

**MEDICAL STAFF
POLICIES & PROCEDURES
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**MEDICAL STAFF
POLICIES & PROCEDURES**

P R E A M B L E

Policy and Procedures of the Medical Staff may include guidelines that determine medical staff operational issues and actions as well as some aspects of patient care applicable to all members of the Medical Staff.

The content material shall not include issues required by regulatory agencies to be included in the Bylaws or Rules and Regulations. Such Policies and Procedures must be approved by the Medical Staff Executive Committee.

Policy and Procedures shall be considered final when approved by the Medical Staff Executive Committee.

APPROVED: Medical Executive Committee 9/2007, 2/2011

REVIEWED: 1/2011

REVISED:

**MEDICAL STAFF
POLICIES & PROCEDURES**

1.0 MEDICAL STAFF DUES

PURPOSE: To alleviate duplicated mailing to Medical Staff.

POLICY: Medical Staff Dues will be payable 2 years in advance at the time of reappointment and shall be a condition for reappointment for members of the Active and Courtesy medical staffs.

APPROVED: Medical Staff Executive Committee 7/1990, 12/1996, 12/1999, 12/2002, 2/2011, 6/2011

REVISED: 12/1996 increase dues to \$50 annually
12/1999 increase dues to \$60 annually
12/2002 increase dues to \$75 annually
09/2011 increase dues to \$140.00 annually

REVIEWED: 12/1996, 12/1999, 12/2002, 1/2011,

REVISED: 6/2011, 12/2012

**MEDICAL STAFF
POLICIES & PROCEDURES**

1.1 MEDICAL STAFF FUNDS

PURPOSE: The officers of the medical staff are occasionally presented with requests for financial support of a program or the need to send an expression of sympathy, congratulations, etc. to a staff member or family. It would be of benefit and assistance to future officers if there was a limited amount of money that could be expended from the staff treasury without specific approval.

POLICY: The President of the Medical Staff is authorized to spend up to \$5000 per year for staff related expenses without specific approval of the Medical Staff Executive Committee. The details of such expenses would be documented in the annual report by the Treasurer to the Medical Staff.

APPROVED: Medical Staff Executive Committee 10/1992, 9/2006, 2/2011

REVIEWED: 9/2006, 1/2011, 6/2011

REVISED: 9/2006, 6/2011

**MEDICAL STAFF
POLICIES & PROCEDURES**

1.2 STRUCTURE/ORGANIZATION OF MEDICAL STAFF

PURPOSE: To provide a roster of the departmental/section organization of the Medical Staff.

POLICY: The Medical Staff structure will consist of departments and sections. The Medical Staff Executive Committee may add or delete sections on the recommendation of the appropriate department chairman.

Table of Organization

A. Department of Anesthesiology

1. Section of Acute and Chronic Pain Management
2. Section of Ambulatory Anesthesia
3. Section of Cardiovascular Anesthesia
4. Section of Critical Care Medicine
5. Section of Neuroanesthesia
6. Section of Obstetric Anesthesia
7. Section of Pediatric Anesthesia

B. Department of Emergency Medicine

1. Section of Emergency Care
2. Section of Ambulatory Emergency Care
3. Section of Occupational and Industrial Medicine

C. Department of Medicine

1. Section of Allergy
2. Section of Ambulatory Care
3. Section of Cardiovascular Diseases
4. Section of Dermatology
5. Section of Endocrinology
6. Section of Family Medicine
7. Section of Gastroenterology
8. Section of Geriatrics
9. Section of Hematology
10. Section of Hospital Medicine
11. Section of Infectious Diseases
12. Section of Nephrology
13. Section of Neurology
14. Section of Oncology
15. Section of Physical Medicine and Rehabilitation
16. Section of Primary Care
17. Section of Pulmonary, Critical Care & Sleep Medicine
18. Section of Radiation Medicine
19. Section of Rheumatology

**MEDICAL STAFF
POLICIES & PROCEDURES**

1.2 STRUCTURE/ORGANIZATION OF MEDICAL STAFF – CONTINUED PAGE 2 OF 3

D. Department of Obstetrics and Gynecology

1. Section of Ambulatory Gynecologic Surgery
2. Section of Ambulatory Obstetrics and Gynecology
3. Section of Gynecology
4. Section of Gynecologic Oncology
5. Section of Maternal-Fetal Medicine
6. Section of Obstetrics
7. Section of Reproductive Endocrinology/Infertility

E. Department of Pathology and Laboratory Medicine

1. Section of Clinical Chemistry
2. Section of Clinical Hematology and Microscopy
3. Section of Cytology
4. Section of Histology
5. Section of Microbiology and Immunology
6. Section of Pathology
7. Section of Transfusion Medicine

F. Department of Pediatrics

1. Section of Adolescent Medicine
2. Section of Allergy and Immunology
3. Section of Ambulatory Medicine
4. Section of Cardiology
5. Section of Developmental Pediatrics
6. Section of Gastroenterology
7. Section of Hematology/Oncology
8. Section of Hospitalist Medicine
9. Section of Neonatology
10. Section of Nephrology
11. Section of Pediatric Neurology
12. Section of Pulmonology

G. Department of Psychiatry

1. Section of Child Psychiatry
2. Section of Geriatric Psychiatry

H. Department of Radiology

1. Section of Body Computed Tomography
2. Section of Interventional Radiology
3. Section of Neuroradiology
4. Section of Nuclear Radiology
5. Section of Ultrasound

**MEDICAL STAFF
POLICIES & PROCEDURES**

1.2 STRUCTURE/ORGANIZATION OF MEDICAL STAFF – CONTINUED PAGE 3 OF 3

I. Department of Surgery

1. Section of Cardio-Thoracic Surgery
2. Section of General Surgery
3. Section of Neurosurgery
4. Section of Ophthalmology
5. Section of Dentistry
6. Section of Orthopedics
7. Section of Otolaryngology and Head and Neck
8. Section of Plastic and Reconstructive Surgery
9. Section of Podiatry
10. Section of Trauma, Burns and Surgical Critical Care
11. Section of Urology
12. Section of Vascular Surgery

APPROVED: Medical Executive Committee 2/2001, 11/2004, 9/2006, 1/2008, 4/2010, 11/2010, 2/2011, 5/2013

REVIEWED: 11/2004, 09/2006, 10/2006, 1/2008, 4/2010, 1/2011, 2/2013

REVISED: 11/2004, 09/2006, 10/2006, 1/2008, 4/2010, 11/2010, 2/2013

**MEDICAL STAFF
POLICIES & PROCEDURES**

1.3 ASSOCIATE CHAIRMAN

PURPOSE: To define the process for appointment of an Associate Department Chairman.

POLICY: A Department Chairman, in consultation with the SVP & Chief Medical Officer and with the consent of the department membership may recommend the appointment of an Associate Chairman. Such appointment is subject to approval by the Medical Staff Executive Committee.

Qualifications:

1. Member of the Active Medical Staff in good standing.
2. Board certification in the specialty of the Department.
3. Expressed interest and aptitude in assuming administrative responsibilities in the organization.

Responsibilities:

1. Provide continuity for department management/leadership in the finite absence of the Chairman, including meeting attendance.
2. Provide additional administrative support for projects and program development.
3. Additional duties and responsibilities as assigned by the Department Chairman.
4. May be considered for the position of Acting or Interim Chairman role in circumstances where the Chairman will be absent for more than 60 days. Such appointment is subject to approval by the Medical Staff Executive Committee and the Board of Directors.

APPROVED: Medical Executive Committee 5/2007, 2/2011

REVIEWED: 1/2011

REVISED:

**MEDICAL STAFF
POLICIES & PROCEDURES**

1.4 REQUIREMENT FOR TUBERCULOSIS SKIN TEST (PPD) AND IMMUNIZATIONS

PURPOSE: To ensure that all members of the medical staff have had recommended immunizations and are screened for tuberculosis on a regular basis in order to protect themselves, patients and employees from the spread of tuberculosis and other contagious diseases.

POLICY: Each member of the medical staff must supply evidence they have received recommended vaccinations, as determined by the Hospital Epidemiologist Each member of the medical staff must also provide documentation of having had an intradermal skin test for tuberculosis (PPD) at least every two years unless such a test has been positive in the past. This is a requirement for initial appointment and reappointment to the medical staff and is required at the time of appointment or reappointment.

FLU VACCINE POLICY

- **PURPOSE:** To ensure that all members of the medical staff caring for patients at a Bridgeport Hospital facility have been vaccinated against influenza immediately before, or during, influenza season.
- **POLICY:** Each member of the medical staff, who is caring for patients at Bridgeport Hospital facilities, must notify the Medical Staff Office when they receive an influenza vaccine. Medical Staff members who have not received an influenza vaccine during the two months prior to the official start of the influenza season will be considered to be out of compliance with this policy as of December 1st until either they notify the Medical Staff Office that they have received an influenza vaccine or the flu season ends (April 30th).
- 1. If a member has religious objections to influenza vaccines they must inform the Medical Staff Office. They are exempted from the requirement for influenza vaccine.
- 2. If a member has had Guillain-Barre Syndrome they must inform the Medical Staff Office. They are exempted from the requirement for influenza vaccine. Other requests for medical exemptions will be forwarded to the hospital epidemiologist who will determine if the condition warrants exemption from the influenza vaccine.

