



**VIRTUA MEDICAL STAFF
POLICY ON APPOINTMENT, REAPPOINTMENT
AND CLINICAL PRIVILEGES**

Approved by the Virtua Board of Trustees on: October 20, 2009
(Date)

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ARTICLE I
DEFINITIONS

The following definitions shall apply to the terms used in this Policy:

1. "Applicant" shall mean a physician, dentist or podiatrist who is seeking appointment, reappointment or clinical privileges to the Medical Staff.
2. "Board of Trustees" or "Virtua Board" shall mean the governing body of the Hospitals.
3. "Bylaws" shall mean the Medical Staff Bylaws and its addendums: Policy on Appointment, Reappointment and Clinical Privileges, Medical Staff Organization Manual and Rules and Regulations.
4. "Chief Medical Officer" or "CMO" shall mean the individual appointed by Virtua as chief medical administrative officer of a Hospital, after consultation with the Officers of the applicable Division(s) as set forth in Article VIII of the Bylaws.
5. "Chief Operating Officer" or "COO" or, collectively, "COOs" shall mean the individual(s) appointed to act on behalf of the overall Virtua administration for hospital management.
6. "Day" shall mean calendar days unless otherwise specified.
7. "Dentist" shall mean any person holding a license to practice dentistry in the State of New Jersey.
8. "Evaluator" shall mean any person who serves as a written reference for an applicant or reapplicant.
9. "Hospital" or collectively "Hospitals" shall mean the acute care facilities operated by Virtua Health System, namely Virtua - Memorial Hospital Burlington County and Virtua - West Jersey Health System.
10. "Mail" shall mean mail sent by electronic communication, which includes, but is not limited to facsimile or e-mail, or by U.S. Postal Service. If sent by electronic communication, the notice shall be deemed delivered when sent to the facsimile number or e-mail address that has been provided to the Hospital as part of the recipient's address of record. If sent by U.S. Postal Service, the notice shall be deemed to be delivered when deposited, postage prepaid, in the U.S. mail addressed to the Member's address of record.
11. "Medical Director" is the individual appointed by Virtua as the physician responsible for a specific hospital.
12. "Medical Director of Medical Affairs" or "MDMA" means the physician who serves as administrative director of Medical Affairs.

13. "Medical Executive Committee" or "Executive Committee" shall mean the Executive Committee of each Division of the Medical Staff.
14. "Medical Staff" shall mean the organization established by its Members, who shall include physicians, dentists and podiatrists, practicing at one or both of the Hospitals.
15. "Member" shall mean those physicians, dentists and podiatrists who have been granted Medical Staff appointment by the Virtua Board to practice at one or both of the Hospitals.
16. "Performance Improvement" or "PI" activities means structured, long-term processes by which a physician or group of physicians can learn about specific performance measures, retrospectively assess their practice, apply performance measures prospectively over a useful interval, and reevaluate their performance.
17. "Physician" shall mean a person licensed to practice medicine and surgery in the State of New Jersey.
18. "Podiatrist" shall mean a person licensed to practice podiatric medicine and surgery in the State of New Jersey.
19. "Policy" means the Policy on Appointment, Reappointment and Clinical Privileges.
20. "President" shall mean the individual elected by each Division of the Medical Staff as the Chief Executive Officer of the Medical Staff as provided for in the Bylaws.
21. "Privilege" means the scope of professional activities granted to a Member by the Board of Trustees.
22. "Proctoring" is an objective evaluation of a member's clinical competence including technical and cognitive skills, as requested by the Medical Executive Committee and/or the appropriate Department Chairperson. Proctoring can be performed on a prospective, concurrent or retrospective basis. A proctor does not directly participate in patient care, has no physician-patient relationship with the patient being treated, and does not receive a fee from the patient. However, a proctor can intervene in the delivery of care when necessary or appropriate to further quality safe care.
23. "Special Notice" means by hand delivery, certified mail, return receipt requested or overnight delivery service providing a receipt. Special Notice shall be required for the most important communications between the Hospital and staff Member, including such circumstances as notice of attendance at a required meeting, notice of change in appointment or privilege status, and notice of any adverse recommendation that triggers a right to a hearing or appeal. Special Notice will

be considered received if the Hospital has sent it three times to the correct address and has been refused.

24. "Virtua" shall mean Virtua Health, Inc.

Words used in this Policy shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only, and are not intended to limit or define the scope or effect of any provision of this Policy.

ARTICLE II
APPOINTMENT TO THE MEDICAL STAFF AND THE GRANTING OF CLINICAL PRIVILEGES

2.1 CONDITIONS AND RESPONSIBILITIES FOR APPLICANTS AND APPOINTEES

2.1.1 Basic Responsibilities:

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every applicant and appointee specifically agree to the following:

- (1) to provide appropriately continuous care and supervision to all patients in the hospital for whom the individual has responsibility;
- (2) to work cooperatively with members, medical associates, medical assistants, nurses and other hospital personnel so as not to affect patient care adversely;
- (3) to accept committee assignments and such other reasonable duties and responsibilities, including professional review activities, quality assessment activities, service calls, and patient care rotations, as shall be assigned;
- (4) to participate in the monitoring and evaluation activities of clinical departments;
- (5) as it relates to the individuals request for, or grant of, clinical privileges, to use the Hospitals and facilities sufficient to allow the medical staff and Virtua Board, through assessment by appropriate medical staff committees and Department Chairpersons, to evaluate in a continuing manner the current competence of the individual;
- (6) to seek consultation whenever necessary;
- (7) to complete in a timely manner the medical and other required records for all patients, as required by the bylaws and its addendums;

- (8) to participate in continuing education programs and provide attestation in accordance with State licensing requirements;
- (9) to abide by the Virtua Physician Code of Conduct and generally recognized professional and ethical principles applicable to the applicant's profession;
- (10) to abide by all bylaws, bylaws addendums, policies, and rules and regulations of the Medical Staff and the Hospital, as they exist from time to time during the term of appointment;
- (11) to pay promptly any applicable medical staff dues;
- (12) to notify promptly the CMO on the next business day of the following events, whether voluntary or involuntary: revocation or suspension of professional license; imposition of terms of probation or limitation of practice by any licensing agency of any state or jurisdiction; termination or expiration of staff membership, curtailment or restriction of privileges at any hospital or health care institution; cancellation or restriction of professional liability insurance coverage or DEA number; adverse determination by a peer review organization; change in eligibility for payments by third-party payors or for participation in Medicare on a reimbursable basis, including any notification of sanctions imposed or recommended by the Federal Department of Health and Human Services, the PRO, or any state program; commencement of formal investigation or filing of charges by any law enforcement agency or regulatory body of the United States or any state. Failure to provide notice as set forth above may result in automatic relinquishment from the Medical Staff;
- (13) to notify the CMO, within seven (7) calendar days of a plea of guilty or nolo contendere or conviction in any jurisdiction of a criminal offense; a disorderly persons charge; a driving while intoxicated (drugs or alcohol) charge; or, reckless driving or careless driving where drugs or alcohol were involved. The individual must indicate the date of the plea or conviction; the name and address of the court where the charge handled; the docket number; the nature of the charge; the sentence or penalty imposed; and acceptance into or participation in any pre trial diversionary program that resulted in any of the foregoing charges being dismissed. If so, the individual must indicate the date and place of the pre trial diversionary program; the nature of the charge; the docket number; and, provide a copy of the final discharge; service of any and all malpractice liability or other professional liability suits. Such notice also shall include a consent to release information from the appropriate government agency or body, or the Applicant's or Member's present and past malpractice

insurance carriers. Failure to provide notice as set forth above may result in automatic relinquishment from the Medical Staff;

- (14) to appear, if requested, for personal interviews with regard to the application;
- (15) to provide to the CMO new or updated information (including but not limited to, new malpractice claims filed, investigations initiated regarding any license, DEA, CDS, clinical privileges at another institution, certification, or any other matter potentially affecting credentials or privileges), within thirty days;
- (16) that any misrepresentation or misstatement in, or omission from the application, whether intentional or not, shall constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and clinical privileges. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatements or omission, such discovery may result in automatic relinquishment from the medical staff;
- (17) to authorize the release of all information necessary for evaluation of the individual's qualifications for initial or continued appointment, reappointment, and/or clinical privileges; and
- (18) that the hearing and appeal procedures set forth in the bylaws shall be the sole and exclusive remedy with respect to any professional review action taken in the Hospital.

2.1.2 **Applicant's Burden:**

- (1) The applicant shall have the burden of producing information deemed adequate by the Virtua Board for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.
- (2) The Applicant shall have the burden of establishing qualifications for and competence to exercise the clinical privileges requested.
- (3) The applicant shall have the burden of providing evidence that all the statements made and information given on the application are true and correct.
- (4) Until the applicant has provided all information requested by the Virtua Board, the application for appointment will be deemed incomplete and will not be processed. If the requested information is not received within fifteen (15) days of notification of the applicant, the application will be deemed voluntarily withdrawn and the applicant will be so notified. Should information provided in the initial application form change during the course of the

appointment term, the appointee has the burden to provide information about such change to the Credentials Committee sufficient for the Credentials Committee's review and assessment.

