Policies & Procedures of the Medical Staff

Mercy Health St. Charles Hospital
2600 Navarre Avenue
Oregon, Ohio 43616

2020

N:\Reg_MedStf\SCMH\Policies and Procedures 11.2020 changes.doc

MERCY HEALTH ST CHARLES MEDICAL STAFF POLICIES AND PROCEDURES

MERCY HEALTH ST. CHARLES HOSPITAL

Title:	Sexual Harassment, Medical Staff	Policy No: 1
Prepared by:	Legal Services	Effective Date: 03/01/01
Department:	Medical Staff Services	Revision Date: n/a
Authorized by:	Medical Staff Executive Committee	Date of Review: 12/12/2017
Applies to:	Medical Staff	

PURPOSE: Mercy Health St. Charles Hospital's commitment to maintaining a work environment that is free of discrimination and harassment and to explain consequences of violations.

CONTENT: Sexual harassment is a form of sex discrimination and violates the Civil Rights Act of 1964.

- Courts view conduct as falling within one of two categories:

1. Quid Pro Quo
   - Harassment where tangible job benefits are conditional on employee's submission to conduct of a sexual nature or (when) adverse job consequences result from the employee's refusal to submit to the conduct.

2. Hostile Environment
   - Harassment that creates an offensive environment that seriously affects the victim's psychological well being.

Charges of Sexual Harassment will be managed in the following manner:

1. **Employee or Patient Charging a Physician**
   - A. The employee is expected to submit their complaint in writing to the Director of Employee Relations. A copy will be given to the appropriate Medical Staff Department Director.
   - B. The Director of Employee relations will investigate by interviewing the employee and the physician involved. She/he will document her/his findings.
   - C. A copy of the Director of Employee relations report will be:
     1. Sent to the Department Director for his information and action, if necessary.
     2. A copy will be filed in the "Sexual Harassment" file maintained by the Director of Employee Relations.
     3. The report is filed for an indefinite period. Should a second charge be filed, both charges will be reviewed to determine appropriate action. Actions may range from counseling to sanctions taken depending on the severity and number of offenses.

2. **Physician Charging Another Physician**
   - A. A complaint will be submitted in writing to the appropriate Medical Staff Department Director and the Chief of Staff.
   - B. The Medical Staff Department Director will investigate by interviewing both parties involved. The Department Director will submit a written report of his/her findings. If deemed appropriate the Chief of Staff and Medical Staff Executive Committee will assign a committee to investigate.
   - C. A written report will be filed in the Medical Staff office.
   - D. As with employee/patient complaints, the report will remain filed and be included in future investigation, should that be necessary.
   - E. Disciplinary action ranges from counseling to sanctions depending on the severity and number of complaints.

MERCY HEALTH ST. CHARLES HOSPITAL

Title:	Peer Review Policy	Policy No:	2
Prepared by:	Amanda Caldwell	Effective Date:	9/30/2019
Department:	Quality Department	Revision Date:	
Authorized by:	Mercy Health Toledo Region Board of Trustees	Date of Next Review:	9/30/2021
Applies to:	Medical Staff		

Purpose:
To ensure that the hospital, through the activities of its medical staff, assesses the professional performance of individuals granted clinical privileges and uses the results of such assessments to improve care and, when necessary, performs Focused Professional Practice Evaluation.

Goals:
1. Improve the quality of care provided by individual physicians;
2. Monitor the ongoing performance of practitioners who have privileges;
3. Identify opportunities for performance improvement;
4. Monitor significant trends by analyzing aggregate data.
5. Assure that the process for peer review is clearly defined, fair, defensible, timely and useful.

Definitions:

Peer review

Peer review involves a series of activities designed to collect, verify and evaluate data relevant to a practitioner's professional performance. These activities serve as the foundation for objective, evidence-based decisions regarding a practitioner's clinical privileges, appointment to membership on the medical staff and recommendations to grant or deny initial and renewed clinical privileges. Integrating these concepts into the peer review process provides for a more comprehensive evaluation of a practitioner's professional practice.

Peer review is conducted using multiple sources of information including: 1) the review of individual cases, 2) the review of compliance with general rules of the medical staff and, 3) clinical standards and use of rates in comparison with established benchmarks or norms.

The individual's evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice as defined by the six TJC/ACGME General Competencies described below:

- **Patient Care:** Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease and at the end of life.
- **Medical Knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
- **Practice Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care.
- **Interpersonal and Communication Skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable and maintain professional relationships with patients, families, and other members of health care teams.
- **Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.
- **System Based Practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize healthcare.

The medical staff has determined that for the purposes of defining its expectations of performance and measuring and providing feedback for The Joint Commission General Competencies, it will use the ACPE/Greeley Physician Performance Dimension Framework outlined below and the Pyramid Approach to Great Physician Performance.

- **Technical Quality:** Skill and judgment related to effectiveness and appropriateness in performing the clinical privileges granted.
- **Service Quality:** Ability to meet the customer service needs of patients and other caregivers.
- **Patient Safety/Patient Rights:** Cooperation with patient safety and rights, rules and procedures.
- **Resource Use:** Effective and efficient use of hospital clinical resources.
- **Relations:** Interpersonal interactions with colleagues, hospital staff and patients.
- **Citizenship:** Participation and cooperation with medical staff responsibilities.

Peer

A "peer" is an individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis. For example, for quality issues related to general medical care, a physician (MD or DO) may review the care of another physician. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent in that surgical specialty.

Peer Review Body

The peer review body designated to perform the initial review by the Medical Executive Committee or its designee will determine the degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed by or on behalf of the hospital. The initial peer review body will be the Peer Review Committee unless otherwise designated for specific circumstances by the Medical Executive Committee.

Ongoing Professional Practice Evaluation (OPPE)

The routine monitoring and evaluation of current competency for current medical staff. These activities comprise the majority of the functions of the ongoing peer review process and the use of data for reappointment.

The criteria used in the ongoing professional practice evaluation may include the following:

- Review of operative and other clinical procedure(s) performed and their outcomes
- Pattern of blood and pharmaceutical usage
- Requests for tests and procedures
- Length of stay patterns
- Morbidity and mortality data
- Practitioner's use of data
- Compliance with Medical Staff rules and regulations
- Other relevant criteria as determined by the Medical Staff

Focused Professional Practice Evaluation (FPPE)

The establishment of current competency for new medical staff members, new privileges and or concerns from current review or OPPE. These activities comprise what is typically called proctoring or focused review depending on the nature of the circumstances.

Conflict of Interest

A member of the medical staff requested to perform peer review may have a conflict of interest if they may not be able to render an unbiased opinion. An automatic conflict of interest would result if the physician is the provider under review. Relative conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner or key referral source. It is the obligation of the individual reviewer to disclose to the peer review committee the potential conflict. It is the responsibility of the peer review body to determine on a case by case basis if a relative conflict is substantial enough to

prevent the individual from participating. When a potential relative conflict is identified, the Peer Review Committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an automatic or substantial relative conflict is determined to exist, the individual may not participate or be present during peer review body discussions or decisions other than to provide specific information requested.

Policy:

1. All peer review information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.

2. Information related to corrective actions and investigations, including, but not limited to, minutes, notes, letters, memoranda, opinions, etc, shall be maintained in a practitioner's quality file in the Medical Staff office. This information shall not be available to the practitioner unless/until there has been a request for a hearing pursuant to the Bylaws.

3. The involved practitioner will receive provider-specific feedback on a routine basis.

4. The medical staff will use the provider-specific peer review results in making its recommendations to the hospital regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.

5. The hospital will keep provider-specific peer review and other quality information concerning a practitioner in a secure, locked file. Provider-specific peer review information consists of information related to:
   - Performance data for all dimensions of performance measured for that individual physician,
   - The individual physician's role in sentinel events, significant incidents or near misses,
   - Correspondence to the physician regarding commendations, comments regarding practice performance, or corrective action.

6. Any written or electronic documents related to the review process along with the final committee decisions shall be considered working notes of the committee and shall be stored in a locked file by policy after the committee decision has been made. Working notes include potential issues identified by hospital staff, preliminary case rating, questions and notes and the physician reviewers and requests for information from the involved physicians and any written responses to the committee.

7. Peer review information in the individual provider quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a medical staff leader or hospital employee. However, they shall have access to the information only to the extent necessary to carry out their assigned responsibilities. Only the following individuals shall have access to provider-specific peer review information contained in a provider's quality file and only for purposes of quality improvement:
   - The specific provider;
   - The Chief of Staff, Chief-elect, and Department Chair's, Section Chief, or their designee, for purposes of considering corrective action;
   - Members of the Medical Executive Committee, Credentials Committee, and Physician Peer Review Committee for purposes of considering correction action;
   - Quality Director and Staff supporting the peer review process;
   - Medical staff services professionals to the extent that access to this information is necessary for the re-credentialing process or formal corrective action;
   - Individuals surveying for accrediting bodies with appropriate jurisdiction, e.g., The Joint Commission or state/federal regulatory bodies; and
   - Individuals with a legitimate purpose for access as determined by the hospital Board of Trustees;
   - The hospital CEO when information is needed to take immediate formal corrective action for purposes of precautionary suspension or suspension for collegial intervention by the CEO and required others as set forth by the Medical Staff Bylaws.