APPROVED: Medical Executive Committee 4/1995, 7/1995, 2/2011, 07/15, 3/16

REVIEWED: 7/1995, 1/2011, 05/2015, 3/2016

REVISED:

**MEDICAL STAFF
POLICIES & PROCEDURES**

1.5 ORDERING OF OUTPATIENT SERVICES BY NON-MEDICAL STAFF PRACTITIONERS:

DN-Specific Outpatient Services That May be Ordered by a Non-Medical Staff Practitioner

PURPOSE: This Policy identifies which outpatient hospital services may be ordered at Bridgeport Hospital (the “Hospital”) by practitioners who are not members of the Hospital’s Medical Staff or Allied Health Professional Staff (such non-medical staff practitioners referred to herein as “NMSPs”).

POLICY: It is the policy of the Hospital that outpatient hospital services may be ordered by a NMSP who is:

1. responsible for the care of the patient (i.e., have treated the patient in the NMSP’s office, clinic or other setting);
2. licensed in, or hold a license recognized in, the jurisdiction where he/she sees the patient;
3. acting within his/her scope of practice under state law;
4. **authorized by this Policy to order the applicable outpatient services;** and
5. not voluntarily or involuntarily excluded from participation in Medicare, Medicaid, or any other Federal health care program.

PROCEDURE:

1. NMSPs may order ALL outpatient hospital services with the exception of the following:

- a. invasive and interventional procedures*
- b. IV infusion,
- c. chemotherapy,
- d. hyperbaric oxygen treatment, and
- e. fetal monitoring.

**For purposes of this Policy, imaging services with contrast shall not be considered invasive or interventional procedures and, as such, may be ordered by NMSPs so long as sedation or anesthesia are not required.*

2. Processing Requests to Order Outpatient Services

- (a) A NMSP may submit orders for outpatient services on the Hospital’s standard outpatient order requisition form, on the unaffiliated practitioner’s prescription pad or letterhead, or in some other written format that includes the information in subsection (b) below. In the event a department of a Hospital determines it would be appropriate to accept orders from NMSPs in another format, such as a verbal order, that department will establish procedures to ensure the information required in subsection (b) below is collected.
- (b) Orders for outpatient services from NMSPs must include, at a minimum, the following:
 - (1) the NMSP’s typed or printed name and telephone number, and signature;
 - (2) patient’s name;
 - (3) requested outpatient service; and
 - (4) date of the order.

**MEDICAL STAFF
POLICIES & PROCEDURES**

**1.5 ORDERING OF OUTPATIENT SERVICES BY NON-MEDICAL STAFF
PRACTITIONERS – CONTINUED PAGE 2 OF 2**

3. Verification of Unaffiliated Practitioners' Eligibility

The YNHHS Government Exclusion from Participation Policy (CC:R-3) sets forth the process and procedures by which the Hospital will verify, on a monthly basis, each NMSP's National Provider Identifier (NPI), State Medical License, and whether he/she has been debarred or excluded from participation in any Federal or State health care program.

4. Effect of Permission to Order Outpatient Services

(a) The Hospital's acceptance of a NMSP's order for outpatient services does not constitute a grant of Medical/Affiliated Staff appointment or membership, clinical privileges or any other permission to practice within the Hospital. The Hospital reserves the right to determine whether the services requested will be provided based upon its evaluation of the appropriateness of the qualifications of the ordering NMSP consistent with this Policy. The Hospital's determination regarding whether to provide ordered services shall not be subject to the Medical Staff Bylaws, including but not limited to any provisions regarding hearings or appeal rights.

(b) Each and every order for outpatient services by a NMSP shall satisfy the requirements set forth in this Policy.

RESPONSIBILITY: The individual or individuals at each Hospital responsible for outpatient services shall ensure this policy is implemented.

REFERENCES: Government Exclusion from Participation Policy (CC:R-3), *[Insert New Type II YNHHS Policy on Same Subject]*, 42 CFR 482.554, CMS Survey & Certification Letter Memorandum dated February 17, 2012 (S&C-12-17-Hospitals))

APPROVED: MEC 3/4/2013, BOD 3/21/2013

REVIEWED: MEC 3/4/2013

REVISED:

**MEDICAL STAFF
POLICIES & PROCEDURES**

2.0 INITIAL APPOINTMENT

PURPOSE: To define the steps for the uniform processing of each application for appointment to the Medical Staff.

POLICY:

OBJECTIVES:

1. To assist the Hospital in assuring that the patients who receive medical care will have such care rendered by individuals appropriately qualified to do so.
2. To assure that each eligible applicant is afforded equal opportunity to be appointed to the Medical Staff.
3. To assure that adequate information pertaining to education, training and relevant experience as well as the six areas of "General Competencies" is obtained and reviewed by the appropriate individuals and committees prior to rendering a final recommendation.

PROCEDURE:

1. Upon request to the Medical Staff Office eligible applicants will be given an application for appointment to the Medical Staff, an excerpt of the Medical Staff Bylaws dealing with the membership criteria and responsibilities, and a detailed list of requirements for completion of the application. A complete set of Medical Staff Bylaws and Rules and Regulations will be provided to the applicant upon admission to the staff. A fee will be required for an application. The amount will be set by the Medical Staff Executive Committee.
2. Documentation necessary to complete an application shall consist of the following:
 - a. A completed application for staff privileges.
 - b. Completed delineation of clinical privileges form signed by the applicant for use in the verification process.
 - c. Completed personal questionnaire and credentials/licensure transmittal authorization forms.
 - d. Copy of medical school diploma.
 - e. Copy of Connecticut State Medical License and/or renewal certificate, if applicable.
 - f. Copy of current federal and state narcotic licenses except for members who do not require these licenses for their respective practices.

**MEDICAL STAFF
POLICIES & PROCEDURES**

2.0 INITIAL APPOINTMENT – CONTINUED PAGE 2 of 4

- g. Certification of current professional liability coverage in the amount of \$1,000,000/3,000,000 and that the company is registered by the Insurance Commissioner to do business in the State of Connecticut.

- h. For individuals who have completed training in the past 10-years, the name and complete address of the chief/chairman of specialty during final year of training as well as residency and fellowship program director(s) and one other supervisory physician from whom the Medical Staff Office may request an evaluation. The references shall seek to determine the applicant's proficiency in the six areas of "General Competencies" including:
 - Patient Care
 - Medical/Clinical Knowledge
 - Practice-Based Learning and Improvement
 - Interpersonal and Communicative Skills
 - Professionalism
 - Systems-Based Practice

For those individuals who completed training more than 10-years ago, the names and addresses of at least two physicians and the Chairmen of the relevant departments at all hospitals where the applicant has practiced.

- i. Completed reference forms from the individuals identified in h.

 - j. A signed photograph taken within 12 months of the date on the application.

 - k. Valid picture I.D. issued by hospital/state or federal agency.

 - l. A certificate of specialty board certification if applicable.

 - m. Documentation of a Tuberculosis Skin Test within the past twelve months or history of a positive PPD.
3. Upon receipt of the above, the Medical Staff Office shall seek to verify by primary sources the contents of the application by letter or other methods acceptable to the Joint Commission (TJC) and other regulatory agencies and collect additional information as needed, including, but not limited to,
- a. Verification of Medical School graduation or appropriate certified training program.

 - b. Information from past malpractice carriers concerning claims during the past five years.

**MEDICAL STAFF
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2.0 INITIAL APPOINTMENT – CONTINUED PAGE 3 of 4

- c. Letters of recommendation from department chairmen of the hospital(s) in which the physician has practiced previously if beyond residency training.
- d. Verification of past activities through the American Medical Association database, verification of the licensure status and all current or past states of licensure (Federation State Medical Boards US).
- e. Review of Office of Inspector General (OIG) and Exclusion list (EPLS).
- f. Query to National Practitioner Data Bank (NPDB).

NOTE: In the event of undue delay in obtaining and verifying information, the Medical Staff office, will contact the applicant to request assistance in obtaining this information.

