


MERCYONE SIOUXLAND MEDICAL CENTER

Medical Staff Services Confidentiality Policy	81010.019
Developed by: Medical Staff Services	Date:
Approved by: Medical Executive Committee	Date:
Scope:	
Date/Revisions: 02.15.16, 3.19.18, 2.15.21	

I. Purpose:

To provide guidance to the Medical Staff on the confidentiality of information.

II. Key Points:

A. Confidentiality of Information in General:


1. In furtherance of its mission and consistent with its values, MercyOne Siouxland Medical Center endeavors to improve the quality of patient care and the health status of the community while protecting the confidentiality and privacy of patients, employees of MercyOne Siouxland and medical staff members.
2. Consistent with The Joint Commission (TJC), the Standards require hospitals to respect the needs of patient for confidentiality, privacy and security (RI.2.130). JCAHO's medical staff standards require, when necessary, that the medical staff bylaws and rules and regulations be revised to reflect the hospital's current practices with respect to medical staff organization and functions (MS 2.4 & MS 1.20) implicit though MS 1.10, self-governing medical staff that provides oversight of care, treatment and services provided by the practitioner)
3. "Confidential Information" is any patient, physician, employee and business information obtained during the course of work for or association with MercyOne Siouxland. All capitalized terms have the meanings set forth in MercyOne Siouxland policies and applicable law, including the Health Insurance Portability and Accountability Act.

B. Medical Staff Obligations: Consistent with MercyOne Siouxland's Confidentiality, Privacy and Security Standards, all medical staff members who have access to patient or business information are required to agree to the terms of this Confidentiality Policy. Please read this Policy carefully and ask questions if you need clarification.

1. All members of the medical staff will treat all Confidential Information as strictly confidential, and will not reveal or discuss Confidential Information with anyone who does not have a legitimate medical and/or business reason to know the information. Medical staff members are only permitted to access Confidential Information to the extent necessary for patient care and to perform their duties.
2. MercyOne Siouxland Medical Center reserves the right to audit, investigate, monitor, access, review, and report on use of any Confidential Information obtained from MercyOne Siouxland with or without advance notice. This right pertains to the use and disclosure of Confidential Information only as defined herein.

C. Information System Security:

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1. All members of the medical staff will abide by all MercyOne Siouxland Medical Center Privacy and Information Security Policies and Procedures in using MercyOne Siouxland's information systems and Confidential Information. These policies are found in the MercyOne Siouxland Medical Center PolicyStat Program.

2. Each member of the medical staff also understands that he or she may use His or her access security codes or passwords only to perform his or her duties and will not breach the security of the information systems or disclose or misuse security codes or passwords. Medical staff members will not intentionally misuse or attempt to materially alter the information systems in any significant way.

3. Each member of the medical staff understands that he or she will be held accountable for all work performed or changes made to the information system or databases under his or her security codes, and that he or she is responsible for the accuracy of the information he or she inputs into the system.

D. Remote Access: Remote Access is the ability to connect to MercyOne Siouxland's information systems from a location outside MercyOne Siouxland's campus via the Internet or a dial-up connection. All MercyOne Siouxland's confidentiality, privacy and security standards apply to this type of access to confidential information.


1. Upon request, Medical Staff members will be permitted remote access.
2. Remote access is granted and/or revoked pursuant to the Physician Remote User Access Terms. This document is available through the Medical Staff Office through the Information Security Officer.
3. If the physician desires his or her office staff be granted remote access they must apply for it and sign the Physician Office Remote User Access Agreement. Each User within the physician's office must sign a Remote Access Confidentiality Agreement before access will be granted.

E. Corrective Action for Breach of Confidentiality: Medical staff members understand that violation of MercyOne Siouxland's confidentiality, privacy and security standards is a serious violation of trust and may subject them to discipline or appropriate corrective action pursuant to Article VI of the medical staff bylaws.

F. Confidentiality of Medical Staff Records

A. Scope and Purpose: This policy applies to all records maintained by or on behalf of the MercyOne Siouxland Medical Center medical staff, including the records or minutes of all medical staff departments and committees, the credentials and peer review files concerning individual practitioners, and the records of all medical staff credentialing, peer review and quality assurance activities.

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The medical staff recognizes that it is vital to maintain the confidentiality of medical staff records for reasons of both law and policy. Medical staff appointees participating in credentialing, peer review and quality assurance activities, and others contribute to these activities, with reliance upon the preservation of confidentiality. The members of the medical staff understand and agree that the confidentiality of these activities, and of all medical staff records, is to be preserved.

B. Location and Security Precautions: All medical staff records will be maintained in the Medical Staff Office, under the custody of the Medical Staff Coordinator. The Medical Staff Office will be locked except during those times that the Medical Staff Coordinator or an authorized representative is present and able to monitor access in accordance with this policy. Medical staff records will only be released from that office in accord with this policy.

C. Access by Persons Within the Hospital and Medical Staff:

1. **Means of Access:** All requests for medical staff records by persons within the hospital and medical staff shall be presented to the Medical Staff Coordinator, who will keep a record of requests made and granted. Those requests which require notice to or approval by other officials shall be forwarded to those persons by the Medical Staff Coordinator. A person permitted access under this section shall be given a reasonable opportunity to inspect the records in question and to make notes regarding them. They will not be allowed to remove them from the Medical Staff Office or to make copies of them. Removal or copying shall only be allowed upon the express permission of the President of the Medical Staff.
2. **Access by Persons Performing Official Hospital or Medical Staff Functions:** Medical staff officers, department chairpersons, medical staff committee members, members of the Divisional Board, consultants, Medical Staff Coordinator, Senior Vice President of Medical Affairs, the Chief Executive Officer, or authorized representatives, and any other persons assisting in credentialing, peer review or quality assurance activities will have access to medical staff records, other than their own, to the extent necessary to perform those functions. More particularly,
 - a. **Medical Staff Officers:** Medical Staff Officers shall have access to all medical staff records.
 - b. **Department Chairpersons:** Department chairpersons shall have access to all medical staff records pertaining to the activities of their departments or respective services. They shall have access to the credentials, peer review and quality assurance files of practitioners whose qualifications or performance activities are reviewed as part of their official functions.
 - c. **Medical Staff Committee Members:** Medical staff committee members shall have access to the records of committees on which they serve and to the credentials, quality assurance and peer review files of practitioners whose qualifications or performance the committee is reviewing as part of its official functions.

