevant to Medicare/Medicaid sanctions, if applicable

*Note*: If there is undue delay in obtaining required information, the Medical Staff Office will request assistance from the applicant. If the applicant fails to respond adequately to a request for assistance within thirty (30) days of the Hospital’s request, the Hospital may terminate the application process.

When the Medical Staff Office has obtained the aforementioned items, he or she will summarize it and present the file to the appropriate Section chair (if applicable), Department chair and the Credentials Committee chair.

The Department chair will review the qualifications of all new applicants and reappointment applicants requesting privileges at JMH. The Department chair must have board certification in the same specialty as the member requesting privileges. If the Department chair has board certification in a different specialty, the Department chair will send the Delineation of Privilege form to the Section chair for review. In the event that there is no Section chair at JMH or if there is a conflict of interest, the Department chair will work to identify Section chair within our regional health ministry who is qualified to review the Delineation of Privilege form.

### **Clinical interview**

JMH may, in its sole discretion, require that applicants for appointment or reappointment for Medical Staff membership and/or privileges participate in an interview as part of the application or reapplication process. Failure to participate in a requested interview will render the application incomplete until the interview is completed and a written summary of the interview is added to the credentials file.

#### **Procedure**

* The interview may be conducted by the Chief Medical Officer (CMO), Department chair or his or her designee.
* The content of the interview is at the discretion of the person conducting the interview but should include, at a minimum, the following items:
* Review of the applicant’s training with special attention to any gaps or changes in training programs.
* Discussion to resolve any concerns raised in the application, including but not limited to less than fully positive references, items in the NPDB report, past disciplinary actions, malpractice cases, frequent changes in clinical practice locations, or an unusual number of state licenses.
* Review of the applicant’s recent practice experience, including the spectrum of clinical services provided
* Review of the applicant’s requested privileges, with special attention to evidence of current competence for potentially problematic privileges (potentially problematic privileges may include privileges not usually requested by the applicant’s specialty, special procedure requests outside the core of the applicant’s specialty, areas of cross-specialty privileging disputes, and components of the core that the applicant may not have had in his or her training or recent practice experience).
* Any concerns that arise out of information obtained as a result of the verification process, including discrepancies between the information the applicant submitted and the information obtained through references/verifications.
* If the applicant is not board-certified, information regarding when the applicant plans to take the exam. The application should disclose whether the applicant has already taken the exam and failed.
* Who will provide coverage to the applicant’s practice.
* Optional question: Clinical questions to explore the applicant’s knowledge base and clinical judgment.
* Review of performance expectations for practitioners granted privileges.

### **Evaluate and recommend**

#### **Section chair**

The Section chair reviews the Delineation of Privileges Form to ensure that it fulfills the established standards for the clinical privileges being requested.

#### **Department chair**

After the Department chair receives the application from the Medical Staff Office, he or she reviews the application to ensure that it fulfills the established standards for membership and clinical privileges. The effect of the Department chair report is consistent with established procedures within the Medical Staff Bylaws, Rules and Regulations related to deferral or favorable/adverse recommendations.

#### **Credentials Committee**

Upon receipt of the Department chair’s recommendation, the Credentials Committee reviews the application to ensure that it fulfills the established standards for membership and clinical privileges. The effect of the Credentials Committee report is consistent with established procedures within the Medical Staff Bylaws, Rules and Regulations related to deferral or favorable/adverse recommendations.

#### **MEC**

Upon receipt of the Credentials Committee’s recommendation, the chair of the MEC (President of the Medical Staff) reviews the application to ensure that it fulfills the established standards for membership and clinical privileges. The effect of the MEC’s report is consistent with established procedures within the Medical Staff Bylaws, Rules and Regulations related to deferral or favorable/adverse recommendations.

#### **Board**

Upon receipt of the MEC’s recommendation, the Board (or a subcommittee of the Board authorized to approve the appointment and clinical privileges on its behalf—see Fast Track Credentialing policy) reviews the application and all supporting documentation. The effect of the Board action is consistent with established procedures within the Medical Staff Bylaws, Rules and Regulations related to favorable/adverse recommendations.

#### **Basis for recommendation and action**

Each individual or group that is required to act on an application—including the Board—may state the reasons for each recommendation or action taken, with specific reference to the completed application and any other relevant documentation. Any dissenting views at any point in the process may also be documented, supported by reasons and references, and transmitted with the majority report. Unsupported commentary or impressions will not be recorded.

#### **Focused professional practice evaluation (FPPE)**

Upon the initial granting of clinical privileges, each practitioner’s performance is subject to a defined period of FPPE in accordance with the Hospital’s FPPE policy and procedure.

#### **Conflict resolution**

If the Board determines that its decision will contradict the MEC’s recommendations, it will submit the matter to a committee comprising an equal number of MEC and Board members. The committee shall review the information and submit its recommendation to the Board within thirty (30) days of the date on which the Board submitted the matter.

#### **Notice of final decision**

The President of the Hospital (or designee) shall notify the MEC and the chair of each relevant Department of the Board’s decision. The applicant shall receive written notice of appointment and special written notice of any adverse final decisions.

A decision and notice of appointment includes:

* The staff category to which the applicant is appointed
* The Department to which he or she is assigned
* The clinical privileges he or she may exercise
* Any special conditions attached to the appointment or exercise of clinical privileges
* The time frame of the appointment

#### **Time periods for processing**

All individuals and groups required to act on an application for staff appointment must do so in a timely manner and in good faith. Unless there is good cause, each application should be processed within an expectation of no longer than four months.

