POLICY AND PROCEDURE MANUAL
OF THE
MEDICAL STAFF
OF
LOWELL GENERAL HOSPITAL

LOWELL GENERAL HOSPITAL

MEDICAL STAFF POLICIES AND PROCEDURES MANUAL

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LOWELL GENERAL HOSPITAL

MEDICAL STAFF APPOINTMENT POLICY AND PROCEDURE

TITLE: Credentialing policy and procedure for initial appointment to the Medical Staff.

PURPOSE: To define the steps for uniformly processing each application for Medical Staff appointment.

OBJECTIVES:

(1) To assist in fulfilling the responsibility of the Hospital and assuring that the patients afforded care at the Hospital shall 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 is reviewed by the appropriate individuals and committees prior to rendering a final recommendation to the Board of Trustees.

PROCEDURE AND RESPONSIBILITIES:

I. Application

The applicant with the appropriate application fee as determined by the Medical Executive Committee shall submit an application for appointment to the Medical Staff. An applicant's appointment period shall not exceed 24 months, under any circumstances, as mandated by the Joint Commission standards and the Medical Staff Bylaws. The application shall be legible and on the form approved by the Board of Trustees. The applicant shall be provided a copy of, or access to a copy of, the Medical Staff Bylaws, Rules and Regulations, and other Hospital and Medical Staff Policies and Procedures relating to the applicant's proposed clinical practice in this Hospital.

II. Application Content

Every applicant shall furnish complete information concerning the following:

A. Personal demographic information.

B. A recent passport type photograph.

C. Educational information, including the name of each institution, major, degrees awarded, dates attended, and graduation date. ECFMG (Education Certificate for Foreign Medical Graduates) Certificate for foreign medical school graduates.

D. Picture Identification. If non-US citizen, then the appropriate INS documentation.

E. Graduate medical training information shall include information regarding internships, residencies, and fellowships/preceptorships, and shall include the name of the institution, address, type of affiliation, program director and dates attended.

F. A copy of all past, expired and current: medical, dental, podiatric, and other professional licenses, certifications, and/or registrations DEA (Federal Drug Enforcement Administration Certificate) and, Massachusetts State Controlled Substances Certificate, with the number and expiration date of each.

Additionally, the applicant shall provide a copy of his most recent application for licensure or license renewal application form, if applicable, and all attachments and other explanatory materials submitted, including Form R1, with the application, filed with the Commonwealth of Massachusetts Board of Registration in Medicine.

G. Specialty or subspecialty board certification, re-certification, and eligibility status dates

H. Professional society memberships/fellowships.

I. Current Curriculum Vitae (dated): Chronology of professional career, including academic appointments, hospital affiliations (past, present, or pending) *covering the previous 10-year period* and other institutional affiliations, and the reasons for terminating these affiliations.

J. A complete list of all health care facilities where the provider has or has had employment, practice, or association for the purpose of providing patient care, or privileges in the previous ten years. Listing shall include the department and staff category at each institution.

K. Location of offices; names and addresses of other practitioners with whom the applicant is associated, and the nature of the association.

L. Professional liability insurance coverage (minimum: $1,000,000 Each Claim/ $3,000,000 Annual Aggregate) and practitioner's information on malpractice claims history and experience (suits, judgments, and settlements made, closed , and pending) during the past ten years, including the names and addresses of present and all past insurance carriers.

M. The nature and specifics of any pending or completed action involving denial, revocation, suspension, reduction, limitation, probation, or non-renewal of: licensure or certificate to practice any profession in any state or country; DEA or other controlled substance registrations; membership or fellowship in local, state, or national professional organizations; malpractice insurance, specialty or subspecialty board

certification or eligibility; faculty membership at any medical or professional school; staff membership status, prerogatives, or clinical privileges at any other hospital, clinic, or health care institution, either voluntarily or involuntarily terminated. Further, the applicant shall provide any challenges to actions regarding or voluntary relinquishment of any licensure or registration and any voluntary or involuntary termination of any hospital medical staff memberships and voluntary or involuntary limitation, reduction, or loss of clinical privileges at any hospital.

N. Vaccination/Immunization Requirements: The following are required of initial applicants to the Medical Staff:

Completed Infection Control Form with proof of a negative Tuberculosis Skin Test. If the applicant has a history of a positive test, the applicant must submit a copy of their last chest x-ray and complete the TB Symptom Assessment Record.

Documentation of immunity to measles, mumps and rubella or evidence of two MMR vaccinations.

Physician documented record of Varicella, proof of two Varivax vaccinations or serology to confirm protection against disease.

Documentation will be approved by the Occupational Health Nurse.

O. Health impairments, if any, affecting the applicant's ability in terms of skill, attitude, or judgment to perform professional and medical staff duties fully. If there is a question related to the applicant's health, the applicant may be asked to furnish information on hospitalization(s) or other institutionalization(s) for significant health problems during the past five-year period; any continuing health problems requiring current therapy; denials of, or ratings on, health, life, or disability insurance because of health problems and names of insurers and/or statements from personal physicians or significant findings on last health examination, as requested by reviewing committees.

P. Any current felony criminal charges pending against the applicant, any past charges, including their resolution. A completed and signed CORI check authorization form shall be submitted.

Q Department assignment, staff category, and specific clinical privileges requested. If requested, completion of the requirements for Conscious Sedation and a signed Privileges in Conscious Sedation statement.

R. Any administrative documents requested by the Hospital, e.g., Medicare attestation statements, UPIN number or appropriate paperwork indicating an application for an UPIN number (if applicable), Environment of Care/Safety Training Form for Physicians, Conflict of Interest and Corporate Compliance Attestation Form, Department of Information Systems Confidentiality Agreement, etc.

S. And any other information that shall be required as a result of changes to the application form, requested by the Board of Trustees of LGH, or changes in state, federal, or Joint Commission standards.

III. Peer Recommendations

The application shall include the names, complete addresses and phone numbers, and fax numbers of three individuals who have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others and who shall provide specific written comments on these matters upon request from the hospital and medical staff authorities. The named individuals shall have acquired the requisite knowledge through recent observation of your professional practice over a reasonable amount of time, and at least one, shall have had organizational responsibility for your performance. None of the individuals shall be related to you by family, or current or impending professional partnership/financial association. One required source is the chief of Residency Training Program, or Department Chairman/Service Chief. The professional reference form shall be directly mailed to the Medical Staff Services Office by the individual reference.

A Professional Reference Questionnaire shall be mailed or faxed to each reference with a copy of the requested delineation of privileges. If any of the referenced physicians do not have enough specific knowledge about the applicant to answer the questionnaire, the applicant shall be asked to furnish other references.

IV. Effect of Application

The applicant shall sign the Conditions of Appointment and Authorization for Release of Information portion of the application form and, in doing so, consents to all of the conditions contained therein. No changes shall be made to the form by the applicant.

V. Processing the Application

Applications for Medical Staff appointment shall be processed in accordance with Article III of the Medical Staff Bylaws.

A. Applicant's Burden

The applicant has the burden of producing adequate information for a proper evaluation of his experience, training, demonstrated ability and health status, and of resolving any doubts about these or any of the qualifications required for Staff membership or the requested Staff category, department assignment, or clinical privileges, and of satisfying any reasonable requests for information or clarification, including health examinations made by appropriate Staff or Board authorities.

B. Verification of Information

1) The applicants' application is submitted along with the approved Staff dues to the Medical Staff Services Office. Medical Staff Services verifies current:

- Massachusetts licensure and Out-of-state licensure(s)

(1) Licensure is verified with the primary source at the time of appointment and initial granting of clinical privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate state

licensing board or from any state licensing board if in a federal service. Verification of current licensure through the primary source Internet site or by telephone is also acceptable, if this verification is documented.