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- d. Consultants: Consultants (who may or may not be members of the medical staff) reviewing a practitioner's credentials or performance as a part of a credentialing, peer review or quality assurance activity may be allowed access to the credentials and peer review files of the practitioner being reviewed, and to any other pertinent medical staff committee records.
- e. Chief Executive Officer/Designated Representative: The Divisional Board members and the Chief Executive Officer or his designated representative, shall have access to the medical staff records to the extent necessary to perform their official functions.

3. General Access by Practitioners to Medical Staff Records:

- a. Credentials and Peer Review Files: A practitioner will have access to the credentials and peer review files of other practitioners only as set out in paragraph c.1 above. A practitioner may have copies of any personal documents in the credentials and peer review file personally submitted (initial appointment application, application for reappointment, requests for privileges, or correspondence), or which were addressed or copied to that individual. A practitioner shall be allowed access to further information in the credentials and peer review files only if, following a written request by the practitioner, the medical staff executive committee and either the Divisional Board, or its designated representative, find that the practitioner has a compelling need for such information and grants written permission. Factors to be considered include the reasons for which access is requested, where the practitioner might further release the information, where the information could be obtained in a less intrusive manner, whether the information was obtained in specific reliance upon continued confidentiality, whether the practitioner will suffer specific serious consequences unless the information is released, and whether harmful precedent might be established by the release.
- b. Medical Staff Committee Files: Except as provided in paragraph C.2 above, a practitioner shall be allowed access to medical staff committee files pertaining to the practitioner only (including committee minutes) only if, following a written request by the practitioner, the medical executive committee and either the Divisional Board or its designated representative find that the practitioner has a compelling need for such information and grants written permission. Factors to be considered include the reasons for which access is requested, where the practitioner might further release the information, where the information could be obtained in a less intrusive manner, where the information was obtained in specific reliance upon continued confidentiality, where the practitioner will suffer specific serious adverse consequences unless the information is released, and whether a harmful precedent

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might be established by the release.

- c. Access by Persons or Organizations Outside of the Hospital or Medical Staff:
 - 1) Credentialing or Peer Review at Other Hospitals: The hospital and the president of the medical staff (or designee) may release information contained in a credentials and peer review file, or other information which is the subject of this policy, in response to a request from another hospital or its medical staff. That request must include information that the practitioner is a member of the requesting hospital's medical staff, or is an applicant for medical staff membership and/or privileges at that hospital, and must include a release for such records signed by the affected practitioner. No information should be released until a copy of a signed authorization, and a release from liability has been received. This often takes the form of a physician's signature on an application for medical staff membership. Disclosure should generally be limited to the specific information requested.
 - 2) If a practitioner has been the subject of disciplinary action at this hospital which is required to be reported to the Board of Medical Examiners, or recently challenged an Executive Committee recommendation or action which, if appealed, will require a report to that Board, special steps must be taken. All responses to inquiries regarding that practitioner shall be reviewed and approved by the President of the Medical Staff or his designee, and legal counsel shall be consulted.
 - 3) Requests by Hospital Reviewers: Hospital surveyors (from The Joint Commission), the State Department of Health, the Federal Health Care Financing Administration, etc., shall be entitled to inspect records covered by this policy on the hospital premises in the presence of hospital or medical staff personnel provided that: 1) No originals or copies may be removed from the premises; 2) Access is only with the concurrence of the Chief Executive Officer of the hospital (or his designee) or the President of the Medical Staff (or his designee); and 3) The surveyor demonstrates the following to hospital and medical staff representatives:
 - a) Specific statutory or regulatory authority to review the requested materials.
 - b) That the materials sought are directly relevant to the matter being reviewed.
 - c) That materials sought are the most direct and least intrusive means to carry out the impending review, bearing in mind those credentials and peer review files regarding individual practitioners are considered the most sensitive of materials.
 - d) Specificity to allow for the production of individual documents without undue burden to the hospital or medical staff.

Additionally, reviewers may be asked to sign the confidentiality and notification statement attached to this policy as Appendix A and shall be given a photocopy of the signed statement. If

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he/she declines to sign, it should be noted at the bottom of the prepared statement that the surveyor, identified by name, has declined to sign but has been provided a copy of the statement. The annotated statement should then be signed and dated by a hospital or medical staff representative and a photocopy of the signed and annotated statement should be given to the surveyor. The original will be preserved as a medical staff record.

4. Subpoenas: All subpoenas of the medical staff records shall be referred to the Chief Executive Officer, who will consult with legal counsel regarding the appropriate response.


5. Requests from the following BME or BDE: Current law allows the Board of Medical Examiners and the Board of Dental Examiners to review actions pertaining to medical staff hearings concerning corrective action, recommendations or decisions. Records of action taken against a physician in a medical staff disciplinary hearing shall be made available to the Board of Medical Examiners or to the Board of Dental Examiners.
The President of the Medical Staff (or designee) and legal counsel must review and approve the disclosure before it is sent. Any requests for documents other than those listed above shall be disclosed only in accordance with paragraph 6.

6. Other Requests: All other requests by persons or organizations outside the hospital for information contained in the medical staff record shall be forwarded to the President of the Medical Staff and the Chief Executive Officer. The release of any such information shall require the concurrence of the medical staff Executive Committee, or its designated representative, and the Divisional Board or its designated representative. The Executive Committee and the Divisional Board may enact disclosure policies applying to requests from specific entities (for example, the PRO). When such disclosure policies are enacted, they shall be appended to this policy.