2.1.3 No Entitlement to Appointment or Clinical Privileges:

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that such individual:

- (1) is licensed to practice a profession in this or any other state;
- (2) is a member of any particular professional organization;
- (3) has had in the past, or currently has, medical staff appointment or privileges at any hospital; or
- (4) resides in the geographic service area of the Hospital.

2.1.4 Non-Discrimination Policy:

No individual shall be denied appointment to the medical staff or the exercise of clinical privileges on the basis of age, race, color, sex, creed, religion, national origin, disability or handicap, sexual orientation, marital status, or veteran status.

2.2 QUALIFICATIONS FOR APPOINTMENT AND CLINICAL PRIVILEGES

2.2.1 Qualifications for Appointment:

2.2.1.1 General:

Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in this policy and in such policies as an adopted from time to time by the Virtua Board. All individuals practicing medicine, dentistry, and podiatry in any facility in the Hospitals, unless excepted by specific provisions of this policy, must first have been appointed to the medical staff and continue as a member in good standing, as determined by the Executive Committee(s).

2.2.1.2 Specific Qualifications:

Only physicians, dentists, and podiatrists who satisfy the requirements set forth in Article IV of the Bylaws shall be eligible for appointment and reappointment to the medical staff.

2.2.1.3 Factors for Evaluation:

Only those individuals who can document that they are highly qualified in all regards will be appointed to the Medical Staff. The following factors will be evaluated as part of the appointment and reappointment processes:

- (a) relevant training, experience, demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;
- (c) good reputation and character;
- (d) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families and other members of health care teams;
- (e) ability to perform safely and competently the clinical privileges requested; and
- (f) recognition of the importance of, and willingness to support, the Hospital's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.2.2 Qualifications for Clinical Privileges:

2.2.2.1 General:

- (a) Neither medical staff appointment nor reappointment shall confer any clinical privileges or right to practice in the Hospital. Each individual who has been appointed to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Virtua Board.
- (b) The grant of clinical privileges shall carry with it acceptance of the obligations of such privileges, including unassigned emergency service and other rotational obligations established to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act or other applicable requirements or standards.
- (c) Applicants for Active and Associate Privileges must hold the following:
 - (i) a license to practice in the State of New Jersey;

- (ii) malpractice insurance to the extent required by the Virtua Board; and
- (iii) the applicant must be able to respond within the time interval as defined by the Department Rules and Regulations.

2.2.2.2 Factors for Evaluation:

The clinical privileges recommended to the Virtua Board shall be based upon consideration of the following:

- (a) education, relevant training, experience, demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families and other members of the health care team and peer evaluations relating to the same;
- (b) the applicant's ability to meet all current criteria for the requested clinical privileges;
- (c) potential utilization patterns;
- (d) the applicant's location within the geographic service area, as defined by the Virtua Board, so as to provide timely care for his or her patients;
- (e) availability of qualified physicians or other appropriate appointees to provide medical coverage for the applicant in case of the applicant's illness or unavailability;
- (f) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;
- (g) adequate levels of professional liability insurance coverage with respect to the clinical privileges requested;
- (h) the Hospital's available resources and personnel;
- (i) the applicant's current licensure status in the State of New Jersey and any previously successful or currently pending challenges to any licensure or registration, or the voluntary relinquishment of such licensure or registration;

- (j) whether the applicant meets the board certification requirements, as defined in Section 4.7 of the Medical Staff Bylaws;
- (k) any information concerning professional review actions, the voluntary or involuntary termination of medical staff appointment, or the voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and
- (l) other relevant information, including the written report and findings by the Chairperson of each of the clinical departments in which such privileges are requested.

2.2.2.3 Dentists:

- (a) The scope and extent of surgical procedures that a dentist may perform in the Hospitals shall be delineated and recommended in the same manner as other clinical privileges.
- (b) The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. A medical history and physical examination of each patient shall be performed by a physician who is a Medical Staff member before dental surgery shall be performed. A designated physician shall be responsible for the medical care of the patient throughout any period of hospitalization.

Dentists may write orders within the scope of their license and consistent with the Medical Staff rules and regulations, and in compliance with the Medical Staff bylaws and this Policy.

2.2.2.4 Podiatrists:

- (a) The scope and extent of surgical procedures that a podiatrist may perform in the Hospitals shall be delineated and recommended in the same manner as other clinical privileges.
- (b) Surgical procedures performed by podiatrists shall be under the overall supervision of the appropriate Department Chairperson. In accordance with the state of New Jersey regulations, a medical history and physical examination shall be performed by a physician who is a medical staff member for all patients ASA 2 and above. A designated physician shall be responsible for the medical care of the patient throughout any period of hospitalization.

- (c) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license, consistent with the Medical Staff rules and regulations, and in compliance with the Medical Staff Bylaws and this Policy.

2.2.2.5 Telemedicine Privileges:

- (a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board will determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate Department Chairperson, the Credentials Committee, and the Executive Committee.
- (b) Only individuals who are working through a corporate entity that is contracted by Virtua may apply for clinical privileges. Individuals who are applying for telemedicine privileges shall meet the qualifications for Medical Staff appointment outlined in this Policy, except for those requirements relating to geographic residency, coverage arrangements and emergency call responsibilities. These individuals will not be eligible for appointment to the Medical Staff.
- (c) Qualified applicants may be granted telemedicine privileges but shall not be appointed to the Medical Staff. Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.
- (d) Applications for telemedicine privileges shall be processed in accordance with the provisions of this Policy in the same manner as for any other applicant, except that the Hospital may utilize the credentialing information provided by the applicant's primary hospital/group, provided that hospital/group is accredited by the Joint Commission.
- (e) Telemedicine privileges, if granted, shall be for a period of not more than two years. Individuals seeking to renew telemedicine privileges shall be required to complete an application and, upon request, provide the Hospital with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the applicant's primary practice affiliation and evaluation form(s) from qualified supervisor(s). If all requested information is not received by dates established by the Hospital, the individual's telemedicine privileges will expire at the end of the current term. Once all information is received and verified, an

application to renew telemedicine privileges shall be processed as set forth above.

- (f) Individuals granted telemedicine privileges will be subject to the Hospital's performance improvement, ongoing and focused professional practice evaluations and peer review activities.

2.2.2.6 Interns, Residents, and Fellows:

Interns, residents, and fellows in training in the Hospital shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Executive Committee or its designee. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

2.2.2.7 Prescribing Privileges:

Each practitioner granted privileges in the Hospital shall be permitted to prescribe and/or order medications in accordance in the specifications of each practitioner's respective Federal and/or State registration. Evidence of current registration shall be maintained with the individual's credentials files.

2.2.2.8 Clinical Privileges for New Procedures:

- (a) Requests for clinical privileges to perform either a significant procedure not currently being performed at the Hospital or a significant new technique to perform an existing procedure ("new procedure") will not be processed until (1) a determination has been made that the procedure will be offered by the Hospital and (2) criteria to be eligible to request those clinical privileges have been established.
- (b) The Credentials Committee and the Executive Committee will make a preliminary recommendation as to whether the new procedure should be offered to the community. Factors to be considered by the Credentials Committee and the Executive Committee include, but are not limited to, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is being performed at other similar hospitals and the experiences of those institutions, and whether the Hospital has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

- (c) If it is recommended that the new procedure be offered, the Credentials Committee will conduct research and consult with experts, including those on the Medical Staff and those outside the Hospital, and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Credentials Committee will forward its recommendations to the Executive Committee, which will review the matter and forward its recommendations to the Board for final action.
- (d) If a new procedure would require the approval of the Institutional Review Board of Virtua, it shall be approved by the Institutional Review Board prior to the development of any privileging and monitoring criteria as specified above.