- DEA certification
- Professional liability insurance coverage.
- Massachusetts State Controlled Substance Certificate
- Out-of-state licensure(s),
- Board certification/Board eligibility status,
- Malpractice claims history,
- ECFMG. certification,
- Medical school of graduation,
- Postgraduate programs,
- Department of Health and Human Service's Exclusion List
- Criminal Offender Record Index (CORI)
- other sources as required by the Board of Registration in Medicine by contacting appropriate organizations for verification.
- National Practitioner Data Bank (NPDB) for information relative to the applicant's malpractice claims history, etc, as mandated by federal law,

2) Primary Source verification is completed in compliance with these bylaws and current Joint Commission standards. A primary source may designate another organization as its agent in providing information to verify credentials. The hospital can use this organization as a designated equivalent source.

3) The Medical Staff Services Office sends a Professional Reference Questionnaire to the references provided with a copy of the requested clinical privileges by the applicant, and promptly notifies the applicant of any problems in obtaining the information required. Upon such notification, it is the applicant's obligation to obtain the required information is sent directly to the Medical Staff Services Office. When collection and verification are accomplished, the application and all supporting materials are transmitted to the Chairman of the Credentials Committee. ***THE APPLICATION IS NOT DEEMED "COMPLETE" UNTIL ALL REQUESTED INFORMATION HAS BEEN OBTAINED AND VERIFIED.***

C. Department Action (Delineation of Clinical Privileges)

The Chief of each department in which the applicant seeks privileges reviews the application and its supporting documentation, makes decisions on the granting of clinical privileges and shall consider criteria that is directly related to the quality of care conducts a personal interview with the applicant, and forwards, to the Credentials Committee, a written recommendation as to approval or denial of, and any special limitations on, Staff appointment, category

of Staff membership and prerogatives, department affiliation, and scope of clinical privileges. If a department chief requires further information about an applicant, he may defer transmitting his recommendation.

D. Credentials Committee Action

The Credentials Committee reviews the application, the supporting documentation, the recommendation of the department chief and section chiefs, and any other relevant information available to it. The Credentials Committee then transmits, to the Medical Executive Committee, its written recommendations as to approval of or denial of, and any special limitations to, Staff appointment, category of Staff membership and prerogatives, clinical privileges and department/section affiliation. If the Credentials Committee requires further information about an applicant, it may defer transmitting its report for 90 days.

E. Expedited Credentialing – Fast Track

The full Credentials Committee shall, at their discretion, approve an applicant, if the applicant meets all the following criteria:

- **No more than 5 years have elapsed since the most recent residency and/or fellowship**
- **No more than 10 years have elapsed since graduation from Medical School**
- **The applicant has not practiced in more than one location (other than Greater Lowell) since finishing the most recent residency and/or fellowship**
- **Never has had any licensure suspensions or Board of Registration sanctions**
- **No significant malpractice history, as determined by the Department Chief and the Chairman of The Credentials Committee. The department chief, and section chiefs where appropriate, have recommended the applicant without reservation**
- **All documentation is in place including, but not necessarily limited to recommendations, licensure, DEA registration, verifications of residency and medical school, report from National Practitioner Data Bank, and CORI check.**
- **The applicant meets the then generally accepted standards of practice in the community**

According to Joint Commission standards, an applicant is usually ineligible for the expedited process if at the time of appointment or reappointment, any of the following has occurred:

- **The applicant submits an incomplete application;**
- **The Medical Staff Executive Committee makes a final recommendation that is adverse or with limitation;**
- **There is a current challenge or previous successful challenge to licensure or registration**
- **The applicant has received an involuntary termination of medical staff membership at another organization**

- **The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges; or**
- **There has been a final judgment adverse to the applicant in a professional liability action.**

The Credentials Committee shall formally review the application and recommend approval to the governing body:

There is no expediting or delegation of the responsibilities of the Medical Executive Committee. The expedited credential process relates only to the governing body function, and allows the governing body to appoint a committee of two or more members of the governing body to review and approve applications between regularly scheduled governing body meetings.

In the event of a dispute, the matter shall be handled by the governing body.

F. Medical Executive Committee Action

The Medical Executive Committee reviews the application at the next scheduled meeting, the supporting documentation, the reports and recommendations from the department chief, Credentials Committee, and any other relevant information available to it. The Medical Executive Committee prepares written recommendations as to approval or denial of, or any special limitations on: Staff appointment, category of Staff membership and prerogatives, department/section affiliation, and scope of clinical privileges, for approval by the Board of Trustees.

Notwithstanding the above, if an applicant has been approved by the Credentials Committee in accordance with the criteria set in Section D above, Medical Executive Committee approval shall not be delegated to the President of the Medical Staff. The committee of the governing body shall review and approve applications between regularly scheduled governing body meetings.

In the event of a dispute, the governing body resolves the matter.

G. Effect of Medical Executive Committee Action

1. **Deferral:** Action by the Medical Executive Committee to defer the application for further consideration shall be followed up within 90 days with subsequent recommendations as to approval or denial of, or any special limitation on, Staff appointment, category of Staff membership and prerogatives, department/section affiliation, and scope of clinical privileges.

2. **Favorable Recommendation**: When the Medical Executive Committee's recommendation is favorable to the applicant in all respects, the President promptly forwards it, together with all supporting documentation, to the Board of Trustees.

"All supporting documentation" means the application form and its accompanying information, the reports and recommendations of the departments, sections, Credentials Committee and Medical Executive Committee, and dissenting views.

3. **Adverse Recommendation:** When the Medical Executive Committee's recommendation is adverse to the applicant, the President immediately informs the applicant, by certified mail, and he is entitled to the procedural rights as provided in Article VIII of the Medical Staff Bylaws. An "adverse recommendation" by the Medical Executive Committee is defined as a recommendation to deny appointment, requested Staff category, requested department/section assignment, or to deny or restrict requested clinical privileges.

H. Board of Trustees Action

The Board may adopt or reject, in whole or in part, a recommendation of the Medical Executive Committee or refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. Favorable action by the Board is effective as its final decision. If the Board's action is adverse to the applicant in any respect, the President promptly so informs the applicant, by certified mail, and he is entitled to the procedural rights provided in Article VIII of the Medical Staff Bylaws.

H. Notice of Final Decision

1. Notice of the Board of Trustees' final decision is given through the President to the applicant.

2. A decision and notice to appoint includes: The Staff category to which the applicant is appointed; the department and section to which he is assigned; the clinical privileges he may exercise; and any special conditions attached to the appointment.

I. Time Periods for Processing

All individuals and groups required to act on an application for Staff appointment shall do so in a timely and good faith manner and, except for good cause, each application should be processed within the following time periods:

Individual/Group	Time
Medical Staff Services	60 days from receipt of completed application

Department Chief	30 days from referral
Credentials Committee	90 days from referral
Medical Executive Committee	next regular meeting following referral
Board of Trustees	next regular meeting following referral

These time periods are to be deemed guidelines and are not directives, such as to create any rights for a practitioner to have an application processed within these precise periods. If the provisions of the Hearing and Appeal Process are activated, the time requirements provided in Article VIII of the Medical Staff Bylaws govern the continued processing of the application.

J. Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment, Staff category, department assignment, or clinical privileges (other than suspension for records or dues), is not eligible to reapply to the Medical Staff for the denied category, department, or privileges for a period of six months. Any such reapplication is processed as an initial application, and the applicant shall submit such additional information as the Staff or the Board may require in demonstration that the basis for the earlier adverse action no longer exists.

LOWELL GENERAL HOSPITAL

MEDICAL STAFF REAPPOINTMENT POLICY AND PROCEDURE

TITLE: Credentialing policy and procedure for reappointment to the Medical Staff.

PURPOSE: To define the steps for uniform reevaluation of each appointee for reappointment.

OBJECTIVES: (1) To assist in fulfilling the responsibility of the Hospital and assuring that the patients afforded care at the Hospital shall have such care rendered by individuals appropriately qualified to do so.

(2) To assure that each eligible appointee is afforded equal opportunity to be re-appointed to the Medical Staff.