7. Medical Staff Participation with Reliance on Confidentiality: Medical Staff appointees participate in credentialing, peer review and quality assurance activities with reliance upon the preservation of confidentiality. They understand that the confidentiality of these activities is to be maintained, and that these communications and information will be disclosed only in furtherance of credentialing, peer review and quality assurance activities.


8. Preservation of Confidentiality: Appointees to the medical staff shall respect and preserve the confidentiality of all communications and information related to credentialing, peer review and quality assurance activities. Appointees pledge to invoke the protections of ICA Section 22.7, 135.40-135.42, 147.135 or such other statutes as may be applicable in legal proceedings in which this confidential

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information is sought, in order to preserve the confidentiality of this information.

9. Corrective Action for Breach of Confidentiality: The quality of patient care and the future of MercyOne Siouxland Medical Center and the medical staff depend upon effective credentialing, peer review and quality assurance. Effective credentialing, peer review and quality assurance activities depend upon the frank and candid exchange of information which is only possible if the confidentiality of medical staff discussions and proceedings is preserved. Consequently, any breach of the confidentiality of medical staff credentialing, peer review and quality assurance activities represents a failure to meet the professional and ethical standards of the medical staff and constitutes a disruption to the operations of MercyOne Siouxland Medical Center. If it is determined that a breach of that type has occurred, the medical staff may undertake appropriate corrective action pursuant to Article VI of the medical staff bylaws.


MEDICAL STAFF CONSULTATION POLICY	81010.11
Developed by: Medical Staff	Date:
Approved by: Medical Executive Committee, Divisional Board	Date: 04/21/2014
Scope: Medical Staff	
Date/Revisions: Reviewed April 2014, February 2015, April 2016, 2.15.21 Divisional Board 5.16.18	

I. Purpose:


To provide the Medical Staff with guidelines related to consultation requests.

II. Policy:

- A. The attending practitioner is primarily responsible for requesting consultation, when indicated, for a patient whose needs exceed the individual's privileges, and for calling in a qualified consultant. He/she will provide written authorization to permit another attending practitioner to attend or exam his/her patient, except in an emergency. Direct provider to provider verbal communication is required between providers for all consultation requests. The method of consultation can also be requested in a confidential text or via Doc Halo. It is requested that with either method, that an acknowledgement of the request is returned.
- B. Consultation should reflect reason for consultation, pertinent historic information relating to that problem, as well as pertinent findings on examination. This should be included with an opinion and appropriate recommendations to the attending physician. The report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. Except in the case of a documented emergency, when operative procedures are involved, the consultation note shall be recorded prior to operation. **The consultant should see the patient within 24 hours of notification and document his/her findings in a separate note. NOTE: The consultation of a midlevel practitioner does not meet the 24 hour requirement of the provider.** If a Department Chairperson feels that his/her Department Members cannot abide by this requirement, he/she will need to file a formal request to appear before the Medical Executive Committee to request an exemption.
- C. **The provider on call is responsible for the consult. If that provider is not able to care for the patient, it is their responsibility to contact the appropriate designee to provide the consultation within the 24 hour time frame as indicate in Section B, unless otherwise arranged by the requesting physician.**
- D. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his/her area of expertise.
- E. A qualified assistant should be present and scrubbed to assist in any surgical procedure of critical risk to the patient.
- F. If a nurse has any reason to doubt or question the care provided to any patient or feels that appropriate consultation is needed and has not been obtained, he/she will call this to the attention of the attending physician and if it is not resolved, they should refer to the Chain of Command Policy. If warranted, the Director of Nursing Service may bring the matter to the attention of the Chairman of the appropriate Department. Where circumstances justify such action, the Chairman of the Department may request a consultation.
- G. Psychiatric consultation treatment should be requested for and offered to all patients who have attempted suicide or have taken a chemical overdose.

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Exceptions to the 24 hour consultation by a physician include:
 Epidurals and the inpatient pain service consultations.
 Palliative Care – approved by MEC 4-18-16

MEDICAL STAFF IMPAIRED PHYSICIAN POLICY	81010.13
Developed by: Medical Staff Services	Date:
Approved by: Medical Executive Committee	Date: 4-21-14
Scope: Medical Staff Services	
Date/Revisions: Reviewed April 2014, March 2018, March 2021	

I. Purpose

To provide guidance on the process to identify and report possible impairment of a provider.

II. Policy:

Definition of Impaired Physician

The American Medical Association defines the impaired physician 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."


Report and Investigation

If any individual working in the hospital has a reasonable suspicion that a physician or self-referral appointed to the medical staff is impaired, the following steps should be taken:

- A. An oral or, preferably, written report shall be given to the respective Department Chairperson or the President of the medical staff. The report shall include a description of the information or incident(s) that lead to the belief that the physician 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.
- B. If, after discussing the information or incident(s) with the individual who filed the report, the Department Chairperson or President of the medical staff and the Chief Executive Officer believe that there is enough information to warrant an investigation, the Chief Executive Officer shall direct an investigation be instituted and a report thereof be rendered by:
 - 1. The President of the medical staff;
 - 2. The respective department chairperson;
 - 3. An ad hoc committee of the medical staff;
 - 4. An outside consultant; or
 - 5. Another individual or individuals appropriate under the circumstances.

If, after the investigation, it is found that sufficient evidence exists that the physician is impaired, the Chief Executive Officer shall meet personally with that physician or designate another appropriate individual to do so.