8. No copies of peer review documents will be created and distributed unless authorized by medical staff policy or bylaws, the Medical Executive Committee, the Board of Trustees or by mutual agreement between the Chief of Staff and the Chief Medical Officer for purposes of deliberations regarding corrective action on specific cases.

Circumstances requiring peer review:

Peer review is conducted on an ongoing basis and reported to the appropriate committee for review and action.

In the event a decision is made by the Board of Trustees to investigate a practitioner's performance or circumstances warrant the evaluation of one or more providers with privileges, the Medical Executive Committee or its designee shall appoint a panel of appropriate medical professionals to perform the necessary peer review activities as described in the Medical Staff Bylaws.

Peer Review Performance Indicators

Peer Review Performance Indicators that shall be used as measurement tools in evaluating a practitioner's performance include, but are not limited to, the following:

- Case Review Indicators – performance brought to review by a specific event review, root cause analysis, incident reporting mechanism, patient/family complaint, routine quality monitoring such as mortality review, blood product utilization, operative review, surgical site infection review, etc., and any direct referral from any source to the Quality Department.
- Rule Indicators – performance measured against general rules, standard or recognized professional guideline or accepted practice. (example: Medical Staff Rules such as Completion of H&P within 24 hours of admission).
- Rate Indicators – performance measured through aggregated statistical data. (example: Surgical Site Infection rates)

Circumstances requiring external peer review:

Either the Medical Executive Committee or the Board of Trustees will make determinations on the need for external peer review. No practitioner can require the hospital to obtain external peer review if it is not deemed appropriate by the Medical Executive Committee or the Board of Trustees. Circumstances requiring external peer review include:

- Litigation – when dealing with the potential for a lawsuit.
- Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly impact a practitioner's membership or privileges.
- Lack of internal expertise – When no one on the medical staff has adequate expertise in the specialty under review; or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as described above. External peer review will take place, if this potential for conflict of interest cannot be appropriately resolved by the Medical Care Evaluation/Peer Review Committee, Medical Executive Committee or Board of Trustees.
- Miscellaneous issues – when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the Medical Care Evaluation/Peer Review Committee, Medical Executive Committee or Board of Trustees may require external peer review in any circumstances deemed appropriate by either of these bodies.

The external peer review organization utilized should have or provide the following:

- Clinical consultants located outside the geographic area of the practice under review
- The ability to ensure that the physician reviewer has no knowledge of or connection to the physician being reviewed
- A network of board-certified consultants nationwide which includes all specialties
- Reviewers who will be available to answer questions from the Peer Review Committee, MSEC, and the Board of Trustees and/or any of their designees, and be available to participate in a medical staff hearing/appeals process.
- Clinical consultants who are all currently in active clinical practice
- Provide a professional final report in a timely manner

If Peer Review Committee has initiated the external peer review process, the appropriate Medical Staff Department Chairman or designee will review the final report. Conclusions and /or recommendations should be considered when submitting final report to the Medical Care Evaluation/Peer Review Committee and notification of the Medical Executive Committee. When MEC initiates the external peer review process, the MEC chairman or designee will review final report.
The final disposition will be kept in the quality portion of the provider's file.

Results of the Peer Review Process are available for the Medical Staff Department Chairman or designee to review at the time of re-appointment.

Participants in the review process:

Participants in the review process will be selected according to the medical staff policies and procedures. The work of all practitioners granted privileges will be reviewed through the peer review process. Clinical support staff will participate in the review process if deemed appropriate. Additional support staff will participate in the review process as included in their job responsibilities. The peer review body will consider the views of the person whose care is under review prior to making a final determination regarding the care provided by that individual providing that individual responds in a timely manner.

In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, the Peer Review Committee or the Medical Executive Committee will replace, appoint or determine who will participate in the process so that bias does not interfere in the decision-making process.

Selection of Physician Performance Measures

Measures of physician performance will be selected to reflect the six General Competencies and will utilize multiple sources of data described in the Medical Staff Indicators listed in Attachment: Quality Triggers for Review.

Thresholds of Focused Professional Practice Evaluation:

If the results of Ongoing Professional Practice Evaluation indicate a potential issue with physician performance, the Medical Executive Committee may initiate a focused evaluation to determine if there is an issue with current competency of the physician for either specific privileges or for more global dimensions of performance. These potential issues may be the result of individual case review or rule or rate indicators.

Oversight and Reporting
Direct oversight of the peer review process is delegated by the Medical Executive Committee to the Peer Review Committee. The Peer Review Committee will report to the Board of Trustees through the Medical Executive Committee.

Statutory Authority
This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986, 42 U.S.C. 1101 *et seq*, and Section 2305.24 and 2305.25-252 of the Ohio Revised Code. All minutes, reports, recommendations, communications and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities. Documents, including minutes and case review materials, prepared in connection with this policy should be labeled "Confidential Peer Review" material.

PEER REVIEW PROCESS

TYPE 1 REVIEWS
Automatic Educational Letter

The following items, when identified, will be subject to review. If any ambiguity or questions exist, or if significant compromise to patient care occurred, these cases will be referred to the Department Chairman for individual case review. In all other cases, an educational letter will automatically be sent.

Educational letters are tracked and trended and reported to Peer Review Committee monthly. If a provider receives three or more educational letters in a quarter, this is reported to Peer Review Committee for intervention.

- H&P not dictated and on chart (signed and/or updated) within 24 hours of admission or prior to surgical procedure
- Failure to respond to page in a timely manner
- Failure to respond to consult request in a timely manner
- Pre-sedation and Post-sedation documentation
- Operative note not dictated within 48 hours
- No immediate brief operative note (or full operative report) available prior to next level of care
- Core Measure failure
- Unclear, incomplete documentation
- Use of unapproved, unsafe abbreviations
- Failure to comply with proper hand hygiene practices and/or appropriate PPE (personal protective equipment) for patients in isolation

TYPE 2 REVIEWS
Individual Case Review

Peer review will be conducted by the medical staff in a timely manner.

All cases not meeting the criteria for Type 1 Reviews will be presented to the Department Chairman for initial review. The Department Chairman may request additional information, refer the case to the Section Chief for further review. Based on the review of the case, the case will be assigned a rating as described in the Peer Review Case Rating Form. The case may be closed or referred to the Peer Review Committee for further review and action.

The Peer Review Committee will review the case, determine if further information is warranted from the provider through a letter of inquiry, send a letter of education, hold a discussion with the provider, request FPPE, refer the case to the Medical Executive Committee or close the case. If a letter of inquiry is sent, the response is required within 21 days of receipt of the letter. The response will be reviewed at the next meeting of the Peer Review Committee. If there is no response to the letter of inquiry within the 21 days, the case will proceed at the next Peer Review meeting with the information that is currently available. The Peer Review Committee may refer the case to Medical Executive Committee with a recommendation for external peer review when the case meets the parameters referenced in the earlier section.

Approved by the ____MEDICAL EXECUTIVE COMMITTEE August 13, 2019_____

CONFIDENTIAL PEER REVIEW
MATERIAL CERTIFIED MAIL

Date

Mercy Health St. Charles Hospital
2600 Navarre Avenue
Oregon, Ohio 43616

Physician Name
Address
City, State, Zip Code

Re: (pt name) MRN:
Admit Date: Discharge Date:

Dear Dr. [provider name] :

The medical staff has selected a number of performance screening indicators designated as **Type 1 or general rule indicators.** These indicators represent the medical staff general rules, standards, or recognized accepted practices of medicine or compliance with Hospital Quality Core Measures as set forth by Joint Commission and Centers for Medicare and Medicaid Services. The list of Type 1 or general rule indicators is enclosed. These indicators do not trigger formal physician peer review but are trended for pattern analysis.

The purpose of providing physicians this feedback is to increase awareness of these rules, standards and/or accepted practice of medicine and improve future physician performance. Quarterly, the Physician Peer Review Committee will analyze patterns of care for concerns, which may have significance beyond a single episode. These patterns may suggest opportunity for improvement.

During a routine review of patient records based on these indicators, the medical record of the above patient for which you were listed as the attending/consulting physician was reviewed. If the patient assignment is incorrect, please inform the quality department immediately so we can assign the patient to the appropriate physician. In this case, the documentation provided in the medical record did not reflect compliance with the following indicator or was found to be deficient concerning the following quality core measure initiative(s):

Insert Here

We ask that you consider the feedback regarding this indicator in the spirit of continuous improvement and apply it to your future practice as appropriate either for improving documentation or approaches to patient care. A response is not required; however, if you have additional information regarding variations you would like the committee to consider, a response letter should be sent within 21 days. This letter and your response, if you chose to send one will be placed in your peer review file. If you feel that you need to speak with someone regarding this matter, please feel free to contact the Quality Department at 419-696-7451.

Thank you for your cooperation with our efforts to create a positive approach to providing physicians with this information.