- 4. The file will be reviewed by the chairman of the Credentials Committee and declared complete or incomplete. If complete, the applicant will be notified to meet with the appropriate section chief, as applicable, and departmental chairman for delineation of clinical privileges and a recommendation concerning appointment to the Medical Staff.
- 5. The applicant will be scheduled to meet with the chief of the section for which he is applying (if applicable) as well as the chairman of that department. They will respectively review the application and delineate the clinical privileges within the department and section prior to the application being presented to the Credentials Committee. The department chairman and/or section chief shall substantiate by telephone the information contained in at least one reference; he will summarize his review of the applicant's file as well as the interview with the section chief, if applicable, and the department chairman in writing, and make a recommendation for appointment. This recommendation will become a permanent portion of the applicant's file.
- 6. Following review and recommendation by the section chief, as applicable, and departmental chairman, the application will be presented to the Credentials Committee for their respective review and recommendation.
- 7. The chairman of the Credentials Committee shall indicate the recommendation of the committee concerning the application through the Credentials Committee minutes and the signature sign-off on the application form. The applicant's file will then be presented to the Medical Staff Executive Committee at its next regularly scheduled meeting.
- 8. The Medical Staff Executive Committee recommendation shall be presented to the Professional & Quality Review Committee of the Hospital Board of Directors by the Sr. Vice President-Chief Medical Officer or designee.

**MEDICAL STAFF
POLICIES & PROCEDURES**

2.0 INITIAL APPOINTMENT – CONTINUED PAGE 4 of 4

Membership and clinical privileges may be granted by this Committee if the following criteria are met:

- a. There is no difficulty in verifying the information on the application or obtaining satisfactory references.
- b. The Medical Staff Executive Committee has given a favorable recommendation to the application.
- c. The applicant does not have either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment.
- d. The applicant has not received involuntary limitation, reduction, denial or loss of clinical privileges consistent with the core privileges as defined for that specialty.

The candidates would be ratified as appropriate by the Board of Directors at its next regularly scheduled meeting.

9. In those cases where there is any question about the suitability for membership, the Professional and Quality Review Committee of the Hospital Board of Directors shall refer the application to the Medical Staff Executive Committee for further discussion.
10. When the appointment action has been taken by the Professional & Quality Review committee, the Senior Vice President-Chief Medical Officer shall transmit the decision to the applicant.
11. When the appointment decision is made by the Board of Directors in cases as noted in section 9, the President and CEO of the Hospital shall transmit the decision to the applicant.

Note: This policy is a supplement to the provisions of the Medical Staff Bylaws.

APPROVED: Medical Executive Committee 7/2001, 7/2007, 4/2010, 2/2011, 7/2012, 5/2013

REVIEWED: 1/2011, 6/2011, 5/2012, 2/2013

REVISED: 7/2007, 4/2010, 6/2011, 5/2012, 2/2013

**MEDICAL STAFF
POLICIES & PROCEDURES**

2.1 INTRODUCTION OF A NEW PROCEDURE OR NEW TECHNOLOGY

PURPOSE: Provide a standard process to use new technology or introduction of a new procedure.

POLICY:

OBJECTIVES:

1. Knowledge of new technology and procedures is a fundamental part of good medicine in the hospital setting. It is essential for those who use new advances to be properly trained and to understand the mechanics of the technology. Bridgeport Hospital Medical Staff has a policy with regards to attaining clinical privileges for a new procedure (Policy No. 2.2).
2. Physicians and other involved clinicians should understand and employ mechanisms for periodic evaluation and testing of equipment in order to anticipate any malfunction. Practitioners and other hospital staff must understand the proper indications for usage. It is imperative that all applicable staff be properly trained in the use of the advanced technology or new equipment.

PROCEDURE:

1. The appropriate Clinical Program Team (CPT) should review a request for the introduction of new technology. The technology may be identified by a physician who would present the technology to the CPT.
2. The new technology should be presented to appropriate department/section members. Topics to be reviewed should include the advantages of the new procedure or equipment. There should be a consensus with regard to the adequacy of training of the personnel including hands-on experience to use the new equipment or to perform the new procedure. There should be a discussion of the justification to introduce the technology into the hospital setting. There should be an evaluation of high risk, low volume of cases including the availability at nearby centers, the patient's needs and profile, the skill sets required, and the critical volume to maintain the skill. These discussions must be documented
3. There should be assurances that the hospital has the resources available including environment, personnel and any ancillary equipment to provide the necessary support for the new equipment or technology.
4. There should be a discussion by the members of the team that would be involved in the new procedure or equipment. Each discipline should have clearly defined roles and understand their role in the procedure or use of the equipment.

**MEDICAL STAFF
POLICIES & PROCEDURES**

**2.1 INTRODUCTION OF A NEW PROCEDURE OR NEW TECHNOLOGY –
CONTINUED PAGE 2 OF 2**

5. Prior to performing the new procedure or using the new equipment, the team should participate in a step by step “practice run”.

6. Following a period of prolonged inactivity (>24 months), the physician or department section shall present the technology again to the appropriate CPT for review. The CPT will render a determination as to whether the procedure/technology should be continued, what retraining needs to occur and what evidence of continuing medical education has been earned during the period of inactivity. These discussions and recommendations of the CPT must be documented.

[Excerpts from: Quality Improvement in Women’s Health Care by the American College of Obstetricians and Gynecologists – 2000]

APPROVED: Medical Executive Committee 9/2005, 2/2011

REVIEWED: 1/2011

REVISED:

**MEDICAL STAFF
POLICIES & PROCEDURES**

2.2 CLINICAL PRIVILEGES FOR NEW PROCEDURES/CLINICAL ACTIVITY

PURPOSE: To formalize the process for attaining clinical privileges for a new procedure.

POLICY:

OBJECTIVES:

Establishing clinical privileges for a procedure or clinical activity that is new to Bridgeport Hospital requires verification that applicants (both prospective and current members of the Medical Staff):

1. Have received training and have a satisfactory record of performing the procedure(s) in question during residency, fellowship or other postgraduate training, or
2. Have maintained a satisfactory experience profile and active privileges performing these procedures at another institution or
3. Have completed a prescribed prerequisite education or mentoring process as defined/approved by the Department Chairman for the procedure in question.

This will be verified through written and/or verbal processes of attestation.

VERIFICATION PROCESS:

1. For a procedure or clinical activity that is new to Bridgeport Hospital, criteria shall be established by the Department Chairman and appropriate Section Chief (when applicable) for presumed competence in this procedure. Such criteria will be written and may include a prescribed course of study/experience, or performing a prescribed number of these procedures with a practitioner who already has the clinical privilege.
2. The prospective or current medical staff member shall complete an application for clinical privileges for a new procedure or clinical activity (example Appendix A) and reference the above training, experience and/or education. This will be reviewed by the Section Chief and/or Department Chairman.
3. If applicable, the Department Chairman, or his designee, will contact an appropriate member of the medical staff (Department Chairman, and/or Section Chief or Vice President for Medical Affairs) from the applicant's current or previous institution of practice or training and obtain and document verbal and/or written verification of information on the application relative to training and/or experience.

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2.2 CLINICAL PRIVILEGES FOR NEW PROCEDURES/CLINICAL ACTIVITY –
CONTINUED – PAGE 2 OF 3

4. The applicable Department Chairman, after review of an applicant's credentials, shall render a recommendation of the applicant's request to the Credentials Committee, who in turn shall render a recommendation to the Medical Staff Executive Committee.

5. For a new procedure that may be performed by physicians in more than one department, criteria shall be established by the respective Department Chairmen and applicable Section Chiefs as in paragraph #3. Outcomes shall be assessed using appropriate common defined objective measures.

APPROVED: Medical Executive Committee 5/2002, 09/2005, 2/2011

REVIEWED: 1/2011

REVISED: 9/2005

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**2.2 CLINICAL PRIVILEGES FOR NEW PROCEDURES/CLINICAL ACTIVITY –
CONTINUED PAGE 3 OF 3**

Appendix A

Clinical Privilege Request Form

Name of Procedure

In order to be eligible to request clinical privileges for (*procedure*) an applicant must meet the following minimum threshold criteria.

Applicant to supply the following information:

- Education: MD or DO
- Minimum formal training:
- Required previous experience:
- References:
- Additional consideration:
- Reappointment criteria to maintain clinical privilege:

I understand that by making this request I am bound by the applicable bylaws or policies of the hospital, and hereby stipulate that I meet the minimum threshold criteria for this request.

Physician's signature: _____

Typed or printed name: _____

Date: _____

APPROVED: Medical Executive Committee 5/2002, 09/2005, 2/2011

REVIEWED: 1/2011

REVISED: 9/2005

**MEDICAL STAFF
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2.3 NATIONAL PRACTITIONER DATA BANK (NPDB) CONTINUOUS QUERY

PURPOSE: To define the steps for reviewing/verifying the information received from the NPDB Continuous Query.

POLICY: To assure that any information received from the NPDB Continuous Query pertaining to licensure, malpractice actions and/or Medicare/Medicaid sanctions is reviewed by the appropriate individuals prior to rendering a final recommendation to the Board of Directors of Bridgeport Hospital.