- C. The physician should be informed of the conclusion that he/she suffers from an impairment that effects his or her practice and informed of potential report to the National Practitioner Data Bank and/or corrective action.
- D. Depending upon the severity of the problem, and the nature of the impairment, the hospital has the following options:
 - 1. Require the physician to undertake a rehabilitation program as a condition of continued medical staff membership and clinical privileges;
 - 2. Impose appropriate restrictions on the physician's practice;
 - 3. Immediately suspend the physician's privileges in the hospital until rehabilitation has been

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accomplished if a physician does not agree to discontinue practice voluntarily.


- E. The hospital may seek the advice of legal counsel to determine whether any conduct must be reported to law enforcement authorities or other governmental agencies and what further steps must be taken.
- F. The original report and a description of the actions taken by the Chief Executive Officer or medical staff President shall be included in the physician's confidential file. If the investigation reveals that there is no merit to the report, the report should be destroyed. If the investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in the confidential portion of the physician's file and the physician's activities and practice shall be monitored until it can be established that there is or is not an impairment problem.
- G. The Chief Executive Officer or medical staff President shall inform the individual who filed the report that follow-up action was taken.
- H. Throughout this process, all parties should avoid speculation, conclusions, gossip, and any discussions of this matter with anyone not essential to the investigation.
- I. In the event of any apparent or actual conflict between this policy and the medical staff bylaws, rules and regulations, fair hearing plan or other policies of MercyOne Siouxland or its medical staff, including the due process section of the Fair Hearing Plan, the provisions of this policy shall control.

Rehabilitation

- J. Hospital and medical staff leadership should assist the physician in locating a suitable rehabilitation program. A physician shall not be reinstated until it is established, that the physician has successfully completed a program the hospital supports. The physician shall be informed that the alternative to rehabilitation will be disciplinary action.

Reinstatement


- K. Upon sufficient proof that an impaired physician has successfully completed a rehabilitation program, the hospital, in its discretion, may consider the physician for reinstatement to the medical staff, if privileges were suspended.
- L. In considering an impaired physician for reinstatement, MercyOne Siouxland medical staff leadership must consider patient care interests paramount.
- M. The hospital must first obtain a letter from the physician authorizing the rehabilitation program to release the following information:
 1. Whether the physician is participating in the program;
 2. Whether the physician is in compliance with all the terms of the program;
 3. Whether the physician attends AA meetings regularly (if appropriate);

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Information can be released to:

1. The President of the medical staff;
2. The respective department chairperson;
3. An ad hoc committee of the medical staff;
4. An outside consultant; or
5. Another individual or individuals appropriate under the circumstances.

If, after the investigation, it is found that sufficient evidence exists that the physician is impaired, the Chief Executive Officer shall meet personally with that physician or designate another appropriate individual to do so.

SUSPENSION FOR DELINQUENT MEDICAL RECORDS		81010.04
Developed by: Medical Staff Services of MercyOne Siouxland Medical Center		Date: 7.21.08
Approved by: Medical Executive Committee , Divisional Board		Date: 8.20.08
Scope:		
Date/Revisions: MEC 6/2010, July 2012, MS Vote 11.26.12; February 2013, August 2015, November 2016, April 2018, 5.19 3.15.21; 6.21.21 Divisional Board July 2010, September 2012, 5.19.21, 7.21.21		

PURPOSE: To establish a policy and procedure for completion of medical records by all physicians on the medical staff at MercyOne Siouxland Medical Center.

All records requiring documentation, dictation or signature will be analyzed by HIM (Health Information Management) staff on a daily basis. All physicians have a 30-day from discharge window to complete their documentation. Documents that require completion **within 30 days** are:

Consultations

History & Physical

The Discharge Provider is responsible to complete and authenticate the discharge summary within 72 hours. An additional 72 hours will be allowed for sign off by the supervising physician, if applicable.

All Procedure Notes shall be dictated and authenticated within seven (7) -days of procedure.

Per Bylaws 2.4.11, a physical examination and medical history (H&P) must be completed and documented for each Patient no later than twenty-four (24) hours after the Patient is admitted or registered, and in any event before the Patient undergoes surgery or a procedure that requires anesthesia.


- If a complete admission history and physical is not in the medical record within 24 hours a phone call will be made to the admitting/attending physician's office notifying them of the deficiency. A deficiency notice will be placed in the physician's in-box within Cerner PowerChart.
- If three deficiencies are noted in a year's time, the physician will be requested to appear before the MEC to discuss the deficiency.
- After this appearance, if the provider is delinquent with the completion of an H&P within 24 hours, the provider will be placed on an automatic 3-day suspension. If following the 3 day suspension a subsequent offense occurs during the same credentialing cycle, an automatic two-week suspension will be invoked. An additional offense during the same credentialing period, will place the provider on an indefinite suspension until which time the practitioner will be requested to appear before the next Divisional Board meeting of MercyOne Siouxland Medical Center. Due to the time element involved, this final step may require a report

to the NPDB if the suspension is for longer than 30 days.

PROCEDURE:

1. A letter from the Chief Medical Officer or designee will be sent to physicians via email notifying them of any deficiency exceeding 21 days as well as the potential for suspension if records are not completed.
2. Five (5) days prior to the suspension date, the physician is contacted directly by phone or paging system.
3. **If records are not completed, suspension will be enforced at approximately 9:00 am on the day of suspension. Any procedures scheduled and started before that time will be allowed but no further procedures will be allowed after 8:00 am. Suspensions will be lifted during business hours only (7:30a – 4:15 p.m.), if records are completed outside of this timeframe the suspension will not be lifted until 8:00 am the next business day.**
4. At the time of suspension, notification is emailed to the following individuals:
 - a) Senior Leadership Team
 - b) Directors
 - c) Patient Care Managers
 - d) Patient Access, Lead Associate
 - e) Patient Access Nursing Staff
 - f) Ambulatory Surgery Nurse Manager
 - g) PACU Manager
 - h) ER Physicians
 - i) Medical Staff Quality Review Committee Chairman
 - j) Informatics
 - k) Telecommunications Manager
 - l) PBX Operators
5. In those instances where problems are encountered, i.e physician presenting in the O.R. after being suspended or attempting to admit or attend patients, Health Information Management should be contacted immediately at 279-2081.
6. In the event that suspension of a particular physician would pose a potential risk to patient care and safety, the suspension will be lifted for a specified period of time at the discretion of the President of the Medical Staff or the Chief Medical Officer. A notation of such will be placed in the physician's credentialing file and reported to the Quality Committee of the Board.
7. HIM continually monitors the que for dictation. Once records are completed, all of the above named individuals are notified via email that suspension has been lifted.
8. Repeated suspensions will be reviewed individually by the Medical Executive Committee. If MEC so determines, termination of clinical privileges may be invoked and provider will be required to re-apply for hospital membership and privileges and will be processed as a Category 2 appointment.