2.3 PROCEDURE FOR APPOINTMENT AND CLINICAL PRIVILEGES

2.3.1 Submission of Application:

- (1) It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed and will not be forwarded to the Virtua Board for action.
- (2) The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications including:
 - (a) the names and complete addresses of at least two physicians, dentists, podiatrists, or other practitioners, as appropriate, who have had recent extensive experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant's present professional competence and character. These references may not be individuals associated or about to be associated with the applicant in professional practice or personally related to the applicant. At least one reference shall be from the same specialty area as the applicant;
 - (b) the names and complete addresses of the Department Chairpersons of any and all hospitals other institutions at which the applicant has worked or trained (i.e., the

individuals who served as chairpersons at the time the applicant worked in the particular department);

- (c) a complete chronological listing of the applicant's professional and education appointments, employment, and positions;
- (d) information as to whether the applicant's medical staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary conditions, reduced, or not renewed at any other hospital or health care facility;
- (e) information as to whether the applicant has ever voluntarily or involuntarily withdrawn his or her application for appointment, reappointment, or clinical privileges, or resigned from any medical staff before final decision by the Hospital's Board;
- (f) information as to whether the applicant's membership in any local, state, or national professional society, is or has ever been voluntarily or involuntarily suspended, modified, terminated, restricted, or is currently being challenged;
- (g) information as to whether the applicant's license to practice any profession in any state, Drug Enforcement Administration license, or CDS is or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being challenged. The submitted application shall include a list and copy of all the applicant's current licenses to practice, Drug Enforcement Administration license, CDS, as well as copies of medical, dental, or podiatric school diploma, and certificates from all postgraduate training programs completed;
- (h) information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company and the amount and classification of such coverage, and whether this insurance covers the clinical privileges the applicant seeks to exercise;
- (i) information concerning the applicant's professional liability litigation experience, including: (1) information concerning any final judgments or settlements; (2) the substance of the allegations; (3) the findings; (4) the ultimate disposition; and (5) any additional information concerning such

proceedings or actions as the Credentials Committee may deem appropriate;

- (j) information as to whether the applicant's professional liability insurance coverage has ever been restricted or terminated by action of the insurance company;
- (k) information concerning any professional misconduct proceedings and any malpractice actions involving the applicant in this state or any other state, which may be closed or still pending;
- (l) information concerning the suspension or termination for any period of time of the right or privilege to participate in Medicare, Medicaid, or any other government sponsored program or any private or public medical insurance program, and whether the applicant is currently under investigation for such;
- (m) a signed consent to the release of information from the applicant's present and past professional liability insurance carriers;
- (n) information detailing any professional misconduct proceedings and any malpractice actions involving the applicant in this state or any other state, which may be closed or still pending;
- (o) information regarding the applicant's physical and mental health;
- (p) information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime with details about any such instance;
- (q) information on the citizenship and/or visa status of the applicant;
- (r) an attestation by which the Applicant agrees that when an adverse ruling is made with respect to his or her medical staff membership status or clinical privileges the Applicant shall exhaust the administrative remedies afforded by the Bylaws before resorting to formal legal action;
- (s) a certification by the applicant that all of the information submitted on the application is complete and accurate to the best of the Applicant's knowledge and that if such information is subsequently found to be incomplete or

false, it may constitute grounds for rejection of the application, with no right to a Due Process Hearing;

- (t) a statement that the applicant has received and read the Bylaws, this Policy, and the Rules and Regulations of the Medical Staff and that the applicant agrees to be bound by the provisions of those documents;
 - (u) the applicant's signature; and
 - (v) such other information as the Virtua Board may require.
- (3) The history of malpractice verdicts and the settlement of malpractice claims, as well as pending malpractice claims, will be evaluated as a criterion for appointment, reappointment, and the granting of particular clinical privileges. The mere presence of verdicts, settlements, or claims will not, in and of itself, be sufficient to deny appointment or particular clinical privileges. What will be evaluated is the extent to which verdicts, settlements or claims evidence a pattern of care that raises questions of clinical competence. In addition, any single incident that gives rise to a claim or settlement or verdict may be examined: (1) to determine if it requires an evaluation of all the similar precedents or incidents; or (2) whether, in and of itself, it represents such a deviation from good practice as to raise overall questions of clinical competence, skill in the particular clinical privilege, or general behavior in giving care.
- (4) The application for appointment and clinical privileges shall be submitted by the applicant to the Medical Affairs Office. The application must be accompanied by payment of the non-refundable processing fee.
- (5) An application form shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified.
- (6) The MDMA or his designee will contact an evaluator by phone for the purpose of obtaining additional information whenever an evaluator declines to complete a written evaluation or whenever a written evaluation indicates a "fair" or "poor" performance, "actions taken," or problems with "conduct and health status." The MDMA or his designee will make a contemporaneous detailed written summary of the conversation with the evaluator.
- (7) After reviewing the application to determine that all questions have been answered, after reviewing all references and other information or materials deemed pertinent, and after verifying the

information provided in the application with the primary sources, the MDMA shall transmit the complete application and all supporting materials to the appropriate Department Chairperson(s)/Section Chief(s). This review and the subsequent interview(s) by appropriate Department and Sectional Chiefs, as described in Section 2.3.2, shall be completed within 60 days of receipt in the Medical Affairs Office of a completed application.

- (8) The completed application, including the review and interview(s) by Department and Section, shall be forwarded to the Credentials Committee, and subsequently to the Medical Executive Committee and thence to the Virtua Board. If all recommendations are favorable, this process shall take no longer than 60 days.
- (9) If additional information is required from the applicant by the Credentials Committee, MEC, or Virtua Board, the applicant shall supply that information within 30 days. Failure to supply required additional information will render the application incomplete. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required shall be deemed to be voluntarily withdrawn. Under extraordinary circumstances, the MDMA may permit and document exceptions.

2.3.2 Department Chairperson/Section Chief Procedure:

- (1) When applicable, the Section Chief will complete the same review process as that of the review process that will be subsequently followed by the Department Chairperson.
- (2) The chairperson of each department in which the applicant seeks clinical privileges shall evaluate the applicant's education, training, and experience to ensure that the applicant fulfills the established standards for membership and clinical privileges. Such evaluation shall include inquiries directed to the applicant's past or current Department Chairperson(s), Section Chiefs, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.
- (3) As part of the process of performing this evaluation, the Department Chairperson(s) shall have the right to meet with the applicant to discuss any aspect of the application, qualifications, and requested clinical privileges. All privilege requests for clinical privileges will be considered preliminary until the applicant has had the opportunity to meet with Department Chairperson or his designee, who may be the section chief. At this interview, the Applicant will be apprised of appropriate criteria for granting specific privileges. The Applicant will then submit a formal

privilege request which shall be considered the official request for clinical privileges.

- (4) If an applicant requests to practice at both North and South Divisions and the recommendations differ among the interviewing Department Chairpersons or Section Chiefs, the MDMA will meet with the Department Chairpersons/Section Chiefs in order to discuss the differences in recommendations and reach a consensus. Recommendations on the applicant will then move to the Credentials Committee for review.
- (5) The Department Chairperson(s) shall provide the Credentials Committee with a written report concerning the applicant's qualifications for appointment and requested clinical privileges. Such report(s) shall be appended to the Credentials Committee's report.
- (6) The Department Chairperson(s) shall be available to the Credentials Committee to answer any questions that may be raised with respect to that Chairperson's report and findings.

2.3.3 Credentials Committee Procedure:

- (1) The Credentials Committee shall examine evidence of the Applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine, through information contained in references given by the Applicant and from other sources available to the Committee, including the report and findings from the Chairperson of each clinical department in which privileges are sought, whether the Applicant has established and satisfied all of the necessary qualifications for appointment and for the clinical privileges requested. The Credentials Committee may request further information as described in Section 2.3.1(i).
- (2) As part of the process of making its recommendation, the Credentials Committee may require the Applicant to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Committee at the Applicant's expense. The results of any such examination shall be made available to the Committee for its consideration. Failure of an Applicant to undergo such an examination within a reasonable time after being requested in writing to do so, shall constitute a voluntary withdrawal of the application for appointment and clinical privileges, and the application shall be processed no further.
- (3) The Credentials Committee shall have the right to require the Applicant to meet with the Committee, without counsel, to discuss

any aspect of the individual's application, qualifications, or clinical privileges requested.

- (4) The Credentials Committee may use the expertise of a Department Chairperson, or any member of the relevant departments, or an outside consultant, if additional information is needed regarding the Applicant's qualifications.

2.3.4 Credentials Committee Recommendation:

- (1) If, after considering all available information, the Credentials Committee's recommendation is favorable, the Committee shall make a written report and recommendation with respect to the Applicant. The report shall recommend provisional departmental/sectional assignment(s) and clinical privileges to be granted. The Credentials Committee may, in its discretion, recommend that certain limitations, conditions, or restrictions be imposed on the initial grant of clinical privileges.
- (2) When the Credentials Committee's recommendation is adverse to the Applicant, the MDMA shall notify by special notice the Applicant of the adverse recommendation and the reason for the recommendation.
- (3) If the Credentials Committee defers the application for further consideration, the Committee must make recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, department affiliations and scope of clinical privileges within 30 days. The MDMA shall promptly notify the Applicant of the action to defer.
- (4) The Credentials Committee's report and any supporting documentation and recommendation shall be forwarded to the Executive Committee through the Chairperson of the Credentials Committee.

2.3.5 Procedure of the Executive Committee:

- (1) Upon receipt of the Credentials Committee's recommendation, the Executive Committee shall review the application for appointment and clinical privileges and other relevant information and shall render its recommendation. The Executive Committee may request further information as described in Section 2.3.1(i).
- (2) The Chairperson of the Credentials Committee shall be available to the Executive Committee to answer any questions members of that Committee may have about the recommendation.

