Department Chair

ARTICLE XI, SECTION 6 - DUTIES OF THE DEPARTMENT CHAIR
Each chair shall:

A. Serve on the EXECUTIVE COMMITTEE as a member thereof.
B. Account to the EXECUTIVE COMMITTEE for all professional and administrative activities within the department and the control of the performance evaluation and other quality maintenance functions delegated to the department.
C. Oversee departmental programs for credentials review, continuing medical education, orientation of department members, utilization review, quality improvement, quality control programs as appropriate, and monitoring of professional practice in the department, including Allied Health staff with CLINICAL PRIVILEGES.
D. Provide guidance to the EXECUTIVE COMMITTEE on the overall medical policy of the HOSPITAL and make specific recommendations and suggestions regarding their own department.
E. Transmit to the Credentials Committee and the EXECUTIVE COMMITTEE the department's recommendations concerning membership and classification, criteria for CLINICAL PRIVILEGES, membership renewal and corrective action with respect to applicants or members within the department.
F. Enforce the BYLAWS, Rules and Regulations within the department, including initiating corrective action and review of the performance of CLINICAL PRIVILEGES within the department.
G. Implement within the department relevant actions taken by the EXECUTIVE COMMITTEE or by the BOARD.
H. Assist in the preparation of such annual reports, including budgetary planning, pertaining to the department.
I. Perform such other duties commensurate with his/her office as may be, from time to time, reasonably requested by the Chief of Staff, the EXECUTIVE COMMITTEE, or the BOARD.
J. Recommend, at the request of the Chief of Staff, a representative to MEDICAL STAFF and active HOSPITAL standing committees.
K. Recommend to the EXECUTIVE COMMITTEE what services if any are appropriately delivered via telemedicine.
L. participate in the administration of his/her department through cooperation with the Nursing Service and the ADMINISTRATOR in matters affecting patient care, including personnel, supplies, special regulations, and standing orders or technique.
M. Delegate administrative duties to and supervise activities of the Vice Chair of the department.

I,_____, have read the roles and responsibilities, according to the Medical Staff Bylaws, bestowed upon me as the elected chair of the department of _____for 2022. I understand my roles and responsibilities and will fulfill them to the best of my ability.

Signature:_____ Date: _____

FAIRBANKS MEMORIAL HOSPITAL

Department of Pediatrics

Dear Dr. Anne Hanley,

The Executive Officers of the Medical Staff is pleased to affirm your selection as Chair of the Department of Pediatrics.

Department chiefs play a vital role. The purposes of this letter are to outline: (1) your duties and responsibilities as a department chief; (2) the orientation program associated with your position; and (3) the significant legal protections that are available to you.

I. LEADERSHIP RESPONSIBILITIES

As a department chief, you are the primary medical administrative officer for the department, responsible for all professional and administrative activities within the department. The most important of those activities relate to the quality/performance improvement and credentialing of individuals who practice within your department.

Your formal duties and responsibilities as a department chief are set forth in the Medical Staff Bylaws, which provide as follows:

ARTICLE XI, SECTION 6: DUTIES OF DEPARTMENT CHIEFS

Each department chief is accountable for the following:

A. Serve on the EXECUTIVE COMMITTEE as a member thereof
.

B. Account to the EXECUTIVE COMMITTEE for all professional and administrative activities within the department and the control of the performance evaluation and other quality maintenance functions delegated to the department.

C. Oversee departmental programs for credentials review, continuing medical education**,** orientation of department members, utilization review, quality improvement, quality control programs as appropriate, and monitoring of professional practice in the department, including Allied Health staff with CLINICAL PRIVILEGES.

D. Provide guidance to the EXECUTIVE COMMITTEE on the overall medical policy of the HOSPITAL and make specific recommendations and suggestions regarding their own department.

E. Transmit to the Credentials Committee and the EXECUTIVE COMMITTEE the department's recommendations concerning membership and classification, criteria for CLINICAL PRIVILEGES, membership renewal and corrective action with respect to applicants or members within the department.

F. Enforce the BYLAWS, Rules and Regulations within the department, including initiating corrective action and review of the performance of CLINICAL

PRIVILEGES within the department.

G. Implement within the department relevant actions taken by the EXECUTIVE COMMITTEE or by the BOARD.

H. Assist in the preparation of such annual reports, including budgetary planning, pertaining to the department.

I. Perform such other duties commensurate with his/her office as may be, from time to time, reasonably requested by the Chief of Staff, the EXECUTIVE COMMITTEE, or the BOARD.

J. Recommend, at the request of the Chief of Staff, a representative to MEDICAL STAFF and active HOSPITAL standing committees.

K. Recommend to the EXECUTIVE COMMITTEE what services if any are appropriately delivered via telemedicine.

L. participate in the administration of his/her department through cooperation with the Nursing Service and the ADMINISTRATOR in matters affecting patient care, including personnel, supplies, special regulations, and standing orders or technique.

M. Delegate administrative duties to and supervise activities of the Vice Chair of the department.

The importance of performing these duties in an effective manner is underscored by the fact that the above list of duties was patterned after the Accreditation Standards of the Joint Commission. The Joint Commission emphasizes that the medical staff leadership is an essential component of the leadership team of the institution, along with the leadership of the board, management, and senior nursing leaders. Such recognition by the Joint Commission is certainly consistent with the hospital's view of your role.

Just as important as the above formal duties is the task of counseling and educating members of your department when questions arise concerning their clinical practice or professional conduct. As examples, your collegial responsibilities include the following:

(1) Educating and advising each member of your department of all applicable policies, such as policies regarding appropriate behavior within the department and the timely and adequate completion of medical records;

(2) Following up on any questions or concerns raised about the clinical practice and/or conduct of members of the department;

(3) Sharing with individual members of the department comparative quality, utilization, and other relevant information in order to assist those members to conform their practices to appropriate norms within the department; and

(4) At the end of your tenure, educating and working with your successor regarding the duties and responsibilities of a department chief, and any issues that carry over into your successor's term.

These collegial and educational responsibilities are perhaps the most challenging aspect of the department chief position and require real leadership skills. But this aspect of your leadership, perhaps more than any of the others, provides an invaluable opportunity to promote the quality of care provided in our hospital and, at the same time, help your colleagues by advising them of adjustments needed in their clinical practice or behavior. In many instances, your efforts in this regard can help prevent the necessity of any formal action if the colleague chooses to work cooperatively (although there may arise a few situations that can appropriately be handled only through the formal provisions of our Medical Staff documents).

II. ORIENTATION AND EVALUATION

In order to assist you in this important position, we have planned an orientation briefing for all department chiefs. This orientation will be conducted within the next month by the Medical Staff Services manager. The purpose of this orientation is to discuss all the matters outlined in this letter in greater detail. Prior to this meeting, it will be very important for you to carefully review this letter, as well as the appropriate provisions of the Medical Staff documents relating to department chiefs, and to prepare any questions you may have. Medical Staff Services will be contacting you soon to set up this meeting at a time convenient to you.

In addition to the orientation, an Executive Officer of the Medical Staff will meet with you at least once a year to review your performance as department chief and to assist you with any difficulties that you may be encountering.

III. LEGAL PROTECTIONS

A department chief is acting on behalf of the medical staff and hospital when you perform the tasks of a chief and are supported by the hospital in all such endeavors. There are significant legal protections to which you are entitled when serving as a department chief.

A. Federal Law: The Health Care Quality Improvement Act of 1986

In enacting the Health Care Quality Improvement Act of 1986, Congress recognized the vital role played by department chiefs and other medical staff leaders in hospitals, by specifically encouraging quality improvement and peer review activities. The encouragement to perform these activities is in the form of significant immunity against liability. The protections of the Health Care Quality Improvement Act are applicable to federal claims such as antitrust as well as to state law claims, such as state antitrust, defamation, breach of contract, and other claims.2

In order to claim the protections of this Act, there are a few essential requirements. It must be clear that the activities you perform as a department chief are performed on behalf of the hospital in the furtherance of the hospital's responsibilities, and you must follow the procedures set forth in our Medical Staff documents.

B. State Law

The State of Alaska also recognizes the importance of your role as a medical staff leader, and of the sensitive nature of much of your responsibilities. Alaska has enacted a peer review protection law, AK Statute 18.23.030, that also provides immunity to you when performing quality improvement and peer review activities. In addition, this state law provides a confidentiality privilege with respect to your quality

improvement and credentialing responsibilities. This privilege allows you to conduct these activities without fear that they will become public. The one essential prerequisite to gaining both the immunity and the confidentiality privilege contained in our state law is that you maintain confidentiality with respect to all quality improvement and peer review activities. So long as you, by your actions, cannot be alleged to have waived any immunity or privilege, you and the hospital will be protected. Carefully adhering to the terms of the hospital's confidentiality policy is essential.

C. Individual Releases

The application forms for appointment and reappointment provide further protection for you. As a condition to applying to the hospital, applicants specifically release you from liability and grant you immunity when performing your responsibilities as a department chief.

D. Insurance and Indemnification

These coverages are set forth in the attached agreement.

We look forward to discussing the matters set forth in this letter in more detail with you during the orientation. Should you have any questions in the meantime, please do not hesitate to contact me personally.

Once again, on behalf of the Executive Officers of the Medical Staff, we are pleased to recognize you as one of the leaders of the hospital.

Sincerely,

Terry A. Conklin MD FAAEM, FACEP
FMH/DC Chief of Staff

Cc: CMO

APPENDIX D – INDEMNIFICATION AGREEMENT
Between The MEDICAL STAFF and Foundation Health

WHEREAS, Fairbanks Memorial Hospital (the "HOSPITAL") is a general acute care hospital in Fairbanks, Alaska, operated by Foundation Health("Foundation Health Partners") ("FHP"), which is duly licensed by the State of Alaska pursuant to A.S. 18.20.020; and

WHEREAS, A.S. 18.20.060 requires that the Alaska Department of Health and Social Services "adopt, amend, and enforce regulations and standards for all hospitals in the interest of public health, safety and welfare"; and

WHEREAS, the Alaska Department of Health and Social Services has adopted exhaustive regulations requiring that the governing body of the HOSPITAL maintain an organized MEDICAL STAFF responsible for investigating, reviewing and analyzing factors which may contribute to any occurrence resulting in patient injuries, keeping records of any corrective action taken against a member of the MEDICAL STAFF, and making annual recommendations to the governing body regarding the membership of and PRIVILEGES for each member for the MEDICAL STAFF; and

WHEREAS, the MEDICAL STAFF of the HOSPITAL (the "MEDICAL STAFF") has organized according to the "Bylaws of the MEDICAL STAFF of Fairbanks Memorial Hospital/Denali Center" (the "MEDICAL STAFF Bylaws"); and

WHEREAS, the Board of Directors of FHP, as the GOVERNING BODY of the HOSPITAL has approved the MEDICAL STAFF Bylaws; and

WHEREAS, pursuant to the MEDICAL STAFF Bylaws, the MEDICAL STAFF performs professional peer review of PHYSICIANS with CLINICAL PRIVILEGES at the HOSPITAL; and

WHEREAS, the parties to this Agreement recognize that it is important to the citizens of the State of Alaska, the HOSPITAL, FHP, and the MEDICAL STAFF that professional peer review be responsibly and effectively accomplished at the HOSPITAL; and

WHEREAS, the members of the MEDICAL STAFF at the HOSPITAL recognize their obligation, by virtue of their acceptance of the privilege to attend patients at the HOSPITAL, under Alaska law and the MEDICAL STAFF BYLAWS, to engage in peer review activities in compliance with requirements of the MEDICAL STAFF BYLAWS and the Federal Health Care Quality Improvement Act of 1986; and

WHEREAS, the threat of private money damage liability under federal and state laws, including treble damage liability under antitrust law, unreasonably discourages PHYSICIANS from participating in effective professional peer review; and

WHEREAS, Congress has recognized the threat noted above and has adopted the Health Care Quality Improvement Act of 1986 (the "Act") which is currently in effect and which provides for, among other things, immunity from actions for monetary damages under federal antitrust

law, provided that a professional review ("professional review") action, as defined in the Act, is taken:

1. In the reasonable belief that the action was in furtherance of quality health care;
2. After a reasonable effort to obtain the facts of the matter;
3. After adequate NOTICE and hearing procedures are afforded to the PHYSICIAN involved or after such other procedures as are fair to the PHYSICIAN under the circumstances; and
4. In the reasonable belief that the action was warranted by the facts known, after such reasonable effort to obtain facts and after following fair NOTICE and hearing ("hearing") or other procedures. (Section 412 of the Act.)

WHEREAS, the parties of this Agreement have determined that participation by PHYSICIANS in effective professional peer review of the HOSPITAL will be promoted if FHP undertakes the responsibility to defend and indemnify MEDICAL STAFF members as described below.

NOW, THEREFORE, the MEDICAL STAFF of the HOSPITAL and FHP (hereinafter jointly referred to as the "parties") agree as follows:

1. FHP Undertaking to Defend and Indemnify
   FHP hereby agrees to defend and indemnify any member of the MEDICAL STAFF of the HOSPITAL against whom a claim is made by any person who claims a legal remedy based upon an assertion that the claimant is or will be damaged in whole or in part by an act or omission of a member of the MEDICAL STAFF or any committee of the MEDICAL STAFF of the HOSPITAL arising from participation by the Member of the MEDICAL STAFF or the committee of the MEDICAL STAFF in professional peer review activities within the purview of the MEDICAL STAFF BYLAWS of the HOSPITAL.
2. FHP Remedy for Wrongful Conduct
   In any case where FHP is called upon to honor and does honor its obligation provided under paragraph 1 of this agreement, it shall have the right to seek to avoid that obligation as to any particular member of the MEDICAL STAFF by commencing and prosecuting to conclusion an arbitration or judicial proceeding at which it shall have the burden of proving by a preponderance of the evidence that the claim from which defense and indemnity is being provided under paragraph 1 was the result of intentional misuse of the professional peer review process (including any willful violation of any law, statute, rule, or bylaw) with improper motives by the particular member of the MEDICAL STAFF.

   If FHP is successful in such proceeding, the member of the MEDICAL STAFF shall reimburse FHP forthwith for all costs incurred, including attorney's fees, in defending such member, and any payment made on behalf of such member, and FHP shall be under no further obligation to defend or indemnify such member.

   The proceeding authorized under this paragraph may not be joined with the legal proceeding against the member of the MEDICAL STAFF which gives rise to the obligation under paragraph 1 of this Agreement.

   No decision or judgment rendered in any legal proceeding against the MEDICAL STAFF member which gives rise to the obligation of paragraph 1 of this Agreement shall have collateral estoppel or res judicata effect in any proceeding authorized by this paragraph.
3. Cooperation
   In providing the defense required by paragraph 1 of this Agreement, FHP shall be solely

responsible for the selection of defense counsel and the member of the MEDICAL STAFF for whom the defense is being provided shall fully and completely cooperate with the selected defense counsel in defending the claims. When, in the opinion of defense counsel, a member of the MEDICAL STAFF fails to fully and completely cooperate with defense counsel in a manner prejudicial to the defense of the claim, FHP shall be immediately relieved from all further obligations to the member of the MEDICAL STAFF under this Agreement, including the obligation to indemnify such member.

4. Definition
   As used herein, the term "member of the MEDICAL STAFF" means all PRACTITIONERS duly licensed in the State of Alaska who are privileged to attend patients at the HOSPITAL as provided in the MEDICAL STAFF BYLAWS and includes any partnership of which such a PRACTITIONER is a partner, any corporation with respect to which such PRACTITIONER is a shareholder, and any association in which such PRACTITIONER is a member.
5. Effective Date
   This Agreement shall be effective upon the execution hereof by both parties and shall apply to claims brought on and after such date.
6. Duration
   This Agreement shall remain in effect until December 31 of the year following the calendar year in which written notice of termination is delivered. Once terminated, the Agreement shall continue to have effect with respect to alleged acts or omissions occurring before the effective date of termination.
7. Legal Construction
   All parties to this Agreement have had full opportunity to consult independent legal counsel, and therefore the rule of construction that a document is construed most strictly against the drafter in a case of ambiguity shall have no application here. This Agreement shall be governed by and construed according to the laws of the State of Alaska.
8. Binding Effect
   This Agreement shall be binding not only upon the parties hereto, but upon their heirs, executors, individual members, administrators, personal representatives and successors.
9. Arbitration
   If under paragraph 2 hereof, FHP seeks to determine such wrongful conduct by arbitration, the following procedure shall apply. If the parties are able to agree upon a single arbitrator, the dispute shall be submitted to him or her for resolution. If not, each party to the dispute shall select a qualified arbitrator, and the two arbitrators will in turn select a third qualified arbitrator. In the event the arbitrators selected by each party are unable to agree upon a third arbitrator within thirty (30) days of their appointment, then such third arbitrator shall be selected by the Chief Judge of the United States District Court for the District of Alaska, or, if such Judge is unable or unwilling to select such third arbitrator, then by the presiding Judge of the Superior Court for the State of Alaska, 4th Judicial District. Any decision made by the single arbitrator or a majority of the three arbitrators, as the case may be, shall be final, binding, and conclusive upon parties to the proceeding for all purposes; and judgment may be entered thereon in any court having jurisdiction.
   If any dispute arises concerning the applicability of the obligation of FHP, under paragraph 1 hereof as to any particular claim, such dispute shall be resolved by arbitration under the

procedure set forth above. FHP will be obligated to provide indemnity and defense pending the outcome of the arbitration proceeding, but shall be entitled to be reimbursed forthwith by the members defended for all costs, fees and amounts advanced should FHP prevail in the proceeding.