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ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION (OPPE AND FPPE)		81010.016
Developed by: Medical Staff Services		Date: 7/21/2008
Approved by: Medical Executive Committee 7/21/2008 Credentials Committee 8/14/2008 Quality Committee of the Board 8/20/2008		
Scope:		
Date/Revisions: Medical Executive Committee, 2010, 02/15/16; 4.16.18, February 2021		

I. PURPOSE

To establish a systematic process through the activities of its medical staff, to assess the ongoing professional practice and competence of its medical staff, conduct professional practice evaluations, and use the results of such assessments and evaluations to improve professional competency, practice and care. Relevant information resulting from the ongoing and focused evaluation processes are integrated into performance improvement activities, consistent with MercyOne's policies and procedures that are intended to preserve confidentiality of information.


II. DEFINITIONS

- A. **Focused professional practice evaluation (FPPE)** is a time-limited process that allows the medical staff to evaluate the *privilege-specific competence* of the practitioner who does not have documented evidence of competently performing the requested privilege at MercyOne Siouxland Medical Center. FPPE will occur in all requests for new privileges and when there are concerns regarding the provision of safe, high quality care by a medical staff member (may be identified through Ongoing Professional Performance Evaluations).
- B. **Ongoing professional practice evaluation (OPPE)** is a process that allows the medical staff to identify individual practitioner professional practice trends that may impact quality of care and patient safety on an *ongoing basis*.

III. Implementing Focused Professional Performance Evaluation (FPPE)

- A. Criteria for conducting FPPE may include the following circumstances:
 - a. Privileges are initially granted at the time of initial appointment to the medical staff (new applicant)
 - b. Granting of new privileges between appointments (existing staff member)
 - c. When a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care (*refer to Medical Staff Policy and Procedure Manual, Peer Review policy that defines decisions/triggers to initiate FPPE for cause*)
 - d. When a privilege is used infrequently
- B. Methods for performing FPPE may include one or more of the following:
 - a. Retrospective proctoring - review of a practitioner's care after he/she has delivered the care
 - o May include review of chart or aggregate performance data (i.e., evaluation of clinical practice patterns, outcomes, complications, etc.) for a determined number of cases, i.e., three cases within the core privileges and one case for each special privilege granted.
 - b. Concurrent proctoring – real-time monitoring which involves direct observation by a proctor

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- c. Discussion with other individuals involved in the care of each patient case being reviewed (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel)
- d. External peer review

C. Process Design


- a. Method for establishing a monitoring plan specific to the requested privilege(s):
 - i. The method & duration of FPPE, the volume of cases to be evaluated, and the sampling selection (core privileges and special privileges) shall be determined by the department chair based on the individual practitioner’s circumstances (i.e., new applicant, request for new privilege, unusual or adverse patient outcome or clinical practice patterns) and nature of privilege(s) requested.
 - ii. It may be possible to bundle privileges together and then evaluate a defined number of any mix of the privileges (i.e., any ten from the group will be evaluated to determine competency for the whole bundle of privileges).
 - iii. The duration of FPPE could vary depending on the practitioner’s documented training and experience, i.e.,
 - 1. Practitioners coming directly from an outside residency program
 - 2. Practitioners coming directly from MercyOne's residency program
 - 3. Practitioners coming with a documented record of performance of the privilege and its associated outcomes
 - 4. Practitioners coming with no record of performance of the privilege and its associated outcomes
- b. Practitioners undergoing FPPE are informed of the process and their responsibilities during the FPPE time period.
- c. FPPE Outcome Reports are maintained in the practitioner’s confidential quality review file.
- d. Quality & Medical Staff Services department staff will utilize a database to identify what privileges have been granted to each practitioner, the method of FPPE for each delineated privilege and the receipt of FPPE reports.

D. Methods and Procedures for conducting FPPE (See Attachment A)

E. Timeframe for FPPE

- a. 6-MONTH FPPE EVALUATION
 - i. Approximately six (6) months after a practitioner’s initial appointment (or the granting of new privileges in an existing staff member), the medical staff department chair/designee will review the practitioner-specific competency profile report and the completed FPPE Case Review Forms.

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Developed by: Medical Staff Services	Date: 7/21/2008
Approved by: Medical Executive Committee 7/21/2008 Credentials Committee 8/14/2008 Quality Committee of the Board 8/20/2008	
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- ii. The department chair/designee makes a recommendation in the FPPE Outcome Report (1) section reserved for that purpose. The recommendation will be one of the following:
 - 1. All FPPE requirements successfully met for all privileges requested. Recommend FPPE period be concluded.
 - 2. FPPE requirements met for selected privileges, but some reports for other privileges are still outstanding.
 - a. Recommend that FPPE period be concluded for selected privileges.
 - b. Recommend that FPPE period be extended 6 months (12 months total) for those privileges where data collection is not yet complete (i.e., low volume for specific privilege). At the 12-month review, a decision will be made to either extend the FPPE period or deny privilege due to failure to meet criteria for privilege(s)
 - 3. FPPE reports are inconclusive. Recommend additional FPPE as documented by the department chair.
 - 4. FPPE report(s) received raise questions regarding the performance of the practitioner relative to the privileges requested.
- iii. After the department chair/designee’s evaluation and recommendation, the FPPE Outcome Report, is routed to the Credentials Committee and to the Medical Executive Committee for recommendation and a final decision related to the practitioner’s completion of FPPE. Recommendations of the Credentials and Medical Executive Committees are documented in their respective Committee minutes.