1. NPDB Continuous Query for each physician, podiatrist and allied health professional is reviewed at initial appointment.
2. Information obtained regarding malpractice action, challenge to licensure or registration (federal or state) and Medicare/Medicaid sanctions is reviewed for consistency with responses submitted by the physician.
3. The appropriate Department Chairman is notified of any discrepancy between the NPDB Continuous Query response and the physician's response on the "Personal Questionnaire".
4. Follow-up, if necessary, occurs at the Department Chairman level.

APPROVED: Medical Executive Committee 3/2000, 2/2011

REVIEWED: 1/2011, 5/2011

REVISED: 06/2011

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2.4 ONGOING MONITORING OF MEDICAL STAFF SANCTIONS & COMPLAINTS

PURPOSE: To define the step for reviewing/verifying information regarding Medicare and Medicaid sanctions, limitations on licensure and complaints.

POLICY: To assure that any information received by the Medical Staff Office pertaining to Medicare & Medicaid sanctions, sanctions or limitations on licensure and complaints are reviewed in an ongoing fashion by the appropriate individuals so that appropriate interventions can be implemented.

1. The Office of Inspector General (OIG) Exclusion listing of Medicare & Medicaid sanctions is reviewed monthly.
2. The Connecticut Medical Examining Board “Notice of Disciplinary Actions” listing sanctions and limitation on licensure are received and reviewed monthly.
3. Written complaints relative to patient care are directed to the appropriate Department Chair for investigation and action as appropriate.
4. All Medicare and Medicaid sanctions, sanctions or limitations on licensure and complaints are reported to the appropriate Department Chair as they are received by the Medical Staff Office.

APPROVED: Medical Executive Committee 11/2001, 2/2011

REVIEWED: 1/2011

REVISED:

**MEDICAL STAFF
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2.5 CRITERIA FOR CLINICAL PRIVILEGES IN SEDATION

PURPOSE: This policy applies to the levels of sedation along a continuum, independent of the agent used or the location of administration.

POLICY: Principles for the Credentialing of Sedation Privileges:
The Department Chairmen use the following criteria in recommending department members have clinical privilege to perform Light to Moderate Sedation and/or Deep Sedation/Anesthesia.

1. Members of the Medical Staff who sedate patients by any route for specific invasive or non-invasive procedures and tests shall qualify for and maintain clinical privileges to administer appropriate levels of sedation.
2. Practitioners whose day-to-day practice (i.e. Anesthesia, Critical Care Medicine and Emergency Medicine) involves age-specific advanced life support may be recommended for privileges in sedation by their department chairman.
3. Practitioners who possess current Basic Life Support (BLS) Certification or who have successfully completed a rescue curriculum recognized by the Department of Anesthesia as meeting criteria equivalent to BLS Certification may be recommended for age-specific privileges in Light to Moderate Sedation by their chairman.
4. Deep Sedation/Anesthesia privileges may be granted to practitioners who have had post graduate training in Anesthesia, Critical Care Medicine or Emergency Medicine and whose day-to-day practice requires utilization of deep sedation/anesthesia.
5. A practitioner must participate in a minimum of 2 hours CME devoted to sedation, analgesia, and life support every 2 years to maintain the clinical privilege.
6. Satisfactory performance of this clinical privilege will be assessed by periodic outcome review and shall be considered at least every 2 years for continuation of the clinical privilege.
7. Allied Health Practitioners (CRNA, PA and APRN), who practice under the supervision of practitioners must maintain all requirements of that supervision in addition to the requirements for sedation privileges.
8. Physicians responsible for the supervision of a practitioner with sedation privileges must themselves maintain current sedation privileges.

**MEDICAL STAFF
POLICIES & PROCEDURES**

2.5 CRITERIA FOR CLINICAL PRIVILEGES IN SEDATION – CONTINUED PAGE 2 OF 2

9. Department Chairmen shall review departmental criteria regarding Deep Sedation privileges with the Department of Anesthesia Chairman.

DEFINITIONS:

Light sedation: Also known as anxiolysis. A drug-induced state during which the patient responds normally to verbal commands. Cognitive function and coordination may be impaired. Ventilatory and cardiovascular functions are unaffected.

Moderate sedation/analgesia (conscious sedation): A drug-induced depression of consciousness during which the patient responds purposefully to verbal command, either alone or accompanied by light tactile stimulation. No interventions are necessary to maintain a patent airway. Spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Deep sedation/anesthesia: A drug-induced depression of consciousness during which the patient cannot be easily aroused, but responds purposefully* following repeated or painful stimulation. Independent ventilatory function may be impaired. The patient may require assistance to maintain a patent airway. Spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

** Reflex withdrawal from a painful stimulus is NOT considered a purposeful response*

OVERSIGHT:

The Department Chairmen are responsible for clinical oversight of the practitioners in their department. Each Chairman will forward to the Chairman of Anesthesia, for his review, any cases where, as a result of procedural sedation, there is: use of a reversal agent, intubation, chest compressions, or emergent anesthesia consultation. The Chairman of Anesthesia will review the case and make an assessment and recommendations about the case to the referring Chairman and, as needed, the VP for Quality and the Chief Medical Officer.

APPROVED: Medical Executive Committee 4/2001, 9/2006, 9/2007, 2/2011,6/2014

REVIEWED: 9/2006, 7/2007, 1/2011, 2/2014

REVISED: 9/2006, 7/2007

MEDICAL STAFF POLICIES & PROCEDURES

2.6 TEMPORARY PRIVILEGES

PURPOSE: To grant temporary privileges to fulfill an important patient care need for an applicant with a complete application awaiting Board approval.

POLICY: Temporary Privileges may be granted by the Chief Executive Officer of Bridgeport Hospital upon a written recommendation by the applicable department chairman. Such privileges may be granted when necessary to enhance patient care and may be given for a period of time not to exceed 120 days or for the care of a specific patient who is hospitalized at Bridgeport Hospital for the duration of that patient's hospitalization.

Temporary privileges may be considered in the following scenarios:

1. Temporary privileges for up to 120 days may be requested by the applicable department chairman when the application for medical staff membership is deemed complete and the applicant has received a favorable recommendation from the Medical Staff Credentials Committee.

2. Alternatively, for unusual circumstances which are indicated and documented by the applicable department chairman and in the interest of patient care, a department chairman may recommend an individual for temporary privileges for up to 120 days when, at a minimum, the following information has been obtained and/or verified by the Medical Staff Office:
 - a. An application for medical staff membership must be completed and on file in the Medical Staff Office.
 - b. Prime source verification of appropriate professional license(s), narcotic permits and graduation from the appropriate professional school.
 - c. Verification of professional liability insurance in the form of a certificate.
 - d. Clinical privileges must be delineated for each physician in this situation by the respective department chairman.
 - e. Verification of competence by the appropriate department chairman. This may be accomplished by a telephone call documented in the file or a letter from an individual who is in a position to verify competence.

It is expected that this latter circumstance will only be used in unusual circumstances which shall be articulated in the letter of recommendation by the Department Chairman to the Hospital Chief Executive Officer.

**MEDICAL STAFF
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2.6 TEMPORARY PRIVILEGES – CONTINUED PAGE 2 OF 2

3. A recommendation for temporary privileges may be made by a department chairman and approved by the Hospital Chief Executive Officer for the care of a specific patient by a physician. Such privileges shall be for the duration of that patient's hospitalization at Bridgeport Hospital.

APPROVED: Medical Executive Committee 4/1992, 5/1996, 7/1999, 9/2001, 2/2011

REVIEWED: 4/1992, 5/1996, 7/1999, 9/2001, 1/2011

REVISED: 4/1992, 5/1996, 7/1999, 9/2001

**MEDICAL STAFF
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**2.7 SUPERVISION OF CERTIFIED PHYSICIAN ASSISTANTS /COLLABORATION
WITH ADVANCED PRACTICE REGISTERED NURSES**

2.7.1 Employed Certified Physician Assistants /Advanced Practice Nurses

PURPOSE: To abide by applicable state law.

POLICY: Certified Physician Assistants (PA-C's) employed by Bridgeport Hospital (the "Hospital") will be supervised by physician members of the Hospital's Medical Staff ("Supervising Physician"), and Advanced Practice Nurses (APRNs) employed by the Hospital will have a collaborative relationship with physicians on the Hospital's Medical Staff, in accordance with this policy and applicable state law. Supervising Physicians have final responsibility for the PA-C's patients and the PA-C's performance at Bridgeport Hospital, but are not responsible for the PA-C's practice at any locations other than Bridgeport Hospital facilities. Medical Staff members collaborating with an employed APRN shall have no responsibility for the APRN's practice at any locations other than Bridgeport Hospital facilities.