Sincerely,

Chairman, Peer Review Committee

Mercy Health – St. Charles Hospital

cc: Quality & Performance Improvement (Type 1 Indicator Educational Letter)

Title:	Physician Advocacy Committee Policy & Procedure	Policy No: 3
Prepared by:	Medical Staff Bylaws Review Committee	Effective Date: 01/25/02
Department:	Medical Staff Services	Revision Date: n/a
Authorized by:	Medical Staff Bylaws Review Committee	Date of Review: 04/09/2019

Applies to: Medical Staff

PURPOSE: Improve the quality of care and promote the competence of the Medical Staff. Provide a framework for giving support to an impaired physician. This policy supplements provisions in the medical staff bylaws.

Circumstances Requiring Impaired Physician Support

As defined by the American Medical Association: "one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol."

Educational Process

Education of the medical staff and other organization staff will be done by the Physician Advocacy Committee on illness and impairment recognition issues specific to physicians. This information will also be reviewed every two years at the orientation of newly appointed medical staff leaders. In addition, this education will be included in the orientation packet for all new medical staff appointments.

Referral Reporting Process

Executive Committee: A written request may be given to the Chair of the Physician Advocacy Committee. This request should specifically describe the reason for referral.

Staff Referral: An oral or, preferably, a written report is to be given to the Chair of the Physician Advocacy Committee. This may also be given to the Department Director of the physician involved, who shall forward a copy or verbally discuss the issue with the Committee Chair. The report shall include a description of the incident or incidents, which led to the belief that the physician may be impaired. The report must be factual. This report will be further reviewed and investigated by the Physician Advocacy Committee.

Self-Referral: A physician may initiate a self-referral by contacting the chairman of the Physician Advocacy Committee, Department Director, or Section Chief.

Referral Assessment and Evaluation

The Physician Advocacy Committee will make the determination of suspected impairment based on their fact-finding investigation into the validity of the referral. Action must be taken on a reasonable belief that impairment exists and if there is some concern about patient safety or the physician's ability to practice capably. If temporary removal of privileges is recommended see the prevailing Bylaws for the procedures associated therewith.

Treatment Referral Process

Following the assessment and evaluation phase, if the practitioner is found to have an Impairment problem, the physician will be referred to the Ohio Physicians Health Program for diagnosis/treatment/rehabilitation and/or to an outside expert, which may include the assistance of the Ohio Physicians Health Program. (Legal counsel to be consulted.) If the practitioner is non-compliant, legal counsel, the Medical Executive Committee and the Board of Trustees will be consulted for next steps.

Maintenance of Confidentiality

All information regarding the physician and his referral will be classified as confidential except as limited by law, ethical obligation or with the safety of the patient is threatened.

Monitoring Process

Periodic reports to the Physician Advocacy Committee from the treating physician. This report shall state the practitioner-patient is continuing treatment or therapy, as appropriate.

The practitioner-patient's exercise of clinical privileges in the hospital shall be monitored by the Department Director and/or Section Chief. The nature of the monitoring shall be determined by the Physician Advocacy Committee, after its review of all of the circumstances.

In considering an impaired physician for reinstatement, the Physician Advocacy Committee must consider patient care interests as completely paramount.
The Committee must first obtain a letter from the physician director (or equivalent) of the rehabilitation program where the practitioner was treated. The practitioner-patient must authorize the release of this information. The letter must contain the following information:

- Whether the physician is participating in the program
- Whether he/she is in compliance with all of the terms of the program
- Whether, in the opinion of the treating physician(s), the practitioner-patient is rehabilitated and capable of resuming his/her medical practice and providing continuous, competent care to his/her patients.
- Whether an aftercare program has been recommended and, if so a description of the aftercare program.
- Whether alcohol/ and or drug testing is needed.

Reinstatement

As per the prevailing Bylaws and Rules and Regulations of the Medical Staff

The Medical Staff member will be reinstated under a custom Focused Professional Practice Evaluation (FPPE) as designed per PAC recommendation for such individual. Upon successful completion of the FPPE terms, the FPPE will be closed. If terms of FPPE are not met, PAC will reconvene to determine additional recommendation for the Medical Executive Committee's consideration regarding the involved medical staff member.,.

Report to Leadership

The Physician Advocacy Committee shall report directly to the Executive Committee and may take or recommend to the Executive Committee such actions as may be desirable to protect patients and the Hospital, but shall otherwise maintain the confidentiality of the identity of the individual with whom it is working or who may be subjects of its investigation, notwithstanding any other provisions of the Bylaws.

APPROVED: signature on file — President & CEO; signature on file — Chief of Medical Staff

MERCY ST CHARLES HOSPITAL

Title:	Credentialing Physicians in the Event of Disaster	Policy No:	4
Prepared by:	Medical Staff Office	Effective Date:	09/24/02
Department:	Medical Staff Services	Revision Date:	09/24/02
Authorized by:	Medical Executive/Board of Trustees	Date of Review :	12/12/2017
Applies to:	Medical Staff		

PURPOSE: To verify credentials and grant privileges to non- staff physicians at Mercy Health St. Charles Hospital in the event of an emergency. Emergency being defined as any officially declared emergency whether it is local, state or national.

POLICY: Any physician providing patient care must be granted privileges prior to providing patient care, even in an emergency or disaster situation.

PROCEDURE: In the event of a disaster, any physician requesting emergency privileges must report to the Medical Staff Office and provide the following information for verification in order to be granted privileges:

A current professional license to practice in Ohio.

Photo identification. (Must be a valid State I.D.)

Current malpractice insurance information and provide a signature on the emergency malpractice attestation.

A list of current hospital affiliations where the physician holds Active privileges in order to verify current competency and privileges.

Consent to having a National Practitioner Data Bank and OIG query.

Declare his/her specialty in which he/she currently practices

Current DEA

Once all of the above information is obtained, approval will be obtained via either the Chief of Staff and/or the CEO. The physician will be under the direction of the Section Chief and/or the Department Director of his/ her specialty. Once the above process is complete the physician will be given a red ID tag that must be worn when exercising privileges at Mercy Health St. Charles Hospital. The ID tag will indicate the following information:
Name and title
Specialty
ID #
Signature of the Chief of Staff and/or Credentials Committee Chairman
Code tag from security

When the emergency situation no longer exists, these temporary, emergency privileges terminate.

Initial Approval by Executive Committee August 2002

MERCY ST CHARLES HOSPITAL

Title:	Disaster Procedure Policy	Policy No:	5
Prepared by:	Medical Staff Office	Effective Date:	09/24/02
Department:	Medical Staff Services	Revision Date:	09/24/02
Authorized by:	Medical Executive, Board of Trustees	Date of Review:	12/12/2017
Applies to:	Medical Staff		

PURPOSE: To provide a Medical Staff Disaster Procedure during a "Code Yellow"

PHYSICIAN CALL IN PROCEDURE:

- The Chief of Staff will be notified immediately and he/she or his/her designee will be the Director of the Physicians' Labor Pool.

- The Director of the Physicians' Labor Pool will contact as many physicians who are in house or from the Physician Call Roster as he/she feels necessary for the initial receiving of the disaster victims. If additional physicians are needed they will be contacted.

- Emergency Center physicians will be called in as needed by the Emergency Department as per their normal procedure and coordinated with the Director of the Physicians' Labor Pool.

THE AREAS TO BE COVERED BY PHYSICANS ARE AS FOLLOWS:

- Emergency Department (until their own staff arrives)

- Minor treatment area. (Short Stay Unit)

- Discharge Team (In-house Nursing Units)

- Surgery

- Other areas based on specialty needed/available

PROCEDURES TO BE FOLLOWED:

- Triage of disaster victims will take place in the Emergency Center. Only critically ill or injured patients will be treated in the Emergency Center. The minor treatment area (Short Stay Unit) will receive all victims in the non-critical category.

- The physicians responding to the disaster will park in the Physicians' parking area and enter the hospital through the Main Entrance to the South Building off Wheeling Street. The Mercy St Charles Hospital I.D. or other photo I.D must be presented to enter. The physicians will then report to the Medical Staff Office on the Mezzanine floor (North Building) for assignment.

- An Assignment Flow Sheet will be used which will include the physician's name, specialty, and where he/she has been assigned. The Director will keep track of all assignments.

- When a physician finishes an assignment, he will report back to the Medical Staff Office personally or by phone (696-7576 or 696-7376) for reassignment. The Director may also choose to reassign a physician, as his/her specialty becomes needed elsewhere.

- Those physicians assigned to the Emergency Center will be treating critically ill or injured victims. As additional Emergency Center physician staff arrives, physicians initially staffed in the Emergency Center will be relieved and reassigned as needed by the Physician Director.

- The Holding Area (Short Stay Unit) will receive those patients stabilized and who are waiting for a hospital bed or surgery.

- A physician designated as part of the Discharge Team will report to the Nursing Unit assigned. They will be responsible to review the patient discharge lists made up by the charge nurse or his/her designee and to approve any patients that can be discharged in the event that the bed space is needed.

THE FOLLOWING ITEMS ARE ATTACHED TO THIS PROCEDURE:

- Assignment sheet that will be used by the Director.

- In patient discharge list that will be at each Nursing Unit and used by the Discharge Physician.

- Copy of the patient record form to be used for disaster victims.

- Mercy Health St. Charles Hospital map.