NOTE: Documentation of potentially adverse findings from FPPE performed on any privilege will be immediately escalated for review by the department chair at the time they are received in the interest of patient safety
- iv. If the recommendation of the Medical Executive Committee is adverse (e.g., change in privileges or termination of membership and/or privileges), the organization follows procedures outlined in the Medical Staff Bylaws.


IV. Implementing Ongoing Professional Performance Evaluation (OPPE)

A. Process Design

- i. OPPE is conducted continuously for all members of the medical staff.
- ii. Date may include:
 - 1. Aggregate (quantitative) or trended quality metrics, i.e., surgical site infection rates, complications of care relevant to the specialty or privileges granted, medical records data, clinical activity data, core measures data, reported adverse events/behavior, patient satisfaction data, etc.

¹ FPPE Outcome Report includes all completed FPPE Case Review Forms and the practitioner-specific competency profile report


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2. Qualitative or chart review data.
3. When there are situations in which there is no other way to collect data or assets, then peer recommendations may be used (low or no volume providers).
4. Data must be from the organization except for low volume providers who have available data from other accredited or CMS certified organizations. However, any data obtained must be supplemental and cannot be used in lieu of a process to attempt to capture “local” performance data.
5. Practitioner performance for following six General Competencies:
 - a. Patient Care
 - b. Professionalism
 - c. Practice-Based Learning and Improvement
 - d. Interpersonal & Communication Skills
 - e. System-Based Practice Patient Care
 - f. Medical/Clinical Knowledge, including Continuing Medical Education (CME)
- iii. The type of data to be collected is defined by individual medical staff departments and approved by the Medical Executive Committee or just the MEC if there are no departments.
 1. The data includes analysis of low volume privilege performance by the practitioner (as determined by the Credentials Committee)
 - a. Low volume performance of a privilege is evaluated to determine possible reasons, including:
 - i. The practitioner is no longer performing the privilege
 - ii. The practitioner is performing this privilege at another institution
 - iii. The privilege is a low volume procedure that has yet to be done
- iv. The data is reviewed by the Credentials Committee Chair/designee at least every 8 months.
- v. An OPPE Outcome Report (2) from the Credentials Committee Chair/designee stating that no adverse trends were identified and the practitioner’s performance is within acceptable thresholds is maintained in the practitioner’s confidential quality review file.

2 OPPE Outcome Report attests that the Credentials Committee Chair/designee has reviewed the six General Competencies and appropriate department specific indicators for the practitioner undergoing OPPE


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- B. The Credentials Committee will receive a report of practitioners undergoing OPPE and the evaluation by the Credentials Committee Chair/designee. One of the following recommendations will be made:
- i. No adverse trends were identified during the review period and performance is within acceptable thresholds, or
 - ii. Concerns or adverse trends identified through the OPPE process
 - 1. The Credentials Committee may make a recommendation for more specific evaluation (FPPE) or limitation/suspension of privileges. The Credentials Committee recommendation will be reported to the Medical Executive Committee for their review and recommendation.
- C. Ongoing professional practice evaluation information is used to determine whether to continue, limit, or revoke any existing privilege(s) at the time the information is analyzed. Based on this analysis, several possible actions could occur, including but not limited to:
- i. Revoking the privilege because it is no longer required
 - ii. Suspending the privilege(s)
 - iii. Determining that the zero or low performance (volume) of a procedure should trigger a focused review whenever the practitioner actually performs the privilege
 - iv. Determining that the privilege should be continued because MercyOne’s mission is to be able to provide the privilege to its patients

<p>RELATED FORMS:</p> <ul style="list-style-type: none"> 1. FPPE CASE REVIEW FORM (TO BE COMPLETED BY THE REVIEWER) 2. PRACTITIONER-SPECIFIC COMPETENCY PROFILE REPORT 3. FPPE OUTCOME REPORT 4. OPPE OUTCOME REPORT

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ATTACHMENT A

Methods and Procedures for Conducting Professional Practice Evaluation (FPPE)


Retrospective Proctoring

1. The Quality Services nurse reviewer (unless directed otherwise by the medical staff department chair) will perform a review qualitative and quantitative analysis along with evaluation of the selected cases and document findings on the FPPE Case Review Form. Any review with potentially adverse findings is immediately forwarded to the department chair (if the department chair was not the reviewer) by the quality services staff to determine if immediate action is needed.
2. The Quality Services department will forward the completed FPPE Case Review Forms, along with the practitioner-specific competency profile report to the medical staff department chair/designee for their review.
3. If the department chair recommends that the period of FPPE can conclude, he/she will sign the FPPE Outcome Report. This Report will be forwarded to the Credentials Committee and the MEC for their review and recommendation regarding conclusion of the FPPE time period.
4. If the medical staff department chair/designee evaluation on the FPPE Case Review Form indicates a Category 3 or Category 4 rating on a case review, the Peer Review process as identified in the Peer Review Policy will be implemented.