(3) To assure that adequate information pertaining to activity levels, membership requirements, and clinical data are reviewed by the appropriate individuals and committees prior to rendering a final recommendation to the Board of Trustees.

PROCEDURE:

I. Application

An application for reappointment to the Medical Staff shall be submitted to the Medical Staff Services Office by the applicant, at least 5 months prior to the appointment expiration date, with the appropriate reappointment fee as established by the Medical Executive Committee. An applicant's reappointment period shall not exceed 24 months, under any circumstances, as mandated by Joint Commission standards and the Medical Staff Bylaws. The application shall be in ink, legible and on the form designated by the Board of Trustees and shall be submitted to the Medical Staff Services Office.

II. Application Content

Every applicant shall furnish complete information concerning the following:

A. Personal demographic information.

B. A copy of all expired and currently valid medical, dental, podiatric, and other professional licenses or certifications with the number and expiration date of each. Additionally, the applicant shall provide a copy of his most recent application for licensure or license renewal application form, if applicable, and all attachments and other explanatory materials submitted with the application, filed with the Commonwealth of Massachusetts Board of Registration in Medicine.

C. A copy of a current Federal Drug Enforcement Administration (DEA) registration certificate and current Massachusetts State Controlled Substance Certificate if applicable.

D. Current Curriculum Vitae, dated.

E. Completed Infection Control Form with proof of a negative Mantoux or chest x-ray within the past 12 months, approved by Occupational Health Nurse at LGH.

F. Proper INS documentation as required.

D. Affiliations: Every health care facility where the physician has had employment, practice; association for the purpose of providing patient care, or privileges in the previous three years. The applicant shall also provide the reasons for any discontinuance of employment, practice, or association of privileges at any of the named health care facilities.

E. Evidence of professional liability insurance coverage ($1,000,000 each claim/ $3,000,000 annual aggregate), copy of certificate, and information on malpractice claims history and experience (suits, judgments and settlements made, concluded and pending) during the past ten years, including the name and address of the present insurance carrier.

F. Health impairments, if any, affecting the applicant's ability in terms of skill, attitude, or judgment to perform professional and Medical Staff duties fully. If there is a question related to the applicant's health, the applicant may be asked to furnish information on hospitalizations or other institutionalization for significant health problems during the past five-year period; any continuing health problems requiring current therapy; denials of, or ratings on, health, life, or disability insurance because of health problems and names of insurers and/or statements from personal physicians or significant findings on last health examination, as requested by reviewing committees.

G. The nature and specifics of any pending or completed action involving denial, revocation, suspension, reduction, limitation, probation, or non-renewal of: license or certificate to practice any profession in any state or country; DEA or other controlled substances registration; membership or fellowship in local, state, or national professional organizations; specialty or subspecialty board certification or eligibility; faculty membership at any medical or professional school; staff membership status, prerogatives or clinical privileges at any other hospital, clinic or health care institution, either voluntarily or involuntarily terminated. Further, the applicant shall provide any challenges to actions regarding or voluntary relinquishment of any licensure or registrations and any voluntary or involuntary termination of any hospital medical staff memberships and voluntary or involuntary limitation, reduction or loss of clinical privileges at any hospital.

H. Any current felony criminal charges pending against the applicant, any past charges, including their resolution.

I. The applicant's request for appropriate clinical privileges indicated on the LGH Delineation of privileges form.

J. Any administrative documents requested by the Hospital, e.g., Medicare attestation statements, UPIN number or proof of application (if applicable), Environment of Care/Safety Training Form for Physicians, Conflict of Interest and Corporate Compliance Attestation Form, Department of Information Systems Confidentiality Agreement, etc. administrative documents requested by

the Hospital, e.g., Medicare attestation statements, safety forms, corporate compliance forms, etc.

K. Information regarding board certification/board eligibility.

III. Hospital Affiliations

The Medical Staff Services Office shall send a Health Care Facility Affiliation form and requested delineation of privileges, to the Department Chairman of the health care facilities (current or within the past 3 years) listed under the Affiliation section of the application form.

IV. Effect of Application

The applicant shall sign the Conditions of Reappointment and Authorization for Release of Information portions of the application form and, in doing so, consents to all of the conditions contained therein. The form shall not be changed by the applicant.

V. Practitioner's Reappraisal Profile

The Medical Staff Services Office shall complete the portion of the form listing the applicant's attendance record at staff, department, and committee meetings held over the previous two-year period.

The chief of each department in which the applicant exercises privileges shall be asked to complete his portion of the reappraisal profile. This reappraisal shall include information relative to the applicant's physical and mental health, clinical medical knowledge, technical and clinical skills, ability to communicate and develop rapport with patients, relationship with peers, relationship with hospital staff, appropriate utilization of hospital resources, and fulfillment of medico-administrative responsibilities. Summary reports of each applicant's activities shall be provided to the Medical Staff Office, by the Performance Improvement Council no later than August 1, and includes relevant practitioner-specific information and compared to aggregate information when these measurements are appropriate for comparison purposes in evaluation professional performance, judgment, and clinical or technical skills, and other Medical Staff monitoring committees, and shall be considered by the chief in his appraisal. The chief of each department shall make decisions on reappointments, revocation, revision, or renewal of clinical privileges considering the criteria that is directly related to the quality of patient care. Such decisions are subject to a fair hearing and appeal process as outlined in these bylaws.

VI. Processing the Application

Applications for Medical Staff reappointment shall be processed in accordance with Article III of the Medical Staff Bylaws.

A. Applicant's Burden

The applicant has the burden of producing adequate information for a proper evaluation of his experience, training, demonstrated ability and health status, and of resolving any doubts about these or any of the qualifications required for Staff membership or the requested Staff category, department assignment or clinical privileges, and of satisfying any reasonable requests for information or

clarification, including health examinations made by appropriate Staff or Board authorities.

B. Verification of Information

The completed application is submitted to the Medical Staff Services Office.

1) Medical Staff Services verifies the following in accordance with the current bylaws and current Joint Commission standards: A primary source may designate another organization as its agent in providing information to verify credentials. The hospital can use this organization as a designated equivalent source.

- current Massachusetts licensure, and out-of-state licensure:

(1) Licensure is verified with the primary source at the time of appointment and initial granting of clinical privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate state licensing board or from any state licensing board if in a federal service. Verification of current licensure through the primary source Internet site or by telephone is also acceptable, if this verification is documented.

- Federal DEA certification,
- Massachusetts State Controlled Substance Certificate,
- Board Certification/Board Eligibility
- professional liability insurance coverage.

Medical Staff Services queries:

- National Practitioner Data Bank,
- Department of Health and Human Service's Exclusion List

Copies of these documents, as well as a copy of the applicant's license renewal application form, shall be provided by the applicant. The Medical Staff Services Office sends a Health Care Facility Affiliation Form with a copy of the requested clinical privileges, to the affiliations provided by the applicant.

When collection and verification are accomplished, the application and all supporting materials are transmitted to the Chairman of the Credentials Committee.

THE APPLICATION IS NOT DEEMED "COMPLETE" UNTIL ALL REQUESTED INFORMATION HAS BEEN OBTAINED AND VERIFIED.

C. Department Action (Delineation of Clinical Privileges)

The chief of each department in which the applicant seeks privileges reviews the application and its supporting documentation, and forwards,

to the Credentials Committee, a written recommendation as to approval or denial of, and any special limitations on, Staff reappointment, category of Staff membership and prerogatives, department affiliation, and scope of clinical privileges. The chief of the department may also, at his discretion, conduct an interview with the applicant. If a department chief requires further information about an applicant, he may defer transmitting his recommendation.

D. Credentials Committee Action

The Credentials Committee reviews the application, the supporting documentation, the reports from the department chief and section chiefs, and any other relevant information available to it. The Credentials Committee then transmits, to the Medical Executive Committee, its written recommendations as to approval or denial of, and any special limitations on, Staff reappointment, category of Staff membership and prerogatives, and department/section affiliation. If the Credentials Committee requires further information about an applicant, it may defer transmitting its report.