Initial Approval by Executive Committee September 2002

MERCY HEALTH ST. CHARLES HOSPITAL

Title:	Corporate Compliance for Sanctions	Policy No.: 6
Prepared by:	Bylaws Review Committee	Effective Date: 05/21/02
Department:	Medical Staff Services	Revision date: n/a
Authorized by:	Executive Committee/ Board of Trustees	Date of review: 12/12/2017
Applies to:	Medical Staff	

PURPOSE: To ensure Corporate Compliance when a physician is identified as "ineligible" by the Office of the Inspector General of the Department of Health and Human Services.

CONTENT: If a member/affiliate of the Medical Staff of Mercy Health St. Charles Hospital is identified as "ineligible" by the Office of the Inspector General of the Department of Health and Human Services, the following shall occur:

- If the practitioner is penalized by a financial penalty, his/ her membership and clinical privileges will be unaffected.
- If the practitioner is penalized by a suspension or limitation of the Medicare/ Medicaid patients for which he/she may bill, the practitioner's privileges will be limited to non-Medicare/ Medicaid patients. The practitioner would receive notification of this limitation; however, no hearing and appeals rights would be afforded.
- If the practitioner is penalized by a suspension or limitation of the Medicare/ Medicaid patients for which he/she may bill, the practitioner would be ineligible to take Emergency Call.
- It is the practitioner's responsibility to notify the Medical Staff Office in writing and to follow the sanctions.

MERCY HEALTH ST. CHARLES HOSPITAL

Title:	Medicare Acknowledgement Statement	Policy No.: 7
Prepared by:	Bylaws Review Committee	Effective Date: 07/01/04
Department:	Medical Staff Services	Revision date: n/a
Authorized by:	Executive Committee/ Board of Trustees	Date of review: 12/12/2017
Applies to:	Medical Staff	

PURPOSE: To ensure compliance with the Code of Federal Regulations 42CFR 412.46 requirement that the hospital have a signed Medicare Acknowledgement Statement on file for each physician that is granted privileges at Mercy Health St. Charles Hospital.

CONTENT: Each physician who applies for privileges at Mercy Health St. Charles Hospital will be required to sign and return a Medicare Acknowledgement Statement. A signed Medicare Acknowledgement statement must be on file to have the application deemed complete.

MERCY HEALTH ST. CHARLES HOSPITAL

Title:	Sponsoring Physician Requirement	Policy No.: 8
Prepared by:	Bylaws Review Committee	Effective Date: 12/15/2006
Department:	Medical Staff Services	Revision date: n/a
Authorized by:	Executive Committee/ Board of Trustees	Date of review: 12/12/2017
Applies to:	Medical Staff	

PURPOSE: To ensure that patients seen by allied health professionals be evaluated by their sponsoring physician in a timely fashion, preferably within 24 hours.

CONTENT: Patients seen by allied health professionals must be evaluated by the respective physician in a timely fashion, preferably within 24 hours.

MERCYHEALTH

Mercy Health St. Charles Hospital

Title:	Professional Behavior Policy	Policy No:	9
Prepared by:	Medical Executive Committee	Effective Date:	12/31/2008
Department:	Medical Staff Services	Revision Date:	02/12/2013
Authorized by:	Medical Executive, Board of Trustees	Date of Review:	08/22/2018
Applies to:	Medical Staff		05/14/2019

PURPOSE: To establish procedures to address disruptive behavior/conduct of members of the Medical Staff that is consistent with the Mercy Code of Professional Conduct and related policies.

The rationale of this policy is:

1. To provide for a consistent process to address complaints or problems brought to the attention of the Mercy Health St. Charles Hospital Professional Behavior Advocacy Committee (PBAC) and/or the Medical Staff Executive Committee regarding disruptive behaviors or activities of members of the medical staff of Mercy Health St. Charles Hospital.
2. To aid practitioners in maintaining and/or regaining optimal professional functioning consistent with the protection of patients with consultative support and direction, where appropriate.
3. To enable members of the medical staff to be more successful in their interactions with others.

CONTENT:

Policy:

It is the policy of Mercy Health St. Charles Hospital that all individuals within the facility should be treated courteously, respectfully, professionally, and with dignity. To that end, the Board requires that all individuals, including employees, physicians and Allied Health Practitioners, conduct themselves in a professional and cooperative manner.

If a physician fails to conduct him or herself appropriately, the matter shall be addressed in accordance with this policy. It is the intention of Mercy Health St. Charles Hospital that this policy is enforced in a firm, fair, consistent and equitable manner.

Organizational structure:

1. Committee Composition: Members of the Professional Behavior Advocacy Committee (PBAC) will be the Past Chief of Staff (Chairman), Chief Medical Officer, designated Administrative Official, The Chief of Staff, Chief of Staff Elect, and Chief Executive Officer. If a matter which has been put to vote results in a tie, the appropriate specialty or medical staff leader will be requested to cast the deciding vote.

2. Authority: PBAC is authorized jointly by administration and the medical staff and ultimately the Mercy Board of Trustees to address Professional Behavior/conduct issues related to the organized medical staff.

3. Meeting Format: Meetings shall be at least quarterly.

Title: Professional Behavior Policy (Cont.)

Guidelines:

1. Each physician who applies for privileges at Mercy Health St. Charles Hospital will be asked to sign and return a Code of Professional Conduct/ Personal Commitment Statement. Medical Staff will participate in the Mercy Health St. Charles Hospital Professional Behavior Action Plan
2. Any physician, employee, patient or visitor may report potentially disruptive conduct. In addition, a written report can be submitted by any witness to such behavior. For consistent and efficient management of such reports, a comprehensive evaluation of accuracy in staff attribution and validity of written report will be completed through the screening process. All reports will be presented to the committee members by the Chairman of the Professional Behavior Advocacy Committee. The identity of the individual initiating such complaint will not be disclosed. The Committee will request Department Chairman participation as deemed appropriate to the case.
3. To provide unbiased, inconsistent evaluation, once a written complaint is received by the Chairman of the Professional Behavior, the complaint will be forwarded for collective review of the members of the PBAC for determination of next steps.
4. Disruptive behavior takes many forms. It may be behavior that is: detrimental to the hospital's and Medical Staff's interest; detrimental to the good practice of medicine by others; highly unprofessional; or vulgar, rude, demeaning, demoralizing, argumentative, insulting, intimidating, profane, harassing and/or abusive. That a member's behavior is unusual, unorthodox or different is not alone sufficient to justify corrective or rehabilitative action. However, when a practitioner's conduct significantly interferes with the effective operation of the Hospital or poses a threat to the Hospital personnel or patient care, steps must be taken to stop or modify that conduct.
5. Disruptive behavior will be classified as follows:
    a. Minor: Perceived intimidating, threatening verbal or non-verbal action without injury, but with potential for impact on care) Unwitnessed or single witness to event which would be reasonably perceived by a witness to be disruptive behavior.
    b. Moderate: Reasonably perceived disruptive action/conduct – with impact on care or insignificant injury) Multiple witnesses to event.
    c. Major: Action/conduct resulting in injury, criminal actions,
6. If it is determined that the incident is a non-PBAC issue, it will be referred to the appropriate person/department. (Example- patient quality of care issues with no behavioral component would be referred to the Quality Department.).
7. Upon receipt of a written complaint deemed appropriate for PBAC, the Manager of Medical Staff Office will send a letter to the source of the complaint to inform him/her that the issue will be reviewed through the established process.
8. Documentation of disruptive conduct will be maintained in peer review files for both isolated incidents and potential patterns of inappropriate conduct. That documentation shall include:
    a. the date and time of the questionable behavior;
    b. if the behavior affected or involved a patient in any way, the name of the patient;
    c. the circumstances which precipitated the situation;
    d. description of the questionable behavior limited to factual, objective language as much as possible;
    e. the consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations;

f. record of any action taken to remedy the situation including date, time, place, action and name(s) of those intervening

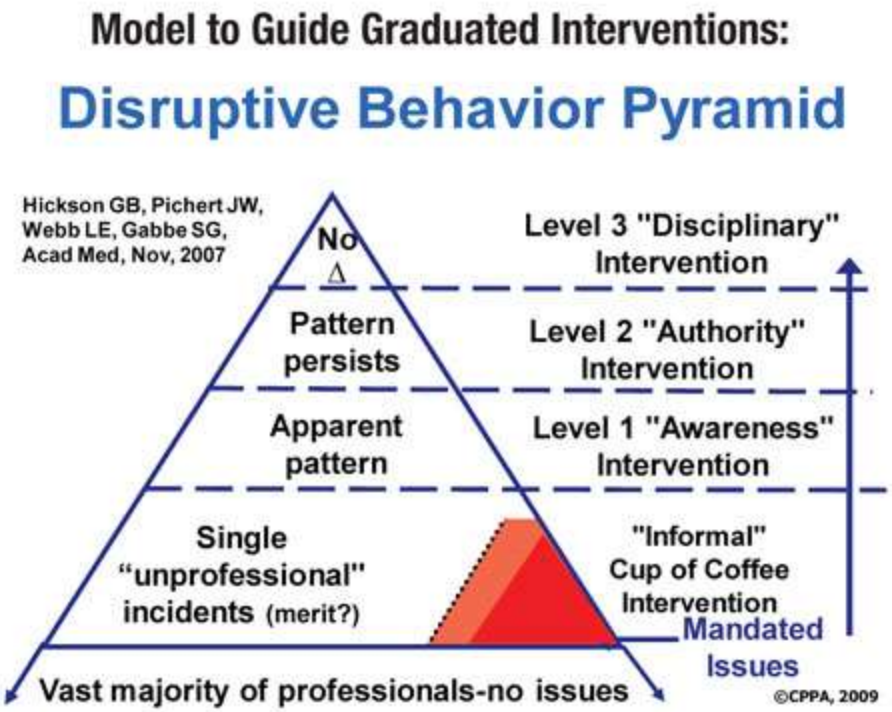
Title: Professional Behavior Policy (Cont.)