Leadership Training 2022

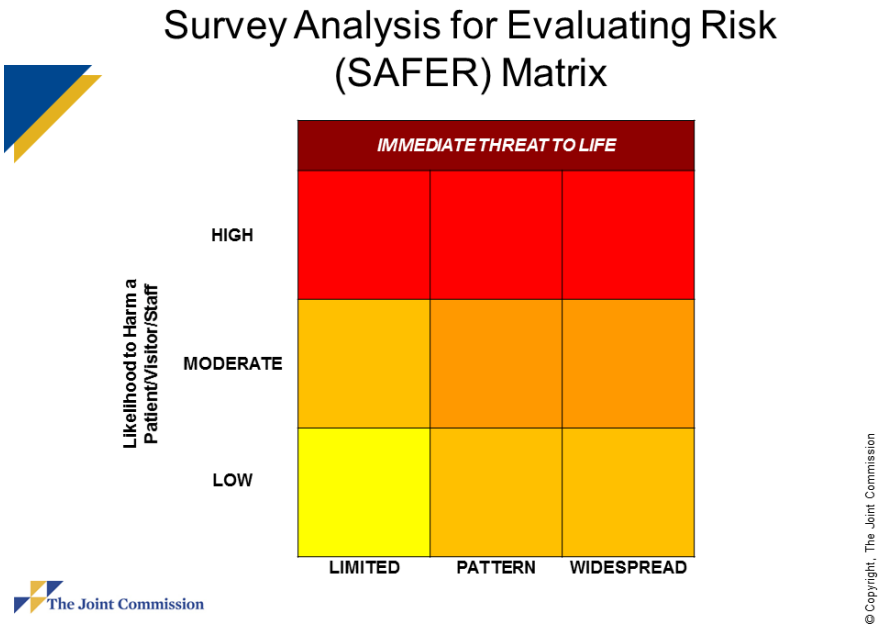
Joint Commission & Center for Medicaid/Medicare Services (CMS)

Medical Staff Bylaws Chapter includes:

- MS 01 – Medical Staff Bylaws
- MS 02 – Structure and Role of Medical Staff Executive Committee
- MS 03 – Medical Staff Role in Oversight of Care, Treatment, and Services
- MS 04 – Medical Staff Role in Graduate Education Programs* (NA)
- MS 05 – Medical Staff Role in Performance Improvement
- MS 06 – Credentialing and Privileging
- MS 07- Appointment to Medical Staff
- MS 08 – Evaluation of Practitioners
- MS 09 – Acting on Reported Concerns About a Practitioner
- MS 10 – Fair Hearing and Appeal Process
- MS 11 – Licensed Independent Practitioner Health
- MS 12 – Continuing Education for Practitioners
- MS 13 – Medical Staff Role in Telemedicine

Key things to know:

- Surveys are conducted every three years. They may also be triggered by patient complaints.
- Surveys include document review, tracers, and interviews. Surveyors can go anywhere in the facility and talk with anyone. It's important for **all** individuals to know expectations.
- Medical Staff Leadership meets the physician surveyor to discuss the Medical Staff Chapter. Typically the CEO, CMO, Executive Officer(s) (typically Chief of Staff and Credentials Committee Chair), and Medical Staff Services Leaders attend the chapter review. In addition, Medical Staff Executive Officers are invited to meet with the physician surveyor for an informal interview.
- Violations in one area may be cited in multiple chapters (ex. Medical Staff, Human Resources, Life Safety, Environment of Care)
- Findings are scored on a matrix:



Joint Commission FAQS: https://www.jointcommission.org/about-us/facts-about-the-joint-commission/joint-commission-faqs/

INSTRUCTIVE INFOGRAPHICS

Development and Enforcement of the Bylaws

The first MS standard, MS.01.01.01, includes 37 elements of performance (EPs). No other Joint Commission standard has as many EPs. These EPs describe how the organized medical staff, the *medical executive committee (MEC)*, and the governing body work together to do the following:

- Determine the content of the bylaws.
- Adopt and amend the bylaws (and related medical staff documents).
- Resolve any conflict during those processes

The chart below breaks down the first 11 EPs of MS.01.01.01 to show exactly who does what about what regarding those central tasks.

EP	Who	Does What	About What
1	Organized medical staff	develops	medical staff bylaws, rules and regulations, and policies
2	Organized medical staff	adopts and amends	medical staff bylaws
2	Organized medical staff	submits	adoptions and amendments of medical staff bylaws to the governing body for approval
2	Governing body	determines whether to approve	adoptions and amendments of medical staff bylaws, submitted by the organized medical staff
3	Organized medical staff	includes	all content named in EPs 12–37 in the medical staff bylaws
3	Organized medical staff	adopts	associated details of the medical staff bylaws
3	Organized medical staff	determines	where associated details, if any, related to the medical staff bylaws will reside—in the bylaws, in rules and regulations, or in policies.
3	Organized medical staff	decides	which associated details of the medical staff bylaws can be delegated to the medical executive committee
3	Organized medical staff	adopts	associated details of the medical staff bylaws residing in the bylaws
3	Organized medical staff	describes	basic steps of processes cited in EPs 12–37
3	Organized medical staff	submits	basic steps and any proposals related to processes cited in EPs 12–37 to the governing body
3	Governing body	determines whether to approve	basic steps and any proposals related to processes cited in EPs 12–37 submitted by the organized medical staff
4	Organized medical staff, governing body, and organization	ensures	compatibility of medical staff bylaws, rules and regulations, and policies with governing body bylaws, organization policies, and other laws and regulations
5	Medical staff	complies with	medical staff bylaws, rules and regulations, and policies
6	Organized medical staff	enforces	medical staff bylaws, rules and regulations, and policies through action
6	Organized medical staff	recommends	enforcement of medical staff bylaws, rules and regulations, and policies to the governing body

EP	Who	Does What	About What
7	Governing body	upholds	the medical staff bylaws, rules and regulations, and policies approved by the governing body
8	Organized medical staff	possesses	the ability to adopt or amend medical staff bylaws, rules and regulations, and policies and propose them directly to the governing body
9	Organized medical staff	communicates	proposals to adopt or amend a rule, regulation, or policy to the medical executive committee first
9	Medical executive committee	communicates	proposals to adopt or amend rules or regulations to the medical staff first (if the governing body has given approval for the organized medical staff to delegate authority over rules and regulations to the medical executive committee)
9	Medical executive committee	communicates	adoption or amendment of a policy to the medical staff (if the governing body has given approval for the organized medical staff to delegate authority over policies to the medical executive committee)
10	Organized medical staff	implements	a process to manage conflict between the medical staff and the medical executive committee on various issues, including those related to adopting or amending rules, regulations, and policies
11	Medical executive committee	provisionally adopts	an urgent amendment to rules and regulations without prior notification of the medical staff (if voting members of the organized medical staff delegate that authority to it)
11	Governing body	provisionally approves	an urgent amendment to rules and regulations without prior notification of the medical staff (if voting members of the organized medical staff delegate that authority to it)
11	Medical executive committee	immediately notifies	the medical staff about any provisionally approved urgent amendments
11	Medical staff	possesses	the opportunity to review the provisionally adopted amendment to rules and regulations (which will stand if there is no conflict between the organized medical staff and the medical executive committee)
11	Organized medical staff	implements	the process for resolving conflict between the medical staff and the medical executive committee (if there is conflict over the provisionally adopted amendment to rules and regulations)

INSTRUCTIVE INFOGRAPHICS

Types of Medical Staff Documents

As you learn about MS standards, you may see the terms *bylaws*, *rules and regulations*, and *policies* used to describe medical staff documents. Outside the standards, the term *bylaws* may be used to refer to all these documents. But within the standards, these terms can't be used interchangeably. The following chart clarifies some key differences among these types of documents—including whether The Joint Commission requires them.

Type	Purpose	Required?
Medical staff bylaws	· Describe the rights, responsibilities, and accountabilities of the medical staff · Explain the self-governance functions of the organized medical staff · Specify how the organized medical staff works with and is accountable to the governing body	Yes
Medical staff rules and regulations	· Expand on provisions of the bylaws · Usually address patient care issues across the organization · Generally pertain to specific processes or circumstances · Typically contain provisions about admissions, transfers, consultations, autopsies, and medical records	No
Medical staff policies	· Outline and describe basic administrative mechanisms of processes in the bylaws · Generally pertain to non-patient care activities and related procedures · May contain specific procedures for carrying out certain functions (appointment, reappointment, privileging, hearing and appeal procedures) · May define mechanisms and procedures for dues, professional conduct, confidentiality, and delinquent medical records	No

CONCISE CONCEPTS

Details in the Medical Staff Bylaws

Medical staff bylaws
should be written with enough detail
to guide the activities of the organization
yet be succinct and understandable.

Medical Staff Documents on the Loop:

Document Name	Document Location
13729 - Termination of Provider-Patient Relationship	/ Medical Staff
14386 - Block Scheduling	/ Patient Care/ Surgery
15076 - Radiology Medical Staff Review of the Qualifications of Radiology and Nuclear Medicine Staff	/ Medical Staff
3165 - Complaints of Sexual Harassment or Other Prohibited Conduct	/ Medical Staff
7414 - Medical Staff Professional Liability Insurance Requirements	/ Medical Staff
FMH Medical Staff Bylaws	/ Medical Staff/ Medical Staff Bylaws
MS01 - Criteria for Administration of Blood and Components	/ Medical Staff
MS02 - Protocol for Funding Speaker	/ Medical Staff
MS03 - Autopsies	/ Medical Staff
MS04 - Background Checks	/ Medical Staff
MS05 - Consultations	/ Medical Staff
MS06 - Credentialing Initial Appointment and Renewal	/ Medical Staff
MS07 - Definition of Attending	/ Medical Staff
MS08 - Delineating Clinical Privileges New Technology	/ Medical Staff
MS10 - History & Physical	/ Medical Staff
MS11 - Medical Student Clinical Rotations	/ Medical Staff
MS12 - Patient Request to Change Attending Physician	/ Medical Staff
MS13 - Medical Staff Peer Review	/ Medical Staff
MS14 - Practitioner Wellness	/ Medical Staff
MS15 - Review of the Medical Staff Bylaws and Rules and Regulations	/ Medical Staff
MS17 - Monitoring Providers Chart Completion	/ Medical Staff
MS18 - Observation of Newly Privileged Anesthesiologists	/ Medical Staff
MS20 - Orders for Outpatient Services	/ Medical Staff
MS21 - FMH Emergency Department Follow-Up	/ Medical Staff
MS23 - Referral of Unassigned Emergency Department Patients	/ Medical Staff

Document Name	Document Location
MS25 - Emergency Department Patient Assignment to On-Call Physicians	/ Medical Staff
MS26 - Focused Professional Evaluation - Proctoring	/ Medical Staff
MS27 - Policy on Allied Health Professionals	/ Medical Staff
MS28 - Screening Ultrasound in Acute Trauma and Emergency Care	/ Medical Staff
MS29 - Resident Physicians	/ Medical Staff
MS30 - Complaints - Compliments Regarding Medical Staff Members and Allied Health Professionals	/ Medical Staff
MS31 - Adult Medicine Unassigned Patient Care Follow-Up	/ Medical Staff
MS33 - Family Medicine Call Coverage	/ Medical Staff
MS34 - Internal Medicine Call Coverage	/ Medical Staff
MS35 - Pediatrics Call Coverage	/ Medical Staff
MS36 - Cardiology Section Call Coverage of Unassigned Patients	/ Medical Staff
MS37 - ENT Call Coverage	/ Medical Staff
MS38 - Pathology Department Call Coverage	/ Medical Staff
MS39 - Ongoing Professional Practice Evaluation	/ Medical Staff
MS40 - OB GYN Call Coverage	/ Medical Staff
MS41 - Diagnostic Radiology Call Coverage	/ Medical Staff
MS42 - Orthopedic Surgery Call Coverage	/ Medical Staff
MS44 - General Surgery Call Coverage	/ Medical Staff
MS47 - Disclosure and Resolution of Conflict of Interest - CME Sponsored Activities	/ Medical Staff
MS48 - Low / No Volume Practitioners	/ Medical Staff
MS49 - Honorary Staff Category	/ Medical Staff

Credentialing & Privileging

Things to know:

- Every member of the medical staff applies for membership (how they are affiliated) and privileges (what they can do). Other requests may require review and recommendation including: temporary privileges, additional privileges, changes in membership/privileges
- All applicants go through the same credentialing (process), however, there are slight differences between initial and reappointment applicants due to the type of data available on each.
- The Medical Staff Services (MSS) department compiles the applicant's file for the department chair's review. This includes obtaining primary sources verifications, completing follow-up on missing or unusual data, and flagging "red flag" information for review. This process can take up to three months to complete.
- The review, recommend, and approval process takes approximately five to eight weeks*:
    - Department Chair recommendation – typically in second/third week of the month
    - Credentials Committee recommendation – fourth Wednesday
    - Medical Executive Committee (Closed) recommendation – last week of month/first week of month
    - FHP Quality Board Subcommittee recommendation – third Monday of the month
    - FHP Executive Board – third Wednesday for approval
- Information is confidential and privileged: No discussions outside appropriate closed session meetings except to another authorized individual with a need to know, and *in private*
    - Alaska Statute 18.23.030
    - HCQIA

Tips for Successful Review of Appointments/Reappointments

- Carefully examine if applicants meet all the minimum requirements.
    - Are they assigned to the appropriate category?
    - Do they meet the minimum threshold criteria to apply for membership and the clinical privileges they requested?
    - Do they hold the correct certifications?
- The department chair is the clinical expert and his/her recommendation needs to address the professional competency to perform requested privileges.
    - Do they demonstrate clinical competence through education, training, clinical activity, and professional references?
    - Are the references appropriate?
- Carefully review RED FLAG information and be ready to explain rationale for recommendation.

- Ask questions or request more information if there is a need to do so. Applicants may be asked to do an interview to obtain more information.
- Make recommendations that are appropriate to the concern/need. A common example is additional FPPE requirements or proctoring plan for low/no volume of a requested privilege.
- **When signing the signature page, you are attesting your recommendation is based on consideration of the following: *(patient care; medical/clinical knowledge; practice-based learning and improvement; interpersonal communication skills; professionalism, system-based practice)***
    - Information related to professional liability claims, settlements or judgments and presence of any significant patterns
    - Peer recommendations that indicate the ability of the applicant to competently exercise the privileges requested
    - Information related to the applicant's health status and impact on the applicant's ability to exercise privileges and competently
    - Documentation in the practitioner's credentials file demonstrating compliance with criteria for privileges requested
    - Information related to interpersonal skills, communication skills, and professionalism

CONCISE CONCEPTS

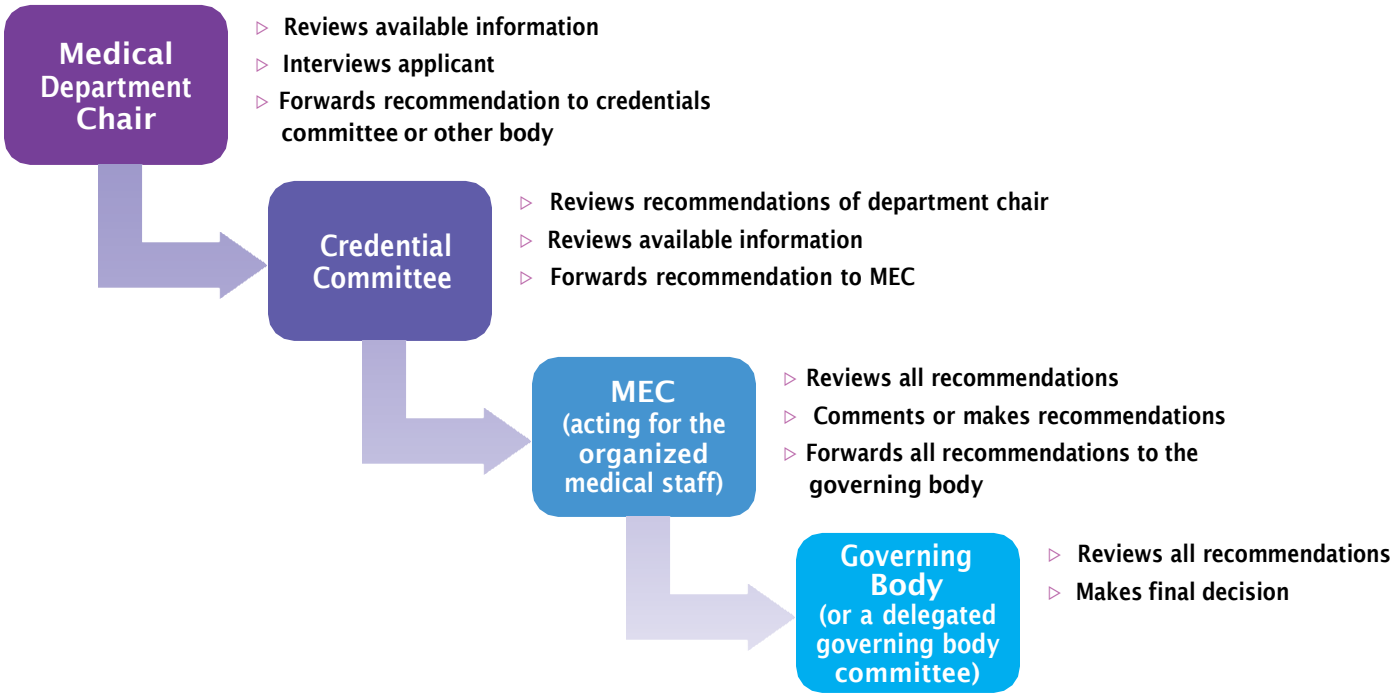
Fairness of the Approval Process

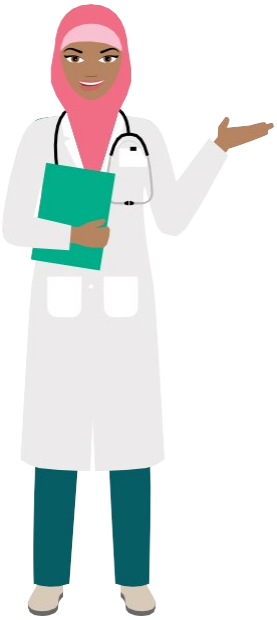
Gender, race, creed, and national origin
must not be used
in making decisions regarding
medical staff membership or privileges.

INSTRUCTIVE INFOGRAPHICS

The Recommendation Process

The responsibility for making a final decision about an applicant lies with members of the governing body—or a delegated governing body committee (per MS.06.01.09). But they rely on information and recommendations from others, including review and analysis from the members of the organized medical staff—or the medical executive committee (MEC) acting on their behalf (per MS.06.01.07). Your hospital will have its own specific system based on its own specific structure. This graphic shows one possible pathway in the recommendation process, from initial review all the way to a final decision.





EXCERPTS that EXPLAIN

General Competencies

Experience, ability, and current competence in performing the requested privilege(s) is verified by peers knowledgeable about the applicant's professional performance. This process may include an assessment for proficiency in the following six areas of "General Competencies" adapted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative.

- **Patient Care**
  Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
- **Medical/Clinical 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 practices.
- **Interpersonal and Communication Skills**
  Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish 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.
- **Systems-Based Practice**
  Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

—from the introduction to MS.06.01.03, *Comprehensive Accreditation Manual for Hospitals*

INSTRUCTIVE INFOGRAPHICS

Comparisons to Initial Processes

Reprivileging and reappointment are similar to the initial privileging and appointment processes, but there are differences. This chart explains what's the same and what's different.