E. Medical Executive Committee Action

The Medical Executive Committee reviews the application, the supporting documentation, the reports and recommendations from the department chief and Credentials Committee, and any other relevant information available to it. The Medical Executive Committee prepares written recommendations as to approval or denial of, or any special limitations on, Staff reappointment, category of Staff membership and prerogatives of the department/section affiliation and scope of clinical privileges.

F. Effect of Medical Executive Committee Action

i. **Deferral**: Action by the Medical Executive Committee to defer the application for further consideration shall be followed up within 90 days with subsequent recommendations as to approval or denial of, or any special limitations on, Staff reappointment, category of Staff membership and prerogatives, department/section affiliation and scope of clinical privileges. The President of the Hospital promptly sends the applicant written notice of an action to defer.

ii. **Favorable Recommendation**: When the Medical Executive Committee's recommendation is favorable to the applicant in all respects, the President promptly forwards it, together with all supporting documentation, to the Board of Trustees. "All supporting documentation" means the application form and its accompanying information, the reports and recommendations of the departments, sections, Credentials Committee and Medical Executive Committee, and dissenting views.

iii. **Adverse Recommendation**: When the Medical Executive Committee's recommendation is adverse to the applicant, the Chief Executive Officer immediately so informs the applicant, by

certified mail, and he is entitled to the procedural rights as provided in Article VII of the Medical Staff Bylaws. An "adverse recommendation" by the Medical Executive Committee is defined as a recommendation to deny reappointment, requested Staff category, requested department/section assignment, or to deny or restrict requested clinical privileges.

G. Board of Trustees Action

The Board may adopt or reject, in whole or in part, a favorable recommendation of the Medical Executive Committee or refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. Favorable action by the Board is effective as its final decision. If the Board's action is adverse to the applicant in any respect, the President promptly so informs the applicant, by certified mail, and he is entitled to the procedural rights provided in Article VII of the Medical Staff Bylaws.

H. Notice of Final Decision

i. Notice of the Board of Trustees' final decision is given through the President to the applicant, sent by the Medical Staff Services Office.

ii. A decision and notice to reappoint includes: The Staff category to which the applicant is reappointed, the department and section to which he is assigned; the clinical privileges he may exercise; and any special conditions attached to the reappointment.

I. Time Periods for Processing

All individuals and groups required to act on an application for Staff reappointment shall do so in a timely and good faith manner and, except for good cause, each application should be processed within the following time periods:

Individual/Group	Time
Medical Staff Services	180 Days
Department Chief	60 Days
Credentials Committee	30 Days
Medical Executive Committee	next regular meeting
Board of Trustees	next regular meeting

These time periods are to be deemed guidelines and are not directives, such as to create any rights for a practitioner to have an application processed within these precise periods. If the provisions of the Hearing and Appeal Process are activated, the time requirements provided in Article VIII of the Medical Staff Bylaws govern the continued processing of the application.

J. Late Fees

The Medical Executive Committee has the right to establish and enforce late fees for reappointment applications not received by the deadline set by the committee.

K. Failure to Reapply

Failure of a Member of the Medical Staff to apply for reappointment and provide all of the necessary documentation within the time limits established by the Medical Executive Committee of the Medical Staff shall be deemed a voluntary withdrawal of staff membership and clinical privileges, and shall become effective at the end of the current reappointment period.

L. Reapplication After Adverse Reappointment Decision

An applicant who has received a final adverse decision regarding reappointment, Staff category, department assignment or clinical privileges (other than suspension for records or dues) is not eligible to reapply to the Medical Staff for the denied category, department or privileges for a period of six months. Any such reapplication is processed as an initial application, and the applicant shall submit such additional information as the Staff or Board may require in demonstration that the basis for the earlier adverse action no longer exists.

LOWELL GENERAL HOSPITAL MEDICAL STAFF

CLINICAL PRIVILEGES DELINEATION POLICY

TITLE: Delineation overview for clinical privileges for the Medical Staff.

PURPOSE: To define the primary goals of Lowell General Hospital's clinical privileges delineation process and an overview of the steps necessary to secure those privileges for new or existing medical staff.

OBJECTIVES: (1) To assist in fulfilling the responsibility of the Hospital and assuring that the patients afforded care at the Hospital shall have such care rendered by individuals appropriately qualified to do so.

(2) To assure that each eligible appointee receives the appropriate clinical privilege delineation.

PROCEDURE AND RESPONSIBILITIES:

OVERVIEW

The primary goals of Lowell General Hospital's clinical privileges delineation process are to:

1. Assure maximum objectivity in the granting of clinical privileges. This is accomplished by Medical Staff adherence to previously developed criteria for granting specific privileges.

2. Avoid, where possible, the use of long "laundry" lists of diagnoses which require constant updating and redrafting. These lists are, in many disciplines, difficult to monitor and are not thought to be clinically realistic.

3. Grant privileges commensurate with medical education, residency training, and prior experience.

4. Assure, to the extent possible, that patients are cared for by individuals possessing the highest degree of competency.

The Medical Staff Services Office shall be responsible for assuring that each applicant for appointment to the Medical Staff receives the appropriate privileges delineation request forms.

These forms are to be given to the applicant with the application and shall include:

1. Privileges delineation overview.

2. Instructions for completion.

3. Requested sections (e.g., an internist shall receive internal medicine forms).

4. Special procedures section.

INSTRUCTIONS FOR COMPLETION OF PRIVILEGES REQUEST FORMS

The Lowell General Hospital Medical Staff is divided into departments, sections, and services. Privileges are requested through the chief of the appropriate department, section, or service. The forms which follow may be used to document your request and to provide additional information for use by the Medical Staff.

You shall note that most Medical Staff appointees are automatically granted "general" privileges (e.g., ordering diagnostic and therapeutic services, writing orders, and progress notes, etc.). You shall, however, specify any additional privileges you desire by completing the appropriate forms.

NOTE: This privileges delineation package does not include every possible situation, diagnosis, or surgical procedure. You are expected to practice within the bounds of your training and competence, and shall not attempt to treat those very complicated cases for which there are individuals on this Staff with higher levels of skills and training.

Newly developed or experimental treatment modalities not included herein shall be cleared by the chief or the appropriate department and the Clinical Research Committee prior to their performance.

Please become familiar with the capabilities of Lowell General Hospital and do not attempt definitive treatment of patients in need of specialty care available only in other practice sessions.

Ordinarily, applicants are given privileges request forms corresponding to their specialty or area of interest. If you desire privileges in more than one department and do not find the forms necessary to document your request, please request assistance from the Medical Staff Coordinator.

When questions seek information concerning the number of times you have performed a procedure, you may generalize. The Medical Staff seeks general, not specific, information, unless your overall volume of procedures is low. It is not expected that you shall have performed every procedure listed.

DEVELOPMENT OF CRITERIA FOR NEW CLINICAL PRIVILEGES

This procedure shall be followed for the creation of new or extended privileges to determine the minimum threshold criteria for the granting of such privileges including basic education, minimum formal training and required previous experience.

1. All new privilege requests for privileges that do not already exist or that are extensions of existing privileges shall be sent to the Chief of the requesting department.
2. He shall complete the "Criteria for Privilege Review" form stating the minimum education, training, and experience criteria required for the granting of such privilege along with any other information or need for references.
3. It is the Department Chief's responsibility to evaluate requests for clinical privileges criteria within the department and he may seek input from his department or other appropriate sources.
4. The Chief shall provide a completed form to the Credentials Committee for approval via the medical staff office.
5. The Credentials Committee is responsible for evaluating recommendations made by the Department Chiefs and assuring that privileging standards are uniform.
6. Upon approval by the Credentials Committee, The Medical Executive Committee shall evaluate the criteria making sure that the medical staff by-laws, policies and procedures are followed along with good medical practice and
7. Make recommendations to the Board of Trustees in regard to the criteria for clinical privileges and the establishment of such privilege.