- (3) A favorable recommendation of the Executive Committee shall be forwarded directly to the Virtua Board (or its designated committee), through the MDMA.
- (4) The Executive Committee may refer the application back to the Credentials Committee for further consideration and responses to specific questions raised by the Executive Committee prior to its final recommendation.
- (5) If the Executive Committee's recommendation would entitle the Applicant to request a hearing pursuant to this policy, it shall be forwarded to the MDMA. The MDMA shall promptly so notify by special notice the Applicant in writing, return receipt requested. The application shall not be forwarded to the Virtua Board until the Applicant has exercised or has been deemed to have waived the right to a hearing provided in this policy.

2.3.6 Action of Virtua Board:

- (1) Upon receipt of a recommendation from the Executive Committee that the Applicant be appointed with the clinical privileges requested, the Virtua Board may meet with anyone who has knowledge about the application and, thereafter, the Board will:
 - (a) appoint the Applicant and grant clinical privileges;
 - (b) refer the matter for additional review or information; or
 - (c) reject the recommendation.
- (2) If the Virtua Board determines to reject a favorable recommendation, it shall first discuss this matter with the Chairperson of the Executive Committee. If the Virtua Board's determination is still unfavorable to the Applicant, the Chief Operating Officer shall promptly send special notice to the Applicant that the Applicant is entitled to request a hearing. The Virtua Board shall make no final decision until the Applicant has exercised or waived the rights to a hearing and appeal as outlined in the Bylaws.

2.4 SPECIAL GRANTS OF CLINICAL PRIVILEGES

2.4.1 Temporary Privileges:

2.4.1.1 General:

- (a) Temporary privileges shall not be routinely granted. Temporary privileges will only be granted: to fulfill an important patient care need or when an applicant with a complete, clean application is

awaiting review and approval of the Executive Committee and the Board.

- (b) Temporary Privileges to Fulfill an Important Patient Care Need: Important patient care needs include: a patient care need that cannot be provided because of the absence of a specific specialty representation; call coverage, proctoring, special consulting privileges when requested by the treating physician. The specific reason for granting such privileges shall be provided in writing. These shall require verification of the applicant's licenses, malpractice insurance and competency prior to issuing such privileges. Temporary privileges may not exceed 90 days.
- (c) Temporary Privileges for An Applicant with a complete, clean application, who is awaiting Executive Committee and Medical Affairs Committee Approval: Temporary privileges may be granted when an Applicant with a complete, clean application is awaiting review and approval of the Executive Committee and the Board. Temporary privileges for an applicant may not be granted if any one of the following exists:
 - (1) The application is incomplete. For an application to be considered complete, it must meet the following criteria:
 - i. All documentation described within this Policy has been received.
 - ii. All required primary source verifications have been received.
 - iii. Any additional information requested from the applicant has been received.
 - (2) There are current or previously successful challenges to licensure or registration.
 - (3) The applicant has been subject to involuntary termination of medical staff membership at another organization or has voluntarily resigned during an investigation.
 - (4) The applicant has been subject to involuntary limitation, reduction, denial or loss of clinical privileges.
 - (5) When a fair or poor rating on clinical competency is noted on verifications, the request for temporary privileges will be evaluated on a case by case basis by the Credentials Committee Chairman or MDMA who will query the primary source. Results of this query will be discussed by both the MDMA and Chairman of the Credentials

Committee. If both agree that there is no concern about past or future competency, temporary privileges may be granted as long as all other requirements of temporary privileges are met.

- (6) Malpractice liability actions resulting in a final judgment against the Applicant will be reviewed on a case by case basis by the MDMA and Chairman of the Credentials Committee. Temporary privileges will not be granted to any Applicant whose application reflects evidence of a significant occurrence or pattern.
- (7) There is other adverse information or concerns regarding the Applicant.
- (d) Temporary privileges may only be granted upon written concurrence of the Department Chairperson, the President of the Medical Staff, the COO and the Chairperson of the Credentials Committee. Temporary privileges shall not be granted unless all of the above-listed persons reasonably believe that the available information supports a favorable judgment to exercise the requested privileges.
- (e) In exercising temporary privileges, the Applicant shall act under the supervision of the Chairperson of the Department in which the Applicant has requested primary privileges.
- (f) A recipient of temporary privileges shall be bound by the Bylaws and other conditions attached to the grant of temporary privileges.
- (g) An individual who is granted temporary privileges may exercise privileges for a maximum of 360 days, consecutive or not, any time during the five-year period following the date they are first granted.

2.4.1.2 Special Requirements:

Special requirements of supervision and reporting may be imposed by the Department Chairperson(s) concerned on any individual granted temporary clinical privileges. Temporary Privileges shall be immediately terminated by the MDMA, or a designee, upon special notice of any failure by the individual to comply with such special conditions.

2.4.1.3 Termination of Temporary Clinical Privileges:

- (a) The MDMA may terminate Temporary Privileges at any time after consulting with the President of the Medical Staff, the Credentials Committee Chairperson, or the Chairperson of the department responsible for the individual's supervision. Clinical

privileges shall then be terminated when the individual's inpatients are discharged from the hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual, a termination of Temporary Privileges may be imposed by the MDMA, a Department Chairperson, the COO or their designee or the President, and such termination shall be immediately effective.

- (b) The appropriate Department Chairperson or the President shall assign to a medical staff appointee responsibility for the care of the terminated individual's patients until such patients are discharged from the hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.
- (c) The granting of any Temporary Privileges is entirely a courtesy on the part of the Hospital and any or all such privileges may be terminated if a question or concern is raised. Neither the granting, denial, or termination of such privileges shall entitle the individual to any of the procedural rights provided in the Bylaws or this Policy.
- (d) Temporary Privileges shall be terminated automatically if the Executive Committee makes a recommendation not to appoint the Applicant. Similarly, Temporary Privileges shall be modified to conform to the recommendation of the Executive Committee that the Applicant be granted Privileges different, from the Temporary Privileges.

2.4.2 Emergency Clinical Care:

- (1) In the event of an emergency, any practitioner, to the extent permitted by his or her license and regardless of department, staff status or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm.
- (2) For the purpose of this section an "emergency" is defined as a condition which could result in death or serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm or danger.

2.4.3 Credentialing Physicians in the Event of a Disaster:

2.4.3.1 Purpose:

The purpose of this section is to provide a process to credential practitioners who are not members of the Medical Staff at the Hospital and do not possess medical staff privileges who may provide patient care

services during a disaster (defined as an officially declared emergency, whether it is local, state, or national).

2.4.3.2 Policy:

Any practitioner providing patient care must be granted privileges prior to providing patient care, even in a disaster situation. Safeguards must be in place to verify that practitioners are competent to provide safe and adequate care.

2.4.3.3 Process:

(a) Disaster privileges are granted on a case-by-case basis after certification of identity and licensure. The following information must be presented by the physician in order to be granted disaster privileges:

- (1) Application for Disaster Credentialing;
- (2) Valid professional license to practice in the State of New Jersey;
- (3) A valid photo ID issued by a state, federal, or regulatory agency;
- (4) In addition to the above, at a minimum, at least one of the following must also be presented;
 - i. Hospital identification that clearly identifies the professional designation of the volunteer
 - ii. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, the American Red Cross, or other recognized state or federal organizations.
 - iii. Primary source verification of license.
 - iv. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in a disaster circumstance (such authority having been granted by a federal, state, or municipal entity).
 - v. Presentation by a current hospital or medical staff member(s) who possess personal knowledge regarding the practitioner's professional ability to

act as a licensed independent practitioner during a disaster.

- (b) The following information must be provided to the Medical Affairs Office as soon it is possible:
1. Certificate of malpractice insurance.
 2. List of current hospital affiliations where the practitioner holds active staff privileges.
 3. After viewing the documents presented, the Medical Affairs staff will record the date and time of the request for the disaster privilege; the state license number and expiration date and any other pertinent information.
 4. If possible, copies will be made of all documents.
 5. The Medical Affairs Office will immediately do the following and complete within 72 hours from the time the volunteer practitioner presents to the organization:
 - i. Attempt to verify the state license
 - ii. Attempt to contact the facility at which the physician has recently practiced to verify that s/he is in good standing
 6. In the event these calls cannot be completed, disaster privileges may still be issued pending verification of good standing.
 7. All physicians who currently have privileges or who receive disaster privileges will work under the direction of the Medical Director as defined under the Hospital Incident Command System. The Medical Director, as defined above, will be responsible to oversee the professional practice of the volunteer practitioner. This can be done through direct observation, mentoring, and/or clinical record review.
 8. The privileges granted to the volunteer practitioner must be re-evaluated every 72 hours, to see if there is still a need to continue the granted privileges.
 9. A physician's privileges, granted under this disaster situation, may be terminated at any time without any reason or cause. Termination of these privileges will not give rise to a hearing or review.

10. The MDMA or ranking Administrator on-site will grant privileges upon recommendation of the appropriate Department Chairperson.
11. When the disaster situation no longer exists, these temporary disaster privileges will terminate.
12. Any licensed independent practitioner presenting to the hospital during a disaster as a spontaneous volunteer; not meeting these requirements, will be referred to the appropriate state or federally recognized organization for processing and registration.