The time period listed above is a merely guideline. If the provisions of the fair hearing plan are activated, the time requirements provided therein govern the continued processing of the application.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Advanced Practice Professionals Credentialing and Privileging** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

## Purpose

It has been agreed by the governing body and the Medical Executive Committee (MEC) that the Medical Staff organization should be directly involved in the credentialing and privileging process for specific categories of Advanced Practice Professionals. The MEC and the governing body of JMH have identified certain categories of non-physician healthcare professionals (hereinafter referred to as “Advanced Practice Professionals” or APPs) who provide patient care services at JMH facilities. These specific categories are defined within this document.

## Definitions

**Advanced Practice Professional (“APP”)** is an individual, other than a licensed physician, who provides direct patient care services at Johnson Memorial Hospital under a defined degree of supervision by a physician who has been granted clinical privileges. APPs exercise judgment that is within the areas of documented professional competence and is consistent with the applicable State Practice Act. APPS are designated by the governing body to be credentialed and privileged through the Medical Staff organization and are granted clinical privileges as defined in the Medical Staff Bylaws, Rules and Regulations, the JMH Credentialing Policy and Procedure manual, and this APP Credentialing and Privileging policy and procedure. The governing body periodically determines the categories of individuals eligible for clinical privileges as an APP. These categories are [psychologists, physician assistants, and advanced practice registered nurses (nurse-midwives, nurse practitioners, and nurse anesthetists)].

APPs may be employed by or contracted by the Hospital or may be employed (contracted or sponsored) by a physician granted privileges at the organization.

**Privileges** are the permissions granted to an APP to render specific patient services. Privileges are based on the APP’s licensure, education, training, experience, and demonstrated current competence, as well as the limitations defined by Johnson Memorial Hospital for operational or risk management reasons. The performance of privileges may be subject to supervision requirements as well as limitations on the settings in which the services may be provided and the patient populations to which services may be provided. Privilege forms include the standardized procedures and/or protocols that the APP has requested and has been determined to be qualified to provide.

## Policy

In the interest of providing high-quality care at Johnson Memorial Hospital and meeting accreditation standards as well as licensing and other regulatory requirements, this document was created to describe how APPs who are credentialed and privileged via Medical Staff organization mechanisms are permitted to provide healthcare services in JMH facilities. This APP Credentialing and Privileging policy and procedure (APP P&P) is to be used in conjunction with JMH’s Medical Staff Bylaws, Rules and Regulations.

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| It should be noted that there are additional categories of healthcare professionals who provide services at Johnson Memorial Hospital who are authorized via the clinical assistant policy. Separate policies and procedures (such as employment or contractual services policies and procedures) cover those arrangements. This APP credentialing policy and procedure is limited to describing credentialing and privileging processes for APPs credentialed via Medical Staff organization mechanisms. |

The APP P&P establishes guidelines for a process to assess, evaluate, and review the qualifications, competency, and professional conduct of and quality and appropriateness of care provided by the categories of APPs.

This APP P&P and all other related policies, procedures, rules, regulations, and requirements related to the practice of APPs at Johnson Memorial Hospital do not constitute a contract of any kind whatsoever and are subject to change at any time without notice to applicants or to APPs who provide services at Johnson Memorial Hospital.

## Requirements

### **Professional liability insurance requirements**

*APPs employed by Johnson Memorial Hospital* are covered for professional liability for services provided as an employee under insurance policies of the applicable organization. This is confirmed during the initial appointment and reappointment processes. *APPs employed (contracted or sponsored)* by a physician holding privileges at Johnson Memorial Hospital must be covered by the practitioner’s employer and specifically named in the professional liability policy (and must meet organization requirements for coverage) or must demonstrate independent professional liability insurance in the amount required by the Medical Staff and governing body. This is confirmed during the initial appointment and reappointment processes (and potentially at intervals between credentialing events).

### **Basic responsibilities**

Each APP shall:

* Provide patients with quality care at the generally recognized professional level of quality and efficiency in the community; to the extent authorized by his or her license, certification, or other legal credentials; by the terms outlined in the APP category privileges description; and by the privileges granted.
* Abide by all applicable state and federal laws regulating healthcare providers, as well as by Bylaws, Rules and Regulations, and all other lawful standards, policies, and rules of Johnson Memorial Hospital; and comply with policies, procedures, rules, regulations, and requirements which relate to the provision of services by APPs at Johnson Memorial Hospital.
* Discharge functions assigned by the MEC, including, but not limited to, quality improvement, peer and professional review, patient care monitoring, utilization review, case management, and other responsibilities.
* Submit to such physical and/or mental examination(s) or provide verification of health status as may be required to verify the AHP’s ability to fully meet his or her responsibilities and/or perform the requested privileges.
* Report to the Medical Staff Office immediately any action taken affecting licensure, certification, registration, or DEA registration, including, but not limited to, probation, restriction, suspension, termination, and voluntary or involuntary relinquishment of same.
* Utilize Johnson Memorial Hospital resources appropriately.
* Treat all individuals at or associated with Johnson Memorial Hospital courteously, respectfully, and with dignity at all times.
* Write orders and provide care, treatment, and services only as permitted by his or her licensure or certification and as outlined in the APP privileges description and the privileges granted to the APP.
* Document in patient medical records in a complete and timely fashion to the extent authorized in the APP privileges description and the privileges granted to the APP.
* Seek consultation, supervision, and direction whenever appropriate or necessary and as required in the APP privileges description and the privileges granted to the APP.
* Abide by the ethical principles of his or her profession and the organization.
* At all times, observe and promote the confidentiality of patient identifiable information.
* Maintain all other qualifications for privileges set forth in this P&P or the applicable APP privileges description.