	Initial Privileging/ Appointment	Reprivileging/ Reappointment
Process described in the medical staff bylaws and other documents	✖	✖
Practitioner makes request by completing an application	✖	✖
Preestablished criteria	✖	
Verification of licensure, current competence, ability to perform privileges	✖	✖
Review of malpractice history, voluntary or involuntary loss or limitation of licensure, and membership on other medical staffs	✖	✖
Query to NPDB	✖	✖
Department input on criteria and department chair's recommendation	✖	✖
Medical executive committee review and recommendation to governing body	✖	✖
Governing body as ultimate decision-making authority	✖	✖
Consideration of information from FPPE		✖
Consideration of information from OPPE		✖
Consideration of participation in continuing education		✖

Medical Staff Services – Credentialing
What We Verify Example

This is the profile of an actual physician who applied for privileges. To protect their identity their name and specialty was changed.

There were **68** primary source verifications performed to verify the provider's character, competence, judgment, education and training.

The Cardiology privilege forms are used as an example of the verifications performed to assure a provider meets privileging requirements.

Profile For: Angelina Jolie, MD

Facility:

Information

Home Address: 11284 Around Blvd
Eagle River, AK 99577
Home Phones: (907)867-5309
Listed: No
Listed: No
Mobile Phone: (907)867-5309
Beeper:
Pager:
Maritial Status:
Spouse: Brad
Social Security #: 200-08-0000
ID Number: 20000
Date of Birth 04/10/1900
Age 95
Sex F
Birth Place: New York, NY
Country: United States
Allied Health: No
Mail Box: Yes
Directory Reprint: No
E-mail: ajolie@gmail.com
Sponsors:

Status

Date on Staff:
Reappointment:
Current Status: Applicant
Status From Date: 02/03/2015
Status Catg: Applicant
Status Thru Date: 02/03/2015
Facility ID Number:
Department: Cardiology
Section: Medicine
NPDB Query Date:

Offices

Some Job LLC

Anchorage, AK 99508

Primary: Yes
Mailing Address: Yes
Billing Address: Yes
Office Contact:
Phone Number 1: (907)900-0000
Fax Number:
Phone Number 2:
Answering Service:

Some Job LLC

Wasilla, AK 99654

Primary: No
Mailing Address: No
Billing Address: No
Office Contact:
Phone Number 1: (907)900-0000
Fax Number:
Phone Number 2:
Answering Service:

Work History

1 Some Job, LLC

Dates: From 02/15/2012 to
Type: Work History

Anchorage, AK 99508

Work Phone: (907)900-0000
Fax: (907)900-0000
Contact:

Contact Phone:

Position Held: physician/owner

2 Medical Place

Kenai, AK 99611

Dates: From 04/01/2013 to
Type: Work History

Work Phone: (907)900-0000
Fax: (907)900-0000
Contact: guy
Contact Phone:
Position Held:

3 Star Wars
3066 E. Pluto
Wasilla, AK 99654

Dates: From 05/01/2012 to 02/15/2013
Type: Work History

Work Phone: (907)900-0000
Fax:
Contact: Harrison Ford,MD
Contact Phone: 907-900-0000
Position Held: physician

4 St. Augustine Clinic
One Clinic Way
Saint Augustine, FL 32086

Dates: From 05/01/2011 to 04/01/2012
Type: Work History

Work Phone: (904)900-0000
Fax: (904)900-0000
Contact:
Contact Phone:
Position Held: physician associate

5 Can't Keep a Job
1500 Job Jumper
Orange Park, FL 32073

Dates: From 12/01/2010 to 04/01/2011
Type: Work History

Work Phone: (904)900-0000
Fax: (904)900-0000
Contact: Bill Clinton, MD
Contact Phone: (561)900-0000
Position Held: physician associate

6 Yet Another Job
1900 Wow Ave
Seattle, WA 98195

Dates: From 12/01/2008 to 11/15/2010
Type: Work History

Work Phone: (206)900-0000
Fax:
Contact: Alex Trebek,MD
Contact Phone:
Position Held: fellowship director/Professor

7 Star Trek Hospital
3401 Voyager
Gainesville, FL 32600

Dates: From 03/01/2007 to 11/19/2008
Type: Work History

Work Phone: (352)900-0000
Fax: (352)900-0000
Contact: **JJ Abrams**
Contact Phone:
Position Held: Klingon Professor

8 The Final Frontier
1500 Warp Drive
Orange Park, FL 32000

Dates: From 07/01/2004 to 03/31/2007
Type: Work History

Work Phone: **(010)001-1010**
Fax:
Contact: William Shatner
Contact Phone:
Position Held: Captain

9 US Navy
YMCA Singing Dr.
Itsfuntosing, FL 32200

Dates: From 01/01/1997 to 01/01/2005
Type: Work History

Work Phone: **Fax:**
Contact: Village People
Contact Phone: **Position Held: Stage Physician**

Specialties

1 **Name:** Cardiology
Primary: No **Eligible:** No **Certified:** Yes
Expiration: **Certified Year:** 1988

1 **Name:** Nuclear Cardiology
Primary: No **Eligible:** No **Certified:** Yes
Expiration: **Certified Year:** 1991

1 **Name:** Internal Medicine
Primary: No **Eligible:** No **Certified:** Yes
Expiration: 12/31/2013 **Certified Year:** 1993

1 **Hospital:** Alaska Regional Hospital **From:** **Thru:**

1 **Hospital:** Taco Bellevue Hospital **From:** 05/1/2011 **Thru:** 07/21/2013

1 **Hospital:** University of ImHurt Hospital **From:** 12/17/2008 **Thru:** 11/16/2010

1 **Hospital:** **DeathValley** Medical Center **From:** 12/01/2008 **Thru:** 11/16/2010
Status: physician/pain fellowship director

1 **Hospital:** Seattle Mental Hospital **From:** 12/01/2008 **Thru:** 04/15/2010
Status: physician/pain fellowship director

1 **Hospital:** Specimen Collection Medical Center **From:** 01/1/2005 **Thru:** 09/15/2008
Status:

1 **Hospital:** Mad Hatter VA Medical Center **From:** 03/1/2007 **Thru:** 10/08/2008
Status:

2 **Hospital:** Ouch Surgery Center **From:** 07/1/2003 **Thru:** 05/1/2012
Status: physician

2 **Hospital:** Batista Hospital - Hurtville **From:** 01/1/1998 **Thru:** 03/1/2008

Status:

2 **Hospital:** Orange Park Tanning Center **From:** 10/01/1995 **Thru:** 10/01/2006

Status:

2 **Hospital:** Orange Park Spray Tanning Center **From:** 10/23/1996 **Thru:** 2/25/2008

Status:

2 **Hospital:** Sandy Beaches **From:** 03/1/2007 **Thru:** 10/08/2008

Status:

2 **Hospital:** Sandy Hospital - Univ of Fun **From:** 03/1/2007 **Thru:** 10/08/2008

Status:

2 **Hospital:** St. Margarita Medical Center **From:** 01/1/1997 **Thru:** 03/1/2008

Status:

2 **Hospital:** St. Moscow Mule Surgery Center **From: 01/01/2005** **Thru:**

Status:

2 **Hospital:** Kind Doctor Hospital **From:** 10/26/2000 **Thru:** 10/31/2009

Status:

2 **Hospital:** Cancer Eliminator Alliance **From:** 03/09/2009 **Thru:** 11/16/2010

Status:

3 **Hospital:** Shady Live Oak **From: 12/15/2006** **Thru:**

Status:

Credentials

Fellowship Children's National Play Ground Center **From:** 07/1/1986 **Thru:** 12/01/1986

3 **Grad Year:** **Degree:** **Specialty: Cardiology**

Residency National Trampoline Medical Center **From:** 07/27/1984 **Thru:** 06/26/1986

3 **Grad Year:** 1986 **Degree:** **Specialty: Cardiology**

Internship National Clown College Center (**From:** 07/1/1983 **Thru:** 06/30/1984

3

Grad Year: **Degree:** **Specialty:** **Internal Medicine**

Medical School Doctors of South Carolina **From:** 06/15/1979 **Thru:** 05/31/1983

3 **Grad Year:** 1983 **Degree:** MD **Specialty:** **Yay Doctor!**

ID Numbers

35-

Type/Number		State	Expiration Date	Issued Date
State License: MEDS000		AK	12/31/2016	2/12/2012
DEA Certificate: BT1400000	Schedule: 22N 33N 4 5		11/30/2017	10/16/2011
DEA Certificate: FT3000004	Schedule: 22N 33N 4 5		11/30/2014	05/14/2012
ACLS - Required:			12/20/2016	12/20/2014
State License: ME 50080		FL	01/31/2017	04/11/1988
State License: MD 60000000		WY	04/13/2015	12/01/2008
NPI Number: 100000005				
UPIN: E60003				
State License: D000019		MA	09/30/1988	03/04/1985
State License: 17000		VA	04/30/1998	02/01/1994
State License: MEDT6000002		AK	08/23/2012	02/23/2012
State License: 00000		GA	12/31/2001	
Nuclear Cardiology: MD00000				
Tomography Cert:				

Insurance Companies

Company: The Doctor's Company
185 Greenwood Road custserv@thedoctors.com
4 Napa, CA 94558-090

Policy Number: 0 **Issued:** 05/17/2012
Amount Per Incident: $1,000,000.00 **Expires:** 03/27/2016
Aggregate Amount: $3,000,000.00
Comment:

Company: The Medical Protective Company
5814 Reed Road Credentialing
4 Fort Wayne, IN 46835

Policy Number: **Issued:** 12/09/2012
Amount Per Incident: $250,000.00 **Expires:** 12/09/2013
Aggregate Amount: $750,000.00
Comment:

Company: University of Fun
Office of Risk Management
5 Seattle, WA 98100

Policy Number: **Issued:** 02/01/2008

Amount Per Incident: $0.00
Aggregate Amount: $0.00
Comment:
Expires: 11/01/2010

Company: University of Clowns - Malpractice
PO Box
Gainesville, FL 32611

Policy Number: Self
Amount Per Incident: $0.00
Aggregate Amount: $0.00
Comment:
Issued: 04/01/2007
Expires: 11/01/2008

Company: Federal Tort - VA
1601 SW Road
Giddy, FL 32600

Policy Number:
Amount Per Incident: $0.00
Aggregate Amount: $0.00
Comment:
Issued: 03/05/2007
Expires: 09/15/2008

Company: Voyager Medical Malpractice
5309 Hermitage Boulevard
Tallahassee, FL 32308

Policy Number:
Amount Per Incident: $250,000.00
Aggregate Amount: $750,000.00
Comment:
Issued: 07/01/2002
Expires: 04/01/2007

Company: A Professional Assurance
PURCHASED BY THE DOCTORS CO
Jackson, FL 32304

Policy Number:
Amount Per Incident: $0.00
Aggregate Amount: $0.00
Comment: Canceled due to claims activity
Issued:
Expires: 05/25/2002

References

Professional Reference:
R. You Reading
10543 Hwy
Kenai, AK 99611
Title:
Salutation:
Phone: (907)900-0000

Professional Reference:
Agnes Despicable Me
700 00rd St NE
Seattle, WA 98115
Title:
Salutation:
Phone: (206)900-0000

Professional Reference:
Natalia Black Widow, MD
300 00nd Ave NE
Seattle, WA 98105
Title:
Salutation:
Phone: (206)900-0000

Professional Reference: (needed additional providers in her specialty)
Solomon T. Great, MD
Title:

1600 000th St SE
Bothell, WA 98021

Salutation:
Phone: (206)900-0000

Professional Reference:(needed additional providers in her specialty)

5

Calvin Hobbes, MD
12100 Tiger Drive
Eagle River, AK 99577

Title:
Salutation:
Phone: (907)900-0000

Languages

Language	Read	Write	Speak
English	Yes	Yes	Yes
Spanish	Yes	No	Yes

60-65

Additional Verifications:

1. OIG
2. SAMS
3. National Practitioner Data Bank
4. Google
5. PreCheck Background

FAIRBANKS MEMORIAL HOSPITAL

Cardiovascular Medicine

Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Core Privileges* or *Special Privileges*.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Minimum Threshold Criteria	
Licensure	M.D. or D.O. Licensed to practice medicine or osteopathy in Alaska. Federally Employed Military Staff must hold a current license to practice medicine or osteopathy in one of the 50 states.
Education/Training	Completion of an ACGME or AOA accredited Residency training program in Internal Medicine. **AND** Completion of an ACGME or AOA accredited Fellowship training program in Cardiovascular Disease.
Certification	Current certification or active participation in the examination process leading to certification in Cardiovascular Disease by the American Board of Internal Medicine or in Cardiology by the American Osteopathic Board of Internal Medicine. Board certification must be attained within 5 years of completion of cardiovascular fellowship.
Clinical Experience (Initial)	Documentation of participation in active practice in the management of cardiovascular inpatients during the previous two years; **OR** Successful completion of a hospital-affiliated formalized clinical fellowship in Cardiology within the past two years.
Additional Qualifications	If the applicant does not meet these requirements, they may petition for the privileges which shall be considered on a case by case basis.

Core Privileges in Cardiovascular Medicine

Description: Physicians with these privileges are expected to have Fellowship training in Cardiology and can serve as a consultant in that field. Physicians with these privileges are expected to obtain consultation when unexpected events arise above their level of comfort and expertise.

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Chief Rec ☐	Dept Chair Rec ☐
☐	Admit, evaluate, diagnose, and provide treatment or consultative services to patients of all ages presenting with cardiovascular disease	☐	☐
☐	Perform history and physical examination	☐	☐
☐	Cardioversion, elective	☐	☐
☐	Coronary or peripheral thrombectomy	☐	☐
☐	Insertion and management of central venous and pulmonary artery catheters	☐	☐
☐	Intra-aortic balloon pump insertion	☐	☐
☐	Infusion and management of GP IIb/IIIa thrombolytic and antithrombolytic agents	☐	☐
☐	Noninvasive hemodynamic monitoring / Interpretation	☐	☐
☐	Pericardiocentesis	☐	☐
☐	Trans-thoracic Echocardiography interpretation	☐	☐
☐	Stress Echocardiogram interpretation	☐	☐
☐	Holter and event monitor interpretation	☐	☐
☐	Exercise and pharmacological cardiac stress testing with ECG interpretation	☐	☐
☐	Tilt table stress testing	☐	☐
☐	Temporary trans venous pacemaker placement	☐	☐

Special Privileges: Moderate Sedation

Description: A drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Non-anesthesiologist sedation practitioners who administer medications for moderate sedation must be able to provide: 1) Safe administration of sedative and analgesic drugs used to establish a level of moderate sedation, and 2) Rescue of patients who exhibit adverse physiologic consequences of a deeper-than-intended level of sedation.

Qualifications	
Education/Training/Experience	Completion of an ACGME or AOA accredited Residency training program in Anesthesiology. **OR** Completion of Fairbanks Memorial Hospital's moderate sedation educational materials; **AND** Successful completion/passing of Fairbanks Memorial Hospital's post-test on moderate sedation for the non-anesthesiologist within the credentialing cycle (must be completed in each appointment period); **AND** Current Advanced Cardiac Life Support certification or documentation of equivalent airway management training.

Request	*Request all privileges listed below.* *Uncheck any privileges that you do not want to request.*	Chief Rec	Dept Chair Rec
☐	Moderate Sedation	☐	☐

Special Privileges: Non-Invasive Procedures

Qualifications

Clinical Experience (Initial)

Formal training in Cardiology Fellowship Program with experience in performing and/or interpreting studies for privileges requested. Graduates within 2 years of training will provide a letter of certification of training and competence from program director;

OR

Physicians beyond two years from training who are already credentialed in the above cardiology privileges at another facility will provide documentation of training and experience in the requested privileges. Documentation requires a minimum of 300 nuclear interpretations, 50 TEE performance and interpretation and/or minimum of 100 vascular ultrasound interpretations. A letter from the appropriate laboratory Medical Director stating experience and competency in the requested procedure.

OR

Physicians beyond two years from training who are not credentialed in TEE at another facility will provide documentation of training in a dedicated TEE course, and a minimum total of 50 proctored studies.

Clinical Experience (Reappointment)

Holding current Cardiology privileges maintained in good standing at FMH;

AND

Demonstrated competence performing and/or interpreting requested procedures as indicated below:
a. Experience in performing TEE procedures with documentation of minimum of 5 procedures per year with acceptable levels of success and complications;
b. Interpretation of nuclear stress imaging studies with documentation of minimum 50 cases over 2 years;
c. Interpretation of vascular ultrasound studies with documentation of a minimum 20 cases per year;
d. Interrogation and interpretation of pacemakers and/or ICDs documentation of a minimum of 50 per 2 years.

AND

A minimum of 15 hours of echo related CME over 3 years (avg 5 hr/yr) will be necessary to maintain reading privileges for echocardiographic studies.

Request	*Request all privileges listed below.* *Uncheck any privileges that you do not want to request.*	Chief Rec	Dept Chair Rec
☐	Trans-esophageal electrocardiogram performance and interpretation (TEE) (Must perform 5 per Year)	☐	☐
☐	Interpretation of Nuclear Studies (Must perform 50 per 2 Years)	☐	☐
☐	Peripheral Vascular Ultrasound Interpretation (Must perform 20 per 2 Years)	☐	☐
☐	Pacemaker and/or ICD Interrogation and Interpretation with or without device reprogramming (Must perform 50 per 2 Years)	☐	☐

Special Privileges: Invasive Procedures (Non-Interventional)

Qualifications	
Clinical Experience (Initial)	Formal training in Cardiology Fellowship Program with experience in performing and/or interpreting studies for privileges requested. Graduates within 2 years of training will provide a letter of certification of training and competence from program director with a minimum number of supervised cases as indicated below: a. Right and left heart catheterization: 100 supervised cases; b. Right and left heart catheterization: 100 supervised cases; c. Permanent pacemakers: 25 supervised cases; d. ICD implantation: 50 supervised cases **OR** Physicians beyond two years from training who are already credentialed in the above cardiology privileges at another facility will provide documentation of experience in the requested privileges. Documentation of procedures in past 24 months will be provided. **AND** A letter from the appropriate laboratory Medical Director stating experience and competency in the requested procedure. **AND** A minimum of 3 cases performed at FMH will be retrospectively reviewed by any staff cardiologist with unobserved privileges at FMH or another Banner facility.
Clinical Experience (Reappointment)	Evidence of holding and having maintained in good standing Invasive Cardiology privileges at FMH; **AND** Demonstrated competence with experience in performing specific privileges requested with acceptable levels of success and complications as indicated below: a. Coronary angiographic catheterization procedures: Documentation of a minimum of 50 procedures per year; b. Peripheral angiographic studies: Documentation of a minimum 5 cases per year; c. Permanent pacemaker implantation: Documentation of a minimum 5 cases per year; d. Cardiac defibrillator implantation: Documentation of a minimum 12 cases per year with acceptable levels of success and complications; e. IVUS and/or FFR: Documentation of a minimum of 5 cases per year **AND** Evidence within the previous credentialing cycle (2 years) of 20 hours of CME related to Coronary Artery Disease and/or Peripheral Artery Disease.