9. Disruptive behavior by physicians will be reported to the Professional Behavior Advocacy Committee as set forth below. Egregious behavior, including without limitation, sexual harassment, assault, felony convictions, fraudulent acts, stealing, throwing objects, or other threatening behavior may result in immediate suspension of clinical privileges, termination of employment and/or medical staff membership as defined by the Mercy Health North Medical Staff Bylaws. The PBAC may, at its discretion, refer disruptive behavior to the Medical Staff Executive Committee or to the Board for action in accordance with the Bylaws.

   The complaint, as well as any related responses from the involved practitioner, will be investigated by the PBAC. Those complaints considered valid and appropriate for review by the PBAC will be addressed as follows:
   SEE PROFESSIONAL BEHAVIOR ADVOCACY REFERENCE GUIDELINES

10. If the Medical Staff recognizes that disruptive behavior may be due to impairment, the Physician Advocacy Policy will be initiated and followed.

Final approval of revisions by the MHN Board of Trustees on May 29, 2019.



Studer Group and Vanderbilt University Medical Center – Center for Patient and Professional Advocacy (CPPA),
Hickson GB, Pichert JW, Webb LE, Gabbe SG. A complementary approach to promoting professionalism: identifying, measuring and addressing unprofessional behaviors. Acad Med, 82(11):1040-1048 (2007).

PROFESSIONAL BEHAVIOR ADVOCACY REFERENCE GUIDELINES

Developed to assist in continuity of evaluation and action.

Suggested Actions based on Chronicity and Severity of behavior/conduct:

Chronicity: → Severity: ↓	1-3 occurrences	>6 occurrences in 12 consecutive months (same/similar issue –Minor or Moderate severity)	Subsequent after formal Notice of pattern	Failed FPPE/additional occurrence
Minor (reasonably perceived[1] disruptive action/conduct – without injury, potential for impact on care) Unwitnessed/one witness	≤ 3 CMO/MS designee collegial conversation or Rule notice (form letter reminding and informing of policy (no response necessary)	Formal PBAC letter notifying of pattern, no response requested, provide formal notification on consequences for future events (cc: Dept Director & Sect Chief)	Formal PBAC letter noting non-compliance and citing policy for formal intervention, response requested, FPPE designed (action plan) (cc: Dept Director & Sect Chief)	PBAC reports to MEC, suggest consideration for formal action-hearing (cc: Dept Director & Sect Chief)
Moderate (reasonably perceived disruptive action/conduct – with impact on care or insignificant injury) Witnessed	Collegial conversation Formal PBAC letter requesting response (Dept Director/Section Chief intervention)	Formal PBAC letter noting pattern, response requested, provide formal notification on consequences for future events (cc: Dept Director & Sect Chief)	Formal PBAC letter noting non-compliance and citing policy for formal intervention, response requested, FPPE designed (action plan) (cc: Dept Director & Sect Chief)	PBAC reports to MEC, suggest consideration for formal action-hearing (cc: Dept Director & Sect Chief)
Major (action/conduct resulting in injury, criminal actions,)	PBAC evaluates and reports to MEC, suggest consideration for formal action-hearing. (Dept Director & Sect Chief notified immediately)			

Invalid reports will be so noted in reporting system. Reports may be determined as invalid for the following reasons:

Unreasonable perception[2]
Anonymous without enough supporting information
Conflicting reports
Duplicative report
Erroneous report
Felonious report
Unsubstantiated by documentation/policy

[1] Occurrence deemed by PBAC as an event that would be reasonably perceived by a witness to be disruptive behavior

[2] Occurrence deemed by PBAC as an event that would most likely not be perceived by a witness to be intentionally disruptive behavior

MERCY ST. CHARLES HOSPITAL

Title:	Emergency Center Guidelines for Prescriptive Authority	Policy No.: 10
Prepared by:	Bylaws Review Committee	Effective Date: 9/2009
Department:	Medical Staff Services	Revision date: 2/23/2011
Authorized by:	Executive Committee/ Board of Trustees	Date of review: 12/12/2017
Applies to:	Medical Staff	

PURPOSE: To establish a guideline for when prescriptive authority will be granted.

CONTENT: Physician assistants (PA's) and nurse practitioners (NP's) who have the validated prescriptive authority licensure endorsement will be granted prescriptive authority. Only PA's and NP's working exclusively in the emergency department who are in provisional or externship status for prescriptive authority will be granted prescriptive authority under direct supervision of the emergency physician.

Mercy St. Charles Hospital

Title: Focused Professional Practice Evaluation (Initial & New Privilege requests)

Policy Number: MSCH-MS-11

Author/Index:	Medical Staff Services	**Original Approval Date:**	6/23/2011
Chapter/Issued By:	Administration-Med Staff	**Effective Date:**	03/2020
Authorized By:	Medical Staff – Executive Committee	**(Retroactive):**	
		Revision Date:	03/2020
Replaces:	None	**Review Date:**	3/3/2020
References:		**Date of Next Review:**	3/2023
Keywords:	FPPE, Focused Professional Practice Evaluation		
Applies To:	All initial appointees and current members requesting new privileges at Mercy St. Charles Hospital.		

Review: Every three years

Purpose

To establish a systematic process to assess practitioners who have been granted initial/new privileges at Mercy St. Charles Hospital. In addition to the bylaws stipulated provisional review periods a Focused Professional Practice Evaluation (FPPE) method shall be set forth in this policy, as a basis for obtaining organization specific information on current competence for practitioners requesting new privileges.

Definition

FPPE is intended to be a relatively short period of time typically not exceeding 10 months. For infrequently performed procedure the FPPE period of review may take greater than 10 months.

Medical Staff Oversight

The Medical Executive Committee is charged with the responsibility of monitoring compliance with this policy and procedure. It accomplishes this oversight through Credential Committee and Medical Care Evaluation Committee activities related to the terms and progress of all practitioners required to be evaluated under this policy as well as any issues or problems involved in implementation of this policy and procedure. FPPE relies on peer review from an oversight/validation perspective. Thus, the medical staff peer review process/committee is responsible along with the Department Director/Section Chief for evaluation of the FPPE reviews for each applicant under evaluation.

Process for assignment of FPPE

Upon review of initial applicants or requests from practitioners for new privileges, the section chief/department chair will recommend a FPPE method.

The decision on which method of focused evaluation is employed to assess a new applicant to the medical staff, or a current member who is requesting a new privilege is based on several factors. Section Chiefs, Department Directors, and/or recommending authority is responsible for determining which method would best assess current competency. The following table is a guide for use in making this decision.

Provider experience:	Suggested FPPE methodology:
Un-established Physician	Concurrent monitoring and/or other focused/ongoing professional review
Recent Graduate	Retrospective monitoring and/or other focused/ongoing professional review
Unknown Training program	Prospective/Concurrent/Retrospective proctoring and/or other focused/ongoing professional review
Possible concerns cited on application	Prospective/Concurrent/Retrospective proctoring and/or other focused/ongoing professional review
Logs missing	Prospective/Concurrent proctoring and/or other focused/ongoing professional review
Lapse in practice (returning to practice)	Prospective/Concurrent/Retrospective proctoring and/or other focused/ongoing professional review

Each specialty shall determine the standard recommended FPPE method/volumes however in no case shall this consist of less than 5 retrospective case reviews. The approved method for FPPE shall be documented on the Credentialing Recommendation Signature Form. This recommendation shall be processed as part of the credentialing approvals process. Standard FPPE is recommended for applications/privileges that raise no concerns. Standard FPPE based on specialty is listed below:

DEPARTMENT	**STANDARD FPPE**
Emergency Medicine	5 retro case reviews
Family Medicine (Pediatric Section)	5 retro case reviews
Internal Medicine (all specialties excluding Pathology)	5 retro case reviews
Internal Medicine (Pathology)*	50 retro case reviews
Psychology*	5 retro case reviews
OB/Gyn	5 retro case reviews
Radiology*	50 retro case reviews
Surgery (all specialties)	5 retro case reviews

Upon board approval, FPPE recommendations shall be forwarded by the medical staff office to the quality department. For Emergency Medicine, Family Medicine, Internal Medicine (excluding Pathology) Psychology, OB/Gyn, and Surgery, the quality department staff shall coordinate a random selection of cases for FPPE monitoring and referral for evaluation by the appropriate specialty leader.

Upon successful completion of FPPE the quality staff shall submit the results to the credentials committee (via medical staff services) with a final recommendation on whether the terms of FPPE were successfully met or if additional FPPE should be considered. This information will be submitted for formal board approval.