## Initial credentialing procedures

### **Eligibility for application**

APPs must be credentialed in accordance with this P&P. In order to be credentialed, APPs must complete an AHP application form. Only APPs who meet the following eligibility criteria shall be provided with an application:

* Practices within a category of APPs approved by the governing body
* Has been offered employment within Trinity Health Of New England (TH Of NE) or is an employee (contracted or sponsored) of a physician holding privileges at Johnson Memorial Hospital
* Through a screening process, appears to meet applicable licensing, certification, registration, education, training, and experience requirements of the applicable APP category and sections of the Medical Staff Bylaws, Rules and Regulations or related documents
* Has not been excluded from any federal health program, including Medicare and Medicaid

### **Demonstration of qualifications**

At all times, the APP is responsible for demonstrating the following qualifications:

* Continued employment by Trinity Health Of New England or employed (contracted or sponsored) by a physician holding privileges at Johnson Memorial Hospital
* Requisite professional education and training, licensure and/or certification, and registration, as applicable
* Demonstrated ability and judgment
* Relevant experience demonstrated by clinical activity
* Current competence to practice his or her profession and perform all requested clinical privileges
* Freedom from any significant physical, emotional, or behavioral impairment, including the use of drugs or alcohol, that prevents the APP from meeting the other qualifications for APP status and the ability to perform requested privileges
* Acceptable professional claims history and continuous professional liability coverage in prescribed amounts
* Adherence to the lawful ethics of the APP’s profession
* The ability to work cooperatively with others in the organization and with healthcare professionals in a consistently cordial and productive manner

### **Application process**

**AHPs employed by Trinity Health Of New England:**

APPs will be instructed by the HR Representative to contact the Medical Staff Office to obtain an APP application and other application materials.

**APPs employed/contracted/sponsored) by a physician holding privileges at Johnson Memorial Hospital:** APPs will be instructed to obtain application materials from the Medical Staff Office.

### **Verification procedures and evaluation and decision-making process**

Verification procedures will be carried out by the Medical Staff Office in accordance with the procedures defined in the JMH Credentialing policy and procedure.

The steps outlined in the JMH Medical Staff Credentialing policy and procedures are applicable to the credentialing process for APPs. This process applies to both initial appointment and reappointment.

**APPs employed by Trinity Health Of New England:** The HR department of Trinity Health Of New England/Johnson Memorial Hospital will be informed by the Medical Staff Office as soon as possible if an unfavorable recommendation is made by the Department chair, the Credentials Committee, and/or the MEC.

## Credentials file/personnel file procedures

Each APP will have a credentials file that is maintained by the Medical Staff Office. APPs employed by Trinity Health Of New England will also have personnel files maintained in accordance with Trinity Health Of New England’s policies and procedures.

## Supervision procedures

APPs must have a designated primary physician, supervisor and/or collaborator/sponsor acceptable to the Medical Staff and in alignment with Connecticut State requirements for that particular APP.

The primary physician, supervisor/collaborator/sponsor must hold privileges in good standing.

The primary physician, supervisor/collaborator/sponsor must agree to participate as requested in the evaluation of competency (i.e., during and at the conclusion of the initial focused professional practice evaluation [FPPE], at the time of reappointment, and as applicable, at intervals between reappointment, as necessary) of the APP(s) whom he or she supervises.

A copy of the collaborating/sponsoring agreement, signed by both parties, will be submitted with the APP’s application.

The primary collaborating/sponsoring physician must sign the privileges of the APP that he or she supervises, in which he or she accepts responsibility for appropriate supervision of the services provided by each APP under his or her supervision and agrees that the APP will not exceed the scope of practice as defined by the privileges granted and by law (within his or her licensing agreement—i.e., supervising/collaborating agreement).

## Procedures for evaluation of performance

The performance of all APPs will be evaluated as part of the Medical Staff’s routine performance improvement processes. Therefore, the APP’s performance will be evaluated, as applicable, and will be consistent with the Medical Staff policies and procedures regarding FPPE and ongoing professional practice evaluation (OPPE).

Any concerns regarding the quality or appropriateness of care provided by an APP identified during such review processes shall be referred to an appropriate Medical Staff review committee. Any concerns regarding the supervision of an APP by a physician shall be referred to the appropriate Medical Staff department or review committee.

In addition, the quality of care provided by APPs employed by Trinity Health Of New England/Johnson Memorial Hospital will also be reviewed on an ongoing basis through the employment performance evaluation process of Trinity Health Of New England/Johnson Memorial Hospital.

### **Reappointment**

Reappointment procedures as defined in the JMH Credentialing policy and procedure are followed for APPs. This includes data that are gathered for all credentialed Medical Staff members and APPs, as applicable to the services provided and available data.

During the reappointment process, the Department chair/designee is permitted access to pertinent performance evaluations. Copies of employment-related performance evaluations are not maintained in credentials files. Peer review data maintained in quality files shall be made available on a case-by-case basis as determined by the CMO and/or the President of the Medical Staff for individuals performing employment-related performance evaluations.