ADDITIONAL OR EXTENSION OF EXISTING PRIVILEGES OR CHANGE OF STATUS

This procedure shall be followed for all requests for additional or extended clinical privileges or any other change of status.

1. All requests for additional or extended clinical privileges or change of status and supporting materials shall be submitted to the Medical Staff Coordinator, who shall:

    a. Verify supporting material, if appropriate;
    b. Compile, with application, current privileges (if any) and administrative review (if any). This section routinely applies to current Medical Staff appointees who are requesting additional or extended clinical privileges;
    c. Send to the chief of the department in which privileges shall be exercised.

2. Department chief shall review request (against departmental criteria for granting clinical privileges) and all supporting material, and may conduct a personal interview with the requester.

3. It shall be the department chief's responsibility to determine if the requested privileges are within the standard scope of practice for

members of the department. The delineation of an individual's clinical privileges includes the limitations, if any, on an individual's privileges to admit and treat patients or direct the course of treatment for the condition for which the patients were admitted. If so, the chief shall formulate a written recommendation and forward to the appropriate committee. (Credentials whenever the Chief has reservations, or Medical Executive whenever the Chief approves of the status change)

4. If the Medical Executive Committee's recommendation is positive, request shall be forwarded to the Board of Trustees.

5. Once the Board of Trustees approves the Medical Executive Committee's recommendation, the applicant shall be notified by the President of his/her new privileges.

6. Once the practitioner's privileges are approved the privileges with any limitations or conditions are posted on the Lowell General Hospital Intranet for viewing by the Operating Room, Admitting, Nurse Managers, and any other area that has a need to know. The appropriate clinical area is responsible to ensure that all practitioners with clinical privileges only provide services within the scope of privileges granted.

7. In accordance with the focused Professional Practice Evaluation Policy a period of review will be initiated.

LOWELL GENERAL HOSPITAL
MEDICAL STAFF PROVISIONAL STAFF STATUS POLICY

TITLE: Delineation of the provisional staff status for the medical staff

PURPOSE: To define the provisional status period of the medical staff.

OBJECTIVES: (1) To assist the responsibility of the Hospital and assuring that the patients afforded care at the Hospital shall have such care rendered by individuals appropriately qualified to do so.

(2) To assure that each member of the Medical Staff receives a uniform provisional period and disposition at the end of such period.

PROCEDURE AND RESPONSIBILITIES:

All initial appointments and grants of initial or increased clinical privileges are provisional for a maximum period of twelve months, unless an extension is granted by the chief of the department and approved by the Credentials Committee, Medical Executive Committee, and the Board of Trustees.

During the first twelve months, all individuals with such provisional status are subject to review by the chief of the respective department(s).

At the end of the provision period, Medical Staff Services notifies the appointee by letter. The appointee shall be given the option of requesting conclusion of the provisional period and advancement from the Associate Staff to another staff category or extension of the period. Failure to act to conclude or extend the provisional period shall be deemed to be voluntary relinquishment of Staff membership and the clinical privileges provisionally granted. A report of clinical activities shall be prepared for the department chief. He shall then evaluate the appointee's clinical competence and shall render a written report of such to the Medical Executive Committee. The report may:

1. Recommend awarding full Staff status and advancement to another Staff category.

2. Recommend termination of appointment.

3. Recommend continuation of provisional status.

NOTE: A reduction or limitation of clinical privileges taken during the provisional period shall not constitute a "disciplinary action" for the purposes of fulfilling the reporting requirements of the Hospital to the Massachusetts Board of Registration.

LOWELL GENERAL HOSPITAL

MEDICAL STAFF COMMITTEES

TITLE: Committees of the Medical Staff

PURPOSE: To define the committees of the medical staff.

OBJECTIVES: (1) To define the various committees of the medical staff, their scope, membership and other appropriate details.

(2) To assure that each Committee of the Medical Staff receives a uniform understanding of its role in fulfilling the responsibility of the Medical Staff in assuring that the patients afforded care at the Hospital shall have such care rendered by individuals appropriately qualified to do so.

PROCEDURE AND RESPONSIBILITIES:

Except as otherwise provided in the Medical Staff Bylaws, the President of the Medical Staff shall appoint all committee members.

I. Special Committees

Special committees shall be appointed from time to time as may be required to properly carry out the duties of the Medical Staff. Special committees shall be appointed by the Active Staff upon recommendation from the Medical Executive Committee or upon motion of the Active Staff. Such committees shall confine their work to the purpose for which they were appointed and shall report to the Active Staff. They shall not have power of action, unless such is specifically granted by the motion which created the committee.

II. Standing Committees

The standing committees of the Medical Staff shall be as follows:

A. Ambulatory Care Committee

B. Bylaws Committee

C. Cancer Committee

D. Credentials Committee

E. Critical Care Committee

F. Emergency Department/Trauma Committee

G. Infection Control Committee

H. Labor and Delivery Committee

I. Medical Education and Library Committee

J. Nominating Committee

K. Operating Room Committee

L. Peer Review Committee

M. Mortality & Morbidity Review Council

N. Performance Improvement Council

P. Perinatal Committee

O. Pharmacy and Therapeutics Committee

P. Physician Health Committee

Q. Radiation Safety Committee

R. Regulatory Review Committee

S. Transfusion Committee

T. Utilization Review Committee

Standing committees be established and/or dissolved by the Medical Staff Executive Committee with the approval of the Board of Trustees.

A. AMBULATORY CARE COMMITTEE

i. Composition

The Ambulatory Care Committee consists of physician members representing but not limited to Anesthesia Department, Medicine, Surgery, Radiology, Cardiology, and Endoscopy. Members also shall consist of the Vice President of Operations/Chief Nursing Officer or designee, a PI Coordinator, Nurse Manager of Ambulatory Care Unit/Endoscopy/Pre-Admission Screening, and Coordinator of Cardiac- Catheterization Laboratory.

ii. Duties

To evaluate the direct services provided to patients as well as results of the intervention. All patients treated in Ambulatory Care settings are subject to review.

To develop and approve policies and types of procedures that are appropriate in an Ambulatory Care setting.

To identify and address potential issues during the Pre-Admission Screening process to promote a smooth transition from admission to discharge.

To establish the monitoring thresholds and to adjust them periodically based on our experiences as well as information available in the current literature and based on established standards of care.

To collect data by the ACU Manager and/or other designees and shall be organized in such a way that the monitoring results shall identify issues/variant cases that may be subjected to more intensive review should the thresholds of care be exceeded.

To review cases that trip the thresholds by the chairman of the Ambulatory Care Committee and discuss with the department chief for a more intensive review and action utilizing a peer review methodology.

To recommend whatever action is deemed appropriate to resolve issues. The action may result in the justification of the variation, direct discussion with the involved party, or updating and changing a policy and procedure.

To monitor recommended corrective action by the peer reviewer. The action taken to be monitored, utilizing the established monitoring methodology, until satisfactory resolution has occurred. All cases requiring corrective action shall be reviewed by the Ambulatory Care Committee during its regular meetings for appropriateness of intervention.

The results of the review process are available to the Performance Improvement Council via the participation of the Vice President of Operations/Chief Nursing Officer or designee and physician representation. The information and actions taken as part of this program are subject to review and intervention by the Medical Executive Committee of the Medical staff and shall be considered as confidential as outlined by the Massachusetts Board of Registration in Medicine. No individual shall solely review or resolve any record or be otherwise involved in any peer review action in which he/she has any financial or other involvement.

iii. Meetings

The Committee shall meet quarterly.

B. Bylaws Committee

i. Composition

The Bylaws Committee shall consist of not less than five members, one of whom shall be the past President of the Medical Staff, who shall act as the Chairman.

ii. Duties

The Bylaws Committee shall amend or revise the Bylaws as the occasion requires, when requested to do so by the Medical Staff. All recommended revisions or amendments shall be submitted to the Medical Staff for its action

under the provisions of Article XX of the Bylaws.