2.4.4 **Temporary Military Privileges:**

- (1) After receipt of an application which is deemed complete, a written request for specific Temporary Military Privileges may be granted upon the written concurrence of the Chairperson of the Department in which the privileges are sought, the President the COO, and the Chairman of Credentials Committee or their designees.
- (2) Temporary Military Privileges may not be granted for more than 120 days.
- (3) A recipient of Temporary Military Privileges shall acknowledge in writing that s/he shall be bound by the Medical Staff Bylaws and any other conditions attached to the Temporary Military Privileges.
- (4) Special requirements for consultation, supervision and other conditions may be imposed by the Department on any individual granted temporary privileges. Temporary Military Privileges shall be immediately terminated by the MDMA, upon special notice of any failure by the individual to comply with the conditions.
- (5) Temporary Military Privileges are not renewable.
- (6) A member who holds Temporary Military Privileges may not transfer to another category. If a Member who holds Temporary Military Privileges desires to become a member of the Active or Affiliate Category, s/he must submit a new application and proceed through the same application as all applicants to the Active or Affiliate Category.
- (7) In all instances where Temporary Military Privileges are granted, the Executive Committee and Virtua Board shall be informed.

ARTICLE III
APPOINTMENT TO THE MEDICAL STAFF

3.1 PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements and procedures relating to initial appointment will apply to continued appointment and clinical privileges and to reappointment.

3.2 QUALIFICATIONS FOR REAPPOINTMENT, RENEWAL OF CLINICAL PRIVILEGES AND ADDITIONAL CLINICAL PRIVILEGES

3.2.1 Qualifications for Reappointment:

3.2.1.1 Factors to be Considered:

In considering an individual's application for reappointment, the factors listed in Section 2.2.1.3 of this Policy shall be considered. Additionally, the following factors shall be evaluated as part of the reappointment process:

- (a) compliance with all qualifications and criteria outlined in the bylaws, policies and rules and regulations of Medical Staff;
- (b) ethical behavior, clinical competence, and clinical judgment in the treatment of patients;
- (c) attendance at department and section meetings, and participation in staff duties;
- (d) compliance with Hospital policies and Medical Staff Bylaws, policies and rules and regulations of the Medical Staff;
- (e) conduct in the Hospital, including cooperation with Medical Staff and hospital personnel as it relates to patient care, the orderly operation of the Hospital, and general attitude toward patients, the Hospital, and its personnel;
- (f) use of the facilities for patients, taking into consideration the individual's comparative utilization patterns;
- (g) ability to perform the clinical privileges requested and the duties and responsibilities of appointment, including, but not limited to, emergency coverage and committee service;
- (h) capacity to treat patients satisfactorily as indicated by the results of the quality assessment activities or other reasonable indicators of continuing qualifications;

- (i) satisfactory attestation that the Medical Staff member has attained the biennial Continuing Medical Education credits as required by their state licensing board. Members may be required to provide documentation of Continuing Medical Education credits if requested during the reappointment process. The failure to provide documentation shall result in the automatic termination of the Medical Staff Member's membership on the Medical Staff. The documentation of Continuing Medical Education credits must include information regarding the topics of the courses or programs in which the credits were attained;
- (j) current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments, and settlements;
- (k) current licensure and registrations, voluntary or involuntary relinquishment, termination, suspension, modification or restriction or any currently pending challenges to any license or registration;
- (l) professional review actions, voluntary or involuntary termination of medical staff appointment, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;
- (m) documentation of patient encounters at other hospital systems, if the practitioner has not had sufficient activity to assess quality of patient care. This may include logs of patient care and quality data from other hospitals. This may be requested by the Section Chief or Department Chairperson or by the Credentials Committee;
- (n) any focused professional practice evaluations;
- (o) attestation that there is no medical condition which would prevent the individual from carrying out the responsibilities of membership on the Medical Staff;
- (p) other regulatory standards that may be required; and
- (q) other reasonable indicators of continuing qualifications.

3.2.1.2 Clinical Privileges After Age 70:

- (a) Any individual who desires to exercise clinical privileges after the age of 70 must provide a report from his or her attending physician stating that the individual is able to perform the clinical privileges requested.

- (b) Prior to submitting an application for reappointment, the individual must have completed a period of focused professional practice evaluation, as determined by the relevant department/section. The department/section chairperson will assign someone to evaluate the individual's care, on a concurrent basis, and prepare a report on the assigned evaluation. The report must address whether the individual is able to safely and competently care for patients.
- (c) The Credentials Committee will review the information in the report and make a recommendation in furtherance of quality health care. If the Credentials Committee has any concerns, it may meet with the individual and discuss the steps that can be taken to address the concerns, including, but not limited to, voluntary restructuring of privileges, further monitoring, or additional focused review.
- (d) The Credentials Committee may require the individual to obtain a physical and/or mental examination by a physician acceptable to the Committee and require that the results of the examination be made available for the Committee's consideration.
- (e) The Credentials Committee may seek the assistance of the Physician Health Committee to review any information received and to make a recommendation about the individual's ability to safely and competently practice.

3.2.1.3 Health Evaluations:

Members of the Medical Staff are recommended to undergo a health evaluation on a regular basis. A Department Chairperson may require a Member to undergo a health evaluation as part of the reappointment process when the Chairperson has good cause to believe that such an evaluation is appropriate. Subject to Section 3.2.1.2, annual health evaluations may be required for members over the age of 70.

3.2.2 **Qualifications for Renewal and Additional Clinical Privileges:**

- (a) In considering an individual's request for renewal of clinical privileges, or a request for additional clinical privileges, the factors

listed in Section 2.2.2.2 of this Policy shall be considered. Additionally, the following factors shall be evaluated when making a recommendation for additional clinical privileges to the Virtua Board:

- (1) relevant recent training;
 - (2) observation of patient care provided;
 - (3) review of the records of patients treated in any of the Hospitals or any other hospitals;
 - (4) results of the Hospital's quality assessment activities;
 - (5) the applicant's qualifications and the criteria for the clinical privileges;
 - (6) whether the privileges are currently offered at a Virtua facility;
 - (7) special criteria that have been developed;
 - (8) other reasonable indicators of the individual's continuing qualifications for the privileges in question.
- (b) The recommendation for increased privileges may carry with it such requirements for supervision or consultation or other conditions as are thought necessary. Such supervision or consultation shall be considered routine.

3.3 PROCEDURE FOR REAPPOINTMENT, RENEWAL OF CLINICAL PRIVILEGES AND ADDITIONAL CLINICAL PRIVILEGES

3.3.1 Procedure for Reappointment and Renewal of Clinical Privileges:

3.3.1.1 Application:

- (a) Each current appointee who is eligible to be reappointed to the Medical Staff shall be responsible for completing a reappointment application form. Members will designate the division(s) in which privileges are requested; if in both, the primary division should be designated.
- (b) To be eligible to apply for renewal of clinical privileges an individual must have performed sufficient procedures, treatment or therapy in the previous appointment term to enable the Department Chairperson(s) to assess the individual's clinical competence.
- (c) At least five months prior to the expiration of the appointment term, the Medical Director or a designee shall provide an

application form to each appointee whose term is scheduled to expire. The reappointment application shall be submitted to the MDMA within forty-five (45) days of the date mailed. Failure to submit the reappointment application within this time period shall result in the imposition of late fees. A reappointment application will not be processed unless accompanied by the late fee.

Failure to submit a reappointment application ninety (90) days prior to expiration of the appointee's current appointment period will result in automatic expiration of the individual's appointment and clinical privileges at the end of the appointment term. The appointee may be permitted to reapply for initial appointment, in the future, in accordance with this policy, if the individual evidences a greater interest in or intention to use the Hospital, and/or commitment to fulfill the duties and responsibilities of appointment to the Medical Staff.

- (d) Reappointment, if granted by the Virtua Board, shall be for a period of not more than two years, with approximately one-half of the staff reappointed in even numbered years and the other half of the staff reappointed in odd numbered years. The reappointment schedule shall be staggered in a manner established by the Medical Affairs Office.

3.3.1.2 Department Chairperson/Section Chief Procedure:

- (a) When applicable, the Section Chief(s) will complete the same review and recommendation process as that of the review and recommendation process that will be subsequently followed by the Department Chairperson(s).
- (b) Three months prior to the end of each appointee's appointment period, the MDMA shall send to the Chairperson of each Department/ Section Chief in which that individual has privileges, the individual's application for reappointment and a description of the individual's clinical privileges.
- (c) No later than 15 days after receipt of the application, the Department Chairperson(s)/Section Chief(s) shall provide the Credentials Committee with a written report concerning the individual seeking reappointment. The Department Chairperson(s)/Section Chief(s) will recommend to the Credentials Committee that the appointment remain unchanged, be modified as to staff category or clinical privileges, or that the applicant not be reappointed. The Chairperson(s) shall include in each written report, when applicable, the reasons for non-reappointment or any changes recommended in staff category or clinical privileges. Such report(s) shall be appended to the Credentials Committee's report.