## Review of specific conduct or care/corrective action

Whenever the activities or professional conduct of an APP adversely affect or are reasonably likely to adversely affect patient safety or the delivery of quality patient care, or are disruptive to the organization’s operations, the matter may be referred to the Physician Quality Improvement Committee (PQIC) or that APP’s supervising/collaborating physician, who shall review the matter or designate an ad hoc or existing peer review body to investigate the matter. The matter maybe handled by the employing organization as described in organization-specific policies and procedures (applicable to Trinity Health Of New England/Johnson Memorial Hospital–employed APPs only).

External third parties may be used by the Physician Quality Improvement Committee (PQIC) to conduct all or part of the investigation or to provide information to the investigating body. The investigation may involve an interview of the APP involved and the collaborating/sponsoring physician, and an interview of other individuals or groups. JMH may also request the APP involved provide any OPPE or FPPE reports from other organizations in which they practice.

### **Automatic relinquishment of privileges**

The privileges and status as an APP shall terminate immediately, without right to due process, in the event that the employment of the APP with Trinity Health Of New England/Johnson Memorial Hospital is terminated for any reason or if the employment contract or sponsorship of the APP with the physician is terminated for any reason.

### **Precautionary and automatic suspensions**

All APPs may be subject to discipline and corrective action. Clinical privileges may be suspended, modified, or terminated consistent with Johnson Memorial Hospital and/or Medical Staff Bylaws, Rules and Regulations, policies, and procedures, as applicable. If the APP is a Hospital employee and/or a union member, applicable fair treatment policies and procedures will be applied.

## Grievance procedures

An APP shall have the right to dispute any action that revokes, suspends, terminates, restricts, or reduces the clinical privileges that the APP has been given permission to provide at Johnson Memorial Hospital unless the action revokes, suspends, terminates, restricts, or reduces the clinical privileges of an entire classification of APPs rather than being focused on an individual APP.

***Exception***: APPs shall not have the right to dispute automatic relinquishment of privileges. Automatic relinquishment would occur if the license or other legal credential of the APP expired or was revoked, if the APP was excluded from Medicare/Medicaid, etc. Automatic termination would occur if the APP failed to meet the eligibility criteria for his or her category.

The APP’s rights of hearing and appeal are identical to those of a Medical Staff member who is a physician and as defined by the Bylaws, Rules and Regulations.

## Responsibility

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It is the responsibility of the MEC of the Medical Staff organization to ensure that this policy is followed.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Fast Track Credentialing** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

It is this Hospital’s policy to process all applications with equal standards only after the Medical Staff Office has obtained a completed, verified application. It is the intent of this policy to expedite applications that meet predefined, Board-approved criteria defined below:

## Fast-Track Procedure

The Credentials Chair and Medical Staff Services Coordinator will review each application and its associated additional information, with recommendations from the appropriate Section Chair and Department Chair, and will categorize the application according to the following criteria:

## Category One

1. All requested information has been returned promptly.
2. There are no negative or questionable recommendations.
3. There are no discrepancies in information received from the applicant or references.
4. The applicant completed a normal education/training sequence.
5. There have been no disciplinary actions or legal sanctions.
6. There have been no malpractice cases.
7. The applicant has an unremarkable medical staff/employment history.
8. The applicant has submitted a reasonable request for clinical privileges based on experience, training, and competence and is in compliance with applicable criteria.
9. The applicant reports an acceptable health status.
10. The applicant has never been sanctioned by a third-party payer *(e.g., Medicare, Medicaid, etc.).*
11. The applicant has never been convicted of a felony.

###### The applicant is requesting privileges consistent with his or her specialty.

1. The applicant’s history shows an ability to relate to others in a harmonious, collegial manner.
2. The applicant has had an interview with the Department Chairman or designee, if requested.

## Category Two

1. Peer references and/or prior affiliations indicate potential problems *(e.g., difficulty with interpersonal relationships, minor patient care issues, etc.).*
2. There are some discrepancies between information the applicant submitted and information received from other sources.
3. Privileges the applicant requested vary from those requested by other practitioners in the same specialty.
4. There are gaps in time for which the applicant has not accounted.
5. There are unsatisfactory peer references and/or prior affiliation references.
6. Disciplinary actions have been taken by a state licensing board or a state or federal regulatory agency, or there has been a criminal conviction.
7. The applicant has experienced involuntary termination of Medical Staff membership.
8. The applicant has experienced removal from a provider panel of managed care entity for reasons of unprofessional conduct or quality-of-care issues.
9. The applicant has been the object of any malpractice claims/settlements/judgments.
10. The applicant has had many health care organization affiliation terminations/resignations in multiple areas during the past five years.

How to process category one and two applications

### **Category One**

1. The Medical Staff Office receives and processes the application.
2. The appropriate Section Chair reviews the completed and verified application and makes recommendation to the appropriate Department Chair.
3. The appropriate Department Chair reviews the completed and verified application, with recommendation from the appropriate Section Chair. The Department Chair has the option to interview the applicant.
4. The Department Chair forwards a recommendation to the Credentials Committee.
5. The Credentials Committee reviews the completed and verified application taking into consideration recommendations from the Section Chair and Department Chair, and forwards a recommendation to the Medical Executive Committee to be reviewed at its next scheduled meeting.
6. The Medical Executive Committee reviews the completed and verified application, taking into consideration recommendations from the Section Chair, Department Chair, and Credentials Committee.
7. The Medical Executive Committee then forwards recommendation to the Board Sub-committee who (pursuant to a policy adopted by the Board) grants the applicant appointment to the Staff and the requested clinical privileges.
8. The Board Sub-committee makes an informational report to the Board at its next regular meeting. The Board does not take any action, as the Hospital’s Bylaws or policy allow the Board’s Sub-committee to act on the Board’s behalf in granting appointment and clinical privileges to any Category One physician for whom the Section Chair, Department Chair, Credentials Committee Chair, and Medical Executive Committee’s recommendations are all in agreement.