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Chief Rec ☐	Dept Chair Rec ☐
☐	Right and Left Heart Catheterizations (Must perform 50 per Year)	☐	☐
☐	Angiographic Injections (Must perform 5 per Year)	☐	☐
☐	Peripheral Angiography (Must perform 5 per Year)	☐	☐
☐	Endomyocardial Biopsy	☐	☐
☐	Cardiac Pacemaker (Permanent) (Must perform 5 per Year)	☐	☐
☐	Cardiac Defibrillator Implantation (with or without biV pacing) (Must perform 12 per Year)	☐	☐
☐	Intravascular Ultrasound (Must perform 5 per Year)	☐	☐
☐	Intracoronary Fractional Flow Reserve Measurement (Must perform 5 per Year)	☐	☐

Special Privileges: Interventional Procedures

Qualifications	
Clinical Experience (Initial)	Formal training in a Cardiology Fellowship Program with experience in performing and/or interpreting studies for privileges requested. Graduates within 2 years of training will provide letter of certification of training and competence from program director with a minimum number of supervised cases as indicated below: a. Coronary PTCA/Stent placement: 200 supervised cases over 2 years b. Peripheral angioplasty and/or stent placements: 150 supervised cases (25 as primary with 10 with stents) c. IV Filters: 10 supervised cases d. Peripheral Embolization: 10 supervised cases **OR** Physicians beyond two years from training who are already credentialed in the above cardiology privileges at another facility will provide documentation of experience in the requested privileges. Documentation of procedures in past 24 months will be provided. A letter from the appropriate laboratory Medical Director stating experience and competency in the requested procedure. A minimum of 3 cases performed at FMH will be proctored by any staff cardiologist with unobserved privileges at FMH.
Clinical Experience (Reappointment)	Evidence of holding and having maintained in good standing Interventional Cardiology privileges at FMH; **AND** Demonstrated competence with experience in performing specific privileges with acceptable levels of success and complications as indicated below: a. Coronary PTCA/Stent catheterization procedures: Documentation of minimum of 75 procedures per year; **OR** Interventional boarded for 15 years: Documentation of minimum of 50 cases per year **OR** Interventional boarded for 18 years: Documenation of minimum of 50 cases per year and may include IVUS and/or FFR. b. Peripheral angioplasty/stent procedures: Documentation of minimum 25 cases per year; c. Peripheral atherectomy: Documentation of a minimum 3 cases per year; d. IV filter placement: Documentation of a minimum of 3 cases per year; e. Peripheral vascular embolization: Documentation of a minimum 3 cases per year. **AND**
Additional Qualifications	Evidence of 30 hours of CME over previous two years (20 cardiac specific).

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Chief Rec ☐	Dept Chair Rec ☐
☐	Coronary artery angioplasty and/or stent placement (Must perform 75 per Year)	☐	☐
☐	Peripheral angioplasty and/or stent placement (Must perform 25 per Year)	☐	☐
☐	Peripheral atherectomy (Must perform 3 per Year)	☐	☐
☐	IV Filters (Must perform 3 per Year)	☐	☐
☐	Peripheral vascular embolization (Must perform 3 per Year)	☐	☐

Special Privileges: Endovascular Stent-Grafting of the Abdominal Aorta

Qualifications	
Clinical Experience (Initial)	1. Applicant must have applied for and be granted or must currently hold one of the following: a. Vascular surgery privileges AND Percutaneous Trans luminal Peripheral Endovascular Therapy (PTPET) privileges; **OR** b. Vascular surgery privileges only - a physician holding PTPET privileges will be required to participate in the procedure; **OR** c. PTPET privileges only - a physician holding vascular surgery privileges will be required to participate in the procedure; **AND** 2. Documentation of: a. Successful completion of training in endovascular stent-grafting of the abdominal aorta as part of an approved residency or fellowship program; **OR** b. Successful completion of a manufactured approved training program in endovascular stent-grafting of the abdominal aorta; **AND** 3. Documentation of: a. Participation in five (5) abdominal aortic endovascular stent-graft procedures under the supervision of an experienced endovascular graft physician; **OR** b. Successful proctoring of at least two (2) endovascular stent-grafting of the abdominal aorta procedures, **AND** 4. Documentation of current competence and experience within the previous 12 months as verified through references; **AND** 5. Agreement to actively participate in and comply with the established policies and protocols regarding these procedures.
Clinical Experience (Reappointment)	1. Demonstrated competence with experience in performing endovascular stent-grafting of the abdominal aorta procedures during the previous credentialing cycle (2 years) with acceptable success and complication rates as identified through the QA review process; **AND** 2. Compliance with established Medical Staff and/or administrative operational policies, procedures, regulations and guidelines.

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Chief Rec ☐	Dept Chair Rec ☐
☐	Endovascular Stent-Grafting of the Abdominal Aorta	☐	☐

Special Privileges: Denali Center Privileges

Qualifications	
Additional Qualifications	Unless "Consulting Only" privileges are requested, your signature below notates your application for admitting privileges for Denali Center. If you need to admit a resident and you have requested consulting privileges only, we will need to ask you to update a new Privilege form to be reprocessed that will allow for the admission.

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Chief Rec ☐	Dept Chair Rec ☐
	Please select the level of privileges desired (check only one)		
☐	I hereby request Denali Center ADMITTING privileges as indicated above.	☐	☐
☐	I hereby request Denali Center CONSULTING ONLY privileges as indicated above.	☐	☐

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Fairbanks Hospital and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature _____ Date _____

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicants performance of the privileges requested:

Privilege	Condition/Modification/Deletion/Explanation

NATIONAL ASSOCIATION MEDICAL STAFF SERVICES
NAMSS™
ADVANCING THE DELIVERY OF QUALITY HEALTHCARE

The Ideal Credentialing Standards: Best Practice Criteria and Protocol for Hospitals

Credentialing best practices include an evidence-based evaluation that verifies 13 specific criteria from primary sources. Secondary sources such as a credential verification from another facility, copies of a credential verification, or confirmation from a source that verified the credential should only be used if primary source queries are unattainable. All information to support the following 13 criteria should be primary-source verified within 120 days at the time of credentialing review.

Each health facility and system should establish specific qualifications for medical staff membership and clinical privileges that reflect practitioner competency. They should incorporate the 13 criteria that NAMSS has identified as the Ideal Credentialing Standards into its medical staff bylaws, rules and regulations, and other governance documents to ensure that its credentialing process is objective, systematic, and without discrimination or bias.

Just as credentialing assesses an applicant's professional abilities outlined in licensing scopes of practice, it also detects professional incompetence, malevolence, behavioral problems, or other red flags that would deter a health facility and system from employing and credentialing an applicant. Although red flags do not automatically preclude a practitioner from the medical staff, Medical Services Professionals (MSPs) should perform a comprehensive review of a practitioner with any red flags, keeping in mind the relativity among different specialties, patient safety, and likelihood of lawsuits.

Examples of red flags:

- Resignation from a medical staff at any time in an applicant's career.
- Reports of problems in an applicant's professional practice.
- All past or pending state licensing board, medical staff organization, or professional society investigative proceedings.
- Unexplained or unaccounted time gaps.
- No response to a reference inquiry from an applicant's past affiliation.
- Disciplinary actions by medical staff organizations, hospitals, state medical boards, or professional societies.
- Any claims or investigations of fraud, abuse and/or misconduct from professional review organizations, third-party payers, or government entities.
- Little or no verified coverage from a professional liability insurance policy.
- Jury verdicts and settlements for professional liability claims (which should still be individually reviewed).
- Inability to maintain a medical practice within the facility's service jurisdiction for any amount of time.[1]

Verifying the following 13 criteria will generate the information necessary to assess an applicant's professional competence and personal decorum as well as help identify red flags or the need for further investigation.

1. Proof of Identity
   - Government-issued photo identification
   - NPI number
   - I-9 documentation listed as List A or List B or C as defined on form
   - VISA card or Employment Verification card

A seemingly straightforward step, verifying a practitioner's identity with government-issued documentation and an identifiable photograph ensures that his/her identity is correct – the critical first step to the credentialing process. Valid government-issued photo identification, in addition to any of the following three documents listed above, can be used to verify an applicant's identity.

Primary Sources: Government-issued identification.

2. Education and Training
   - Complete list (domestic and foreign) of medical school, internship, residency, and fellowship enrollment and completion dates, as well as clinical degrees and other relevant experience in MM/YY format
   - Completion status
   - Explanation of any time gaps
   - Fifth Pathway certification, if applicable
   - ECFMG validation

All listed education and training entities that confirm training or education from medical school and beyond must include start and end dates. Applicants are required to submit a written explanation of any time gap greater than 90 days. Time gaps shed light on details of an applicant's education and training experience that are not explicit in self-reported materials. Explanations of these gaps, or lack thereof, may provide insight into an applicant's past that may be critical to the credentialing decision/recommendation.

Primary Sources: National Student Clearinghouse, AMA, AOA, ECFMG, and applicable professional schools or residency training programs.

3. Military Service
   - DD214 if recently discharged; comprehensive list of military experience, including military branch and enlistment dates, if currently serving

Similar to education and training history, verifying an applicant's military experience provides insight into an applicant's training and work history – and overall professional competency. The details derived from the above information provide a thorough overview of an applicant's training history and performance. Enlistment time gaps may not be as straightforward as education and training gaps, but should not be overlooked and may require further investigation, including a written explanation by the applicant.

Primary Sources: DD214, National Personnel Records Center (NPRC), verification from the applicable military branch, and current duty station.

4. Professional Licensure
   - Complete list and/or copies of all professional licensure including the issuing state, license type, license number, status, and issue and expiration dates

The applicable state licensing agencies primary source verify the validity, dates, and status of licenses listed on an application. Licenses obtained, held, and/or rescinded shed further light on an applicant's professional competency, performance, experience, and demeanor. Obtained licenses certify an applicant's ability to practice within the scope of each license held. Rescinded licenses provide insight into an applicant's history and may require further investigation such as a written explanation from the applicant.

A practitioner must be licensed in the states in which he/she practices. MSPs should directly investigate surrendered licenses or license sanctions, restrictions, revocations, suspensions, reprimands, or probations that the licensing entity or the National Practitioner Data Bank (NPDB) verifies.

Primary Sources: State licensing boards, FSMB.

5. DEA Registration and State DPS and CDS Certifications
   - Complete list and/or copies of DEA, DPS, and/or CDS certificates including issuing state, status, registration number, and issue and expiration dates

The U.S. Drug Enforcement Agency (DEA) confirms an applicant's DEA certification, as well as the states in which the applicant is certified to prescribe, dispense, or administer controlled substances at the time of the credentialing assessment. The listed DEA address must match the state in which the applicant practices. Applicants in states that require a specific license or certificate to dispense, prescribe, or administer controlled substances must obtain Departments of Public Safety (DPS) and/or Controlled Dangerous Substance (CDS) certifications and abide by each state's rules, regulations, and renewal policies.

Primary Sources: DEA, National Technical Information Service, state DPS, state CDS.

6. Board Certification
   - Complete list of Board-specialty certifications held including original dates, recertification dates, and expiration dates

The applicable certifying Board is the primary source for this verification. Board-certification verification must adhere to specific state requirements, if applicable. Physicians may be required to be active members of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA), or be an active candidate for the applicable board-certification exam.

Primary Sources: ABMS, AOA.

7. Affiliation and Work History

- Chronological, comprehensive list of all facilities in which a practitioner has worked or held clinical privileges (e.g. academic appointments, hospitals, practice groups, surgery centers, etc.), including start date, date on staff, employment or staff status, verification of good standing, and end date
- Explanation of any time gaps

A practitioner's application and resume/CV should be checked against a primary source. A practitioner in good standing should have no adverse professional review action taken by an employer or work affiliation. The Health Care Quality Improvement Act defines "adverse actions" as "reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity." Good standing asserts that neither the practitioner's staff membership nor clinical privileges have been reduced, restricted, suspended, revoked, denied, or not renewed.[2]

Applicants must provide a written explanation for any work history time gaps greater than 30 days. Affiliation history should include the start and end months and years (MM/YY-MM/YY). The start and end year is sufficient for applicants affiliated with a specific employer for more than five years (YYYY-YYYY).

Primary Sources: NAMSS PASS or verification from applicable facilities.

8. Criminal Background Disclosure

- Federal, state, and county databases

Background checks include conducting a County Criminal Search and National Criminal Search to check an applicant's criminal activity within at least the past seven years. MSPs must query each County Criminal Search for all counties in which the applicant has resided and worked. Collectively, the County and National Criminal Searches use an array of databases to collect information such as sex-offender data and terrorist activity.

Frequent adverse incidents throughout an applicant's work history, felony convictions, criminal history, and rehabilitation history may require additional, more extensive review. Criminal background checks should occur during initial credentialing and every four years thereafter, or according to state law.

Primary Sources: National, state, and county criminal databases.

9. Sanctions Disclosure

- Federal and state, if applicable

Temporary and permanent sanctions or licensure restrictions are relevant. Explanations should accompany any sanctions from certifying boards, payers, CMS, or licensing agencies. NPDB's Continuous Query issues alerts for new and monthly reports of all CMS sanctions, federal sanctions, state sanctions, and restrictions on licensure, certification, or scope of practice. The Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) maintains and

provides monthly updates on practitioners currently barred from participating in CMS and/or other federal healthcare programs. The General Services Administration's Excluded Parties List System (EPLS) and System for Award Management (SAM) monitor federal agency debarments, including those from OIG.

Although some of the above reported information may overlap with NPDB, LEIE is the primary database for exclusion screening for current and potential employees and contractors. Unlike the NPDB, which reinstates by revising original reports, LEIE and EPLS reinstatements purge the practitioner's original exclusion record. This may result in query inconsistencies, as an OIG exclusion may show up in the NPDB, but in neither the LEIE nor ELPS.

Primary Sources: NPDB, OIG, EPLS, SAM, FSMB.

10. Health Status

Verifying whether the applicant has, or ever had, any physical or mental condition that would affect his/her ability to exercise the requested clinical privileges.

Primary Sources: Attestation from applicant, application.

11. NPDB

The NPDB provides healthcare-specific information on state and federal criminal convictions and civil judgments, as well as malpractice history and hospital sanctions. The Data Bank should be queried during the initial credentialing process and continuously thereafter through NPDB's Continuous Query Monitory Service. The latter step should be a part of the practitioner's enrollment process with the facility.

Primary Source: NPDB.

12. Malpractice Insurance
- Comprehensive list of insurance carriers, including coverage dates and coverage types
- List of open, pending, settled, closed, and dismissed cases
- Current certificate of insurance

The applicant should provide proof of all current and past malpractice insurance within at least the past five years, including coverage dates, coverage types, and policy numbers. MSPs should query relevant databases to verify the past five years of malpractice history and ascertain the background, status, and nature of any malpractice cases associated with the applicant.

Primary Sources: Self-reported verification, current and past malpractice carriers, NPDB.

13. Professional References
    - Professional references noting current competence

Professional authorities who have worked directly with the applicant within the past two years – such as training program directors and department chairs or chiefs – who can authoritatively speak to an applicant's experience, as well as peer references within the same professional discipline, are ideal references.

The Accreditation Council for Graduate Medical Education (ACGME) recommends six best-practice standards for assessing an applicant's competencies: patient care, medical knowledge, practice-based learning and improvement, systems-based practice, professionalism, and interpersonal skills and communication.[3] Those providing references should consider ACGME's list when assessing an applicant's professional competencies.

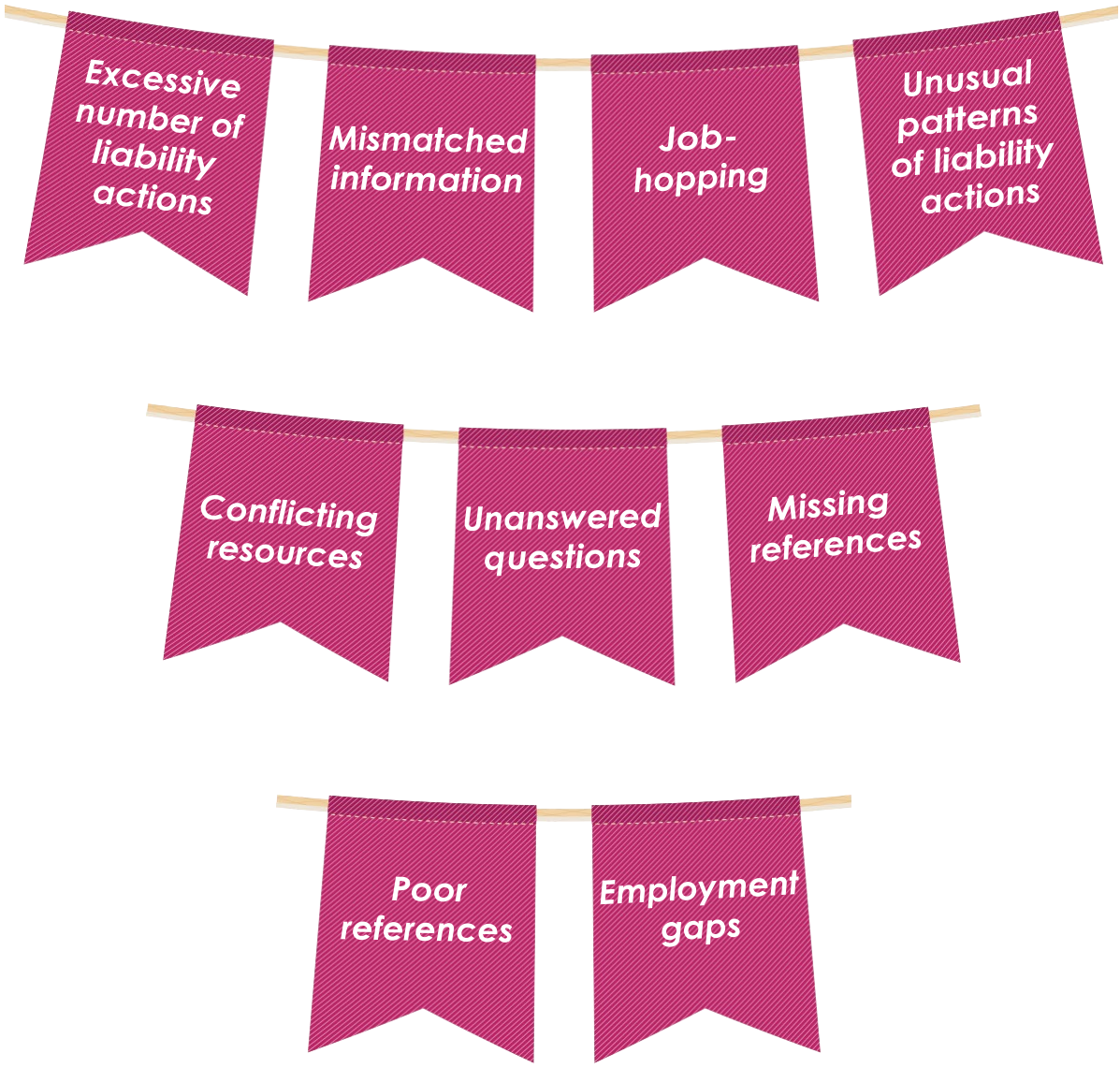
Primary Sources: Letter signed and dated from the professional reference.