Concurrent Proctoring

1. If concurrent proctoring is recommended, the department chair assigns the proctor(s) and is responsible for notifying the medical staff office of the name(s) of the proctor(s).
2. The practitioner undergoing FPPE is notified of the name(s) of the assigned proctor(s) when they are sent the letter notifying them of privileges granted.
3. The medical staff office notifies the proctor(s) that their assistance is needed to complete FPPE and forwards instructions as well as a FPPE Case Review Forms for completion.
4. It is the responsibility of the practitioner undergoing FPPE to ensure that FPPE requirements are fulfilled. If the practitioner is unable to communicate successfully with the assigned proctor(s), the practitioner should notify the department chair/designee. The practitioner undergoing concurrent proctoring is responsible for the following:
 - Notifying the assigned proctor(s) of all admissions at the time of or prior to an admission, until informed otherwise by the medical staff office that the FPPE requirement has been lifted.
 - Notifying the assigned proctor(s) of any procedures that require concurrent observation in order that the proctor may concurrently observe the procedure(s) prior to the procedure and coordinating scheduling with the proctor.
5. Proctors will document their opinions regarding the performance of a case/procedure by utilizing

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the FPPE Case Review Forms. The completed forms shall be forwarded to the Quality Services department.

6. Any form with potentially adverse findings is immediately forwarded to the department chair by the Quality Services department to determine if immediate action is needed.
7. If no adverse findings are identified, the Quality Services department will present all the completed FPPE review forms and the practitioner-specific competency profile report to the department chair for review. If the department chair recommends that the period of FPPE can conclude, he/she will sign the FPPE Outcome Report. This Report will be forwarded to the Credentials Committee and the MEC for their review and recommendation regarding conclusion of the FPPE time period.
8. If the medical staff department chair/designee evaluation on the FPPE Case Review Form indicates a Category 3 or Category 4 rating,³ the Peer Review process as identified in the Peer Review Policy will be implemented.


Use of Other Individuals Involved in the Care of the Patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel)

1. Quality services staff pulls the medical record and identifies the name of a consulting physician, assistant at surgery, and nursing or administrative person.
2. Quality services staff contacts the prospective reviewer(s) and requests completion of an FPPE Case Review Form, which is forwarded to the prospective reviewer(s).
3. The prospective reviewer completes the review and documents the outcome on the FPPE Review Form and forwards it to the Quality Services department.
4. Any form with potentially adverse comments is immediately forwarded to the department chair by the Quality Services department to determine if immediate action is needed.
5. If no adverse findings are identified, the Quality Services department will present all the completed FPPE Case Review Forms and the practitioner-specific competency profile report to the department chair for review. If the department chair recommends that the period of FPPE can conclude, he/she will sign the FPPE Outcome Report. This Report will be forwarded to the Credentials Committee and the MEC for their review and recommendation regarding conclusion of the FPPE time period.
6. If the medical staff department chair/designee evaluation on the FPPE Case Review Form indicates a Category 3 or Category 4 rating, the Peer Review process as identified in the Peer Review Policy will be implemented.

³ Category 3 – Marginal deviation from the standard of care (events reflect care this is minimally outside the contemporary standards of the specialty or expected standards of the department)


Category 4 – Significant deviation from the standard of care (most physicians would have managed the patient care process differently)

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Date/Revisions: Medical Executive Committee, 2010, 02/15/16; 4.16.18, February 2021		

External Peer Review (*refer to Medical Staff Policies and Procedures, Peer Review*)

1. The Quality Committee of the Medical Staff can recommend the use of an external peer reviewer. This is primarily done when there is concern that the expertise is not available within the hospital or there are concerns for conflict of interest.
2. The Medical Executive Committee may have input into the selection and the role of the external reviewer.

PATIENT ADMISSION/DISCHARGE/TRANSFER/HAND OFF POLICY	81010.03
Developed by: Medical Staff, Utilization Review	Date: 3/2008
Approved by: Medical Executive Committee	Date:
Scope:	
Date/Revisions: MEC 9-17-12; 4.16.18, 5.17.21 Divisional Board September 2012	

Patient Admission/Discharge/Transfer/Hand Off Policy

- A. The hospital shall admit patients suffering from all types of diseases, care of inpatients, emergency care patients and hospital-sponsored ambulatory care patients to be attended only by members of the medical staff with clinical privileges at MercyOne Siouxland Medical Center, except for emergency privileges as provided for in the Credentialing and Privileging Manual.
- B. Each patient shall be the responsibility of a medical staff member. Such practitioners shall be responsible for the medical care and treatment, for the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the conditions of the patient to the referring practitioner and to relatives of the patient.
- C. Hand Off Communication: The purpose of hand off communication is to provide continuity of care and patient safety. Medical staff members shall provide accurate information about a patient's care, treatment, and services, current condition and any recent or anticipated changes during the time the care of the patient is being transitioned from one provider to another. This includes but is not limited to physicians transferring complete responsibility for a patient, physicians transferring on-call responsibility, and physicians handing off care from the emergency room department to the in-patient units.

Hand off communication shall be interactive and include the opportunity for the receiving physician to ask questions.
- D. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis has been documented. In case of emergency, the provisional diagnosis shall be documented as soon after admission as possible.
- E. In the case of an emergency admission, patients who do not have a private practitioner may request any known practitioner in the department or service to which he needs to be admitted.


- F. Each member of the medical staff shall name a member of the medical staff, who is a resident of the city, as an alternate who may be called to attend the patient during an emergency or when the original physician cannot be reached. In case of failure to name such associate, the administrator of the hospital, president of the medical staff, or chairman of the department concerned, shall have authority to call any member of the active staff to attend a patient.
- G. No patients will be transferred without such transfer being approved by the attending physician.
- H. Patient transfer to or from an exempt unit must have a newly updated History and Physical with a summary of the hospital course.
- I. The admitting medical staff member should document any known information which may assist staff in protecting the patient from self harm and the protection of others.
- J. When an adequate number of beds are not available in the Intensive Care or Cardiac Care Units, admission/transfer decisions must be made in compliance with the Guidelines for Placement of Patients When Specialty Bed Availability Exceeds or is Near Capacity Policy #8339614.
- K. The attending practitioner must document the need for admission and for continued hospitalization after specific periods of stay as identified by the Utilization Review Committee of this hospital. This statement must contain:
- An adequate written record of the reason for admission or continued hospitalization past 60 days. A simple reconfirmation of the patient's diagnosis is not sufficient.
 - An acknowledgement that the physician shall comply with department guidelines for providing rotational call for unassigned patients.
 - Upon appropriate request, each member of the medical staff is required to document to the QRC Committee the necessity for admission and for continued hospitalization for any patient hospitalized. This statement must be documented within 24 hours of receipt of notice. Failure to comply with this policy will be brought to the Executive Committee for resolution.