Note: If the Department Chair, Credentials Committee Chair, Medical Executive Committee or Boards’ Sub-committeenotes any concern or discrepancy, the application is automatically classified as Category Two and processed accordingly.

#### **Category Two**

1. The application is forwarded to the appropriate Section Chair for review and recommendation. Section Chair recommendation is forwarded to the appropriate Department Chair.
2. The Department Chair reviews the application to make sure it meets the established standards for membership and clinical privileges.
3. The Department Chair forwards the application to the Credentials Committee for review and recommendation. The Credentials Committee reviews the application for membership and clinical privileges.
4. The Credentials Committee then forwards the application to the Medical Executive Committee for final action.
5. The MEC forwards the application, with its recommendation, to the Board’s Sub-committee and the Board for final action.
6. The MEC prepares a report for the Board that identifies those practitioners who were appointed and granted clinical privileges via this mechanism.

Note: In the event the MEC’s recommendation is negative, the Hospital must review and follow its fair hearing plan.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Peer References** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

It is the policy of this institution to process applications for appointment and/or clinical privileges only after receipt of acceptable peer references (either a completed questionnaire or other) by the institution. Peer references must be practitioners who have recent, extensive experience in observing or working with the applicant and can provide information pertaining to the applicant’s present clinical competence, character, and ability to work as a member of the healthcare team. This institution requires three references upon initial appointment and at least two references upon reappointment.

Peer references:

* Must be an appropriate practitioner in the same professional discipline (i.e. MD/DO to MD/DO, DPM to DPM, DMD to DMD, PA-C to PA-C, APRN to APRN)
* At least one physician evaluation for members of the Advanced Practice Professional Staff
* No more than one reference from a member of the applicant’s group practice (if applicable)

Note: Family members and spouses are not permitted to submit peer reference questionnaires.

*Note:* In the event this institution does not receive references from the designated individuals, processing of the application will cease, and the Medical Staff Services Coordinator and Credentials chair will review the application to determine further action.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Credentialing Reappointment and/or Renewal of Privileges** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

All appointments and grants of clinical privileges are for a period not to exceed two (2) years. At least three (3) months before the expiration of a Medical Staff appointment or expiration of privileges, the Medical Staff Office will notify the practitioner of the date of expiration of his or her current appointment and/or privileges and provide him or her with an application-for-reappointment/renewal-of-privileges packet.

## INFORMATION COLLECTION AND VERIFICATION

### **From Medical Staff members**

At least ninety (90) days before the expiration date of his or her appointment and/or privileges, the reapplicant shall provide the Hospital with the following information:

* Complete information to update his or her file on items listed in his or her original application
* Continuing training and education external to the Hospital during the preceding period if requested
* Specific request for the clinical privileges sought on renewal of privileges, with any basis for changes
* Additional documentation (if applicable) required for any newly added privileges (privilege-specific criteria)
* Requests for changes in staff category or department assignments

If the practitioner fails, without good cause, to provide this information, the Hospital will deem the failure a voluntary resignation, and the appointment and/or privileges will automatically expire at the end of the current appointment.

The Medical Staff Office will verify this additional information and notify the reapplicant of any inadequacies in the information or verification problems. The practitioner will have the burden of producing adequate information and resolving any doubts about the data.

### **From internal and/or external sources**

The Medical Staff Office will collect the following information regarding the reapplicant’s professional and collegial activities:

* Currency of licensure and registrations
* Professional board certification status
* Any pending or completed disciplinary actions, malpractice issues, or sanctions
* Performance and conduct in this Hospital and/or other healthcare organizations as applicable, including his or her:
* Patterns of care as demonstrated in findings of quality
* Assessment/performance improvement activities (ongoing professional practice evaluation and focused professional practice evaluations as they may exist)
* At least two peer references
* All hospital affiliations for the past two years
* Insurance Malpractice coverage/verifications for the past two years
* Satisfactory completion of the number hours of continuing medical education (CME) activities required for licensure and in relation to the privileges requested
* Attendance at required Medical Staff and Department meetings, as applicable
* Adherence to the JMH Credo

The Hospital shall review and verify the preceding information according to the initial appointment policy.

## PROCEDURE FOR PROCESSING APPLICATIONS FOR REAPPOINTMENT AND/OR RENEWAL OF PRIVILEGES

The chair of each Section and Department in which the reapplicant requests or has exercised privileges will be notified of the practitioner’s reapplication for membership and/or privileges when the application is complete.

### **Section action**

* The Section chair reviews the Delineation of Privileges Form to ensure that it fulfills the established standards for the clinical privileges being requested.