[1] CNA HealthPro. Medical Staff Credentialing: Eight Strategies for Safer Physician and Provider Privileging. Pg. 5. VP O9, Issue 3. 2009. http://www.cna.com/vcm_content/CNA/internet/Static%20File%20for%20Download/Risk%20Control/Medical%20Services/MedStaffCredentialing.pdf
[2] "Public Law 99-660: Health Care Quality Improvement Act of 1986." (100 Stat. 3743). Date: 11/14/86.
[3] The Accreditation Council for Graduate Medical Education. https://www.acgme.org/acgmeweb/

INSTRUCTIVE INFOGRAPHICS

Application Red Flags

Sometimes red flags are raised by the information included in—or left out of—an application. Red flags don't always mean the applicant should be rejected. Family obligations, for example, might explain an employment gap. The organized medical staff and governing board should investigate all concerns until they're resolved. Common red flags are shown in the illustration below.



Credentialing "red flags"

***Medical Staff Legal Advisor*, June 18, 2007**

Q: Which "red flags" are important to be aware of during the credentialing process?

A: There are different ways to categorize credentialing. "A+" credentialing refers to thorough, detailed verification of all education, training, experience, practice, criminal background, and any other information reported during the credentialing process. "B" credentialing refers to verification of the minimum information needed to meet regulatory requirements. Although this process is sufficient, it is easy to miss detailed information or "red flags" which may not appear without the more thorough verification process.

Red flags include:

- Time gaps-periods of time that are unaccounted for or information reported by the applicant that does not match the timeline or information reported by the organizations with which the applicant is or was affiliated. Ensure that your credentialing policy defines what will be considered a significant "time gap" (i.e. 30 days or 90 days).
- Vague or unduly narrow answers from references or references that refuse to complete a detailed evaluation.
- Numerous lawsuits reported.
- Prior disciplinary action by any other healthcare organization or licensing body.
- Failure to disclose information.
- Extra time needed to complete a training program.
- Inability to verify information reported on the application.
- Information indicating that the applicant holds a license in another state that was not listed on the application, and documentation provided by the applicant does not show that he or she ever practiced, trained, or otherwise had a need for a license in that state.
- Inability to provide references that can attest to current clinical competence.
- Rumors, discussion, or documentation from co-workers or staff related to professional conduct or possible impairment.
- Change of insurance companies several times in recent years.

Example Carter, MD
Consulting
Anesthesiology – Pain Medicine

MEDICAL EDUCATION: University of North Carolina (2001-2005)

INTERNSHIP: Albert Einstein College of Medicine (2005-2006)

RESIDENCY: New York Presbyterian Hospital (2006-2007)

FELLOWSHIP: New York Presbyterian Hospital (2007-2009)

BOARD STATUS: American Board of Anesthesiology, Pain Medicine

PRACTICING WITH: Carter Center for Pain Relief

LICENSE: All in good standing: AK is Current; MD, DC, VA expired

INSURANCE: Current

DATABANK: No Reports

PRIMARY FACILITY: Providence

OPPE/FPPE: NO ISSUES
LEGAL: NO ISSUES
PEER REFERENCES: NO ISSUES
CREDENTIALING SUMMARY:

- NO TIME GAPS OR DISCIPLINARY ACTIONS ON RECORD
- Missing work history from National Spine and Pain center
- Fellowship missing

PRIVILEGES

Core: Yes
Special/Advanced: Yes

- Pain Medicine: Kyphoplasty/Vertebroplasty
- Fluoroscopy Imaging

Denali Consulting

YELLOW FLAGS: Missing Work History x1, Fellowship
RED FLAGS: NONE
DEPARTMENT CHAIR:
CREDENTIALS:
MEC:

Request for Initial Appointment

APPLICANT:
DEPARTMENT: Family Practice

CATEGORY: Courtesy
SPECIALTY: Family Medicine

Comments: _____
_____

DEPARTMENT RECOMMENDATION

_____ Recommend initial appointment and clinical privileges as requested.
_____ Recommend initial appointment and clinical privileges with the following conditions:

_____
_____

_____ Recommend denial of appointment and clinical privileges (reasons outlined/attached separately)

_____ _____
Department Chair (designee) Date

CREDENTIALS COMMITTEE RECOMMENDATION

_____ Concur, upon review of supporting documentation, with recommendation of Department Chair for initial appointment and clinical privileges as requested.
_____ Recommend initial appointment and clinical privileges with the following conditions:

_____
_____

_____ Recommend denial of initial appointment and clinical privileges (reasons outlined/attached separately)

_____ _____
Credential Committee Chair Date

MEDICAL EXECUTIVE COMMITTEE RECOMMENDATIONS

_____ Concur with recommendations of Credentials Committee for initial appointment and clinical privileges.
_____ Recommend approval of initial appointment and clinical privileges with the following conditions:

_____
_____

_____ Recommend denial of initial appointment and clinical privileges (reasons outlined/attached separately)

_____ _____
Secretary, Executive Committee Date

GOVERNING BOARD ACTION

_____ Approve initial appointment and clinical privileges as requested.
_____ Approve initial appointment and clinical privileges with the following conditions:

_____
_____

_____ Deny initial appointment and clinical privileges (reasons outlined/attached separately)

_____ _____
Foundation Health Board Representative Date

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WHAT PHYSICIAN LEADERS NEED TO KNOW ABOUT THE NPDB

The Health Care Quality Improvement Act of 1986 ("HCQIA"), which provides immunity from damages for hospitals and their medical staff leaders who perform peer review, also mandated the establishment of the National Practitioner Data Bank ("NPDB" or "Data Bank"). The Data Bank began operation on September 1, 1990. It was intended as a "flagging mechanism" and serves as a confidential repository for malpractice payments, adverse licensure actions, **adverse actions pertaining to clinical privileges**, and Medicare/Medicaid exclusions[1]. This information is to be used "solely with respect to activities in the furtherance of the quality of health care." The Health Resources and Services Administration, a division of the Department of Health and Human Services, is responsible for Data Bank operation. The NPDB Guidebook can be accessed on the internet through the Resources, Health Law Links page of www.HortySpringer.com or at www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf.

ADVERSE PROFESSIONAL REVIEW ACTIONS BY HOSPITALS

Hospitals must report:

(1) a professional review action taken by the Hospital Board[2] following a hearing (or waiver of hearing) which adversely affects **(denying, reducing, restricting, revoking and suspending or not renewing) a physician's or dentist's** clinical privileges for **more than 30 days** and is based upon the physician's or dentist's **professional competence or professional conduct**; and

(2) the **surrender** of clinical privileges by a physician or dentist **while under investigation** relating to questions of professional competence or conduct, **or in return for not conducting an investigation**.

Hospitals may (but are not required to) report such actions taken with respect to the clinical privileges of other health care practitioners. Failure of a hospital to comply with the reporting requirements may result in the loss of the immunity under the HCQIA for three years. However, no sanctions will be imposed against a hospital until the Secretary of HHS has conducted an investigation and provided the hospital with a written notice describing the alleged non-compliance and informing the hospital that it has 30 days to request a hearing.

[1] Adverse professional society membership actions may also be reported. Other "health care entities" (i.e., HMOs or physician groups that follow a formal peer review process and file a certification with the NPDB) may choose to report and query.

[2] Withdrawals of initial applications prior to final Board action are not reportable if no temporary privileges were granted.

Precautionary or Summary Suspensions for Longer than 30 Days

If a precautionary (or summary) suspension lasts more than 30 days, a report to the Data Bank is required. A reasonable effort to obtain the facts is an element of the HCQIA immunity, yet this can be very difficult to conclude in less than 30 days (especially if an outside peer review is sought). Because of the risk of litigation, physician leaders should work carefully with counsel to determine if there are any less restrictive alternatives to protect patients pending the completion of a reasonable investigation. The affected practitioner might seek to obtain an injunction against the filing of a report. Providing a fair process before a precautionary suspension, and at the MEC meeting to review the suspension, can help reduce the risk of litigation. "Precautionary" is a better term than the traditional "summary" because it may help a judge (in a physician suit) understand the purpose of the suspension, to protect patients.

Restrictions for Longer than 30 Days

The statute does not define "restriction." The April 2015 Guidebook states that "a 'restriction' is the result of a professional review action based on clinical competence or professional conduct that leads to the inability of a practitioner to exercise his or her own independent judgment in a professional setting." Analysis of whether a reportable restriction has occurred is often complex and leaders should work with counsel in these situations.

Investigations

Because the April 2015 Guidebook introduces a significant change, and provides a new interpretation, we repeat the section in its entirety:

> *"Investigations should not be reported to the NPDB. However, a surrender of clinical privileges or failure to renew clinical privileges while under investigation or to avoid investigation must be reported.*
>
> *"NPDB interprets the word "investigation" expansively. It may look at a health care entity's bylaws and other documents for assistance in determining whether an investigation has started or is ongoing, but it retains the ultimate authority to determine whether an investigation exists. The NPDB considers an investigation to run from the start of an inquiry until a final decision on a clinical privileges action is reached. In other words, an investigation is not limited to a health care entity's gathering of facts or limited to the manner in which the term "investigation" is defined in a hospital's by-laws.*
>
> *"An investigation begins as soon as the health care entity begins an inquiry and does not end until the health care entity's decisionmaking authority takes a final action or makes a decision to not further pursue the matter.*

"A routine, formal peer review process under which a health care entity evaluates, against clearly defined measures, the privilege-specific competence of all practitioners is not considered an investigation for the purposes of reporting to the NPDB.

"However, if a formal, targeted process is used when issues related to a specific practitioner's professional competence or conduct are identified, this is considered an investigation for the purposes of reporting to the NPDB.

"A health care entity that submits a clinical privileges action based on surrender, restriction of, or failure to renew a physician's or dentist's privileges while under investigation should have evidence of an ongoing investigation at the time of surrender, or evidence of a plea bargain. The reporting entity should be able to produce evidence that an investigation was initiated prior to the surrender of clinical privileges by a practitioner.

"Examples of acceptable evidence may include minutes or excerpts from committee meetings, orders from hospital officials directing an investigation, or notices to practitioners of an investigation (although there is no requirement that the health care practitioner be notified or be aware of the investigation).

"Guidelines for Investigations

- *For NPDB reporting purposes, the term 'investigation' is not controlled by how that term may be defined in a health care entity's bylaws or policies and procedures.*
- *The investigation must be focused on the practitioner in question.*
- *The investigation must concern the professional competence and/or professional conduct of the practitioner in question.*
- *To be considered an investigation for purposes of determining whether an activity is reportable, the activity generally should be the precursor to a professional review action.*
- *An investigation is considered ongoing until the health care entity's decisionmaking authority takes a final action or formally closes the investigation.*
- *A routine or general review of cases is not an investigation.*
- *A routine review of a particular practitioner is not an investigation."*

The analysis of whether a reportable surrender has occurred is often complex and leaders should work with counsel in these situations. Most routine peer review, even when focused on a particular practitioner, is not a precursor to a professional review action. Peer review is a continuum. When physician-specific issues are identified, many can be addressed through voluntary collegial steps and performance improvement plans. Most routine peer review is handled by a Peer Review or Professional Practice Evaluation Committee, which may refer

issues to the MEC when a performance improvement plan has not resulted in improvement or when a practitioner is not cooperative. Only the MEC typically has the authority to recommend professional review actions, and thus the MEC typically is the body authorized to initiate an investigation.

Confidentiality

Information reported to the Data Bank is confidential. Therefore, only those individuals and medical staff committees involved in credentialing (usually department chiefs and the Credentials and Medical Executive Committees and employees assisting them) should have access to Data Bank reports. There is a civil money penalty of up to $10,000 for each violation of the confidentiality provisions. Physicians who self-query may share the information, but a hospital cannot circumvent its querying obligations by requiring physicians to self-query.

Termination of Employment

The April 2015 Guidebook made it clear that termination of employment or contract, absent a professional review action, is not reportable, even if termination results in loss of privileges.

HOSPITAL POLICY

Medical Staff Bylaws do not need to address reporting to and querying the Data Bank, as these obligations are imposed by law. Having a policy could be helpful not only to provide guidance for leaders, but also in the event a question is ever raised about why a particular matter was not reported. The policy should address the following:

1. Authorized Representative

The hospital must designate an authorized representative for purposes of Data Bank certification. Often this is the Vice President for Medical Affairs/Chief Medical Officer ("VPMA/CMO").

2. Queries

Queries to the Data Bank about applicants for appointment or clinical privileges should be made routinely prior to transmitting the application to the department chief. Queries on applicants for reappointment and renewed clinical privileges should be made routinely as part of the reappointment verification process. Hospitals may participate in the NPDB's Continuous Query process and thus not need to query specifically at reappointment. The authorized representative should maintain a record that queries were made at least every two years for every individual granted clinical privileges. Copies of all query results should be maintained as part of the individual's permanent confidential medical staff credentials file.

3. Adverse Action Reports (final Board action after hearing or waiver of hearing)

(a) denial of initial medical staff appointment;

(b) denial of medical staff reappointment;

(c) revocation of medical staff appointment;

(d) denial of requested initial clinical privileges;

(e) denial of requested increased clinical privileges;

(f) decrease of clinical privileges;

(g) suspension of clinical privileges for longer than 30 days; or

(h) restriction of clinical privileges for longer than 30 days.

The Chief Executive Officer ("CEO") or designee should determine what language to use in a report after consulting with appropriate physician leaders, most often the Chief of Staff and the VPMA/CMO, and after obtaining the advice of hospital legal counsel. Withdrawal of an initial application before final Board action that would deny appointment, when no temporary privileges have been granted, is not reportable.

4. Resignation or Surrender of Clinical Privileges

Physician leaders should consider whether any resignation of privileges constitutes a "surrender" while under investigation or in return for not conducting an investigation. A final determination as to whether a report is required should be made by the CEO after consultation with leaders and legal counsel.

5. Resolving Disputes

The Data Bank process by which an individual can dispute the factual accuracy of a report requires, among other things, that the individual first attempt to resolve any dispute with the entity that filed the report. If an individual wishes to dispute the accuracy of an Adverse Action Report submitted by the hospital, the individual must state in writing to the CEO the reasons why he or she believes the report is factually inaccurate.

Within a specified time, the CEO should consult with the Chief of Staff, other appropriate leaders and legal counsel. The practitioner should be notified in writing whether the hospital will revise the report.

Careful language in the selection of reporting codes (action and basis) and the required narrative description of the reasons can minimize the potential for disputes. The dispute process is not another opportunity for the physician to challenge the merits of the professional review action. The purpose of the dispute process is simply to correct inaccuracies.

ALWAYS CHECK STATE LAW — ALL STATES HAVE REPORTING STATUTES THAT MAY OR MAY NOT TRACK THE NPDB.

Negligent Credentialing

I. Hospital's Duty on Quality of Care

A. The hospital has a legal duty to its patients to use reasonable care to ensure that privileges are granted to only competent physicians who practice safe patient care.

1. Jackson v. Power (1987)

a) "A hospital owes an independent duty to its patients to use reasonable care to insure that physicians granted hospital privileges are competent, and to supervise the medical treatment provided by members of its medical staff."

2. Ward v. Lutheran Hospitals (1998)

a) "Hospitals have a duty to their patients to verify the qualifications of admitted physicians and to review their performance."

3. Fletcher v. South Peninsula (2003)

a) "A hospital owes an independent duty to its patients to use reasonable care to insure that physicians granted hospital privileges are competent, and to supervise the medical treatment provided by members of its medical staff."