- (d) The Chairperson(s) or Section Chief(s), as applicable, shall be available to the Credentials Committee to answer any questions that may be raised with respect to any such report.
- (e) If an appointee seeks reappointment at both North and South Divisions and the recommendations differ among the interviewing Department Chairpersons or Section Chiefs, the MDMA will meet with the Department Chairpersons/Section Chiefs in order to discuss the differences in recommendations and reach a consensus. Recommendations on the appointee will then move to the Credentials Committee for review.

3.3.1.3 Credentials Committee Procedure:

- (a) The Credentials Committee, after receiving the reports from each Department Chairperson(s), shall review all available pertinent information, including all information provided from other committees of the medical staff and from hospital management, for the purpose of determining its recommendations for staff reappointment, change in staff category, and the granting of clinical privileges for the ensuing appointment period.
- (b) As part of the process of making its recommendation, the Credentials Committee may require that an individual currently seeking reappointment undergo a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee. The Credentials Committee may also require such an examination during the appointment period to aid it in determining whether clinical privileges should be continued. The results of such examination shall be made available to the Credentials Committee for its consideration. Failure of an individual to undergo such an examination within a reasonable time after being requested to do so by the Credentials Committee, in writing, shall constitute a voluntary relinquishment of all clinical privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon. The results of any examination shall be forwarded to the Executive Committee through the MDMA no later than 24 hours before the meeting at which the individual's reappointment will be discussed.
- (c) The Credentials Committee shall have the right to require the appointee to meet with the Committee, without counsel, to discuss any aspect of the individual's reappointment application, qualifications, or clinical privileges requested.

- (d) The Credentials Committee may use the expertise of a Department Chairperson(s), or any member of the department, or an outside consultant, if additional information is needed regarding the appointee's qualifications for reappointment.

3.3.1.4 Credentials Committee Recommendation:

- (a) If, after considering all available information, including the reports of the clinical Department Chairpersons, the Credentials Committee's recommendation is favorable, the Credentials Committee shall make a written report and recommendation with respect to the appointee. Prior to issuing an unfavorable report, the provisions of Section 3.3.1.7 shall be followed.
- (b) The Credentials Committees report and recommendation shall be forwarded to the Executive Committee through the MDMA.
- (c) The Chairperson of the Credentials Committee of the respective Division shall be available to the Executive Committee to answer any questions they may have about the recommendation.

3.3.1.5 Procedure of the Executive Committee:

- (a) Upon receipt of the Credentials Committee's recommendation, the Executive Committee shall review the application for reappointment and clinical privileges and other relevant information and shall render its recommendation.
- (b) If the recommendation of the Executive Committee is favorable it shall be forwarded directly to the Virtua Board (or its designated committee), through the MDMA.
- (c) If the Executive Committee's recommendation would entitle the individual to request a hearing pursuant to this policy, the recommendation shall be forwarded to the MDMA. The MDMA shall notify by special notice the individual in writing, return receipt requested. The application shall not be forwarded to the Virtua Board (or designated committee) until the applicant has exercised or has been deemed to have waived the right to a hearing as provided in the Bylaws.

3.3.1.6 Action of Virtua Board (or designated committee):

Upon receipt of a recommendation from the Executive Committee that the individual be reappointed with the clinical privileges requested, the Virtua Board may meet with anyone who has knowledge about the Applicant and may:

- (a) appoint the individual and grant clinical privileges;

- (b) refer the matter for additional or information; or
- (c) reject the recommendation. If the Virtua Board determines to reject the favorable recommendation, it should first discuss matter with the Chairperson of the Executive Committee. If the Virtua Board's determination is still unfavorable to the individual, it shall make no final decision until the individual has exercised or waived the rights to a hearing and appeal as outlined in the Bylaws.

3.3.1.7 Collegial Intervention:

- (a) If, during the processing of a particular individual's application for reappointment, it becomes apparent to the Credentials Committee, or its Chairperson, that the Committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the Chairperson of the Credentials Committee may notify the individual of the general tenor of the possible recommendation and ask if the individual desires to meet with the Committee, without counsel, prior to any final recommendation.
- (b) At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain, or refute it.
- (c) This interview shall not constitute a hearing and none of the procedural rules provided in the Bylaws with respect to hearings shall apply. Minutes of the discussion in the collegial meeting shall not be kept. However, the Committee shall indicate as part of its report to the Executive Committee and the Virtua Board whether such a meeting occurred, including a summary of the meeting.

3.3.2 **Procedures for Requesting Additional Clinical Privileges:**

3.3.2.1 Application for Additional Clinical Privileges:

- (a) Whenever additional clinical privileges are desired, the member requesting increased privileges shall apply in writing to the MDMA. The application shall state in detail the specific additional clinical privileges desired and the appointee's relevant recent training and experience which justify increased privileges.
- (b) This application shall be transmitted by the MDMA to the appropriate Department Chairperson(s) and/or Section Chief(s). Thereafter, it will be processed in the same manner as an application for initial clinical privileges.
- (c) Any recommendation for additional privileges that includes clinical privileges to perform a significant procedure not currently being

performed at the Hospital or a significant new technique to perform an existing procedure, shall be subject to Section 2.2.2.8 of this Policy.

3.3.2.2 Processing of Requests:

Applications for increased privileges will be processed in the same manner as an initial request for privileges. Primary source verifications and other regulatory requirements will apply and the request for increased privileges must be approved through the existing committee structures and approval processes.

ARTICLE IV

ACTIONS AFFECTING MEDICAL STAFF APPOINTEES

4.1 PROCEDURE FOR PROCTORING

4.1.1 Identification of Procedures:

As necessary, the Chairperson of each Department/Section will confer and agree upon those new procedures and treatments that shall require specific privilege delineation before they can be performed and shall forward this to the Credentials Committee. In the event of any question as to whether a procedure or treatment requires a new delineation of privileges or is within the scope of existing privileges, the Chairperson(s) of the relevant Department(s)/Section(s) shall be the decision-maker.

4.1.2 Proctoring Guidelines (Privileges to be Proctored):

- (1) Proctoring Guidelines will establish a general set of requirements applicable to all Departments/Sections regarding the proctoring aspects of credentialing Members to perform procedures or treatments which are not within the scope of privileges granted to all members of the Department/Section or to a Member specifically.
- (2) Each Department/Section shall be responsible for developing its own specific criteria for granting privileges for such procedures or treatments, which criteria shall not be inconsistent with the Proctoring Guidelines. The criteria established by each Department/Section shall include a stated minimum number of

proctored cases, if any, which the Applicant for the privilege must successfully complete.

- (3) Departmental/Sectional criteria shall be reviewed by the Credentials Committee and approved by the Executive Committee.
- (4) The proctoring physician may be asked to perform the proctoring according to the following guidelines:
 - (a) Observation and verification – the proctoring physician may not perform or participate in the procedure or treatment in any way, but may only observe the Member being proctored and verify whether the Member has the requisite skill and knowledge to be granted privileges to perform the procedure or treatment.
 - (b) Observation, teaching and verification – the proctoring physician may participate in the procedure or treatment in a limited manner for the purpose of providing additional training to the Member being proctored.
 - (c) The proctoring physician may be permitted to act as the assistant surgeon provided the activities of the proctoring physician as assistant are limited to the parts of the procedure which are not essential aspects of the case being proctored and do not impede the proctoring physician's ability to observe and verify the Member's performance.
 - (d) Notwithstanding the limitations contained in paragraphs 1, 2 and 3 above, the proctoring physician may participate in a procedure and treatment to the extent necessary whenever the best interests of patient care require it.
- (5) The proctoring physician shall certify whether in his or her professional judgment the applicant for the privileges possesses the required levels of skill and knowledge for the privileges being sought. This certification shall be provided in accordance with the Proctoring Guidelines and the relevant Departmental/Sectional criteria. These criteria may include a requirement that a Departmental/Sectional representative be present to verify the appropriateness of the proctoring physician's certification.

4.1.3 Procedure for Granting Proctor Privileges to Non-Staff Members:

- (1) In situations where a Member desiring privileges to perform a new procedure or treatment must successfully complete a stated minimum number of proctored cases in order to satisfy his or her Department's/Section's rules and there are no members of the Staff who are qualified and eligible to perform the proctoring, a

non-Staff Member may be granted Proctor Privileges in accordance with the following:

- (a) Physicians requesting Proctor Privileges must submit the following documents:
 - copy of curriculum vitae
 - copy of current license
 - copy of current insurance
 - evidence that demonstrates current clinical competence and overall qualifications to perform the privileges in question.
- (2) No Proctor Privileges may be granted in cases in which the Proctor Guidelines of the Medical Staff and the credentialing criteria of the Department/Section are not met.
- (3) Proctor Privileges may be granted upon the concurrence of the affected Department/Section Chairperson, the Chairman of the Credentials Committee, and the President of the Medical Staff, or their designees, each of whom must be satisfied as to the qualifications of the Member's applicant for such privileges and as to the need for proctoring.
- (4) Proctor Privileges shall be granted through the issuance of a written delineation form which shall describe in reasonable detail the scope and duration of the privileges being granted.