PROCEDURE – Employed PA-C's:

1. PA-C's who become employed at the Hospital will be assigned a Supervising Physician in the appropriate department. The assignment of a Supervising Physician will be documented in the "Certified Physician Assistant Delegation and Supervision Agreement" signed by the Supervising Physician and the Certified Physician Assistant and kept in the PA-C's file in the Medical Staff Office. .
2. In accordance with Department of Public Health requirements, Supervising Physicians may be the supervisor for as many PA-C's as is appropriate under the circumstances, but in no event may any Supervising Physician be assigned to supervise more than six (6) PA-C's on shift at the same time.
3. Supervising Physicians are responsible for fulfilling all physician responsibilities set forth in the Certified Physician Assistant Delegation and Supervision Agreement.
4. Supervising Physicians have final responsibility for a PA-C's patients and performance, but only within the scope of the PA-C's employment at Bridgeport Hospital. PA-C's employed by Bridgeport Hospital must secure other supervising physicians for any practice outside the Hospital.
5. Each Supervising Physician is responsible for notifying the Medical Staff Office of any absences (planned or unplanned) that will preclude the Supervising Physician from fulfilling his/her supervision responsibilities in accordance with this Policy. The Department Chairman will adjust the assignment of Supervising Physicians as necessary to ensure quality patient care and compliance with applicable law.

**MEDICAL STAFF
POLICIES & PROCEDURES**

**2.7 SUPERVISION OF CERTIFIED PHYSICIAN ASSISTANTS /COLLABORATION
WITH ADVANCED PRACTICE REGISTERED NURSES – CONTINUED PAGE 2 OF 2**

PROCEDURE – EMPLOYED APRNS

1. APRN's who become employed at the Hospital will collaborate with an assigned physician in the appropriate department on the Hospital's Medical Staff ("Collaborating Physician"). Such collaboration will be documented in the "Advanced Practice Nursing Collaboration Agreement" signed by the Collaborating Physician and the APRN and kept in the APRN's file in the Medical Staff Office.
2. Collaborating Physicians are responsible for fulfilling all physician responsibilities set forth in the Collaborating Physician Agreement.
3. Collaborating Physicians only collaborate with employed APRNs within the scope of the APRN's employment at Bridgeport Hospital. APRNs employed by Bridgeport Hospital must secure other collaborating physicians for any practice outside the Hospital.
4. APRNs and Collaborating Physicians will make all necessary coverage arrangements to ensure compliance with applicable laws and appropriate patient care.

2.7.2 Certified Physician Assistants and APRN's not employed by the Hospital

PA-C's and APRN's seeking appointment or reappointment to the Medical Staff must provide the Medical Staff Office with a copy of a signed, currently effective Supervision or Collaboration Agreement, as the case may be, that meets the relevant requirements of state law. Template Delegation and Supervision Agreements and Collaborative Agreements are available through the Medical Staff Office. This requirement shall not apply to certified nurse anesthetists (CRNA's), certified nurse-midwives (CNMW's) and other Allied Professional Staff members for whom such a written Agreement is not required by law.

APPROVED: Medical Executive Committee 10/2012

REVIEWED: 10/2012

REVISED:

**MEDICAL STAFF
POLICIES & PROCEDURES**

3.0 ELEMENTS OF A HISTORY & PHYSICAL EXAMINATION OF A PATIENT

PURPOSE: To define the Minimal Elements that should appear in the documentation of hospital patient's history & physical exam (H & P).

POLICY: It is the policy of the Medical Staff that an H & P examination be performed on every patient. For elective admissions including one for a procedure, the H & P exam may be completed and recorded up to 30 days before the admission and updated on the day of the admission/procedure. The H & P may be recorded on the hospital's H & P form or forms/letterhead from the physician's office. A H & P recorded by a physician assistant or resident/fellow physician must be authenticated by an attending physician. The following components of the patient assessment should be included as a minimal standard.

1. History
 - Chief complaint, presenting symptoms/indication for procedure
 - Gender/age of patient
 - Past family/social/medical history as relevant to the problem
 - Problem-pertinent review of systems
 - Current medications/allergies

2. Physical Examination
 - Vital Signs including, at a minimum, blood pressure (for patients \geq 6 years age) and pulse
 - Complete (inpatient) OR Focused (ambulatory) examination –

 - Detailed examination – comment on findings related to:
 - head and neck
 - heart and lungs
 - abdomen
 - neurologic/mental status
 - skin/extremities

 - Focused examination
 - a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

 - Focused examination for moderate sedation/anesthesia.
 - As above for focused examination,
 - Assessment of heart and lungs,
 - Complete "Short Term Diagnostic and Procedural Sedation Assessment Form" (form #115659)

APPROVED: Medical Executive Committee 7/2001, 1/2005, 9/2007, 4/2010, 2/2011

REVIEWED: 7/2001, 1/2005, 9/2007, 4/2010, 1/2011

REVISED: 4/2010

**MEDICAL STAFF
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3.1 ADMISSION OF ORTHOPEDIC TRAUMA PATIENTS

PURPOSE: For primary evaluation of patients presenting with orthopedic injuries. To make primary recommendation for service assignment.

POLICY:

1. Emergency physician is responsible for primary evaluation of patients presenting with orthopedic injuries and to make primary recommendation for service assignment. Patients with primary medical cause for orthopedic injury or unstable co-morbidities will be admitted to Medicine with orthopedic consultation. Patients with a non-medical cause for their injury and no unstable co-morbidities will be admitted to Orthopedics with medical consultation. The existing trauma guidelines for referral to the Trauma Service will continue to be honored. There may be cases which do not easily fit these guidelines and the judgment of the emergency physician will be required to recommend the most appropriate placement. The decision as to the service assignment by the attending emergency physician will be final.
2. Orthopedic PA's may perform admission evaluations for staff orthopedists. The PA is responsible to contact and review all cases with the attending orthopedist and is responsible to follow up results of all ancillary testing.
3. The patient's internist should be called immediately for any urgent or emergent medical problem; notification for routine consultation may be via a message to the internist's service.
4. The attending anesthesiologist will be contacted by the orthopedic PA with a brief summary of the patient's exam and laboratory findings at the time of patient admission and will make an effort to expedite the preoperative assessment.
5. The senior surgical resident or trauma (911 Pager) resident is to be considered a primary resource for surgical consultation by the orthopedic PA.
6. The practice of orthopedic PA's is subject to existing medical staff Q.A. and Q.I. review and as members of the medical staff, they are accountable for their practice.

APPROVED: Medical Executive Committee 4/2000, 2/2011

REVIEWED: 1/2011

REVISED

**MEDICAL STAFF
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3.2 TELEMEDICINE SERVICES

PURPOSE: Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care from a location remote to where the care is being rendered.

POLICY: The Medical Staff of Bridgeport Hospital recognizes that technology exists which can support the diagnosis and treatment of a patient from a remote location. The Medical Staff Executive Committee is responsible for determining which clinical services may be appropriately delivered via telemedicine technology. In the event that the Medical Staff Executive Committee approves the use of telemedicine practices in any discipline, it will require the same application of acceptable quality practices as all other methods of providing and/or supporting clinical care.

Individuals who provide and/or support clinical care via telemedicine to Bridgeport Hospital patients must always be appropriately credentialed and privileged through the medical staff process for credentialing and privileging at Bridgeport Hospital.

APPROVED: Medical Executive Committee 9/2001, 2/2011

REVIEWED: 01/2011

REVISED:

**MEDICAL STAFF
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3.3 CREDENTIALING FOR THE DAVINCI™ SURGICAL ROBOT

PURPOSE: To outline the process for attaining clinical privileges for using the daVinci™ Surgical Robot.

POLICY: These multi-specialty criteria are intended to apply to abdominal, thoracic and/or pelvic surgery utilizing the daVinci™ surgical robot.

NOTE: All documentation described herein must be submitted **in writing** to the respective Department Chairman/Section Chief.

INITIAL CREDENTIALING

A surgeon may qualify for privileges to utilize the daVinci™ surgical robot as described below:

Step I. Must have, or be applying for, privileges in a Department/Section in which surgical procedures using the daVinci™ have been approved by the FDA.*

Must be currently privileged to perform laparoscopic surgery (if applicable) for the procedure for which the daVinci™ is intended to be utilized* and,

Must provide evidence of having completed an approved training program which includes the following components:**

- ◆ Minimum of 8 hours in duration and,
- ◆ Minimum of three hours personally operating the daVinci™ robot utilizing animate or cadaver models and,
- ◆ Evidence of having observed a minimum of two clinical cases involving the daVinci™ robot

**successful completion of the training program offered by “Intuitive Surgical” fulfills these criteria.

The surgeon must complete an application for clinical privileges for use of the daVinci™ surgical robot referencing evidence of having completed an approved training program as described above. Requests will be reviewed by the respective Department Chairman, who in turn will render a recommendation to the Robot Use Committee, subcommittee of the Surgical Services Committee (SSC).

Upon approval of the SSC, the Department Chairman will render a recommendation to the Credentials Committee, who in turn will render a recommendation to the Medical Staff Executive Committee. Once approved by the Medical executive Committee, the applicant must utilize the daVinci™ with **continuous in person proctoring** by an approved departmental representative in the same specialty as the applicant.