All patients admitted to the hospital shall be seen on a daily basis by the attending physician or his/her qualified designee and the Operating Surgeon or his/her qualified designee. Daily visits will be documented in the form of a Progress Note in the patient's medical record. Exceptions to this rule include:

- Required visits three times weekly for Rehab patients.
- It is recommended that patients/residents be seen at least weekly in the Skilled Care Unit
- The Operating Surgeon signs off the case

- An Emergency Room physician who provides admission documentation for patient shall not have attending responsibility for patient who is admitted.
- L. Patients shall be discharged only on a written order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record, using the AMA form.
- M. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. Policies with respect to release of dead bodies shall conform to state law.
- N. It shall be the duty of all staff members to secure autopsies, whenever appropriate. An autopsy may be performed only with written consent, signed in accordance with state law (ICA Section 144.56). All autopsies shall be performed by the hospital pathologist, or by a practitioner delegated this responsibility. Post mortem findings shall become a part of the record of such a case in the hospital.
- O. Ancillary support services provided by MercyOne Siouxland Medical Center to patients referred for such services by clinicians not on the medical staff of MercyOne Siouxland Medical Center will be reviewed and requested by the Physician Director of the Department in which services are being requested.

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PROFESSIONAL BEHAVIOR POLICY		81010.009
Developed by: Medical Staff Office		Date
Approved by: Medical Executive Committee		Date:
Scope:		
Date/Revisions: February 2014, September 2016, 5.21.18, 5.19.21		

All MercyOne Medical Staff members (active, courtesy, etc.) are included for the purpose of this policy.

It is the policy of MercyOne Siouxland Medical Center, that all individuals within its facilities be treated with courtesy, respect, and dignity. Physicians and independent practitioners are expected to conduct themselves in a professional and cooperative manner while at MercyOne Siouxland.

Disruptive behavior is defined as any conduct or behavior which:

- disrupts the operation of the hospital
- constitutes the physical, written, or verbal abuse of others involved with providing patient care
- interferes with an individual's ability to practice competently
- adversely affects or impacts the community's confidence in the hospital's ability to provide quality patient care

Some of the common behaviors that are considered disruptive include the following:

Inappropriate anger or resentments

- disrespectful, demeaning, humiliating
- intimidation
- abusive/profane language
- blames or shames other physicians/staff for possible adverse outcomes
- unnecessary sarcasm or cynicism
- threats of violence, retribution, or litigation

Inappropriate words or actions directed toward another person

- sexual comments or innuendoes
- sexual harassment
- seductive, aggressive, or assaultive behavior
- racial, ethnic, gender, or socioeconomic slurs
- lack of regard for personal comfort and dignity of others
- exhibiting mood or behavior problems, swings
- non-verbal behavior (glaring, violation of personal space)
- behavior excesses and deficits (not speaking)
- inappropriate comments and or illustrations in patient medical records

Inappropriate response to patient needs or staff requests

- late or unsuitable replies to pages or calls
- unprofessional demeanor or conduct
- uncooperative, defiant approach to problems
- putting staff, others at risk

Note: Any behavior that falls into the sexual harassment area is addressed separately in the medical staff policies and procedures.

Disruptive behavior occurs in varying degrees. Any corrective action will be commensurate with the nature and severity of the disruptive behavior. Repeated instances of disruptive behavior will be considered cumulatively and action taken accordingly.

Disruptive behavior by members of the medical staff, or refusal of members to cooperate with the procedures described in this Policy, may result in corrective action, which shall be carried out according to the medical staff bylaws.

The medical staff shall promote continuing awareness of this Policy among the medical staff and the hospital community, including the following efforts:

- sponsoring or supporting education programs on disruptive behavior to be offered to medical staff members and hospital employees
- disseminating this Policy to all current members upon the adoption of the Policy and to all new members of the medical staff upon joining the staff
- requiring members of the Medical Executive Committee to assist a member of the medical staff exhibiting disruptive behavior to obtain education, behavior modification, or other treatment to prevent further violations

Procedure:

Complaints about a member of the medical staff regarding alleged disruptive behavior must be in writing and/or submitted through the appropriate reporting system (currently VOICE). This will ensure confidentiality for all parties involved. Documentation shall include the following:

- date and time of the alleged behavior
- who the behavior affected
- circumstances that precipitated the situation
- description of the alleged behavior that is limited to facts only
- consequences, if any, of the alleged behavior as it relates to patient care or hospital operations
- a record of action taken to remedy the situation, including the date, time, place, action, and names of those intervening

Action Taken:

- The report will be initially reviewed by the Chief Medical Officer (CMO)
- The CMO will make an initial determination of authenticity and severity
- The affected Medical Director and President of the Medical Staff will be contacted
- The President of the Medical Staff will next review the complaint with the CMO within 5 working days of submission
- The alleged physician member involved shall be contacted regarding the complaint
- If no corrective action is taken but report is found to be significant a confidential memorandum summarizing the disposition of the complaint shall be retained in the physician member's quality file for one year, and then expunged, if no related action is taken or pending. The alleged physician will be notified of this action
- After investigating, the findings will be reported to the MEC at their next scheduled meeting for action

The Medical Executive Committee may utilize any of the following options, depending on severity of the complaint:

- determine that no action is warranted
- issue a warning or reprimand
- require a written apology to the complainant
- refer member to the MEC for help
- initiate corrective action pursuant to the medical staff bylaws