Fees charged by the Proctoring Physician will be the responsibility of the Physician requesting Proctor Privileges.

ARTICLE V

CONFIDENTIALITY, REPORTING AND PEER REVIEW PROTECTION

5.1 CONFIDENTIALITY AND REPORTING

Actions taken and recommendations made pursuant to this policy shall be treated as confidential in accordance with applicable legal requirements and such policies regarding confidentiality as may be adopted by the Virtua Board. In addition, reports of actions taken pursuant to this policy shall be made by the MDMA to such governmental agencies as may be required by law.

5.2 PEER REVIEW PROTECTION

All minutes, reports recommendations, communications, and actions made or taken pursuant to this Policy are intended to be covered by the provisions of

N.J.S.A. 2A:84A-22.8; 22.9 and 22.10 or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this Policy shall be considered to be acting on behalf of the Hospital and the Virtua Board when engaged in such professional review activities and thus are "professional review actions" as that term is defined in the Health Care Quality Improvement Act of 1986.

ARTICLE VI **AMENDMENTS**

This Policy may be amended by a majority vote of the members of the Executive Committee present and voting at any meeting of the Committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Executive Committee. No amendment shall be effective, unless and until it has been approved by the Virtua Board.

ARTICLE VII **ADOPTION**

This Policy is adopted and made effective upon approval of the Virtua Board, superseding and replacing any and all other policies pertaining to the subject matter thereof. All activities and actions of the Medical Staff and of each individual exercising clinical privileges in the Hospital shall be taken under and pursuant to the requirements of this Policy.

Focused Professional Practice Evaluation Policy

OVERVIEW

Focused professional practice evaluation (FPPE) is a process whereby the organization evaluates the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege at the organization. FPPE is for a time-limited period during which the organization evaluates and determines the practitioner's professional performance.

Initial competency of practitioners new to the medical staff shall have privilege specific competency evaluated by review of competency information obtained from current and former institutions, where privileged, followed by a focused review during the provisional period.

FPPE will occur under the following circumstances:

- New Applicants: During the provisional period (as defined by the Bylaws)
- Current staff requesting new/additional privilege(s) not previously performed at Virtua
- When a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care

Specific competency will be determined by either:

- Proctoring: as determined by the specific service
- Chart review as determined by the specific service

POLICY

Purpose: To establish a systematic proctoring process to ensure that there is sufficient information available to confirm the current competence of Practitioners who initially request privileges at Virtua, as part of a Focused Professional Practice Evaluation ("FPPE").

Definitions: Proctoring may be performed using prospective, concurrent or retrospective approaches. Practitioners, who most often provide cognitive care as opposed to procedural care, will be evaluated prospectively and/or retrospectively. Prospective proctoring and concurrent proctoring will be used for evaluating practitioners who request privileges to perform various procedures.

Proctoring includes one or more of the following as part of a FPPE:

- (1) presentation of cases with planned treatment outlined for treatment concurrence or review of case documentation for treatment concurrence (prospective proctoring),
- (2) real-time observation of a procedure (concurrent proctoring),
- (3) review of a case after care has been completed, which may include interviews with personnel involved in the care of the patient (retrospective proctoring), or
- (4) evidence of successful proctoring at another JC accredited hospital, subject to the following requirements

- i. The practitioner required to be proctored is responsible to identify the hospital where information may be obtained and to assure that the hospital provides the requested information*
- ii. The practitioner must consent to authorize the hospital to release copies of his/her proctoring reports or provide a summary of proctoring activities.*
- iii. The hospital must provide Virtua with a copy of the clinical privileges that have been granted to the practitioner and the practitioner must assure that the hospital provides the requested information.*

Scope: This Policy applies to all Practitioners who request initial privileges, including initial applicants for Medical or Allied Staff appointment and current members of the Medical or Allied Staff who request additional clinical privileges.

Practitioners requesting membership but not exercising specific privileges do NOT need to be proctored.

The scope of the proctoring plan shall be as indicated above. However, each department shall define the appropriate proctoring method to determine what constitutes a practitioner's current competency.

Oversight/Responsibilities:

The Virtua Credentials Committee (VCC) is charged with the responsibility of monitoring compliance with this policy. It accomplishes this oversight by submitting regular reports related to the progress of each practitioner, who is required to be proctored, as well as any issues or problems involved in implementing this policy to the Medical Executive Committee.

The Department Chief/Chair, or his/her designee, will determine changes to improve performance based on results of FPPEs, including proctoring, and implementation of practitioner-specific performance improvement plans, if appropriate, for practitioners who complete the FPPE. Practitioner specific improvement plans will be submitted to the VCC to ensure compliance with the policy. The VCC will then forward the Department Chief/Chair's recommendation to the MEC for final approval.

The department Performance Improvement Coordinator (PIC) involved with Ongoing Physician Performance Evaluation ("OPPE") can provide the Department chair/chief or their designee with data that is systematically collected through the OPPE processes for those practitioners, as appropriate, to confirm current competence during the FPPE period.

Proctoring Method: Proctoring may be performed using prospective, concurrent, or retrospective approaches, as defined above. The appropriate methods for proctoring for each individual practitioner will be determined by the Department Chief/Chair, or designee. Virtua's proctoring forms must be utilized during this process.

Selection of Proctor(s): The Department Chief/Chair shall be responsible for selecting the proctor(s).

Duration of Proctoring Period: For a new applicant to the medical staff, core privileges and special request privilege (if applicable) must be reviewed during the first six months of appointment. For existing medical staff members requesting a new privilege the department Chief/Chair will determine the minimum number of cases that will be over the first six months. The cases shall be representative of the practitioner's principle practice for newly appointed practitioners or for practitioners currently on staff for the new procedure(s) requested. The proctoring period may be extended by the Department Chief/Chair if initial concerns are raised that require further evaluation or there is insufficient activity during the initial period, provided, however, the total proctoring period should not exceed one year.

Minimum Clinical Activity - Reciprocal Observation: When a practitioner has insufficient (minimal) clinical activity at Virtua or does not have the type of clinical activity for the requested privilege that is required to be proctored, Virtua may accept evidence of successful proctoring

from another facility, provided the conditions defined above for reciprocal proctoring are met.

Responsibilities of Proctors:

1. The proctor's role is that of an evaluator, to review and observe cases, not of a supervisor or consultant. The practitioner who is serving solely as a proctor is an agent of the hospital. The proctor receives no compensation directly or indirectly from any patient for this service.
2. Proctors must be members in good standing of the medical staff of Virtua and must have unrestricted privileges to perform any procedure(s) to be concurrently proctored.
3. Proctors will monitor those portions of the medical care rendered by the practitioner that are sufficient to be able to judge the quality of care provided in relationship to the privilege(s) requested. The performance of a specific procedure shall be reviewed, or in the situation that the privilege encompasses cognitive care, then the relative components of the patients chart must also be reviewed for that aspect of care.
4. Proctors will ensure the confidentiality of the proctoring results and forms. The proctor will forward the completed proctoring form(s) to the Office of Medical Affairs.
5. If at any time during the proctoring period, the proctor has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), the proctor should promptly notify the respective Chief of Service.
One of the following may be recommended:
 - (a) The Department Chair/Chief or designee will intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for the patient.
 - (b) The PIC will review the case for possible peer review at the next department meeting.
 - (c) Additional or revised proctoring requirements may be imposed upon the practitioner until the proctor can make an informed judgment and recommendation regarding the clinical performance of the individual being proctored.
6. If during the initial period of proctoring the proctor feels there may be imminent danger to the health and safety of any individual, the continuation of the privilege(s) requested and proctoring are subject to being discontinued by the Department Chair/Chief or Medical Director.
7. All members of the medical staff with relevant privileges, within each department, must serve as proctors when asked to do so.
8. In addition to specialty and privilege specific issues, proctoring also will address the general competencies.

Responsibilities of the Proctored Practitioner:

1. The practitioner must provide the necessary cases to the proctor for review in a timely manner; if applicable, must obtain agreement from the proctor to attend and observe the procedure and/or the practitioner must provide the proctor with access to all information regarding the patient's clinical history and care, pertinent physical findings, lab and x-ray results; the course of treatment or management including a copy of the H&P, operative reports,

consultations, and discharge summaries.