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POLICIES & PROCEDURES**

**3.3 CREDENTIALING FOR THE DAVINCI™ SURGICAL ROBOT –
CONTINUED PAGE 2 OF 3**

Step II. Applicants who have personally completed a minimum of **four (4) cases** from start to finish with **continuous in person proctoring** utilizing the daVinci™ robot may apply for independent privileges.

Information about the cases performed including:

- ◆ patient initials and medical record number
- ◆ date and name of procedure
- ◆ the proctor for each case

must be submitted to the Department Chairman/Section Chief in writing.

Outcomes, complication rates and proctors' evaluations will be considered in making the determination to approve an applicant to utilize the daVinci™ independently.

Requests will require approval by the Surgical Services Committee, the respective Department Chairman and the recommendation forwarded to the Credentials Committee, who in turn will forward the request to the Medical Executive Committee.

Surgeons Approved for daVinci™ at another Institution:

Individuals having independent, unrestricted privileges to utilize the daVinci™ robot at another institution, may apply for privileges by submitting: (1) documentation of training as described in Step I above and (2) evidence of having performed a minimum of four daVinci™ cases independently. A case list including the name of the hospital at which each case was performed; name and date of each procedure must be included.

A reference, in writing, from the relevant Department Chairman at that institution is required and will be solicited by the Department Chairman/Section Chief

Requests will require approval by the respective Department Chairman before presentation to the Robot Use Committee, and if approved, the recommendation will be forwarded to the Credentials Committee.

Re-Credentialing

In order to qualify for recredentialing for use of the daVinci™ robot, practitioners must provide documentation of having performed a minimum of twenty-five (25) cases every two years with acceptable outcomes and complications.

Monitoring

Ad hoc review of outcomes including length of stay, blood loss, complications, operating room time and rate of conversion to laparoscopic or open procedure for each surgeon privileged to utilize the daVinci™ system will be the responsibility of the Department Chairman/Section Chief. It is expected that the Departments/Sections with members' credentialed to use the daVinci™ will include these cases in their respective Morbidity and Mortality conference discussions. Robot Use Committee will provide physician specific data each December.

**MEDICAL STAFF
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**3.3 CREDENTIALING FOR THE DAVINCI™ SURGICAL ROBOT –
CONTINUED PAGE 3 OF 3**

Proctors

In addition to the above, individuals willing to serve as proctors to members of the Bridgeport Hospital Medical Staff must provide evidence of having performed a minimum of ten(10) cases as surgeon with independent privileges utilizing the daVinci™ with acceptable outcomes and complications. A case list including the hospital at which each case was performed, the name and date of each procedure must be included. Reference letters will be sought from the department Chairman/Section Chief at the hospital at which the cases were performed.

Requests will require approval by the respective Department Chairman/Section Chief before presentation to the Robot Use Committee.

***Procedures for which the daVinci may be utilized**

The daVinci™ robot will be used only for FDA-approved procedures.

RECREREDENTIALING

The Department Chairman will propose renewal of privileges on a biannual basis, based on surgeon performance. Interruption of such privileges by the Department Chairman could be instantaneous based on failure of surgeon to abide by Robot Use Committee standards for use, as updated periodically.

APPROVED: 02/2007, 2/2011

REVIEWED: 1/2011

REVISED

**MEDICAL STAFF
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4.0 PEER REVIEW

PURPOSE: The medical staff is responsible to ensure that an effective and fair peer review process is conducted when the findings of a quality assessment process may be relevant to an individual medical staff practitioner’s performance. The medical staff is responsible for using the results of the peer review process in its reappointment and privileging processes as one means of evaluating a practitioner’s competency.

POLICY:

DEFINITIONS:

Peer Review

Peer Review is defined as the evaluation of the quality of care provided by individual practitioners, including identification of opportunities to improve care, by individuals with the appropriate subject matter expertise to make this evaluation.

Peer Review is part of an overall process of quality improvement. The Peer Review Process differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner’s performance on a case by case basis, rather than appraising the quality of care rendered by a group of practitioners or a system of care. The individual is evaluated compared to standards of care and the review offers a constructive critique of the performance observed. Through the framework of the peer review process, practitioners receive feedback for professional improvement or confirmation of professional achievement related to the effectiveness of their professional, technical and interpersonal skills in providing patient care.

Peer Reviewer

A peer reviewer is defined as an individual practicing in the same profession. The level of subject matter expertise required to provide meaningful evaluation may require a more specific interpretation of “practicing in the same profession.” For example in the review of a specialty-specific clinical issue, a peer may be defined as an individual trained in that specialty.

An individual functioning as a peer reviewer will not have performed any significant medical management on the patient whose case is under review. As part of the peer review process, the Peer Reviewer may request opinions and information from others who were involved in the patient’s care.

**Authority and
Accountability for the
Peer Review Process**

Board of Directors - The Board of Directors maintains final authority and responsibility for the effectiveness and fair processes of the peer review function, The Board of Directors delegates’ authority, and accountability for the oversight of the peer review process to the Professional and Quality Review Committee of the Board.

Medical Staff Executive Committee - Peer Review of the quality of care rendered by members of the medical staff is the responsibility of the Medical Staff Executive Committee. The Medical Staff Executive Committee (MSEC) designates the Clinical Risk Mortality Review Committee (CRMRC) to carry out the process of Peer Review.

**MEDICAL STAFF
POLICIES & PROCEDURES**

**4.0 PEER REVIEW
Authority and
Accountability for the
Peer Review Process -
continued**

– CONTINUED PAGE 2 of 5

Clinical Risk Mortality Review Committee - The CRMRC is accountable to carry out the activities of peer review in an effective and fair manner, consistent with parameters set forth in this document. The CRMRC is responsible to make appropriate recommendations to the Medical Staff Executive Committee, who in turn may make a recommendation to the Professional and Quality Review Committee of the Board.

**Clinical Risk Mortality
Review Committee
Membership**

Standing membership on the Clinical Risk Mortality Review Committee consists of representatives from the Department of Surgery, Medicine, Pediatrics, OB/GYN, Emergency Medicine, and Anesthesia. Individuals are appointed by the President of the Medical Staff and may be reappointed at the discretion of the President of the Medical Staff

The Sr. Vice President-Chief Medical Officer, Sr. Vice President of Patient Care Services, Directors of Risk Management and Quality Management serve as non-voting members of the Clinical Risk Mortality Review Committee. The Risk Management Specialist provides staff support to the Clinical Risk Mortality Review Committee

**Role of other hospital
and/or Medical Staff
Committees/forum**

During the review of quality of care processes or outcomes rendered as a system of care, a need to evaluate an individual medical staff practitioner's performance, apart from the quality of care improvement scope of the Committee/Forum, may arise. At such a time, the chairman or designee of the committee or forum is to halt discussion at this level and refer the case to the Clinical Risk and Mortality Review Committee, where the full level of peer review protection may occur.

**Selection of Peer
Reviewers for Special
Circumstances**

Sub-specialty peer review - Representatives from sub-specialties may be called upon, by the Chairman of the CRMRC, to serve as a Peer Reviewer of specialty specific cases. During this time these representatives act as members of the Clinical Risk Mortality Review Committee and all provisions of this policy apply.

Peer review of other health professionals – In the event that the need for peer review is identified which involves other health professionals, (e.g. nursing, pharmacy etc.) the Clinical Risk Mortality Review Committee will refer the review to the SVP of Patient Care Services to provide or obtain peer review.

MEDICAL STAFF POLICIES & PROCEDURES

4.0 PEER REVIEW – CONTINUED PAGE 3 of 5

Circumstances for and Use of External Peer Review

External peer review may be used under the following circumstances and/or when deemed appropriate by the Clinical Risk Mortality Review Committee, the Medical Staff Executive Committee or the Board of Directors.

- Ambiguity – when dealing with ambiguous or conflicting recommendations from internal reviewers, or when there does not appear to be a strong consensus for a particular recommendation.
- Lack of internal expertise – when no one on the medical staff has adequate expertise in the specialty under review or when the only practitioners on the medical staff with that expertise are associated in a practice with the practitioner under review and this potential for conflict cannot be appropriately resolved by the medical staff.
- Miscellaneous issues – when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file or for assistance in developing a benchmark for quality monitoring.

Provision for Participation in the Review Process by the Individual Whose Case is Being Reviewed

For cases where the CRMRC is considering the recommendation of a risk level indicating a significant deviation from the expected level of care, the practitioner involved is given the opportunity to explain his/her thought processes of care and the circumstances of the case to the Committee. This can be done in writing or in person as the practitioner requests.

The practitioner upon providing the Committee with his/her explanation is not to be present during any further deliberations of the case by the Committee to determine risk level recommendation.

Following completion of the review process and assignment of risk level by the CRMRC and approval by the Medical Staff Executive Committee, the involved practitioner may forward a written statement to his/her Department Chairman.