### **Department action**

* Each appropriate Department chair will review the reapplicant’s file as described earlier and forward to the Credentials Committee or Medical Executive Committee (MEC) (as applicable) a written report of the reapplicant’s performance. That report must include the following:
* A statement as to whether he or she knows of, has observed, or has been informed of ***any*** conduct that indicates significant present or potential physical or behavioral problems that affect the practitioner’s ability to perform professional and Medical Staff duties appropriately
* Recommendations regarding:
* Reappointment
* Staff category
* Department assignment
* Clinical privileges
* Focused professional practice evaluation (FPPE) as applicable to new privileges

### **Credentials Committee action**

The Credentials Committee will review the reapplicant’s file, Department reports and recommendations, and all other relevant information and forward to the MEC a written report with recommendations regarding:

* Reappointment
* Staff category
* Department assignment
* Clinical privileges
* FPPE as applicable to new privileges

The Credentials Committee will follow the decision process outlined in the initial appointment policy.

### **MEC action**

The MEC will review the member’s file, the Department report(s), the Credentials Committee report(s), and all relevant information available to it and forward to the Board a written report with recommendations for:

* Reappointment
* Staff category
* Department assignment
* Clinical privileges
* FPPE as applicable to new privileges

The MEC shall follow the decision process outlined in the initial appointment policy. If the MEC’s recommendation is deemed adverse, no such adverse recommendation will be forwarded to the Board until after the practitioner has exercised or has waived his or her right to a hearing as provided in the Medical Staff Bylaws, Rules and Regulations.

### **Final processing and Governing Board action**

To complete processing of the application, the Hospital shall follow the procedures in the initial appointment policy. The Board will respond to any adverse recommendation by:

* Denying reappointment
* Denying a requested change in the member’s staff category or department assignment
* Changing, without the member’s consent, his or her staff category or department assignment
* Denying or restricting requested clinical privileges

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Credentialing of Telemedicine Practitioners** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

## Policy

It is the policy of this Hospital that telemedicine services will be provided at this facility as an originating site in a manner that seeks to ensure a high level of care consistent with the standards of care for other hospital services.

## Definitions

* **Originating site**: site where the patient is located
* **Distant site**: remote location where the image/test is interpreted

## Telemedicine privileges

Practitioners providing telemedicine services must be granted privileges at this Hospital. For a practitioner to be eligible to request telemedicine privileges, the following requirements must be met:

* The Medical Executive Committee (MEC) has recommended that the scope of telemedicine services provided at this originating site hospital and the distant site hospital include the privileges requested by the practitioner. Both the originating site MEC and the distant site MEC must approve this scope of services.
* The practitioner must concurrently maintain similar privileges for the same scope of services at the distant site hospital as he or she is requesting at the originating site hospital.

Requests for telemedicine privileges at the originating site hospital will be processed through the established procedure for reviewing and granting privileges at the originating site hospital. Information included in the completed practitioner application for telemedicine privileges at the originating site hospital may be collected in the usual manner or may be collected from the distant site hospital.

For the originating site to use credentialing and privileging information from the distant site in credentialing and privileging decisions, the following conditions must be fulfilled:

* The distant site hospital is accredited by The Joint Commission.
* The practitioner is privileged at the distant site hospital for those services to be provided at the originating site hospital.
* The originating site hospital has evidence of an internal review of the practitioner’s performance of these privileges and sends hospital information to the distant site hospital that is useful to assess the practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. this information will include all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site hospital from patients, other licensed independent practitioners, and staff members at the originating site hospital.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Temporary Privileges** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

Temporary privileges may be granted by the President of the Hospital or designee, acting on behalf of the Board and based on the recommendation of the President of the Medical Staff and/or designee and the Chair of the Department, provided there is verification of current licensure and current competence. Temporary privileges may be granted only to fulfill an important patient care, treatment, or service need.

Important patient care, treatment, or service need

Temporary privileges may be granted on a case-by-case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed one–hundred and twenty (120) calendar days, while the full credentials information is verified and approved. For the purposes of granting temporary privileges, an important patient care, treatment, or service need is defined as including the following:

* A circumstance in which one or more individual patients will experience care that does not adequately meet their clinical needs if the temporary privileges under consideration are not granted (i.e., a patient scheduled for urgent surgery who would not be able to undergo the surgery in a timely manner)
* A circumstance in which the institution will be placed at risk of not adequately meeting the needs of patients who seek care, treatment, or service from the institution if the temporary privileges under consideration are not granted (i.e., the institution will not be able to provide adequate emergency room coverage in the provider’s specialty; or the Board has granted privileges involving new technology to a physician on your staff provided the physician is precepted for a specific number of initial cases, and the precepting physician, who is not seeking Medical Staff membership, requires temporary privileges to serve as a preceptor)

Criteria for Granting Temporary Privileges

Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following, which has been verified by the Hospital: current licensure, current competence, current DEA; current professional liability insurance in the amount required; two positive references specific to the applicant’s competence from an appropriate medical peer; ability to perform the privileges requested; and results from a query to the National Practitioner Data Bank.

Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. The JMH Medical Staff Bylaws, Rules, and Regulations, and policies control all matters relating to the exercise of clinical privileges.