2. The practitioner shall notify the proctor of each case in which care is to be evaluated and, when concurrent proctoring is required, do so in sufficient time to enable the proctor to conduct. For surgical or invasive procedures where concurrent proctoring is required, the practitioner must secure agreement from the proctor to attend and observe the procedure.
3. The practitioner has the option of requesting from the Department Chair/Chief, a change of proctor if disagreements with the current proctor may adversely affect his/her ability to complete the proctorship timely and satisfactorily.
4. Inform the proctor of any unusual incidents associated with his/her patients.
5. It is the responsibility of the practitioner to ensure documentation of the satisfactory completion of his/her proctorship, including the completion and delivery of proctorship forms to the Medical Staff Office.
6. If the summary proctor report is not completed and submitted to the Medical Staff Office when due, or if the practitioner fails to complete the proctoring requirements prior to the expiration of the proctoring period, the additional or new privileges that are the subject of proctoring shall be deemed to be voluntarily relinquished by the practitioner and the practitioner shall immediately stop performing these privileges.

Procedural Rights: Failure to Meet FPPE/Proctoring Requirements:

1. Failure to meet proctoring requirements will automatically result in a review, conducted by the departmental PI committee, of clinical cases performed. If failure to satisfy proctoring requirements is simply numerical, the privilege(s) is deemed to be withdrawn for administrative reasons, which is not reportable
2. If a practitioner's appointment or clinical privileges are deemed to be voluntarily relinquished for failure to complete proctoring requirements, the practitioner shall be notified in writing before a report of that voluntary relinquishment is made to the MEC.
3. As part of the notice of acknowledging the voluntary relinquishment and the reason(s) for it, the practitioner shall be given an opportunity to request, within ten days, a meeting with the Department Chair/Chief and the Medical Director of Medical Affairs, at which time the practitioner shall have an opportunity to explain or discuss extenuating circumstances involving his or her failure to provide sufficient clinical experience for a satisfactory evaluation. At that meeting none of the parties shall be represented by counsel; minutes shall be kept; the practitioner may present evidence of extenuating circumstances and why the evaluation period should be extended; any party may ask questions of any party relative to the practitioner's appointment or clinical privileges.
4. At the conclusion of the meeting, the Department Chair/Chief shall make a written report and recommendation. The report shall include the minutes of the meeting held with the practitioner. After reviewing the Chief/Chair's recommendation and report, the recommendation shall be forwarded to the MEC. The MEC shall adopt the Chair/Chief's recommendation as its own, send the matter back to the Department Chair/Chief with specific concerns or questions, or make a recommendation different from the Department Chair/Chief outlining specific reasons for disagreement.

5. The Practitioner shall not be entitled to a hearing or other procedural rights as set forth in the Medical Staff Bylaws for any privilege that is voluntarily relinquished.

Procedural Rights: Recommendations for Termination of Appointment or Reduction in Clinical Privileges:

If there is a recommendation by the MEC to terminate the practitioner's appointment, privileges being proctored, or other clinical privileges due to questions about qualifications, behavior or clinical competence, the practitioner shall be entitled to the hearing and appeal process outlined in the Medical Staff Bylaws.

FPPE shall be conducted when a question arises, as a result of peer review, regarding a currently privileged practitioner's professional performance that may affect the provision of safe and high quality patient care, ongoing monitoring or when there appears to be a trend of any of the following circumstances.

Sentinel Events - as defined by the Joint Commission (JC).

Near Misses – Any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Serious Events – An event, occurrence or situation involving the clinical care of a patient that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services.

Unusual pattern of behavior or pattern of care

Professional practice that impacts on the quality of care and patient safety

Other complaints/issues that may arise that are referred by the President Medical Staff, Department Chair/Chief, Chief Medical Officer, or Medical Director.

The decision to assign a period of performance monitoring to further assess current competence will be based on the evaluation of a practitioner's current clinical competence, practice behavior and ability to perform the requested privileges that are at issue. Other existing privileges in good standing should not be affected by this decision. The terms, methods and duration of the evaluation period shall be determined by the Department Chair/Chief or designee and may include:

Chart review

Monitoring clinical practice patterns

Proctoring

Continuing Medical Education

Retraining

Medical evaluation and treatment

External peer review

Participants in the FPPE Process: The FPPE shall be conducted by the respective Department Chief/Chair. In the event that the review requires specific expertise in a clinical area, the Chief/Chair may supplement their review by obtaining the assistance of a practitioner with expertise in the specific area.

It is essential that the FPPE be conducted in a way that avoids conflict of interest or circumstances that suggest a conflict of interest.

External Peer Review: If external peer review is necessary, the external peer review process delineated in the Rules and Regulations shall be followed. External peer review may be

obtained when:

- there is a lack of internal expertise or when the only practitioners on the medical staff with the expertise are partners, associates, or direct competitors of the practitioner under review.
- the potential for conflict of interest cannot be appropriately resolved by the MEC or Medical Board.
- the MEC or Medical Board requires external peer review in any circumstances deemed appropriate by either of these bodies.
-

No practitioner can require the hospital to obtain external peer review.

References: Joint Commission MS 08.01.01

January 13, 2009

Ongoing Professional Practice Evaluation Policy

Ongoing Professional Practice Evaluation (OPPE) requires that the medical staff conduct an ongoing evaluation of each Medical staff member's and Allied Health Professional's (hereafter referred to as "practitioner") professional performance. This process allows any potential problems with a practitioner's performance or trends that impact quality of care and patient safety to be identified and resolved in a timely manner. OPPE also fosters an efficient, evidence-based privilege renewal process. The information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privileges(s).

PROCEDURE:

1. The Department Chief/Chairs and the performance improvement coordinator (PIC) for the department are responsible to coordinate the Ongoing Professional Practice Evaluation (OPPE) review. OPPE will be performed for all privileged practitioners on a yearly basis.
2. The type of information and the process for evaluation of each practitioner's ongoing professional practice has been approved by the departments through the Medical Executive Committee. The defined process is below.
3. Every year, every practitioner will be reviewed by the performance improvement coordinator. This review is forwarded to the Department Chief/Chair or designee and will be factored into the recommendation to maintain existing privileges(s), to revise existing privilege(s) or to revoke an existing privilege prior to or at the time of renewal. The fact that a practitioner doesn't fall out on screening criteria does not meet the requirement for performance data review although zero data is in fact data and can be evidence of good performance (e.g. no returns to the OR, no complaints, etc.). Review of privileges are evaluated at reappointment and consideration of the reason for zero or low volumes is taken into consideration (e.g. no longer performing the procedure, taking patients elsewhere for the procedure or privilege is typically a low volume procedure, etc.).
4. PICs will continue to review all fallouts on a quarterly basis. That data will be reviewed with the appropriate Performance Improvement Committee and Department Head.
5. Aggregate data reports and information that are included in OPPE include, as applicable:
 - a. Admission Activity
 - b. Length of Stay Data (actual and expected)
 - c. Mortality Data (actual and expected)
 - d. Readmissions
 - e. Procedures
 - f. Risk related occurrences
 - g. Quality Indicator related occurrences (system indicators & one indicator as selected by each department)
 - h. Outcomes as a result of the above occurrences

- i. Medical Records suspensions
 - j. Behavior related events
5. When available peer or benchmark comparative data will be utilized for items b. through d. as listed in item 4. above and for the department specific indicator.
6. The PIC will document pertinent findings and recommendations on the review form to include:
- a. Confirmation that the practitioner has been reviewed and there are no potential problems with performance or trends that would impact the quality of care and patient safety. The individual practitioner will then be reviewed again at their next sixth-month OPPE.
 - b. Assessment of general competencies to include:
 - i. Patient Care
 - ii. Medical Knowledge
 - iii. Practice Based Learning
 - iv. Interpersonal communication
 - v. Professionalism
 - vi. System based learning
 - c. Request for additional review for an individual practitioner based on an identified issue. Information gathered for review may include, but not be limited to:
 - i. Drill down reports
 - ii. Additional performance of a specific procedure
 - iii. Additional Periodic Review
 - iv. Direct Observation
 - v. Concurrent Monitoring
 - vi. Retrospective Chart Review
 - vii. Discussion with other individuals involved in the care of the practitioner's patients including consulting physicians, assistants at surgery, nursing and administrative personnel
 - d. This review process will continue until the Department Chief/Chair is either:
 - i. Satisfied with the information received and reviewed, or

- ii. Recommendations are made to the Medical Executive Committee for action including, but not limited to the initiation of the Intensified Review per the Medical Staff Peer Review Policy.
 - e. Request for immediate action according to the Medical Staff Bylaws can be taken at anytime during the OPPE process, which may include, but not limited to, forwarding concerns to the Medical Executive Committee.
7. The information gained by the review of the above information will be filed in the practitioner's quality file and incorporated into the two-year reappointment process. Single incidents or trending of quality and safety issues that impact the safety of patients will require immediate action by the medical staff.
 8. "Trigger" -There may be circumstances where a single incident or evidence of a clinical practice trend may be identified through the OPPE process. If so, this will trigger a Focused Professional Practice Evaluation, which will be conducted according to Medical Staff Policy.
 9. If behavior is identified as a possible issue, the Medical Staff Professional Conduct Policy will be followed as a component of OPPE.
 10. Relevant information obtained from OPPE will be forwarded for inclusion into the performance improvement activities maintaining confidentiality.