Case Identification for Peer Review

Cases for peer review are identified through a clinical risk and mortality (CRM) screening process and from direct referrals.

Screening Process - CRM Screen Failures include but are not exclusive to:

- Unexpected mortality
- Unexpected complication in care
- Critical delays in diagnosis of treatment
- Mortality occurring during surgery procedure
- Autopsy identifies an unanticipated diagnosis with the potential to have significantly changed treatment if known.
- Deviations from acceptable standards of care

Direct referrals – Referrals to the Risk Management Department, Quality Management Department, Department Chairmen, and Members of the Clinical Risk Mortality Review Committee by health care professionals identifying a quality concern may be brought to the Clinical Risk Mortality Review Committee if sufficient questions exist to warrant peer review.

**MEDICAL STAFF
POLICIES & PROCEDURES**

4.0 PEER REVIEW – CONTINUED PAGE 4 of 5

Timeframes for Peer Review Process	<p>It is expected that the peer review process will be complete within three months of the trigger (direct referral, CRMRC screen failure). Complete refers to the:</p> <ul style="list-style-type: none">• completion of an individual peer review of case, including if necessary discussion with individuals involved in the case• presentation and discussion of case at CRMRC if need determined by Peer Reviewer• review of additional information requested or offered by the involved practitioner(s)• recommendation of risk level by the CRMRC and• acceptance of risk level by CRMRC Committee to the Medical Staff Executive Committee at their next regularly scheduled meeting. <p>If circumstances so dictate, the review may extend beyond this timeframe, for example, the case is particularly complicated, involves multiple departments/practitioners, issues are identified that weren't initially known, or an external review is requested.</p>
High Risk Case Time Lines	<p>In case of a situation that may pose a danger to patient safety, the SVP of Patient Care Services and/or the SVP / Chief Medical Officer in conjunction with the Director of Risk Management will refer the situation to the appropriate Department Chairman/Director for action within 72 hours.</p>
Classification of Findings of Peer Review Process	<p>The CRMRC will maintain a case severity classification level that is used in describing the findings of the peer review process and is consistently applied to all cases brought to peer review.</p>
Support for Peer Review Recommendations	<p>The CRMRC supports the rationale for their recommendation by clearly identifying the issues for which the peer review was conducted, the deviations in practice that prompted the risk level recommendation and as appropriate the literature or relevant standards of care or practice guidelines that were referenced in the decision making.</p> <p>The Medical Staff Executive Committee and the Board of Directors shall function in good faith to support the recommendations of the CRMRC and the individuals involved in the Peer Review Process.</p>
Rights of Individual Practitioners	<p>All provisions of the Medical Staff Bylaws including the submission of a grievance (Article IX) are upheld by this policy</p>
Documentation of the Peer Review Process	<p>All peer review information, including but not limited to, screening worksheets, review notes, agenda and minute documents are considered privileged and confidential in accordance with state and federal laws and regulations covering peer review protection.</p>

**MEDICAL STAFF
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4.0

PEER REVIEW – CONTINUED PAGE 5 of 5

Documentation of the Peer Review Process - CONTINUED

Documents of the Clinical Risk Mortality Review Committee are not to contain individual practitioner's names and are to be available only to those individuals who are authorized to review as defined by this policy or by legal counsel.

Authorization to Review Peer Review Documents

Peer review information is available only to authorized staff when they have a legitimate need for the information. Authorized staff may include:

- Risk Management Department
- Quality Management Department
- Applicable Department Chairmen and Section Chiefs
- President, COO and Sr. VPCMO of Bridgeport Hospital
- Professional and Quality Review Committee Members and Board of Directors
- Individuals from state/federal regulatory bodies and accrediting bodies with appropriate jurisdiction
- Individuals with a legitimate purpose for access as determined by legal counsel and/or the Board of Directors

Trending Over Time

Physician specific peer review findings are trended over time to identify patterns of care.

Use of Peer Review Findings in the Reappointment and Credentialing Process

Department Chairmen and Section Chiefs must review and consider practitioner specific peer review results, including when appropriate, trended findings over time, while making recommendations regarding a physician's reappointment and privileging.

Responsibilities for Referral of Quality Concerns Outside of the Scope of the Peer Review Process

Often, system and process concerns affecting the quality of care provided that are not practitioner specific are identified as part of the peer review process. It is the responsibility of the committee to clearly delineate such system and process issues and bring them to the appropriate forum to address as part of the organization's ongoing quality improvement process.

APPROVED: Medical Executive Committee 6/2001, 2/2011

REVIEWED: 1/2011

REVISED:

**MEDICAL STAFF
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4.1 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

PURPOSE: To monitor the clinical performance and ability of each practitioner.

POLICY:

OBJECTIVES:

A process whereby the organization evaluates the privilege specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization.

PROCEDURE:

A FPPE shall be utilized in the following situations:

1. To monitor the clinical performance and ability of each practitioner during the period of provisional appointment.
2. To monitor clinical performance when there is a question of competence in the performance of a specific clinical privilege.
3. To monitor clinical performance following a leave of absence of 12 months or more.
4. To monitor clinical performance when a new clinical privilege is granted.

The duration of the monitoring process shall be defined in each specific case. Monitoring may be shorter than the provisional period at the discretion of the Department Chairman.

The information utilized to accomplish FPPE may include but not limited to:

Chart review, monitored clinical practice patterns, simulation, proctoring, external peer review and discussions with other individuals involved in the care of practitioner's patients.

Each clinical department will indicate the information to be reviewed for practitioners during the provisional appointment period. This information will be reviewed by the respective Department Chairman and utilized for the recommendation to full medical staff appointment.

When a FPPE is utilized for a question of specific clinical competence or a new clinical privilege, the information to be utilized will be defined for the specific situation.

APPROVED: Medical Executive Committee 8/2008, 4/2010, 2/2011

REVIEWED: 4/2010, 1/2011

REVISED: 4/2010

**MEDICAL STAFF
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4.2 ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

PURPOSE: Assure ongoing clinical competency of staff members.

POLICY:

OBJECTIVES:

Obtain clinical and professional information to facilitate the responsibility of the respective department Chairmen to reappoint clinically competent physician and mid-level practitioners to the Medical Staff.

PROCEDURE:

Article III, Section 3.7 of the Medical Staff Bylaws defines the reappointment process for members of the Medical Staff. Among the standards for assessment is “evidence of continuing clinical competence”.

The Joint Commission states that the “credentialing and privileging process involves a series of activities designed to collect, verify and evaluate data relevant to a practitioner’s professional performance”. It further defines a process of **Ongoing Professional Practice Evaluation** which “requires the medical staff to conduct ongoing evaluation of each practitioner’s professional performance”.

Data pertaining to the six areas of general competencies (Patient Care, medical/clinical Knowledge, Practice Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, Systems Based Practice) shall be obtained from varied sources. This information shall be collated by the Performance Management Department and forwarded in a report to the respective department Chairmen at least every six months.

Each of the nine clinical departments have defined the information they need to accomplish this process and are appended.

Ongoing medical record reviews will be performed by the applicable Chairman or their designees. Deficiencies or concerns will be brought to the attention of the member.

The Medical Staff recognizes the critical importance of maintaining professional competence and believes this process will provide information to carry out its responsibility.

APPROVED: Medical Executive Committee 8/2008, 4/2010, 2/2011

REVIEWED: 4/2010, 1/2011

REVISED: 4/2010

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4.3 POLICY ON PROFESSIONALISM: PROFESSIONALISM AND BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY

PURPOSE: Consistent with the callings we have received to provide healthcare for others, the Medical Staff at Bridgeport Hospital strives to provide the best and safest care for our patients. This objective has been a longstanding tradition of the Medical Staff of our institution. The Medical Staff therefore wishes to formalize this tradition by adopting this Medical Staff Policy on Professionalism setting forth expectations for professional behavior.

POLICY:

1. General Statement of Policy:

Members of the Medical Staff of Bridgeport Hospital are committed to providing the safest and best quality care to all patients at all times. This commitment is considered to be the standard at Bridgeport Hospital. It is recognized that unprofessional or disruptive behavior on the part of physicians or Advanced Practice Providers (APPs) may compromise this expectation and jeopardize patient care and/or patient safety.

The AMA Report of the Council on Ethical and Judicial Affairs defines disruptive behavior as "...a style of interaction...that interferes with patient care...(and) that tends to cause distress among other staff and affect overall morale within the work environment, undermining productivity and possibly leading to high staff turnover or even resulting in ineffective or substandard care."

This Medical Staff Policy on Professionalism outlines the expectations for professional behavior for members of the Medical Staff at Bridgeport Hospital and establishes a process for review and resolution of reported concerns and complaints of Policy on Professionalism violations and behavior that undermines a safety of culture.

This Policy on Professionalism shall be interpreted and applied in conjunction with the Medical Staff Bylaws, and in particular with Section 8.12 and Articles IX and X thereof. In the event of a conflict between this Policy on Professionalism and the Medical Staff Bylaws, the Bylaws shall govern.