Termination of temporary privileges

The President of the Hospital, acting on behalf of the Board and after consultation with the President of the Medical Staff, may terminate any or all of the practitioner’s privileges based on the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner’s privileges. Where the life or well-being of a patient is determined to be endangered, any person entitled to impose a precautionary (summary) suspension under the Medical Staff Bylaws, Rules and Regulations may affect the termination. In the event of any such termination, the practitioner’s patients then will be assigned to another practitioner by the President of the Hospital or his or her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

Rights of the practitioner with temporary privileges

A practitioner is not entitled to the procedural rights afforded in the Bylaws because his or her request for temporary privileges is refused or because all or any part of his or her temporary privileges are terminated or suspended unless based on a determination of clinical incompetence or unprofessional conduct.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Exclusive Contract** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

It is the policy of JMH that the Governing Board has the authority to designate that selected services be provided through exclusive contracts. Except in an emergency or life-threatening situation, all practitioners providing services pursuant to an exclusive contract are required to abide by this exclusive contract policy when arranging for or providing patient care.

The Hospital will not accept or process applications for Medical Staff appointment or clinical privileges for services covered by an exclusive contract unless the applicant qualifies under the terms of the exclusive contracts. This policy will be followed independent of any information regarding the competence of an applicant who does not qualify under the terms of the exclusive contract.

Being party to an exclusive contract makes a practitioner eligible for application for Medical Staff appointment or privileges. However, the Hospital shall not automatically award Medical Staff appointment or privileges to an applicant by virtue of the candidate’s inclusion in an exclusive contract. For each such applicant, the Hospital shall perform a thorough review of the applicant’s education, training, experience, and demonstrated current competence through the credential and privileging system described in the Medical Staff Bylaws, Rules and Regulations or Credentials policy.

In the event of a disagreement between the Medical Staff Bylaws, Rules and Regulations and the exclusive contract, the terms of the contract shall prevail, provided this is compatible with state and federal law. All exclusive contracts shall include this stipulation.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Emergency Privileges** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

Emergency privileges are often confused with disaster privileges. Many interpret disasters as emergencies (which oftentimes is true) and that disaster privileges are interchangeable with emergency privileges, (which is false).

Emergency privileges deal with emergencies of specific patients and are granted to existing practitioners on staff performing a task that is outside of their already granted privileges to save the life, limb, or organ of a patient. As soon as a practitioner with the appropriate privileges can assume care, the practitioner no longer holds that emergency privilege. Emergency privileges legitimize the actions of practitioners when patients are *in extremis*.

For the purposes of this policy, in the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient’s life or to save the patient from serious harm, to the degree permitted by the practitioner’s license, regardless of department affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Sharing of Credentialing Information** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:**  **February 5, 2013** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

**Policy**

It is the policy of Johnson Memorial Hospital (“JMH”) to credential physicians and other individual licensed professionals in accordance with the regulations and requirements established by the State of Connecticut Department of Public Health and the Joint Commission on the Accreditation of Healthcare Organizations, as well as JMH’s Medical Staff Bylaws, Rules and Regulations.

Under the terms of the Master Affiliation Agreement between JMH and Saint Francis Hospital and Medical Center (“SFH&MC”), credentialing information may be shared between JMH and SFC if it has been obtained in accordance with the standards of the applicable regulatory bodies.

Physicians and other individual licensed professionals on either JMH or SFH&MC’s medical staff who wish to apply for medical staff membership and/or clinical privileges with the other party may authorize JMH and SFH&MC to share such physician’s or other individual licensed professional’s credentialing information by executing a release form.

**Procedure for Sharing Credentialing Information**

1. A physician or other individual licensed professional who has a medical staff appointment at either JMH or SFH&MC may request to have a medical staff appointment and/or clinical privileges with the other party.
2. The physician or other individual licensed professional contacts either JMH or SFH&MC and requests an application for medical staff membership and/or clinical privileges. If the physician or other individual licensed professional currently holds medical staff membership and/or clinical privileges with the other party then they will be given a release form authorizing JMH and SFH&MC to share credentialing information.
3. After the physician or other individual licensed professional has completed the application and release form, JMH or SFH&MC, as the case may be, will provide the other party with the completed release form and request that the other party share the physician’s or other individual licensed professional’s credentialing information.
4. The credentialing information that may be shared among JMH and SFH&MC is limited to the following:
   * Certificate of Malpractice Insurance
   * Identification Photo
   * Driver’s License
   * State Licensure
   * DEA Registration
   * Procedural Logs
   * All education information including verification of:
     + Medical School (or ECFMG Certificate for foreign graduates);
     + Internship
     + Residency(ies)
     + Fellowship
     + Other Post Graduate Training
   * Medical Staff Membership Hospital Affiliations
   * Peer References
   * Employment Verification
5. All requested information will be forwarded to the requesting party within ten (10) days of receipt of a properly executed release form.

Johnson Memorial Hospital

201 Chestnut Hill Road

Stafford Springs, CT 06076

AUTHORIZATION TO RELEASE MEDICAL STAFF RECORDS

I, the undersigned practitioner, have made application to the Medical Staff of Saint Francis Hospital and Medical Center for membership and privileges to practice at Saint Francis Hospital and Medical Center. I understand that Johnson Memorial Hospital (JMH) and Saint Francis Hospital and Medical Center are parties to an affiliation agreement whereby the hospitals collaborate with respect to various clinical programs and that the hospitals have agreed they will share certain credentialing information with respect to those practitioners who may be participating in such programs and who have agreed to authorize the release of such information.

Therefore, I the undersigned practitioner, hereby authorize Johnson Memorial Hospital (JMH) to provide from its own records to Saint Francis Hospital and Medical Center certain credentialing information related to my membership and privileges at JMH including verification of my Connecticut license to practice medicine, DEA registration, medical school attendance, graduate and post graduate attendance, completion of residency and fellowships, and current privileges. I hereby release and hold JMH harmless from any liability that may accrue as a result of the release of information which is the subject of this authorization.