II. Independent Duty of Hospital to Patient

A. In addition to a physician's duty to his/her patient, the hospital is liable when:

1. Malpractice is committed;

2. Harm is caused to the patient that would not otherwise have occurred; and

3. Hospital knew or should have known "that the physician would act negligently before the negligence at issue occurred"

III. Evidence Showing "Hospital Knew or Should Have Known"

A. Evidence that the physician either

1. Lacked "standard credentials"; or

2. Had been the subject of a malpractice suit or disciplinary proceeding

a) Caveat:

(1) Likely more than one claim or lawsuit now

IV. Showing Needed to Establish Liability for Negligent Credentialing

A. Multiple in-hospital examples of patient care below standard of care without response from medical staff

B. Multiple disciplinary proceedings while kept on the staff

C. Multiple complaints without investigations

D. Failure to verify upon application for privileges or reappointment

E. Failure to undertake FPPE when a concern raised, or undertake OPPE and other Joint Commission requirements

F. Failure to follow bylaws/procedures for discipline when complaint made or action warranted

G. Failure to inquire of NPDB upon application or reappointment

H. Failure to take some action upon a clear example of breach of standard of care

V. Hospital Is The Real Target

A. High damages due to catastrophic injury

B. Insurance limits of physician exceeded

C. Hospital the real target for the deep pockets

VI. Hospital's Duty is Carried Out by the Organized Medical Staff

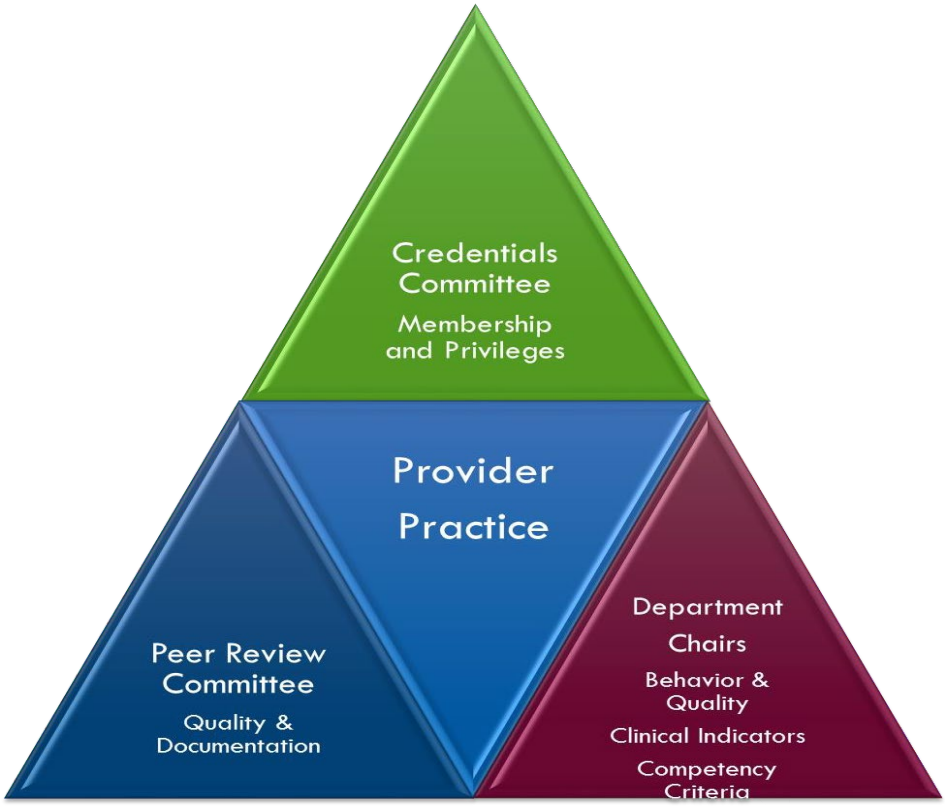
A. Only physicians can assess clinical proficiency of other physicians

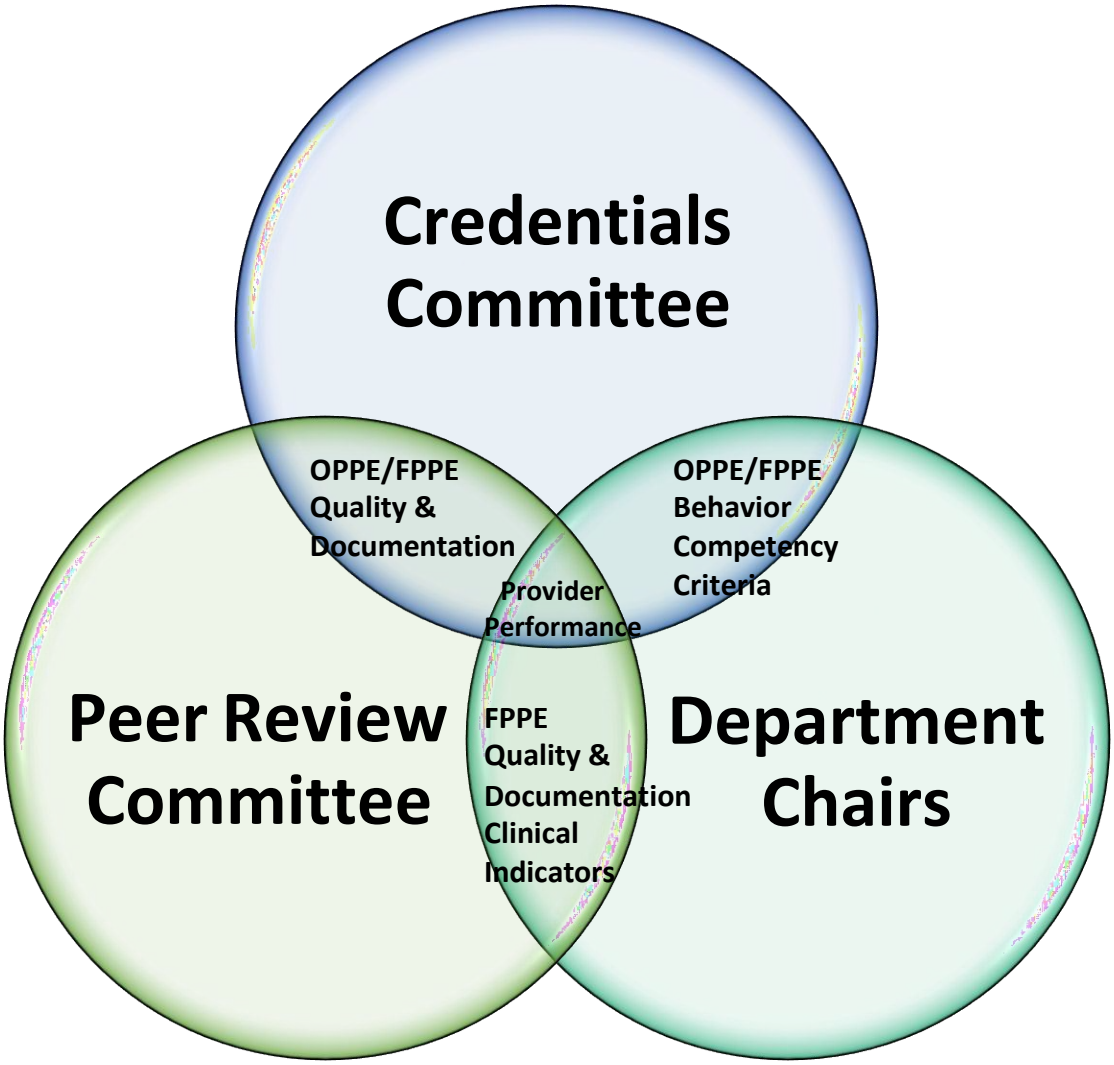
B. Only physicians can assess the real risk of harm to patients from certain practice patterns

C. Only physicians understand how healthcare is safely delivered in hospital settings

1. And the degree of coordination and cooperation required to deliver safe patient care

D. The organized medical staff acts as the hospital's agent to evaluate the clinical proficiency of physicians holding and applying for privileges


Credentials Committee
Membership and Privileges
Provider Practice
Peer Review Committee
Quality & Documentation
Department Chairs
Behavior & Quality
Clinical Indicators
Competency Criteria


Credentials Committee
OPPE/FPPE Quality & Documentation
OPPE/FPPE Behavior Competency Criteria
Provider Performance
Peer Review Committee
FPPE Quality & Documentation Clinical Indicators
Department Chairs

FPPE Overview: MS 26 Focused Professional Evaluation/Proctoring

What is the purpose? A system established to monitor professional competence

Who is subject to this evaluation?

- Practitioners new to FMH
- Practitioners requesting additional privileges
- Practitioners who have had concerns raised regarding ability to provide safe, high quality patient care

What is included in the Department Chair/ Vice Chair Responsibilities?

- Evaluation

  Under the *peer review process*:
  - Confidential and Privileged Alaska Statute 18.23.030
  - No discussions outside appropriate closed session meetings except to another authorized individual with a need to know, and *in private*

  - Review the record/procedure
  - Discussions with others involved in the care (including consulting practitioners, assistants in surgery, anesthesiologists, pharmacists, nurses as appropriate)
  - Discussions with the practitioner
  - A written report of evaluation that will go to the appropriate Department Chair
  - If any concerns are found during the course of evaluation regarding the ability to exercise the privileges granted, the reviewer shall immediately contact the Department Chair. The Department Chair shall initiate appropriate action.

  The Department Chair (or designee) has primary responsibility for assuring the clinical competency and conduct is evaluated
- Evaluation Process
  - **Notification:** Medical Staff Services (MSS) will notify the Department Chair, Vice Chair, or designated Department reviewer that an evaluation is required for review and appropriate forms will be provided.
  - **Evaluation Form:** Fillable evaluation forms have been created to help facilitate documentation. These are peer protected forms and should be kept and sent securely.
  - **Department Chair Recommendation Form:** Once all the appropriate evaluation forms have been completed, the Department Chair Recommendation form must be completed (this will be done in the MSS office). Once signed, the recommendation will go to the Credentials Committee.

Accountability: If at any time during the evaluation period, the Chair of the Department determines that the practitioner is not competent to perform specific clinical privileges and the continued exercise of those privileges jeopardizes patient safety, the Department Chair shall immediately report his/her findings and assessment to the Credentials Committee. (MS 26 Section 4)

Please see MS26 on the Loop for current and complete information

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) Policy MS26

MSS will find appropriate cases and assign out for review:

New fillable evaluation forms have been created and may be used with secure FHP email.

Please remember that FPPE information is peer protected and must be kept confidential and sent securely.

FOUNDATION HEALTH PARTNERS

Patient Label

Focused Practitioner Performance Evaluation (FPPE)

MEDICINE EVALUATOR'S REPORT

PHYSICIAN BEING EVALUATED:		DEPARTMENT: MEDICINE	APPT DATE:
PHYSICIAN(S) ASSIGNED TO EVALUATE:		SPECIALTY:	
TYPE OF REVIEW ☐ CONCURRENT ☐ RETROSPECTIVE		ADMITTING DIAGNOSIS/ PROCEDURE:	☐ Minor Case ☐ Major Case
MRN AND/OR ACCT. NO.:			
Date of Service:	Emergency Case YES ☐ NO ☐		

DIAGNOSTIC WORKUP

			Comments:
Was there adequate evidence to support the patient's admission?	YES ☐	NO ☐	
Was the level of care appropriate?	YES ☐	NO ☐	
Was the physician's problem formulation (i.e., initial impressions, rule-outs, assessment, etc.) appropriate?	YES ☐	NO ☐	
Was all necessary information (i.e. history, physical, progress notes, and summary) recorded by the physician in a timely manner in the patient's medical record in a legible manner?	YES ☐	NO ☐	
Were the entries made in the patient's record by the physician informative and appropriate?	YES ☐	NO ☐	
Was the physician's use of X-ray/Lab Services/ Invasive Diagnostic procedures appropriate?	YES ☐	NO ☐	
Were the physician's initial orders (i.e., activity, diet, vital signs, parenteral fluids, etc.) appropriate?	YES ☐	NO ☐	

PATIENT MANAGEMENT

	Satisfactory	Unsatisfactory		Satisfactory	Unsatisfactory
Use of Medication	☐	☐	Monitoring of Patients Condition	☐	☐
Use of Blood and Blood Components	☐	☐	Patients Length of Stay	☐	☐
Use of Ancillary Services (PT, RT, SS, Dietary)	☐	☐	Complications (anticipated, recognized promptly, dealt with appropriately)	☐	☐

Comments:

DISPOSITION

	Satisfactory	Unsatisfactory	N/A
Was the discharge summary timely and complete	☐	☐	☐
Placement (transfer, home, ECF, home health, etc.)	☐	☐	☐
Patient education/instruction (diet, medications, follow-up, level of activity, etc.) ☐ Not documented	☐	☐	☐
Discharge/transfer summary (timeliness, completeness, clarity, legibility, etc.)	☐	☐	☐

GENERIC COMPETENCIES

	Satisfactory	Unsatisfactory		Satisfactory	Unsatisfactory
Basic medical knowledge/clinical judgment	☐	☐	Professional attitude	☐	☐
Communication w/patient, family & staff	☐	☐	Relationship with patient	☐	☐
Use of consultants	☐	☐	Record keeping	☐	☐

Thank you for your assistance in evaluating of this physician. Upon completion of this form, please forward to the Medical Staff Office.

Signature of Evaluating Physician	Date

Confidential Peer Review/Performance Improvement Program Information Confidential Pursuant to: AR 10.23.030

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) Policy MS26

Once all FPPE evaluation forms are complete, a Department Chair Recommendation is needed. The Department Chair will be notified to come to the MSS office to review relevant information and complete this form.

FAIRBANKS MEMORIAL HOSPITAL MEDICAL STAFF
OBSERVATION/EVALUATION CREDENTIALING REPORT AND RECOMMENDATION

PROVIDER: *New to FMH, MD* SPECIALTY: _____
DEPARTMENT: *Your Department* INITIAL APPOINTMENT/PRIVILEGING DATE: _____

Quality/Performance Information: Attached reports provide information, as applicable to the practitioner and the practitioner's specialty, related to clinical activity, mortalities, invasive procedures, blood product utilization, medical record review, medication use, utilization, complaints, etc. during the period of observation/evaluation.

Recommendation of Department Chair: The Department Chair has reviewed information related to the performance of the staff member, reports demonstrating ongoing review of information related to his/her clinical performance, and other matters related to competency and conduct. The Department Chair's recommendation is based on the following appraisals:

Appraisal Factor	Yes	No	N/A	Comments on Significant Issues
Timely and adequate completion of patient records				
Compliance with applicable Medical Staff and organization policies and procedures				
Evidence of an acceptable level of Hospital clinical activity				
Technical skill / judgment				
Evaluation of peer review findings and evaluation/ observation reports, as applicable				
APPRAISAL FACTOR	Yes	NO	NA	Comments on Significant Issue
Patient/staff complaints or other incident reports				****Decide what your Yes or No means for this question.**

DEPARTMENT CHAIR:

☐ Successful conclusion of observation/evaluation: The practitioner has satisfactorily demonstrated his/her ability to exercise the clinical privileges initially granted and is recommended to be released from further observation/evaluation.

☐ Extension of observation/Evaluation with no change in privileges: Recommend that the practitioner remains in observation/evaluation status without any changes in privileges for an additional _____ days.
Explanation: _____

Specific observation/evaluation requirements: _____

☐ Alternative Recommendation (explain specific recommendation and rational): _____

Department Chair: _____ Date: _____

CREDENTIALS COMMITTEE RECOMMENDATION:

☐ Concur with recommendation of the Department Chair

☐ Recommend the following: _____

Credential Committee Chair: _____ Date: _____

EXECUTIVE COMMITTEE RECOMMENDATION:

☐ Concur with recommendation of the Department Chair

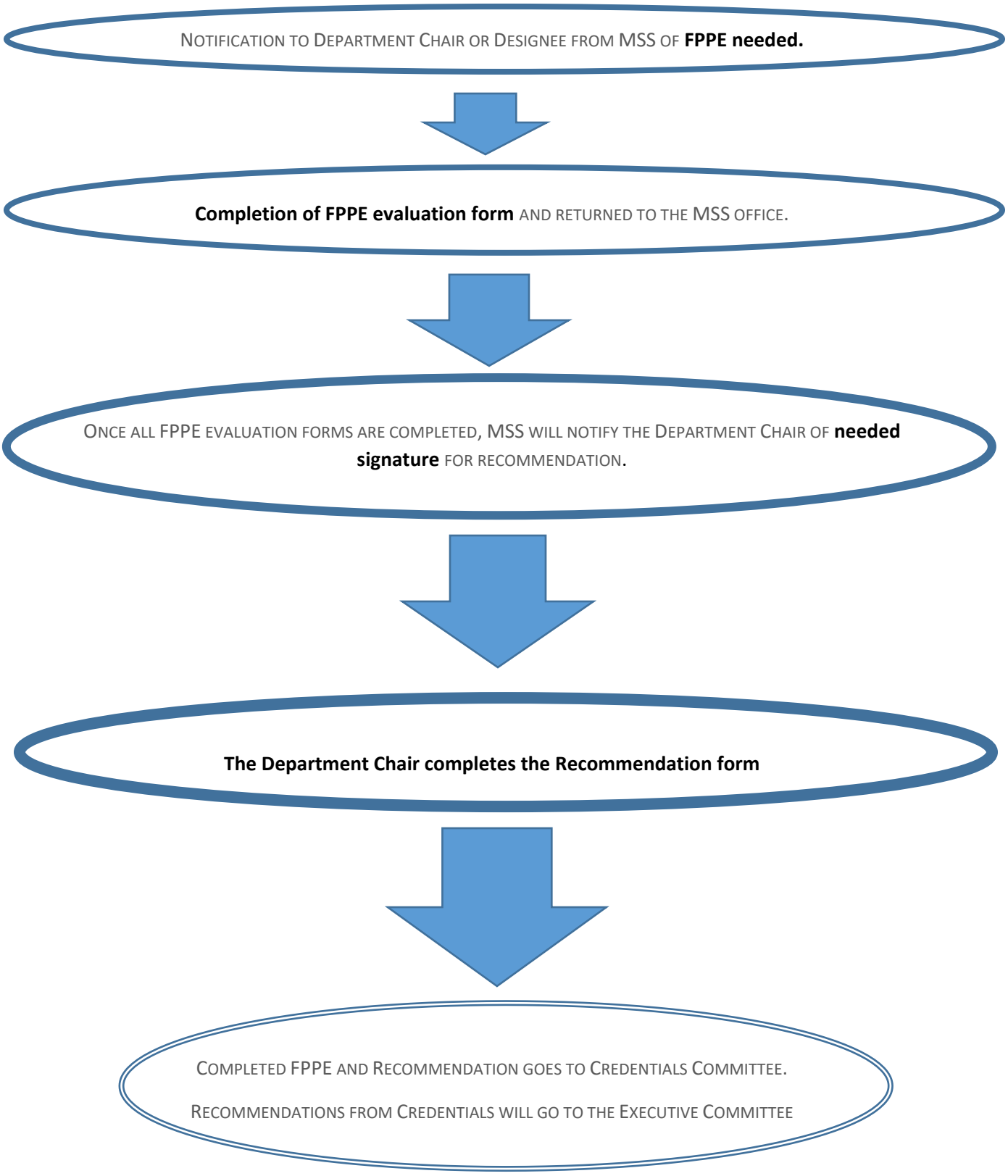
☐ Recommend the following: _____

Secretary, Executive Committee: _____ Date: _____

Revised: 01/26/2011

CONFIDENTIAL: Protected under Alaska Statute 18.23.030 regarding confidentiality for the purpose of evaluating and improving the

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) Policy MS26



OPPE: MS 39

What is it?

- A system established to monitor on-going professional competence

Who is it for?

- All practitioners who are privileged through the Medical Staff provileging process

How is it done?