2. Code of Professional Behavior:

As a condition of membership, all members of the medical staff and all APPs at Bridgeport Hospital shall commit to the following:

A. Maintenance of appropriate relationships with patients:

Providing excellent care for patients is at the core of our healing mission. As leaders or members of health care teams, we strive to ensure optimal care and treatment of our patients.

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In doing so:

- Patients will be treated with respect, without discrimination, and with strict adherence to confidentiality guidelines.
- Patients and their legally authorized representatives will be fully informed of their health status and plan of care and encouraged to participate in their care planning and their treatment.
- All communication with patients will be honest and forthright.
- Physicians and APPs will advocate for their patient's best interest at all times.

B. Maintenance of appropriate relationships with peers and Bridgeport Hospital coworkers:

All Medical Staff members working at Bridgeport Hospital must treat others with respect, courtesy, integrity, and dignity and conduct themselves in a professional and cooperative manner.

Unacceptable behavior includes, **but is not limited to**, the following:

- Threatening or abusive language directed at nurses, hospital personnel, or other physicians, either in person or on the telephone (e.g., belittling, berating, threatening another individual)
- Threatening gestures or body language
- Degrading or demeaning comments regarding patients, families, nurses, physicians or medical center coworkers or colleagues
- Non-constructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle or infer incompetence
- Profanity or similarly offensive language while in the hospital or while speaking with patients, families, or medical center coworkers or colleagues, in person or on the telephone
- Inappropriate physical contact with another individual that is threatening or intimidating
- Inappropriate medical record entries, including entries concerning the quality of care being provided or attacking particular physicians, nurses or hospital policies
- Throwing charts, instruments, or other objects
- Criticizing other caregivers in front of patients or other coworkers or colleagues
- Sexual comments, jokes, or innuendo
- Sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature, including such conduct that interferes with an individual's work performance; that will create an intimidating, hostile or offensive work environment; or that is presented as a condition of or affects an individual's employment or working conditions, opportunities for advancement and the like
- Unreasonable refusal to accept medical staff assignments or participation in committee or departmental affairs
- Non-accidental destruction of hospital property

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PROCEDURE:

1. Complaints or concerns regarding Policy on Professionalism violations and any other issues regarding behavior or professionalism by a Medical Staff member or APP shall be made or referred to the President of the Medical Staff or Chief Medical Officer. The person making the report should be requested to provide as much specificity as possible regarding the matter, to include the following whenever feasible under the circumstances:
 - the date and time of the questionable behavior;
 - a statement of whether the behavior affected or involved a patient in any way, and, if so, the name of the patient;
 - the circumstances that precipitated the situation;
 - a description of the questionable behavior that is limited to factual, objective language;
 - the consequences, if any, of the behavior that undermines a culture of safety as it relates to patient care or hospital operations; and
 - a record of any action taken to remedy the situation, including the date, time, place, action, and name(s) of those intervening.

2. Once received, the report will be reviewed and discussed by at least two of the following: the President of the Medical Staff, the Chief Medical Officer and the relevant Department Chair or his/her designee (such as a Section Chief). In addition, the Sr. VP of Human Resources or his/her designee shall be included in this discussion if the report concerns an individual who is an employee of Bridgeport Hospital or another Yale New Haven Health System entity. This initial review is focused on establishing whether or not the complaint or concern has enough merit to warrant further discussion or action.

3. If it is determined that the complaint may represent a violation of the Policy on Professionalism, one of the following will meet with the practitioner: the President of the Medical Staff, the CMO, or the Department Chair or his/her designee. The leader holding this meeting with the practitioner shall determine whether it is appropriate to include an additional participant as a witness to the conversation. If the practitioner is an employee, a representative from the Human Resource Department may also be present or may be the lead in holding this meeting. The complaint will be reviewed and a response from the practitioner requested. After this meeting, depending on the apparent severity of the incident and whether or not the incident was previously addressed unsuccessfully or is part of a pattern of inappropriate behavior, one of the following will occur:
 - A. If it is determined that the complaint is unfounded, the complaint will be dismissed and no further action will be taken.

 - B. If the incident seems to be of a minor nature and is not part of a pattern of repeated problems, a collegial education of the practitioner will take place by one of the following: the Department Chair or his/her designee, the President of the Medical Staff, the CMO, the Sr. VP of Human Resources or his/her designee if applicable. The inappropriate nature of the practitioner's behavior will be discussed along with the objective of promoting patient safety, quality, teamwork and a comfortable work environment, and the need to avoid any future similar behavior. A summary of the meeting along with a written rebuttal from the practitioner, if any, will be documented

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and maintained in the practitioner's credentialing file (and human resource file if applicable). The practitioner will also be sent a letter summarizing the nature of the problem and expectations for professionalism and appropriate behavior within the hospital.

- C. If the incident seems to be of a severe nature or if there is a repeated pattern of inappropriate behavior, a meeting with the practitioner will include the President of the Medical Staff or the Chief Medical Officer, and the Department Chair. The Sr. VP of Human Resources or his/her designee may also participate if applicable. The nature of the reported incident will be relayed to the practitioner and a response will be requested. Input from any other witnesses will be sought. The leaders conducting the review will determine in their discretion whether to counsel the practitioner or whether the incident should be reported to the Medical Staff Professionalism Committee (MSPC). If it is determined that the reported incident is of a severe nature or is part of a pattern of repeated incidents, the matter is likely appropriate for referral to the MSPC for review and consideration of further action. If the matter is not referred to the MSPC, the practitioner shall receive a reprimand and a warning and shall be counseled that the conduct at issue has continued and remains in violation of the Policy on Professionalism, is intolerable and must stop. Thereafter, a summary of the complaint, including a summary of the review undertaken and meetings with the practitioner, as well as the practitioner's written response, if any, will be maintained in the practitioner's credentialing file (and human resource file if applicable). The practitioner will also be sent a follow-up letter summarizing the nature of the problem and expectations for professionalism and appropriate behavior within the hospital.

- D. If the incident is referred to the MSPC, the procedures outlined in the Medical Staff Bylaws shall be followed.

- E. Whenever a Medical Staff member or APP, Medical Staff or hospital leader, or the MSPC involved in this process deems it appropriate, they may contact Legal & Risk Services to request counsel on how to best proceed. To the extent that additional actions are undertaken at the direction of counsel or at counsel's request, such activities will be deemed privileged and confidential, protected by attorney-client privilege. In addition, to the extent elements of the investigation and disciplinary process are within the scope of the Connecticut Peer-Review Statute, such documents and records will be deemed protected to the extent allowed by law.

APPROVED: Medical Executive Committee 5/ 2001, 2/2011, 7/2012, 07/23/2015

REVIEWED: 4/2004, 1/2011, 5/2012, 1/2015

REVISED: 4/2004, 5/2012, 01/2015

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4.4 PRACTITIONER HEALTH

PURPOSE: Practitioners are at risk for the same health problems found in the general population, including physical, emotional and behavioral health (for example addictive behavior) which can impair a practitioner's ability to practice. Recognition of the signs of practitioner health problems and prompt response, including referral as appropriate, is of critical importance in order for practitioners to provide quality health care to patients at Bridgeport Hospital.

Bridgeport Hospital utilizes the Health Assistance Intervention Education Network (HAVEN)

POLICY: Identification/Referrals

Any practitioner or member of the Bridgeport Hospital staff shall make a referral, including a self-referral, to HAVEN when he/she has sufficient reason to believe that a practitioner has a health problem that interferes with the safe practice of medicine. HAVEN will review the referral. If in their opinion, intervention is recommended, the practitioner will be encouraged to agree to a monitored program of rehabilitation. In the event that a practitioner is referred to HAVEN by Hospital Administration, periodic reports of the progress of the program are reported to the Sr. Vice President – Chief Medical Officer at Bridgeport Hospital.

If the practitioner does not agree to the rehabilitation program, a report of such is made to the Hospital Sr. Vice President – Chief Medical Officer and to the Department of Public Health.

Bridgeport Hospital shall conduct at least one education session per year for practitioners and Hospital staff focusing on the recognition of practitioner illness and the process of referral to HAVEN.

All minutes, reports, recommendations, communications, and actions, made or taken pursuant to this policy are covered by federal and state statute or the corresponding provisions of any subsequent federal or state statutes providing protection to peer review or related activities. Furthermore, any committees and/or individuals charged with making or reviewing reports or recommendations pursuant to the policy will be considered to be acting on behalf of Bridgeport Hospital and its governing board when engaged in such professional review activities and thus are "professional review bodies" as defined in federal statutes.

This policy is intended to complement Medical Staff Rule and Regulation 6.9.

APPROVED: Medical Executive Committee 6/2001, 2/2011, 1/2014

REVIEWED: 1/2011 **REVISED:** 1/2011, 8/2013,