I understand that I may revoke this authorization for the release of future information at any time by giving written notice to the Medical Staff Office at the Johnson Memorial Hospital, 201 Chestnut Hill Road, Stafford Springs, CT 06076. Such revocation shall be effective upon its receipt by the Medical Staff Office.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name *(Print)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| I:\LOGOS\TH Of NE_Johnson_Horiz_PMS.png | **TITLE:**  **Disaster Privileges** | | |
| Johnson Memorial Hospital, Inc. | **Department:**  **Medical Staff** | **Category:**  Board  Clinical  HR  EOC  Medical Staff  Other | **Level:**  System  Division  Department |
| **Published Date:** | **Review Cycle:**  1 year  3 years  As Needed | **Revision #:** |

**PURPOSE:** To appropriately credential practitioners who are not members of the Johnson Memorial Hospital Medical Staff in cases of declared emergency or disaster.

**SCOPE:** Any practitioner not currently credentialed for the Johnson Memorial Hospital Medical Staff who volunteers or is requested to provide assistance at Johnson Memorial Hospital due to extenuating emergency circumstances or disaster.

**POLICY:** Practitioners who are not currently members of the Johnson Memorial Hospital Medical Staff may be granted Disaster Privileges during an “emergency” or “disaster” situation. “Disaster” or “Emergency” is defined as either a government declared or Johnson Memorial Hospital declared local, state or national disaster or emergency in which the Hospital’s Emergency Management Plan has been activated. This procedure sets forth the requirements to manage and verify the credentials of such individuals.

In all circumstances, before soliciting or accepting support from outside practitioners, the Johnson Memorial Hospital Disaster Command Post will, in consultation with the Medical Staff President (or his/her designee), have determined that the resources of current members of the Johnson Memorial Hospital Medical Staff have been, or are anticipated to be, reasonably exhausted and the Hospital is unable to handle the immediate patient needs.

The Statewide Emergency Medical Staff Credentialing Program will be accessed to identify potential volunteers from other institutions as necessary.

The Hospital President or his/her designee will grant Disaster Privileges upon approval by the Medical Staff President or his/her designee.

**PROCEDURE:**

1. When it has been determined as described above that outside practitioners are necessary, the Hospital President or his/her designee or the Medical Staff President or his/her designee will access the Statewide Emergency Medical Staff Credentialing database to identify and contact potential volunteers.
2. Upon presentation to the Hospital, volunteer practitioners will be required to show a current, valid license to practice their profession *(if the Internet is functional and the volunteer does not have a copy of his/her license at presentation, the license may be verified on-line).*

*AND* any **one** of the following:

* A current picture hospital ID card
* A valid picture ID issued by a state, federal, or regulatory agency
* Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT)
* Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances *(such authority having been granted by a federal, state or municipal entity)*
* Presentation by current Hospital or Medical Staff Member(s) with personal knowledge regarding the practitioner’s identity

1. Absent the ability to immediately perform primary source verifications indicated in #5 below, the Hospital President or his/her designee may choose to visually inspect the items listed in #2 above and grant approval for Disaster Privileges with approval from the Medical Staff President or his/her designee.
2. The Hospital President or his/her designee and the Medical Staff President or his/her designee, will maintain a list of individuals that have been approved for Disaster Privileges including each individual’s name and contact information. A copy of this list will also be maintained in the Medical Staff Office.
3. As soon as the immediate situation is under control and within 72 hours, a Medical Staff Office representative will initiate primary source verification of volunteers’ credentials including the following:
   * Verification of current licensure to practice.
   * Documentation of appropriate malpractice coverage.
   * Basic demographic and contact information will be on file with the medical affairs department.
   * Only those specific privileges for which the practitioner is qualified will be granted if the emergency is ongoing.
   * The practitioner’s primary hospital will be contacted to verify his/her status and current privileges as soon as possible.
   * A National Practitioner DataBank (NPDB) query will be performed.
4. Disaster Privileges will terminate immediately upon determination that any information received through the verification process indicates any adverse information or suggests the practitioner is not capable of rendering services in a disaster or emergency.
5. The duration of Disaster Privileges will be for the period of the “emergency” only.
6. These individuals will be issued temporary identification badges or another form of identification to distinguish them as volunteers.
7. Individuals who are granted Disaster Privileges will be paired with an existing member of the Johnson Memorial Hospital Medical Staff in the same specialty or Department for proctoring and/or supervision as appropriate if available.

1. For the purposes of this policy, the terms “letter,” “notice(s),” “correspondence,” “questionnaires,” and other such documents shall mean communication provided in an electronic format (e.g. email, PDF file, Fax, etc.) or in hard copy. Some of this information is maintained in an electronic format within credentialing software program. [↑](#footnote-ref-1)
2. The credentials file may be hard copy, electronic, or a combination of both. [↑](#footnote-ref-2)
3. Questions arise through various sources. A physician may actually request a new privilege, one may indicate that he or she desires to use a new piece of technology, the OR scheduler notices something new on the schedule, the OR staff is requested to set up differently than in the past, a Medical Staff service professional or Department chair brings the issue to your attention, or you read in the local paper that your hospital was the first in the state to introduce this new patient care technique. [↑](#footnote-ref-3)
4. *All healthcare organizations must comply with the Americans with Disabilities Act.* [↑](#footnote-ref-4)