- Evaluation
    - Under the *peer review process*:
        - Confidential and Privileged per Alaska Statute 18.23.030
        - No discussions outside appropriate closed session meetings except to another authorized individual with a need to know, and *in private*
        - Any reported OPPE will be in aggregate and/or de-identified except for the use of determining privileges (department chair, Credentials Committee, MEC [closed], and the FHP Board Quality Committee)
    - Department Chair/Vice Chair reviews OPPE reports for his/her department members throughout the year, not to exceed nine months.
        - Relevant information from the practitioner's performance will be integrated into performance improvement activities and will be utilized to determine whether to continue, limit or revoke existing privileges.
        - Depending upon the findings of the ongoing professional practice review, interventions may be implemented. The criteria utilized to determine the type of intervention includes a risk of severity and/or frequency of occurrence. Interventions include, but may not be limited to, proctoring, education, focused review, performance improvement plan, and corrective action.
        - The Department Chair (or designee) has primary responsibility for assuring the clinical competency and conduct is evaluated and concerns addressed with the provider.

- Evaluation Process
    - **Notification:** Medical Staff Services (MSS) will notify the Department Chair and/or Vice Chair that an evaluation is required. The evaluation forms will be in the MSS office.
    - **Evaluation Form:** Once the OPPE reports are marked with a determination to continue, limit, or revoke privileges by the Department Chair and/or Vice Chair, the signed reports will be kept in the MSS office. If a concern is noted, the Department Chair/Vice Chair will notify the appropriate individual/committee of his/her recommendation.
    - **Information Access:** Each practitioner will be given a copy of his/her OPPE report and a copy will be saved in the Practitioner's credential file to be used for future privileging decisions. A report of aggregate OPPE data may be shared with the medical staff for performance improvement activities.

- OPPE Report Information
    - Departments will determine specific clinical performance measures to monitor along with the established data to evaluate the six general competencies defined by Joint Commission (Patient Care, Medical/Clinical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-Based Practice).
    - Data sources for OPPEs may come from a variety of sources within the hospital. Examples of data on OPPE reports may include, but not limited to:
        - Patient encounters, patient complaints/compliments, infection rates, length of stay, complication rates, mortality rates, antibiotic prescription patterns, opioid prescription patterns, medical documentation deficiency volumes, CPOE utilization, rate of eprescribing medications, behavioral complaints, responsiveness to ED call, meeting attendance, FPPE volumes

	Six core competencies and sample indicators		
Indicator type and scope	**Competency area**	**Demonstration of competency**	**Sample indicators**
Hospital-level indicators: Select the same indicators for all practitioners at the hospital. If your facility is part of a system and your OPPE/FPPE program is at the system level (which is recommended), select the same indicators for all practitioners in the system.	**Medical/clinical knowledge:** Demonstrated knowledge of established and evolving biomedical, clinical, and social sciences, and the application of this knowledge to patient care and the education of others.	Based on availability and recommendation by the relevant specialty, use evidence-based guidelines to select the most effective and appropriate approaches to diagnosis and treatment.	• Number of continuing medical education (CME) credits earned in established time frame and in accordance with privileging criteria or other measure of appropriateness. • Results of retrospective case/chart review focused on appropriateness of care. • Performance on simulations. • Board certification.
	Practice-based learning and improvement: Use of scientific evidence and methods to investigate, evaluate, and improve patient care.	Review individual and specialty/group aggregate data for all general competencies, and use this data to continuously improve patient care.	• Dating/timing/signing of all orders. • Compliance with established evidence-based practice guidelines. • Appropriate drug use—VTE prophylaxis, ASA on admission for AMI patients, statins at discharge for all AMI patients.
	Interpersonal communication skills: Demonstrated ability to establish and maintain professional relationships with patients, families, and other members of healthcare teams.	Communicate clearly with other physicians and caregivers, patients, and their families through appropriate oral and written methods to ensure accurate transfer of information.	• Legibility of orders. • Timeliness of history and physical examinations. • Patient satisfaction with practitioner communication. • Incident reports that reflect a practitioner's unwillingness to cooperate. • Compliments from patients, family, staff.

	Six core competencies and sample indicators (cont.)		
Indicator type and scope	**Competency area**	**Demonstration of competency**	**Sample indicators**
	Professionalism: Demonstrated commitment to continuous professional development; ethical practice; sensitivity to diversity; and a responsible attitude toward patients, the profession, and society.	• Act in a professional, respectful manner at all times to enhance the spirit of cooperation, mutual respect, and trust among members of the patient care team. • Respond promptly to requests for patient care. • Respect patients' rights by communicating unanticipated adverse outcomes and by refraining from discussing patient care details in public settings. • Participate in emergency department (ED) call coverage as determined by medical staff policy.	• Validated incidents of inappropriate behavior. • Responsiveness to ED call, including episodes of noncompliance. • Meeting attendance. • Medical record suspensions. • Number of delinquency warnings. • Number of unsafe/Do Not Use abbreviations. • No show/late/cancellations to scheduled procedures or office visits.
Department-specific indicators: Select the same indicators for your medicine, surgery, and OB/GYN departments/ service lines.	**Systems-based practice:** Demonstrated understanding of patient care systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare.	• Strive to provide cost-effective quality patient care by cooperating with efforts to manage the use of valuable patient care resources. • Participate in the hospital's efforts and policies to maintain a patient safety culture, reduce medical errors, meet National Patient Safety Goals, and improve quality.	• Severity-adjusted average length of stay. • Pharmacy cost per case. • Number of as needed (PRN) medications prescribed without indication. • Rate of e-prescribing. • CPOE rates.

	Six core competencies and sample indicators (cont.)		
Indicator type and scope	**Competency area**	**Demonstration of competency**	**Sample indicators**
Specialty-specific indicators: Select indicators relevant to individual specialties, and if there are specialties that provide similar care (e.g., internal medicine and family practice), select the same indicators for groups of similar specialties at the same time. Consider working with small groups of specialties at a time.	**Patient care:** Delivery of compassionate, appropriate, and effective patient care that helps promote health, prevent illness, treat disease, and provide comfort at the end of life.	• Achieve patient outcomes that meet or exceed generally accepted medical staff standards as defined by comparative data and thresholds, medical literature, and results of peer review evaluations. • Use sound clinical judgment based on patient information, available scientific evidence, and patient preferences to develop and carry out patient management plans. • Demonstrate caring and respectful behaviors when interacting with patients and their families.	• Risk-adjusted mortality by medical diagnosis-related group (DRG). • Risk-adjusted complications by surgical DRG. • Peer review cases with unacceptable results. • Blood transfusions that do not meet established criteria. • Percentage of women who had mammograms within the year.

ONGOING PROFESSIONAL PRACTICE EVALUATION
PHYSICIAN PROFILE
Department Chairman Review

FAIRBANKS MEMORIAL HOSPITAL

Physician Name: Provider Name, MD Facility ID#
Specialty: Surgery Department
Review Timeframe: 01/01/2018-06/30/2018

PROFESSIONAL PRACTICE DATA	**Individual #**	**Department #**
# Cases		1348
PEER REVIEW DATA	**Individual #**	**Department #**
Focused Professional Practice Evaluation (FPPE) - *new privileges*		
Triggered Focus Professional Practice Evaluation (FPPE) - q*uality review*		
Total cases scored by Peer Review Committee		20
Peer Review Case Scoring:	**Individual #**	**Department #**
Quality of Care Score 0: Satisfactory care/care appropriate		15
Quality of Care Score 1: Opportunity for care improvement, minor		4
Quality of Care Score 2: Opportunity for care improvement, major		1
Documentation Score 0: No issue with documentation		19
Documentation Score 1: Opportunity for improvement minor, did not significantly impact patient care / illegible		1
Documentation Score 2: Opportunity for improvement minor, did not substantiate clinical course or treatment / not timely		0
Documentation Score 3: Opportunity for improvement major, did not substantiate clinical course or treatment / not timely		0
DEPARTMENTAL SELECTED QUALITY METRICS	**Individual #**	**Department #**
Surgical Site Infections – ***all surgeries*** (Jan thru March 2018)		436 / 2
Surgical Site Infections – ***Colo*** TheraDoc (May and June)		22 / 2
Surgical Site Infections – ***Chol*** TheraDoc (May and June)		47 / 2
Withdrawal times of scopes **national standard 6 min or greater*		17 min 30 sec (55 scopes)
% of scopes reaching the cecum		100 %
Blood Utilization: Crossmatch Vs. Transfused		151 / 36
HCAHPS *(see separate sheet if applicable)*		
CITIZENSHIP		
Leadership Positions		
PROFESSIONALISM	**Individual #**	**Department #**
Behavior Events sent to Department Chair*		2
Behavior Interventions by Department Chair*		0
Compliments *(future data)*		

ONGOING PROFESSIONAL PRACTICE EVALUATION
PHYSICIAN PROFILE
Department Chairman Review

CHART COMPLETION	Individual #	Department #
Medical Record Reminders: 7-day notices		99
Medical Record Delinquencies: 15 day delinquency notices		11

Quality, Documentation or Behavior events can originate from Verge incident reporting, patient complaints, quality screens or referrals.

****Vice Chair or designated Medical Staff Leadership***

Upon reviewing this provider's profile, the Department Chairman determined:

_____Reviewed and no concerning trends were identified. Provider is recommended for continuation of privileges as granted.

_____Reviewed, concerns identified, and the following action(s) is/are recommended for continuation of privileges as granted:

____Refer to Medical Executive Committee for action on privileges.

____Recommend FPPE for specific issues noted below.

Specific Issues Identified:

_____

_____

_____

_____

_____ _____

Reviewed per Department Chair/Vice Chair Date

MEDSTAFF PEER REVIEW PROCESS

- **EVENT REPORTS** (Verge)
- **PATIENT COMPLAINTS** (Patient Experience)
- **REFERRALS** (i.e. Risk, RCA, Committees, Physicians, Admin, Staff)
- **QUALITY REPORTS/SCREENS** (i.e. PSI, Premier, OPPE, Morgue report, ADT…)

MSS NURSE REVIEWER (CNR) reviews for peer review clinical indicators and behavior/conduct criteria

PRC CHAIR screens care related cases with CNR – assigns case reviews for committee members or designated reviewers as appropriate

Does not meet criteria

Refer as appropriate

Screen & Close

Behavior/Conduct Concerns sent to **Medical Staff Leadership** for Follow-up & Documentation

Case REVIEWER conducts initial review with provider discussion as appropriate

SECONDARY / EXTERNAL REVIEW if needed

REPORT as appropriate

MEC
BOARD
CREDENTIALS
OPPE
GENERAL STAFF

SYSTEM ISSUE REPORT:
QUAILTY COMMITTEE
QUALITY DEPARTMENT

PRC MEETING

- Discussion of case
- Concern/No concern
- Additional actions/ recommendations as appropriate (i.e. letter, collegial intervention, PIP…)
- Identification of lessons learned/ Educational Opportunities
- Identification of System Issues

SYSTEM ISSUES sent to appropriate bodies.

Feedback from system issues brought back to PRC for follow-up

LESSONS LEARNED shared
Department Meetings
General Staff Meetings

ATTRIBUTED PROVIDER given feedback as appropriate

Revised 1/4/2022

Behavior/ Conduct Issues

The Chief of Staff, Department Chair, or designee shall make an initial determination of authenticity and severity, and arrange for an inquiry accordingly. (Bylaws Article VII – Conduct)

- *Timely* and *brief* preliminary call or personal discussion with the colleague involved.
- If this is a low level concern/no pattern or history with colleague, document a memorandum summarizing the disposition of the complaint.
- If the complaint is more significant or there is a pattern/history with your colleague, give a "heads up" that a concerns have been raised and that more details will be soon to follow. ("Courtesy call", no fact-finding at this point).
- Fact-find to determine if report is credible.
- Remember that this is *confidential* and explain this to anyone you are interviewing.
- If found credible, share details with the colleague for response.
- There is also a *non-retaliation policy*: this should be clearly made known to both the colleague and the witnesses.

Any actions required must be communicated with the appropriate medical staff leaders.

Confidentiality

It is important that you maintain confidentiality and only discuss this matter with individuals who are a formal part of the review process and not with colleagues or staff members. This should be done in an area where privacy can be ensured and the importance of confidentiality should be discussed.

Per Alaska Statute 18.23.030, all data and information acquired in the review process shall be held in confidence and may not be disclosed to anyone except to the extent necessary to carry out the purposes of the review organization. Non-adherence to confidentiality may subject this to subpoena or discovery, as well as violating state law.

Non-retaliation

Policy 2749 established as part of a compliance program

As a part of safety and quality care, no retaliation is permitted against anyone who reports a concern. The practitioner at issue may not approach that individual directly to discuss the matter or engage in any abusive or inappropriate conduct toward that person.

Department Chair and Vice Chair Responsibilities: Behavior Complaints

Documentation of your findings must be turned in to Medical Staff Services:

- Any additional information you found by speaking with the provider or others
- Any determinations you have found and any education you have provided
- Any further actions needed

The most important classifications for behaviors are the severity levels
Further definition of inappropriate behavior is found in Article 7 of the Bylaws

- **Level I** examples include, but are not limited to:
  - Verbal abuse which is directed at-large, but has been reasonably perceived by a witness to be inappropriate behavior as defined above;
  - Non-compliance of hospital policies that has minimal or no impact on patient care or staff.
  - LevelI complaints have a **10 day timeframe** (from receiving the complaint to conducting interview. See Bylaws.)
- **Level II** examples include, but are not limited to:
  - Verbal abuse such as unwarranted yelling, swearing or cursing; threatening, humiliating, sexual or otherwise inappropriate comments directed at a person or persons verbally;
  - visual abuse such as threatening, humiliating, sexual or otherwise inappropriate writing or picture(s) directed at a person or persons, or
  - physical violence or abuse directed in anger at an inanimate object;
  - Non-compliance of hospital policies resulting in minor potential or actual harm to patients or staff.
  - Demeaning or rude interactions with patients.
  - LevelII complaints have a **5 working day** timeframe (from receiving the complaint to conducting interview. See Bylaws.)
- **Level III** examples include, but are not limited to:
  - Physical violence or other physical abuse which is directed at people;
  - sexual harassment or harassment involving physical contact;
  - non-compliance of hospital policies resulting in major or potential or actual harm to patients or staff;
  - substance abuse;
  - Inappropriately accessing the medical record.
  - LevelIII complaints have a **24 hour** time frame (from receiving the complaint to conducting interview. See Bylaws.)

If you have more information at a later time, please send your documentation to one of the nurses in Med Staff Services:

Susan Pressley RN, Peer Review Specialist Susan.Pressley@foundationhealth.org (907) 458-5304	Sharon Davis RN, Peer Review Specialist Sharon.Davis@foundationhealth.org (907) 458-5304

All information must be sent securely: FHP email is acceptable.

How to Prepare for a Difficult Conversation

By **Harvard Business Review**
https://www.physicianleaders.org/news/how-to-move-forward-after-a-difficult-workplace-conversation
June 6, 2018

Don't like conflict? Here are five tactics for tough talks that are constructive and can maintain mutual respect.

Avoiding or delaying a difficult conversation can hurt your relationships and create other negative outcomes. It may not feel natural at first, especially if you dread discord, but you can learn to dive into these tough talks by reframing your thoughts.

Here are five strategies that can help:

Begin from a place of curiosity and respect. Stop worrying about being liked. While it's natural to want to be liked, that's not always the most important thing. Lean into the conversation with an open attitude and a genuine desire to learn. Start from a place of curiosity and respect — for yourself and the other person. Genuine respect and vulnerability typically produce more of the same: mutual respect and shared vulnerability.

Focus on what you hear, not what you say. You don't actually need to talk that much during a difficult conversation. Instead, focus on listening, reflecting and observing. Gather as much detail as possible. Ask follow-up questions without blame.

Be direct. Address uncomfortable situations head-on by getting right to the point. Have a frank, respectful discussion where both parties speak frankly about the details of an issue. Talking with people honestly and with respect creates mutually rewarding relationships, even when conversations are difficult.

Don't put it off. Instead of putting off a conversation for some ideal future time, tackle it right away. Get your cards on the table so you can resolve the issue and move on.

Expect a positive outcome. Focus on the long-term gains that the conversation will create for the relationship. When your attention is focused on positive outcomes and benefits, it will shift your thinking process and inner dialogue to a more constructive place.

How to Move Forward After a Difficult Workplace Conversation

By **Harvard Business Review**
https://www.physicianleaders.org/news/how-to-move-forward-after-a-difficult-workplace-conversation
October 24, 2017

Here are three suggestions for rebuilding a good relationship after a tough talk, while also making progress on the problem at hand.

Much has been written about how to have difficult conversations, but what are you supposed to do afterward? Following up and building a relationship after a hard conversation matter just as much as tackling the conversation in the first place.

Here are three key steps that can rebuild a good working relationship following a challenging conversation, while also making progress on the problem at hand.

ACKNOWLEDGE THAT THE CONVERSATION HAPPENED: Rather than pretend it never happened, you should always follow up, acknowledge that it was a tough situation and focus on the positive. There is huge value in appreciating that you were able to come together, identify an issue and even have the initial conversation. Thank your colleague for taking the time to engage in the discussion.

FIND WAYS TO MOVE THE CONVERSATION FORWARD: Be proactive in showing that you are resilient and solutions-oriented, and that you want to stay in the conversation. Even if you were only able to come to an agreement about a few action steps during the difficult conversation, send a follow-up email to summarize the conversation and focus on the outcomes you both want.

FOCUS ON BUILDING THE LONG-TERM RELATIONSHIP: Remember that every interaction is just one human talking to another. If the only interaction you have with someone is a difficult conversation, that person may start avoiding you or associating you with awkward meetings. Instead, pay attention to building the relationship outside of the challenging conversation. This step balances both the outcome you desire regarding the specific issue under consideration and the work relationship you want for the long term.

Immunity for Participants

E. Fairbanks Memorial Hospital's Protection and Indemnification

A. Article XVI – Immunity from Liability and Indemnification states:

1. Any act, communication, report, recommendation, or disclosure, with respect to any such applicant or member, performed or made in good faith and without malice at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by laws.

2. Such privilege shall extend to members of the STAFF, HOSPITAL personnel, members of the LOCAL BOARD, the ADMINISTRATOR and his/her representative, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XVI, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the BOARD or of the STAFF.

3. There shall, to the fullest extent permitted by law, be **absolute immunity** from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

II. State Law

A. AS 18.23.010

1. Protects:

    a) Persons reporting concerns
    b) Persons testifying at a peer review hearing

2. "A person providing information to a review organization is not subject to action for damages or other relief…unless the information is false and the person providing the information knew or had reason to know the information was false."