Removal of FPPE is a privileging matter and does not affect staff category/status.

The quality department will inform the Credentials Committee if the terms of FPPE cannot be completed within 10 months, or a period commensurate with evidence of current competence (in the matter of infrequently performed procedures/surgeries).

The Credentials Committee will re-assess the assigned FPPE parameters in collaboration with the Section Chief/Department Chair and practitioner's desires.

Extension of FPPE may be recommended if the practitioner's activity and/or desire(s) are valid. If the practitioner no longer intends on exercising the privilege a withdrawal or adjustment to staff privilege(s) will be considered. These recommendations will be forwarded through the standard credentialing approval process.

Providers who refuse to comply with recommended FPPE will be notified that failure to complete the recommended FPPE may result in suspension of privileges. If FPPE is not completed within 90 days of suspension, MEC may recommend automatic termination.

* The Department Chairman/Section Chief will be responsible to monitor and report completion of initial FPPE for new privilege requests.

MERCY HEALTH ST. CHARLES HOSPITAL
CASES TO BE PROCTORED RETROSPECTIVELY

PLEASE RETURN TO QUALITY AND ACCREDITATION ONCE YOU HAVE COMPLETED YOUR FIRST FIVE CASES
FAX: 419 696 7441 (Attention: Renee Moore, RN)

CASE #1

PATIENT NAME _____
MEDICAL RECORD # _____
ADMIT DATE _____
LOCATION/DEPT _____

CASE #2

PATIENT NAME _____
MEDICAL RECORD # _____
ADMIT DATE _____
LOCATION/DEPT _____

CASE #3

PATIENT NAME _____
MEDICAL RECORD # _____
ADMIT DATE _____
LOCATION/DEPT _____

CASE #4

PATIENT NAME _____
MEDICAL RECORD # _____
ADMIT DATE _____
LOCATION/DEPT _____

CASE #5

PATIENT NAME _____
MEDICAL RECORD # _____
ADMIT DATE _____
LOCATION/DEPT _____

_____ _____
Please print name **Date**

MERCY ST. CHARLES HOSPITAL
PROCTORING FORM – PROCEDURAL ASSESSMENT (one evaluation per patient)
Return this form to Clinical Quality Department (fax: 419-696-7441)

Practitioner being proctored:	**Medical record number:**
Proctor:	**Patient's primary diagnosis:**
Date review took place:	**Procedure(s) observed:**
Type of review: (check type) **_____Prospective chart review (e.g. pre tx./surg.)** **_____Direct observation/concurrent review** **_____Retrospective chart review**	**NOTE: The proctor should report any poor or significant substandard performance to the Department Chair immediately.**

EVALUATION:

Evaluate in terms of completeness and accuracy:	**Acceptable**	**Marginal* (explain)**	**Not Acceptable* (explain)**	**Not applicable**
Pre-procedural workup:				
H&P complete/accurate				
Lab/x-ray appropriate				
Consent(s) appropriate/signed				
Indications for procedure				
Intra-procedural phase:				
Procedural technique				
Management of any complication				
Procedural judgment				
Completeness and degree/extent of resection				
Operation conforms to accepted practices				
Accuracy of diagnosis				
Pre-op diagnosis compares with post-op				
Procedures appropriate to consent signed				
Surgery justified by the findings				
Retrospective observations:				
Operative reports/progress notes appropriate/timely				
Chart reflects discharge plans/instructions to patient				
Length of stay within accepted standards				
Complications appropriately documented				
Surgery was justified by the pathology reports				
Overall performance:				
Appropriate use of consultants				
Interactions with patient, colleagues, staff				

Is there any aspect of this patient's treatment or follow-up with which you are uneasy or uncomfortable (marginal or not acceptable evaluations)? _____No _____Yes* (please explain below)

*Comments:_____

_____

_____

_____ _____

Proctor's signature Date

_____

Printed Name:

Mercy Health St. Charles Hospital

Title: Provider Response Times

Policy Number: MSCH-MS-12

Author/Index: Medical Staff Services

Approval Date: 7/12/2017

Chapter/Issued By: Administration-Med Staff

Effective Date (Retroactive):

Authorized By: Medical Staff – Executive Committee

Revision Date:

Replaces: None

Review Date: 7/12/2017

References:

Date of Next Review: 7/2020

Keywords: Provider Response Time

Applies To: All current members holding privileges at Mercy Health St. Charles Hospital.

Review: Every three years

Purpose

To establish a systematic process to facilitate timely communication amongst providers and hospital staff.

Definition

Timely response to requests from a privileged provider is essential to care. The following flowchart depicts the process to ensure issues are conveyed and responded to in a timely prescribed manner.

Medical Staff Oversight

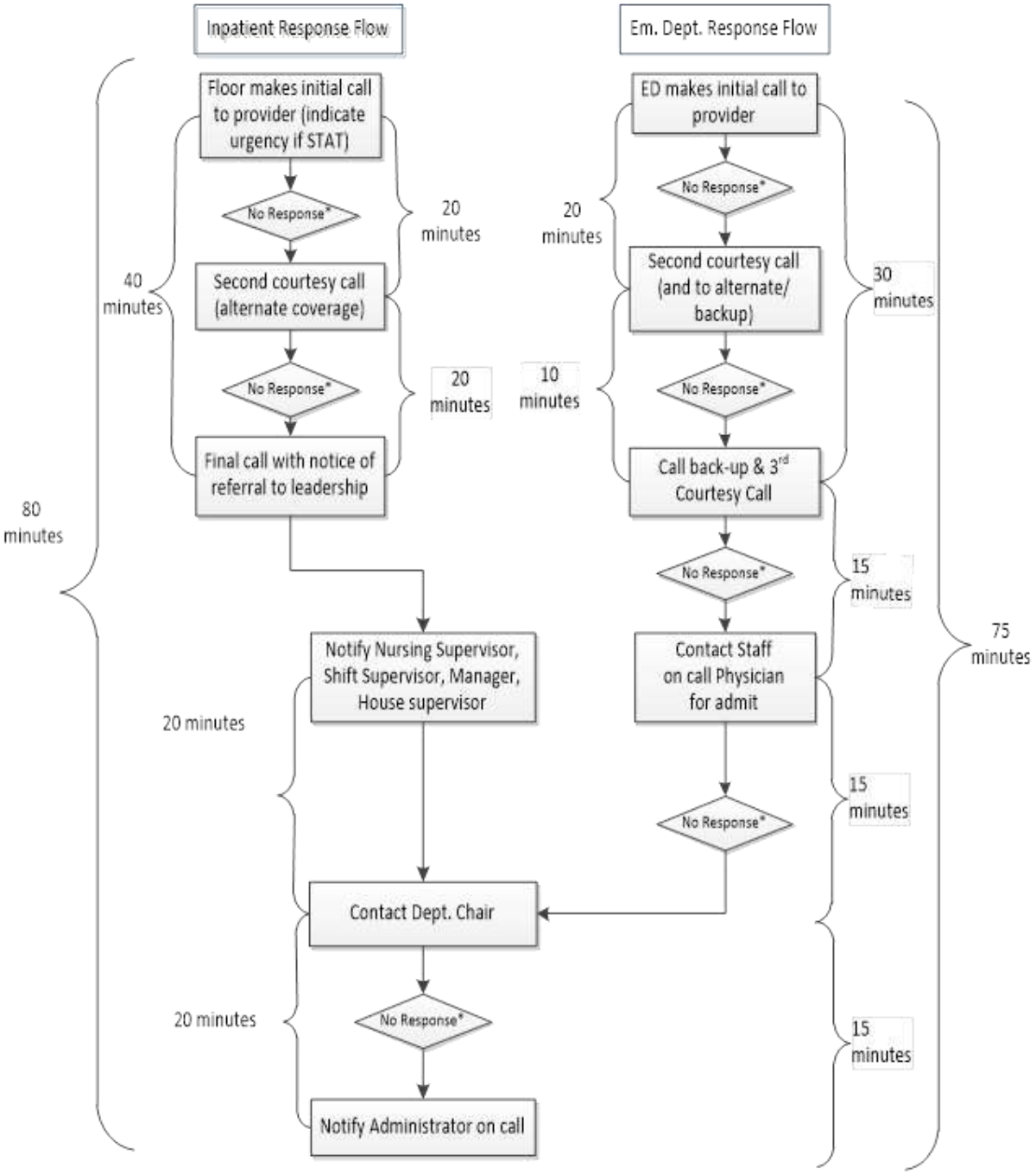
The Medical Executive Committee is charged with the responsibility of monitoring compliance with this policy and procedure. It accomplishes continual oversight through assigned professional performance monitoring functions (e.g. Medical Care Evaluation Committee) and carries out the process through the defined leadership hierarchy (Med staff = section chief, department chair, and chief of staff; Management = Managers/Supervisor, Directors, VP, President). Thus, the medical staff leaders in conjunction with hospital management are responsible for following this protocol.