Whenever a question of interpretation of these Bylaws, Rules and Regulations, or procedural rules is raised in the deliberations of the Medical Staff or its committees, the question shall be referred to this Committee for interpretation.

The Committee members shall carefully consider the question and prepare an opinion or recommendation which shall be forwarded to the Medical Executive Committee, which shall forward the report to the Active Staff for final action. Upon forwarding the report of the Bylaws and Accreditation Committee to the Active Staff, the Committee shall append its own opinion and recommendation.

iii. Meetings

The Committee shall meet as often as the nature of its work demands, but not less than semi-annually.

C. Cancer Committee

i. Purpose

The purpose of the Cancer Committee is to collaborate with Executive leadership to provide oversight of existing cancer care programs and services, to develop and implement new programs within the framework of the strategic plans, goals and objectives at Lowell General Hospital.

ii. Accountability

This committee serves as a standing committee of the Medical Executive Committee and as such reports. Attendance and minutes of the meetings shall be documented and forwarded to the Medical Staff Executive Committee.

iii. Composition

The Cancer Committee is chaired by the Medical Director of the Cancer Center, or designee. The Associate Chair shall be re-appointed annually and shall be a physician selected on a rotating basis from medical oncology, radiation oncology or the department of surgery. The committee shall include at least (1) physician member from the required specialties: diagnostic radiology, pathology, general surgery, medical oncology and radiation oncology and shall include a guest chair for affiliates. The cancer committee includes at least one physician member representing the five major cancer sites (breast, prostate, lung, colon/rectum and bladder). The cancer committee shall consist of at least one non-physician member from: Cancer program administration, oncology nursing, social services, cancer registry, and quality improvement. Additional physician and non-physician members may include: Hospice, palliative care, clinical research, nutrition, pharmacy, pastoral care, mental health, American Cancer Society.

iv. Meeting Statement

The Cancer Committee shall meet at least quarterly. More frequent meetings may be required to meet the overall program needs.

v. Responsibilities

The Responsibilities of the Cancer Committee shall be to:

1. Promote a coordinated interdisciplinary approach to patient care management at all levels.
2. Approve key components of patient care delivery, disease/treatment management, practice guidelines and clinical pathways as they relate to oncology patients.

3. Be responsible and accountable for all cancer program activities at Lowell General Hospital.
4. Designate one coordinator for each of the four areas of cancer committee activity; cancer conference, quality control of cancer registry data, quality improvement, and community outreach.
5. Initiate cancer patient care audits and review similar data supplied by other hospital committees.
6. Develops annual goals and objectives for clinical, community outreach, quality improvement, and programmatic endeavors related to cancer care.
7. Evaluate annual goals and objectives for clinical, community outreach, quality improvement, and programmatic endeavors on an annual basis. The Administrative Director or designee reports to Performance Improvement Council quarterly review results.
8. Evaluate resource utilization in the delivery of effective, efficient care within budgetary guidelines and make recommendations for change as necessary.
9. Establish the cancer conference frequency, format, and multidisciplinary attendance requirements for cancer conferences on an annual basis.
10. Ensure that the required numbers of cases are discussed at cancer conference and that at least 75 percent of the cases discussed at cancer conferences are presented prospectively.
11. Monitor and evaluate the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation on an annual basis.
12. Ensure that consultative services in all appropriate disciplines are available and that all major cancer sites are represented in education and tumor conference review activities.
13. Establish and implements a plan to evaluate the quality of cancer registry data and activity on an annual basis.
14. Complete site-specific analysis that includes comparison and outcome data and disseminates the results of the analysis to the medical staff.
15. Review 10 percent of the analytic caseload to ensure that AJCC staging is assigned and recorded in the medical record on at least 90 percent of eligible analytic cases.
16. Review 10 percent of the analytic caseload to ensure that 90 percent of cancer pathology reports include the scientifically validated data elements outlined in the CAP protocols.
17. Provide a formal mechanism to educate patients about cancer-related clinical trials.
18. Review the percentage of cases accrued to cancer-related clinical trials each year in conjunction with sponsoring agencies and or Clinical Trial Affiliates.
19. Monitor community outreach activities on an annual basis.
20. Offer one cancer-related educational activity each year.
21. Complete and document the required studies that measure quality and outcomes both clinical and programmatic and initiate improvements based on results and service goals.
22. Implement two improvements that directly affect patient care.
23. Establish subcommittees or workgroups as needed to fulfill cancer program goals.
24. Obtain and maintain approval for the Cancer Program by relevant private and public agencies.
25. Ensure compliance with JCAHO and other national, state and local regulatory agencies and organizations.
26. Monitor technological advances in oncology and recommend use at Lowell General Hospital when appropriate.
27. Provide an annual report for the Medical Staff and Lowell General Hospital Executive committees.

vi. **Breast Program Leadership**

1. **Purpose:**
   To define the organization structure and level of responsibility and accountability of the Breast Program Leadership for provided breast center services.

2. **Accountability:**
   The committee shall be designated as a subcommittee of the Cancer Committee.

3. **Composition:**
   The Breast Program Leadership shall consist of the following representatives: The Chief of Nursing Officer, the surgical breast physician champion, a representative from Medical Oncology, Director of Imaging Services, Director of Cancer Center, Representative from Surgical Services, Chief of the Department of Pathology, and representative from Radiation Oncology. A quality Improvement representative shall be present as well as physician members from primary care and Breast Imaging Services.

4. **Meeting Statement**:
   The Breast Program Leadership under the direction of the Cancer Committee, shall meet at least quarterly. More frequent meetings may be required to meet the overall program needs.

5. **Responsibilities**
   The responsibilities of the Breast Program Leadership shall be to perform annual audits on the following program requirements National Accreditation Program for Breast Centers (NAPBC):

   - Interdisciplinary Breast Cancer Conference Activity (Standard 1.2)
   - Breast Conservation Rate (Standard 2.3)
   - Sentinel Lymph Node Biopsy Rate (Standard 2.4)
   - Breast Cancer Staging (Standard 2.6)
   - Needle Biopsy Rate (Standard 2.9)
   - Radiation Oncology Quality Assurance (Standard 2.12)
   - Support and Rehabilitation (Standard 2.15)
   - Reconstructive Surgery Referral Rate (Standard 2.18)
   - Breast Cancer Survivorship Care (Standard 2.20)
   - Clinical Trial Accrual (Standard 3.2)
   - Quality and Outcomes (Standard 6.1)
   - Quality Improvement (Standard 6.2)
   -

D. Credentials Committee

i. Composition

The Credentials Committee shall consist of five members of the Active Staff selected on a basis that shall insure representation of the major clinical specialties.

ii. Duties

a. To review the Credentials of all applicants and to make recommendations for membership and delineation of clinical privileges in compliance with the provisions of the Bylaws.

b. To make a report to the Medical Executive Committee on each applicant for Medical Staff membership or clinical privileges, including specific consideration of the recommendations from the departments in which such applicant requests privileges.

c. To periodically review all information available regarding the competence of Medical Staff members and, as a result of such reviews, make recommendations for granting of privileges, reappointments, and the assignment of practitioners to the various departments in compliance with the provisions of the Bylaws.

d. To investigate any breach of ethics that is reported to it.

e. To review reports that are referred by the Committee, Medical Records, and Continuous Performance Improvement Council and the President of the Medical Staff.

iii. Meetings

The Committee shall meet at least quarterly.

E. Critical Care Committee

i. Composition

The Critical Care Committee is chaired by the Medical Director of the ICU/CCU and membership shall include six to eight members of the medical staff from varied disciplines to include Medicine, Surgery, Anesthesiology, and Emergency Medicine. The Committee shall also include nursing representation as Nurse Manager from ICU/CCU/IMC, ED, the MS/CC Director of Nursing, Nursing Education and Respiratory Therapy. It shall also include a representative from Administration as needed.

ii. Duties

The Critical Care Committee shall direct the activities of the critical care areas Including generating and reviewing medical policies and procedures, performance of medical quality assurance and ensuring quality, safety and appropriateness of patient care.

iii. Meetings

The Critical Care Committee meets as often as required, but not less than quarterly.