3. A "review organization" is:

    a) A committee
    b) Established by the governing body of the hospital (such as setting out in a Quality Improvement Plan)
    c) Composed of only health care providers and administrative staff
    d) To gather and review information relating to the care and treatment of patients
    e) For the purpose of evaluating and improving the quality of health care rendered in the hospital
    f) Including an MEC and CMB when acting on peer review matters

4. Review organization includes:

    a) Physician Quality Committee
    b) Credentials Committee

c) Medical Executive Committee
d) Hearing Panel
e) Appellate Review Committee
f) Governing Board when acting on a peer review matter

B. AS 18.23.020

1. Protects:

a) Members of a review organization
b) Employees of review organization
c) A person who advises a review organization
d) A person who furnishes counsel to a review organization
e) A person who provides services to a review organization

2. Such a protected person "Is not liable for damages or other relief in an action brought by another whose activities have been or are being scrutinized or reviewed by a review organization…unless the performance of the duty, function or activity was motivated by malice toward the affected person."

3. Such a protected person is "…not liable for damages or other relief…by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made."

C. Sections together provide immunity for all individuals participating in the peer review process

D. The law was recently tested in a recent Alaska Supreme Court case

1. "Reasonable efforts" means "whether or not the totality of the process leading up to the board's decision evidenced a reasonable effort to obtain the facts of the matter.

E. State law does not protect the hospital as an institution

F. If a claim is asserted, the issue of immunity is determined first on a motion

III. Federal Law – Health Care Quality Improvement Act (HCQIA)

A. Provides immunity to both physicians and to the hospital as an entity

B. Provides immunity against damages

1. But not against "equitable relief"

a) Such as injunctions, reinstatement

2. Nor against claims of racial, gender, *etc.* discrimination

C. Immunity depends upon the peer review process having been taken:

1. With the reasonable belief that the action was in the furtherance of quality health care

2. After a reasonable effort to obtain the facts of the matter

3. After adequate 1) notice and 2) hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances

4. In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after providing a notice and hearing complying with the Act

D. The statute establishes a presumption that the above four requirements were met

E. Requirements for the hearing and notice

1. A hearing is provided and is held before:

   a) An arbitrator;
   b) A hearing officer; or
   c) A panel of individuals not in direct economic competition

2. At the hearing the physician has the right:

   a) To be represented by an attorney
   b) To have a record made of the proceedings
   c) To call, examine and cross-examine witnesses
   d) To present evidence as long as it is relevant even though it may not be admissible in court (hearsay)
   e) To submit a written statement at the close of the hearing

3. Upon completion of the hearing:

   a) The physician is entitled to receive written recommendations including a statement of the basis for the recommendations
   b) The hospital issues a written decision including a statement of the basis for the decision

F. A review body's failure to meet these due process requirement does not automatically mean that there has been a failure to provide due process

G. A hearing is not required before the action if

1. The suspension or restriction of privileges is for no longer than 14 days; or

2. Failure to take such action may result in an imminent danger to the health of any individual

The Healthcare Quality Improvement Act – 1986

The federal HCQIA was passed by Congress in 1986 to extend immunity to good faith peer review of physicians and dentists and to create the National Practitioner Data Bank (NPDB). The statute is located at 42 United States Code section 11101 et seq.

Note that HCQIA only protects the review of physicians and dentists; review of allied health professionals is not protected by the HCQIA. The statute was enacted as a result of the decision in Patrick vs. Burgett, a federal antitrust case in which physicians were held liable for damages caused to Dr. Patrick by abusive and inappropriate peer review.

HCQIA Immunity Coverage Availability

1. Professional review bodies – Medical staffs are examples of professional review bodies.
2. Members and/or staff of those bodies – The individual members and medical staff coordinators and credentialing specialists should qualify for protection under this section.
3. Those under contract with the bodies – Peer review consultants contracting to provide impartial review should be protected under this section.
4. Anyone who participates or assists the bodies with respect to action.
5. Those who provide information regarding competence/conduct unless the information is false and the person giving the information knew it was false. Whistle blowers are protected under this section.

Exceptions to the Immunity Coverage

1. Healthcare entities failing to meet the standards for immunity below.
2. Healthcare entities failing to report information to the National Practitioner Data Bank. The federal Health and Human Services Department would determine whether a hospital or healthcare entity failed to report as required, and could take away the immunity protection for up to three years.

Standards for Immunity

Only good faith peer review qualifies for HCQIA protection. The HCQIA sets these standards for good faith peer review. To be considered good faith peer review, peer review must:

1. Be carried out with the reasonable belief that the action was taken to further quality healthcare
2. Follow a reasonable effort, through investigation and review, to obtain the facts
3. Meet adequate notice and fair hearing procedures afforded to the physician or dentist, either by proving in court that the procedure was fair, or by meeting fair hearing standards listed in the HCQIA (see below)
4. Have been conducted in the reasonable belief that the action was warranted by the facts after #2 (fact-finding) and #3 (fair hearing) are accomplished. The hearing procedures that automatically qualify as a fair hearing under the HCQIA must have these elements:
    a. The physician or dentist is given written notice of the proposed action, stating:
        i. That a professional review action has been proposed to be taken against the physician or dentist;
        ii. The reasons for the proposed action;

iii. That the physician or dentist has the right to request a hearing on the proposed action;
iv. Any time limit (of not less than 30 days) within which to request such a hearing; and vs. a summary of rights in the hearing.

b. If a hearing is requested, the physician or dentist must be given notice of hearing, stating:
   i. The place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice of hearing; and
   ii. A list of the witnesses (if any) expected to testify at the hearing on the part of the professional review body.
c. If a hearing is requested, the hearing shall be held (as determined by the hospital or healthcare entity):
   i. before an arbitrator mutually acceptable to the physician or dentist and the hospital;
   ii. before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician or dentist involved; or
   iii. before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician or dentist involved.
d. In the hearing, the physician or dentist involved has the right:
   i. to representation by an attorney or other person of the physician's or dentist's choice;
   ii. to have a record made of the proceeding, copies of which may be obtained by the physician or dentist upon payment of any reasonable charges associated with the preparation of the record;
   iii. to call, examine and cross-examine witnesses;
   iv. to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; and vs. to submit a written statement at the close of the hearing.
e. Upon completion of the hearing, the physician or dentist has the right:
   i. to receive the written recommendation of the hearing body, including a statement of the basis for the recommendation; and
   ii. to receive the written decision of the hospital or healthcare entity, including a statement of the basis for the decision.

Application of Immunity

The HCQIA had been successfully applied in cases brought by physicians challenging the peer review action taken by the hospitals, to protect the hospital and the physicians who conducted the review. In Mathews vs. Lancaster General Hospital, 87 F. 3d 624 (Pa.
1996), committee including competitors found substandard care; outside consultant agreed; surgeon challenged summary judgment applying HCQIA immunity; HCQIA presumption of good faith upheld.

Department Meetings

Things to Know:

- A quorum for meetings is three ACTIVE physicians. No formal voting is valid if a quorum is not present.
- Notifications of meetings are emailed out from Medical Staff Services (MSS) department a week in advance. Recurring Outlook calendar invites are sent out as well.
- The agenda items should be reviewed by the Chair/Vice Chair in advance. Any staff may ask to add agenda items.
- In situations in which a small number of members voted and the result is a tie, a second vote may be held to solicit input from all voting members of the department. Voting that result in a tie a second time may be sent to the Medical Executive Committee or the Chief of Staff to break the tie.
- For closed sessions, in which peer review protections would be afforded, it is important to dismiss all non-members. It is also important to verbally remind those present that the material is confidential and should not be discussed outside of the meeting. Any printed materials should be returned to MSS before leaving the meeting.

Tips to a Successful Department Meeting

- Start on time and end on time.
- Stay on task. Make sure you cover all the agenda items.
- Invite guest speakers to go first. Not only does it show the presenter you value your time, it may allow for more members to be arrive without missing their chance to vote on items.
- Keep the discussion to one topic. Ensure members do not hold other/side conversations at the same time.
- Encourage discussion on topics. This may require asking specific individuals for their thoughts.
- When voting on an item, be sure to ask for a motion, second, and if there are any objections. If the vote is controversial in nature, asking if anyone abstains should be included. Blind voting on paper is always an option if open voting may cause unnecessary conflict.
- Take time to review the minutes thoroughly. Minutes are the formal record that may be reviewed in the future. It is important they reflect any actions voted on and the information is accurate.
- Table items to be addressed at another meeting that require more information or excessive time for discussion in order to ensure all agenda items are presented.
- If you will be out, coordinate with the Vice Chair or Past Chair to run the meeting. Please notify MSS so staff can assist in making arrangements.

Executive Committee/Committee Meetings

Things to Know:

- Quorum and voting requirements are the same for committees. Meeting notifications are the same and will often include the full meeting packet for review.
- Closed Session MEC is composed of the elected Executive Officers and designated administration members. If necessary, department chairs may be invited to discuss department specific issues. A department chair may request to present a topic to the Closed MEC by contacting Medical Staff Services.
- For closed sessions, in which peer review protections would be afforded, it is important to dismiss all non-members. It is also important to verbally remind those present that the material is confidential and should not be discussed outside of the meeting. Any printed materials should be returned to MSS before leaving the meeting.

Tips to a Successful Committee Meeting

- Be sure to arrange to have the alternative representative attend the meeting if you are unable to attend.
- Review material prior to the meeting. Committee meetings often move quicker than department meetings, so plan to arrange on time and having reviewed the material prior to the meeting.
- If you have questions prior to the meeting, send those to Medical Staff Services. This may allow time to research and have information prepared for the actual committee meeting discussion.
- Be sure to voice any questions or concerns at the meeting, especially if there will be a vote on the topic.

Who's Who in Medical Staff Services

Main Phone: 907-458-5304

Fax: 907-458-5193

Group email: fmhmedstaff@foundationhealth.org

Medical Staff Coordinators

Department/Committee Meetings & Project Coordination

Christine Forster
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email: Christine.forster@foundationhealth.org

Hannh Irigoyen
907-458-5317
Email: Hannah.irigoyen@foundationhealth.org

Provider Credentialing

Initial Appointments/Providerer Orientation

Brittney McDevitt
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email: brittney.mcdevitt@foundationhealth.org

Reappointments & Expirables

Kira Avery
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Peer Review Specialists

Professional Practice Evaluation: Peer Review and Behavior/Conduct Events, FPPE

Susan Pressley, BSN,RN
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Sharon Davis, BSN, RN
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Leadership

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Chief Medical Officer
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Chief Medical Officer Admin Assistant
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Executive Admin Assistant
Donna Cook
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MEDICAL STAFF OF FAIRBANKS MEMORIAL HOSPITAL

2022 MEDICAL STAFF LEADERSHIP

EXECUTIVE COMMITTEE

OFFICERS of the STAFF – Leadership Council
Kerry Wappett, MD - Chief of Staff
Abraham Tsigonis, MD – Chief of Staff Elect
Terry Conklin, MD –Past Chief of Staff
David Evans, MD – Secretary/Treasurer
Kimberly Schumacher, DO – Member at Large

Additional Closed MEC Members
Bruce Footit, MD – Credentials Chair (April)
Jessica Panko, MD – Peer Review Chair
Kristin Flowers, MD – Quality Improvement Chair

DEPARTMENTS	CHAIRS	VICE CHAIRS
Anesthesiology	William Quirk, MD	Androcles Lester, MD
Emergency Medicine	Michael Burton, MD	William McIntyre, MD
Family Medicine	Julia Franklin, MD	Richard Sheridan, MD
Internal Medicine	Owen Hanley, DO	Barbara Creighton, MD
OB/GYN	John McKenna, MD	Anne Baker-Bealer, DO
Orthopedic Surgery	Neal Everson, DO	Dustin Hubbard, DPM
Radiology	David Evans, MD	Timothy Ryan, MD
Pathology	Andrew Evanger MD	
Pediatrics	Anne Hanley, DO	Jessie Allen, DO
Surgery	Mark Kowal, MD	Dante Conley, MD
Foundation Representative	Kimberly Schumacher, DO	David Evans, MD

QUALITY IMPROVEMENT COMMITTEE

Kristin Flowers, MD-Chair
Mark Butcher, MD
Catherine Hompesch, MD
Dustin Hubbard, DPM
Michael Burton, MD
Claire Waite, MD
Stephanie Willet, MD
Abraham Tsigonis, MD

PEER REVIEW COMMITTEE

Jessica Panko, MD-Chair
Michael Burton, MD
Catherine Hompesch, MD
Anne Baker-Bealer, DO
Robert Greenwood, DO
Dante Conley, MD
Terry Conklin, MD
Androcles Lester, MD
Carla Cartagena De Jesus, MD
Lee Pierson, MD
Mark Wade, MD

CREDENTIALS COMMITTEE

William McIntyre, MD-Chair (Jan)
Bruce Footit, MD (Chair-April)
Abraham Tsigonis, MD
Stephanie Willet, MD

MEDICAL STAFF OF FAIRBANKS MEMORIAL HOSPITAL

2022 MEDICAL STAFF LEADERSHIP

ADDITIONAL COMMITTEES

WELLNESS COMMITTEE
Mark Simon, MD-Chair
Peter Lawrason, MD
Monique Smith, MD
Katrin Tsigonis, MD
Jean Tsigonis, MD

EMR COMMITTEE
Michael Burton, MD-Co-Chair
Roy Roehl-Co-Chair
Barbara Creighton, MD
Kendrick Blais, DO
Owen Hanley, DO
Jeffrey Banks, MD
Angelique Ramirez, MD

INFECTION CONTROL COMMITTEE
Eiluned Hogenson, MD - Chair
Laura Brunner, MD
Kendrick Blais, DO

PHARMACY & THERAPUTICS COMMITTEE
Barbara Creighton, MD - Chair
Gary Molk, DO
Gina Pender, MD
Jessie Allen, DO

PERIOP COMMITTEE
Joseph Livengood, MD - Chair
Mark Kowal, MD
Dustin Hubbard, DPM
Karl Baurick, MD
Neal Everson, DO
William McKenna, MD
William Quirk, MD

DISASTER COMMITTEE
Charles Steiner MD-Chair
Art Strauss, MD

BIOETHICS COMMITTEE
Janice Onorato, MD-Chair
Corrine Leistikow, MD
Michael Swenson, MD
Bruce Footit, MD

Updated 12.13.21

2022 Fairbanks Memorial Medical Staff Department / Committee Meetings

Dept / Committee	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
ANESTHESIA Dept. Alt. Month, 3rd Thurs, 7:30 am, **Montano Rm**	20		17		19		21		15		17	
ETHICS COMMITTEE Monthly, 2nd Tues, 12:00 pm**, FIC 252 Rm**	11	8	8	12	10	14	12	9	13	11	8	13
BYLAWS COMMITTEE (As Needed)												
CREDENTIALS COMMITTEE Monthly, 2nd Wed, 7:00 am, **Miss Ghezzi Rm**	12	9	9	13	11	8	13	10	14	12	9	14
EMERGENCY MEDICINE Dept. Alt. Month, 1st Wed, 7:30 am, **Montano Rm**		2		6		1		3		5		7
EMR COMMITTEE Monthly,3rd Wed 7:00 am, **Montano Rm**	19	16	16	20	18	15	20	17	21	19	16	21
EXECUTIVE COMMITTEE Monthly, 1st Tues., 7:15 am, **McGown Rm**	4	1	1	5	3	7	5	2	6	4	1	6
EXECUTIVE COMMITTEE (CLOSED SESSION) Monthly, 4th Thurs., 7:00am **Miss Ghezzi Rm**	19	16	16	20	18	15	20	17	21	19	16	21
FAMILY MEDICINE Dept. Qtrly, 2nd Thurs, 5:30 pm, **Clausen Rm**		10			12			11			10	
GENERAL STAFF MEETINGS & CME Qtrly, 2nd Tues, 5:30pm Dinner, 6pm CME, 7 pm Meeting, **McGown/Kiewit/Chandler Rm**			2			14				11		13
INFECTION CONTROL Alt Months, 3rd Tues, 11:00 a.m**, Montano**		15		19		21		16		18		20
INTERNAL MEDICINE Dept. Alt. Months, 1st Thurs, 7:00 am, **Montano Rm**	6		3		5		7		1		3	
OB/GYN CME ** Monthly, 2nd Mon, 2:00 pm, **Miss Ghezzi Rm**	10	14	14	11	9	13	11	8	12	10	14	12
OB/GYN Dept. Monthly, 2nd Mon, 3:00pm **Miss Ghezzi Rm**	10	14	14	11	9	13	11	8	12	10	14	12
ORTHOPEDIC SURGERY Dept. Alt. Monthly, 3rd Tues, 5:30 pm, **Montano Rm**		15		19		21		16		18		20
PATHOLOGY Dept ** Monthly, 4th Tues, 1:00 pm, **Path. Conf. Rm**	25	22	22	26	24	28	26	23	27	25	22	27
PEDIATRICS Dept. Alt. Monthly, 2nd Thurs, 12:30 pm **McGown Rm**		10		14		9		11		13		8
PEER REVIEW COMMITTEE *(scheduled by PRC specialist)* Monthly, 2nd Wed, 5:00 pm, **FIC 252 Rm**	12	9	9	13	11	8	13	10	14	12	9	14
PHARMACY/THERAPEUTICS Alt. Monthly, 1st Tues, 12:45 pm, **Montano Rm**		1		5		7		2		4		6
PERIOP GOVERNANCE COMMITTEE Monthly, 2nd Thursday 4:00 pm, **Montano Rm**	13	10	10	14	12	9	14	11	8	13	10	8
QI COMMITTEE Monthly, 2nd Tues, 7:00 AM **Montano Rm**	11	8	8	12	10	14	12	9	13	11	8	13
RADIOLOGY Dept. Qtrly, 4th Tues, 5:30 pm, **FIC 252 Rm**		22			24			23			22	
SURGERY Dept. Qtrly, 1st Wed, 5:00 pm, **Montano Rm**			2			1				5		7
WELLNESS COMMITTEE Alt. Month, 3rd Wed, 4:00pm, **Montano Rm**	19			20			20			19		

(*) = Alternate Meeting Location/Date (Committee in Red **) = Meeting not supported by MSS MC = Meeting canceled *CS –closed session only

Updated 12.28.21-Subject to change. Contact MSS (907) 458-5304 or group email fmhmedstaff@foundationhealth.org to verify meeting dates