FLOWCHART on following page…

Revision approved by RGS: 07.27.2016

MERCYHEALTH

Flowchart for Response Time
(paging or phone call)



* Should patient status deteriorate at any time rapid response or other approved actions should be implemented

Flowchart Revision 7/12/16

Mercy Health St. Charles Hospital

Title:	ICU Consultation Policy	**Policy Number:**	MSCH-MS-13
Author/Index:	Medical Staff Services	**Approval Date:**	7/27/2017
Chapter/Issued By:	Administration-Med Staff	**Effective Date (Retroactive):**	
Authorized By:	Medical Staff – Executive Committee	**Revision Date:**	
Replaces:	None	**Review Date:**	7/27/2017
References:		**Date of Next Review:**	7/2020
Keywords:	ICU Consultation		
Applies To:	All current members holding privileges at Mercy Health St. Charles Hospital.		

Review: Every three years

Purpose

To improve patient outcomes by establishing a systematic process to ensure critical care consultation is obtained (when indicated) for patients requiring a stay beyond 72 hrs. in the ICU. Mortality has been shown to increase on patients who stay in the ICU over 72 hrs. and do not have critical care consultants involved in the patient care.

Definition

Critical care consultation is defined as members in the specialty of Pulmonology, Cardiology, and Critical Care Medicine.

Medical Staff Oversight

The Medical Executive Committee is charged with the responsibility of monitoring compliance with this policy and procedure. It accomplishes continual oversight through assigned professional performance monitoring functions (e.g. Medical Care Evaluation Committee) and carries out the process through the defined leadership hierarchy (Med staff = section chief, department chair, and chief of staff; Management = Managers/Supervisor, Directors, VP, President). Thus, the medical staff leaders in conjunction with hospital management are responsible for following this protocol.

Procedure:

On or before 72 hrs. of ICU admission, nursing staff will request consultation from attending as necessary. If ICU admission occurred between 11pm-7am consult will be requested 8am following the 72 hours of the time of ICU admission. If the physician refuses to consult when indicated, nursing staff will execute chain of command to resolve issue.

Procedure revision approved by RGS: 07.27.2017

Mercy Health St. Charles Hospital

Title:	Medical Staff/Medical Record Policy	**Policy Number:**	MSCH-MS-14
Author/Index:			
Chapter/Issued By:	Medical Record Utilization Committee	**Effective Date:**	**11/2012**
Authorized By:	Medical Record Utilization Committee/ Medical Executive Committee	**Revision Date:**	**9-23-14, 7-28-15, 1-8-16, 8-19-19**
Replaces:		**Review Date:**	**9-24-19**
References:		**Date of Next Review:**	**9-26-21**
Keywords:			
Applies To:			

PURPOSE: In accordance with the Rules and Regulations of the Medical Staff at Bon Secours Mercy Health St. Charles Hospital, the procedure below is followed to insure compliance with the medical record completion requirement.

POLICY: Medical Records are to be completed no later than 30 days after discharge of the patient according to the Rules and Regulations of the Medical Staff.

RESPONSIBILITY OF RESPONSIBLE STAFF MEMBER: The responsible staff member will be accountable for the preparation of a complete and legal medical record for each patient. Its contents will be pertinent and current. The record will include identification data; the patient's complaint, the history of the patient, the patient's family history; the patient's present illness; the results of the patient's physical examination; special reports such as consultations, clinical laboratory and radiological services; provisional diagnosis; medical or surgical treatment and informed consents thereto; operative report; pathological finding; progress notes; final diagnosis; condition on discharge; summary or discharge note; any attestation requirements; and autopsy report when an autopsy is performed. All patient medical record entries will be legible, complete, dated, timed and authenticated in written or electronic form including, but not limited to orders, progress notes, procedure notes, patient assessments and history and physicals.

Inpatient admission order authentication: All admission orders (electronic, written or verbal/telephonic) shall be authenticated within the lesser of 48 hours of admission or prior to discharge.

Non-admission order authentication: All non-admission orders (electronic, written, or verbal/telephone) shall be authenticated within 14 days of discharge.

Authentication by on-call/covering providers: In some instances, the ordering provider may not be able to authenticate his or her order, including a verbal order, (e.g., the ordering practitioner gives a verbal order and then is "off duty" for the weekend or an extended period of time). In such cases, it is acceptable for another provider who is responsible for the patient's care to authenticate the order, including a verbal order as long as it is permitted under State law, hospital policies and medical staff bylaws, rules and regulations. The authentication time requirements remain the same. All providers responsible for the patient's care are expected to have knowledge of the patient's hospital course, medical plan of care, condition, and current status. When a provider other than the ordering provider authenticates an order, that provider assumes responsibility for the order as being complete, accurate and final.

PROGRESS NOTES: Per CMS guidelines, “services should be documented during, or as soon as practicable after they are provided in order to maintain an accurate medical record.” Bon Secours Mercy Health St. Charles requires all progress notes be documented before midnight on the date of service provided. Pertinent progress notes will be recorded at the time the matter is recorded or observed. Clinical problems should be clearly identified in the progress notes and correlated with specific orders and results from the test and treatment. Progress notes will be written at least daily, this includes psychiatric progress notes.

HISTORY AND PHYSICAL: A complete admission history and physical examination will be completed and placed in the patient’s medical record within the first twenty-four (24) hours of admission. If a complete history and physical examination has been performed within thirty (30) days prior to admission, such as in the office of a physician staff member or, when appropriate, the office of a podiatrist, dentist or oral-maxillofacial surgeon staff member, a durable, legible copy of this report may be used in the patient’s hospital medical record. History and Physical examinations completed more than twenty-four (24) hours prior to admission must be updated to include any changes subsequent to the original examination. The history and physical examination are authenticated by a physician or, when appropriate, by a podiatrist, dentist, or oral-maxillofacial surgeon member of the medical staff.

OPERATIVE REPORTS: Operative and invasive procedure reports shall be dictated or created in EPIC CarePath immediately following the procedure, and shall be dated, timed and signed/authenticated. The dictated report shall include a detailed account of the findings, as well as the technical procedure used, the specimen removed, the type of anesthesia, any complications encountered, any prosthetics used, the pre and post procedure diagnosis, estimated blood loss and the name of the physician(s) performing the procedure. An operative/invasive procedure progress note must be immediately entered on the chart. The note must include name of primary surgeon, assistants, findings, technical procedures used, specimens removed, post-op diagnosis and estimated blood loss.

CONSULTATIONS: Reports of consultations will document the consultant’s review of the patient’s medical record, findings on examination of the patient, opinion, and recommendations. The report will be made a part of the patient’s record. A statement, such as “I concur” is not an acceptable report of the consultation. For surgical cases, the consultation note will be recorded prior to surgery except in a documented emergency.

SYMBOLS AND ABBREVIATIONS: Symbols and abbreviations may be used in a patient’s medical record only when the medical staff has approved them. The only exception to this is for the principal diagnosis, complications, co-morbidities, and procedures performed; these cannot be abbreviated on the discharge summary/attestation. An official record of approved abbreviations and unacceptable abbreviations (Official Do Not Use List) will be kept on file in the Nursing Department as well as Health Information Management Department.

Documentation/Authentication/Hand Stamp Use: Medical record entries shall be restricted to staff members and physicians who are providing care to the patients. All entries created in EPIC CarePath are authenticated electronically. All clinical written entries in a patient’s medical record will be legible, written in black ink, accurately dated, timed and authenticated. All diagnoses that are not legible by the coding staff shall be returned to the physician for clarification. Any late entries in a medical record must be dated, timed and signed. In the case of a mistaken/incorrect entry on a hard copy document, draw a single line through the word (s), then initial, date and identify as a “mistaken entry”. NEVER ERASE OR OBLITERATE THE MISTAKEN ENTRY. Errors made in EPIC CarePath will be corrected per CarePath administrative PC located in the HIM department per policy. To authenticate a medical record means to prove authorship. Authentication may be done electronically or by signing or initialing the entry. Hand-stamp signatures are prohibited on all medical record entries.

Medical Student Documentation Privileges: Medical students who have been vetted through the Bon Secours Mercy Health St. Vincent Medical Center medical education department have the privileges to create a progress note in EPIC CarePath that will be cosigned by either a resident or attending staff member.

Resident Documentation Privileges: Residents have the privilege to create progress notes and physician's orders without a co-signer. They also have the privilege to dictate/ create discharge summaries and history & physicals that will be co-signed by an attending staff member.

Co-signing and Designated Alternates: Medical Staff members may co-sign for their designated alternates.

FINAL DIAGNOSIS: The final diagnosis will be recorded in full, without the use of symbols or abbreviations, dated, timed and signed by the responsible staff member at the time each patient is discharged. The responsible staff member has the responsibility for establishing the final diagnoses.

CONFIDENTIALITY OF MEDICAL RECORDS: All records and information regarding current or former patients will remain confidential. Medical Staff members are to use this information only within the scope of their professional responsibilities. No information contained in the medical record may be disclosed except in accordance with the hospital's policies concerning confidentiality of medical records.

FILING: A medical record will not be permanently filed/closed until it is completed by the responsible staff member or is ordered filed by the Medical Record Committee. Records are kept electronically in EPIC CarePath, which is considered the legal medical record.