F. Emergency Department/Trauma Committee

i. Composition

a. Chief of Trauma, who shall be Chairperson.

b. Trauma surgeons.

c. Physician representation from the Anesthesia, Radiology, and Emergency Departments.

d. Administration representation from the Vice President of Nursing/Chief Nursing Officer or designee.

e. Nurse Manager of the Emergency Department.

f. Nurse Manager of the Operating Room.

g. Supervisor of the Blood Bank.

ii. Duties

a. Monitor statistical data to assess the interdisciplinary team function.

b. Develop solutions for patient care issues.

c. Monitor quality assurance activities within the trauma system.

iii. Meetings

The Committee shall meet at least quarterly.

G. Infection Control Committee

i. Composition

The Infection Control Committee shall include representation from the Medical Staff, Administration, and Nursing Department. Only the following shall be voting members of this Committee: One representative from the Medical Staff Departments of Surgery, Medicine, Obstetrics and Gynecology, Pediatrics, and Pathology; the Infection Control Nurse; and one representative from Administration.

Representatives from Environmental Services, Dietary, Pharmacy, Central Supply, Operating Room, and other appropriate departments, as requested, shall work with the Committee on a consultative basis, without vote.

The Chairman of the Committee shall be a physician whose credentials document knowledge of special interest or experience in infection control. The role of the physicians on the Committee shall be to provide direction and strengthen the clinical aspects of the program. Policies and clinical decisions shall be recommended by this Committee to the Medical Executive Committee for approval.

ii. Duties

a. Maintaining surveillance over the Hospital's Infection Control programs.

b. Developing a system for reporting, identifying, and analyzing the incidence and cause of all infections.

c. Developing and implementing a preventative and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic isolation and sanitation techniques.

d. Developing, evaluating, and revising preventative, surveillance, and control policies and procedures relating to all phases of the Hospital's activities, including Operating Rooms, Delivery Rooms, special care units, Central Service, Housekeeping and Laundry; sterilization and disinfection procedures by heat, chemicals, or otherwise; isolation procedures; prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment; testing of Hospital personnel for carrier status; disposal of infectious material; food sanitation and waste management; and other situations as required.

e. Coordinating action on findings from the Medical Staff's review of the clinical use of antibiotics.

f. Acting upon recommendations related to infection control received from the President of the Staff, the Medical Director (if appointed), the Medical Executive Committee of the Medical Staff, the departments, and other Staff and Hospital committees.

g. Maintaining a record of all activities relating to infection control and submitting periodic reports thereon to the Medical Executive Committee of the Medical Staff and to the President.

iii. Meetings

The Committee shall meet quarterly.

H. Labor and Delivery Committee

i. Composition

a. Four physician representatives from the Department of OB/GYN.

b. Four nurse representatives from Nursing Administration, Labor and Delivery, and Prenatal Nursing.

c. The Chief of the Department of OB/GYN and/or a representative of Hospital Administration may be included when requested by this Committee.

d. The Chairman of the Committee is selected by the Chief of the Department of OB/GYN.

e. The term of office for the Chairman and Committee Members shall

be one year or until otherwise notified.

ii. Duties

To establish appropriate physician and nursing protocols relative to the Department of OB/GYN. Included within the protocols shall be current methods of medical management and risk analysis based upon current literature review. The Department of OB/GYN or its Chief may refer specific concerns for review and opinion to this Committee.

All recommendations of this Committee shall be reviewed and voted upon by the Department of OB/GYN and Nursing Staff prior to their being included in departmental policy.

iii. Meetings

The Committee shall meet at least quarterly.

I. Medical Education Committee

i. Composition

The Medical Education and Library Committee shall consist of at least five members of the Active Staff, selected on a basis that shall insure representation of the major clinical specialties, together with the Librarian and the President of the Hospital, who shall be a member ex-officio. The Committee is chaired by the Director of Medical Education who is appointed by the President of the Medical Staff.

ii. Duties

a. To assist the various departments with educational materials and see that the Library contains current and adequate periodicals and literature.

b. To assure accreditation of the CME Program by the state accrediting body and to assure continuing compliance with the accreditation criteria.

c. To improve the quality of education and other services provided by the program.

d. To enrich the program through introduction of outside talent or by planning special educational events.

e. To support the Hospital's outreach on marketing efforts by arranging CME Programs for physicians in non accredited hospitals.

f. To undertake special educational projects at the request of the Hospital administration.

g. To coordinate library, audiovisual, and computer services

in support of continuing medical education and other Hospital educational services.

iii. Meetings

The Committee shall meet at least quarterly.

J. Nominating Committee

i. Composition

The Nominating Committee shall consist of the President, the President-elect, the Secretary/Treasurer, and three members-at-large elected after nomination from the floor of a regularly scheduled Medical Staff meeting, at least two months in advance of that meeting of the Medical Staff at which officers are to be elected.

ii. Duties

The Nominating Committee convenes at least two months prior to the Annual Meeting at which an election for officers is to occur for the purpose of the nominating one or more qualified candidates for each of the offices of President Elect, Secretary/Treasurer, and/or members-at-large of the Medical Executive Committee.

The Nominating Committee shall submit its report to the Medical Executive Committee.

K. Operating Room Committee

i. Composition

The Committee shall consist of representatives of the Departments of Surgery, Anesthesia, Obstetrics, Orthopedics, Neurosurgery, Dentistry, Ophthalmology, Plastic Surgery, Urology, ENT, and Podiatry, who shall be members of the Active Staff. They shall serve for a term of two years on the Committee and shall be eligible for re-election. The Chief of Surgery shall be the Chairman of this Committee. The Nurse Managers and Nursing Director of Surgical Services shall be represented on the Committee. Administration shall have a representative on the Committee (e.g., Vice President of Operations/Chief Nursing Officer, Executive Vice President).

ii. Duties

a. To monitor the statistical data obtained relating to the interdisciplinary team function that affects the Operating Room schedule.

b. To discuss scheduling and operational issues that affect the Operating Room schedule.

c. To discuss surgical issues that affect both surgeons and nursing with recommendations as to which solutions to pursue.

d. To review, as a group, supplies, equipment, and/or instrumentation that shall be evaluated.

e. To discuss instrumentation or equipment that may need to be repaired, replaced, or purchased that would affect the surgical process and submit recommendations to the VAC (Value Analysis Committee).

f. To seek, from Administration, clarification on hospital, nursing, or regulatory agency issues that arise.

g. To monitor Quality Assurance/Risk Management issues that affect patient care, and to develop and implement solutions.

iii. Meetings

The Committee shall meet bimonthly on the second Tuesday of the month at 12 noon in the Operating Room Conference Room.

L. Peer Review Committee

Ad Hoc Committee to review Sentinel Events involving patient safety and ensure appropriate follow up.

i. Composition

The membership of the Peer Review Committee shall be chaired by the Past President of the Medical Staff, Chief of the Department being reviewed, Chairman of the Performance Improvement Council and the Vice President, Operations/CNO.

ii. Quorum

Two members of the medical staff shall be present to constitute a quorum.

iii. Duties

The Peer Review Committee responds i*mmediately* to patient safety issues and reviews regulatory reporting requirements.

Patient Safety Issues are also reviewed through the current peer review process. The process is as such: that the PI liaison reviews the issue with the Chief of the appropriate department, who in turn discusses the case with the physician and/or department involved.

The Committee shall identify all mandated reportable events.

If the issue is deemed reportable it is the responsibility of the Department Chief to notify the physician involved that the results of his/her action is a

mandated reportable event. The VP, Operations/Chief Nursing Officer is responsible for the report.

iv. Meetings

The Peer Review Committee convenes immediately when patient safety is in question.