DISCHARGE SUMMARY: A discharge clinical resume will be created or dictated on all records of patients hospitalized over forty-eight (48) hours, except normal obstetrical deliveries, and normal newborn infants. For the latter category, a final summation-type progress note and all diagnoses and procedures documented on either the Discharge Summary or a final progress note will be sufficient. In all instances, the content of the medical record must be sufficient to justify the diagnosis and warrant treatment and results. For patients hospitalized over forty-eight (48) hours, the clinical resume must list the principal diagnosis, complications, co-morbidities, and procedures performed. It must also concisely recapitulate the reason for hospitalization, the significant findings, treatment rendered, (procedure performed), information provided to the patient and family, (n/a if patient expires), which includes discharge medications, diet, activity, the condition and disposition of the patient on discharge. The responsible staff member will authenticate all summaries.

SLEEP DISORDERS: Physicians who are board-certified in Sleep Medicine (i.e. Diplomates of the American Academy of Sleep Medicine) are permitted to interpret sleep studies for those patients they have personally referred to the Sleep Center, or patients referred by partners in their practice. Once a patient's sleep study is completely scored, the interpreting physician will be *notified by sleep center* that the record is ready for review and interpretation. The first notification will occur by fax to the physician's office, with a follow-up phone call five (5) days later if the interpretation has not yet been conducted. If the interpreting physician fails to complete the dictation of a final report within ten (10) days of their first notification, the record will be interpreted by the Medical Director of the Sleep Disorders Center.

FILING OF INCOMPLETE RECORDS: When medical records cannot be completed, a process is established to review and approve the retiring of incomplete medical records. In these cases, the Retiring Incomplete Medical Records policy will be followed.

COMPLETION OF MEDICAL RECORDS: The Joint Commission considers the record delinquent thirty (30) days post-discharge. A patient's medical record will be completed at the time the patient is discharged. Where it is not possible to complete the medical record at the time of discharge, the patient's medical record will be available for completion by the staff from any computer that has MHP portal access utilizing EPIC CarePath and Document Imaging HPF Web. Per the Chart Completion Policy/Management of Delinquent Medical Records and Suspension Process, the provider will be suspended at thirty (30) days post discharge if the record is still incomplete for the required elements.

PROCEDURE:

See Standard Operating Procedure for Mercy Health St. Charles Suspension Policy below:

Thursday prior to the following Wednesday of suspension- physicians with a delinquency over 24 days is sent an ALERT letter to their CarePATH In Box and the letter is faxed to the physician's office by the HIM specialist. (A deficiency notification letter was previously sent for records with deficiencies greater than 7 days).

Monday prior to the Wednesday suspension – a list of physicians to be suspended is sent to the Medical Records Utilization Review Chair (MR UR) or in his/her absence, the Chief Medical Officer, (CMO), who will place a personal call to those physicians.

Tuesday prior to suspension- a final personal courtesy call is made to the physicians by the HIM specialist.

Every Tuesday- HIM will provide a hospital deficiency list to the Medical Staff Office, Chief of Staff, Chief Medical Office, Chief Executive Officer and MR UR Chair. The list will include three categories:

a. Those physicians/Advanced Practice Providers (APPs) who have received a deficiency notification
b. Those physicians/Advanced Practice Providers (APPs) who have received an alert notification
c. Those with impending suspension status

On Wednesday at 3 PM the day of suspension - the physician will be suspended. The physician will be called by the HIM specialist notifying him/her that their admitting, surgical and consulting privileges have been suspended and the designated HIM specialist will suspend the physician in EHR/CarePATH and notify the Medical Staff Office personnel who will suspend providers privileges in the electronic credentialing/privileging software and send a certified suspension letter to the physician.

Upon completion of record delinquencies, the HIM staff will lift the suspension in EPIC/CarePath and notify Medical Staff services personnel who will update the electronic credentialing/privileging software and send a certified reinstatement letter to the physician.

If applicable, a quarterly report is submitted by the HIM specialist to the Medical Staff Executive Committee to identify providers who have been suspended three (3) or more times in the current rolling twelve-month period and may have his or her privileges automatically terminated in accordance with the applicable facility's Medical Staff Medical Records Suspension Policy.

Further action may be taken by the Medical Executive Committee in accordance with the applicable provision of the Medical Staff Bylaws for Automatic Suspension or Automatic Termination. The reinstatement of a member's suspended admitting privileges shall be carried out in accordance with the applicable provisions of the Medical Staff Bylaws and this policy.

A staff member whose practice is interrupted for a significant length of time due to extenuating circumstances will be given a one week "grace" period following his/her return to practice to complete his/her delinquent records subject to the approval of the Chairman of the Medical Records Committee.

Mercy Health St. Charles Hospital

Title:	Medical Staff Funds	**Policy Number:**	MSCH-MS-15
Author/Index:	Medical Staff Services	**Approval Date:**	05/08/2018 Tentative
Chapter/Issued By:	Administration-Med Staff	**Effective Date (Retroactive):**	
Authorized By:	Medical Staff – Medical Executive Committee (MEC)	**Revision Date:**	
Replaces:	None	**Review Date:**	05/08/2018
References:		**Date of Next Review:**	04/30/2021
Keywords:	Medical Staff Funds, Dues, Fees, Account		
Applies To:	Secretary Treasurer, Manager Med. Staff, & MEC Mercy Health St. Charles Hospital.		

Review: Every three years

Medical Staff Funds Policy & Procedure

Policy: The funds collected from fees, fines, and dues collected from members, affiliated allied health providers, and telemedicine providers are deposited in FDIC bank account. These funds are associated to the Mercy Health tax ID. As such, the funds are included in the Mercy Health tax and business records. Statements and copies of the register are provided to Mercy accounting division to monitor activity and report for regulatory purposes.

Procedure:

1. Account Management:
    a. Medical Staff manager arranges for monthly account statements to be provided to designated Mercy financial entity.
    b. Medical Staff manager provides copy of check register to designated mercy financial entity.
    c. Medical Staff personnel collects funds (i.e. dues, fees, and fines) at Medical Executive Committee's direction.
    d. Payments are allocated to the appropriate providers account (i.e. record of payment posted toward provider account in tracking database)
    e. Deposit slips are filled out and attached to the corresponding payments. Deposit is placed in a sealed envelope and Security Department will physically make deposit at the bank.
2. Disbursements: (by check or Debit card)
    a. Automatic disbursements: (by authorize account designee(s))
        i. Payments for medical staff leadership stipends covered through professional service agreements.
        ii. Payments of expenses directly associated with annual dinner not to exceed a combined total of $25,000.00 (requires MEC approval for additional expenditure).
        iii. Pre-approved MEC contributions to societies, corporations, businesses, staff educational conference (e.g. Ohio Physician Health Program, & Mercy Foundation, & OAMSS).
        iv. Memorial contributions and expenses for cards/floral/memorial items (contribution as specified in policy with total not to exceed $350.
        v. Reimbursement for educational conferences associated with medical staff functions, roles, appointments (AMA rep). Excluding AMA representative, a professional service agreement should be executed and reimbursement is compliant with current Mercy travel and expense policy.
        vi. Gifts for recognition events (i.e. doctors day (combined total not to exceed $500.00), 25 year awardees gift (individual total not to exceed $150.00).
        vii. Discretionary expenses not to exceed $500 per month.
    b. Pre-approval by MEC prior to disbursement:
        i. Expense exceeding $5,000.00 not eligible for automatic disbursement.
        ii. New or additional contribution to societies, corporations, businesses.
        iii. Expenses petitioned for education not covered by professional service agreements.

Mercy St. Charles Hospital

Title: Memorial Contributions
Policy Number: MSCH-MS-16
Author/Index: Medical Staff Services
Approval Date: 7/12/2016

Chapter/Issued By: Administration-Med Staff
Effective Date (Retroactive):
Authorized By: Medical Staff – Executive Committee
Revision Date:
Replaces: None
Review Date: 7/12/2016
References:
Date of Next Review: 7/2019
Keywords: Contributions, Donations
Applies To: Medical Staff Members (past & present)

Review: Every three years

Purpose

To provide a consistent framework in recognition for memorial contributions

Definition

The medical staff will provide memorial contributions based on the following table.

Amount:	Affiliation:
$250.00	Administrative/Medical Staff Leader (current)
$200.00	Administrative/Medical Staff Leader (past) OR
	Medical Staff Member current
$100.00	Medical staff members (past)
	Medical Staff Member (current) Immediate family (Parents, Children, Spouse, Grandparent). OR

Medical Staff Oversight

The Chief of staff and the Medical Executive Committee is charged with the responsibility of proper disbursements and recognition of memorial contributions.

Procedure:

Upon notice of a death, the medical staff office will obtain information to validate death, and determine the affiliation of the deceased. The Chief of Staff will review information provided by the medical staff office and standard contributions listed above to determine the amount of donation and assess which organization/service will receive the contribution.

For continuity and to prevent conflicts associated in the recipient organizations beliefs/associations, all contributions will be directed to the Mercy Health Foundation, earmarked to benefit Mercy St. Charles Hospital.

A letter will accompany the donation requesting confirmation of receipt. The letter will identifying the namesake of the donation and the person's affiliation to the Mercy St. Charles Hospital Medical Staff.

Exceptions to this policy will be determined jointly at a Medical Executive Committee meeting.

Procedure approved by MEC: 07.12.2016