M. **Medical Staff Peer Review**

Medical Staff Peer Review forums are meant to identify learning opportunities for the medical staff, identify opportunities for standardization across specialties, improve coordination across specialties and the continuum, prevent adverse occurrences and outcomes, improve patient care, and meet regulatory requirements. Much of the medical staff's peer review activities takes place at the department level or through the multidisciplinary Mortality & Morbidity Council.

i. **Department/Section-Level Peer Review Committees**

a. Composition

Department/section-level peer review committees will be chaired by the Chief of the Department or designee. Chiefs shall appoint department members to serve on the committee ensuring representation from a broad spectrum of practices. Members may serve from one to two years depending on interest and ability to serve. Representatives from other specialty departments will be invited to participate as needed.

b. Quorum

A quorum will be five members of the Committee.

c. Function

The Department/section-level peer review committees examine cases identified for peer review purposes that pertain to their respective specialty. Case reviews include but are not limited to unexpected mortalities, complications, criteria set by the Department, targeted focuses of improvement. Findings are recorded and communicated to the involved providers(s) and department along with recommended corrective action.

d. Meetings

These forums are meant to encourage dialogue, focus on preventability, and identify learning opportunities. It is recommended that the involved provider(s) presents the case with the support of 1-2 providers that have pre-reviewed cases. Meetings will be held 3-12 times per year at the discretion of the Chief.

ii. **MORTALITY AND MORBIDITY COUNCIL**

a. Composition

The Mortality and Morbidity Council shall consist of the President-elect of the Medical Staff, who will chair the Council, and the following members of physician leadership or their designee: Chief of Emergency Medicine, Medical Director of Critical Care, Medical Director of Hospitalist Program, Chief of Geneal Surgery, Chief of Cardiology, Chief of Radiology, Chief of Anesthesiology, Outpatient Practitioner, Medical Director of Specialty Services, President of the Medical Staff, Past-president of the Medical Staff.

Additionally, a member of the Medical Staff will be appointed to serve in an at-large basis. The at-large member may serve from one to two years depending on interest and ability to serve. Representative from other specialty departments will be invited to participate as needed.

b. Quorum

A quorum will be five members of the Council.

c. Function

The Mortality & Morbidity Council examines cases identified for peer review purposes that cross department lines. Findings are recorded and communicated to the involved provider(s) and/or department(s) with recommended corrective action.

d. Meetings

The Council will meet on a monthly basis and will be closed to maintain confidentiality.

N. **Performance Improvement Council**

i. Composition

The membership of the Performance Improvement Council (PIC) shall be co-chaired by Chief Operating Officer and the President Elect of the Medical Staff. Membership shall consist of three physicians of the Medical Staff, the Medical Director, the Vice President / Treasurer, the Vice President Marketing or designee, the Vice President Development, the Vice President Operations / Chief Nursing Officer, the Vice President Operations, the Medical Director of the PHO, the Director of Regulatory Compliance and the Manager of Performance Improvement.

ii. Duties

The PI Council 's role is to coordinate, facilitate, expand and sustain the performance improvement initiatives based on direction provided by the strategic plan of Lowell General Hospital, issues identified through data

collection for performance monitoring efforts and benchmarking. The Council determines the scope and focus of performance monitoring and data collection activities and recommends an integrated, interdisciplinary approach wherever appropriate. Its responsibilities are identified in detail in the Lowell General Hospital Performance Improvement Plan.

iii. Meetings

The Performance Improvement Council meets at least ten times a year.

O. **Perinatal Committee**

i. Composition

a. Level II Nursery Director, who shall be Chairman.

b. Family Medicine practitioners with neonatal and/or obstetrical privileges.

c. All pediatricians are invited to participate.

d. All obstetricians are invited to participate.

e. Vice-President of Operations/Chief Nursing Officer or designee when needed

f. Director of Maternal Child Health.

g. Clinical educator of Maternal Child Health.

h. Nurse Managers of Labor and Delivery, Maternity, Nursery, and Pediatrics.

ii. Duties

Each maternal and newborn service shall establish a multidisciplinary perinatal committee or its equivalent responsible for developing a coordinated approach to maternal and newborn care including but not limited to the following:

a. Developing a statement of goals and objectives of family-centered care.
b. Long-range program planning.
c. Establishing, approving, reviewing and planning the implementation of policies and procedures.
d. Reviewing and evaluating process and outcome of maternal and newborn care delivered by the service, including appropriateness of multidisciplinary staffing patterns to ensure safe patient care.
e. Reviewing service data and statistics.
f. Providing a mechanism to encourage and obtain community input on the service.
g. Participating in the evaluation of staff education needs.

iii. Meetings

The Committee shall meet quarterly on the second Tuesday of March, June, September and December at 8 a.m. Attendance shall fulfill the requirement for the monthly Pediatric Department meeting.

P. Pharmacy and Therapeutics Committee

i. Composition

The Pharmacy and Therapeutics Committee shall consist of at least three voting representatives of the Medical Staff and nonvoting representatives from the Pharmacy, the Nursing Department, and Hospital Administration. The Hospital's Director of Pharmacy Services shall be a member of and act as secretary for this Committee.

ii. Duties

This Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital. It shall also perform the following specific functions:

a. Serve as an advisory group to the Hospital's Medical Staff and Pharmacy Department on matters pertinent to the choice of available drugs.

b. Make recommendations concerning drugs to be stocked on the Nursing Unit floors and by other services.

c. Develop and periodically review the drug formulary for use in the Hospital.

d. Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

e. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

f. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

g. Define and review all significant untoward drug reactions.

h. Develop criteria and review ongoing monitoring activities dealing with antibiotic usage and drug utilization.

i. Written reports of conclusions, recommendations, actions taken, and results of actions taken shall be maintained.

iii. Meetings

The Committee shall meet at least quarterly.

Q. Physician Health Committee

i. Composition

This Committee shall consist of six (6) physician members of the Active Medical Staff appointed by the President of the Medical Staff to include the Past President, Chief of Psychiatry and Medical Director.

ii. Duties

a. The Committee educates the Medical Staff and other organization staff about illness and impairment including recognition of issues specific to physicians by scheduling "Grand Rounds" on relevant topics.

b. Ensures the safe practice of medicine by providing necessary assistance and support to impaired physicians. Physicians shall be self-referred or referred by other organizational staff.

c. The Committee shall maintain the confidentiality of the physicians seeking referral or referred for assistance, except as limited by law, ethical obligation or when the safety of a patient is threatened.

a. The Committee shall evaluate the credibility of a complaint, allegation or concern.

b. The Committee shall monitor the affected physician and the safety of patients until the rehabilitation or any disciplinary process is complete.

c. The Committee shall report to the Medical Staff leadership in which a physician is providing unsafe treatment.

iii. Meetings

The Committee shall meet on an as needed basis.

III. Notice

Written or oral notice stating the place, day, and hour of any special meeting or of any regular meeting, not held pursuant to resolution, shall be given to each member of the committee not less than seven days before the time of such meeting, by the person(s) calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States Mail, addressed to each member at his address as it appears on the records of the Hospital, with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

IV. Quorum

The presence of 10% of the Active Medical Staff members in good standing of a committee, but not less than two members, shall constitute a quorum at any committee meeting.

V. Manner of Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of the committee. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to vote thereat.

VI. Rights of Ex-Officio Members

Persons serving under the Bylaws or the Policies and Procedures of the Medical Staff as ex-officio members of a committee, other than the Medical Executive Committee, shall have all rights and privileges of regular members, except they shall not be counted in determining the existence of a quorum.

VII. Agenda

The chairman of each committee is responsible for preparing the agenda. This duty may be delegated to another member of the committee. When possible, the agenda shall be provided to the committee members with the meeting notice.

VIII. Minutes

Minutes of each committee meeting shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding chairman and copies thereof, shall be promptly submitted to the Medical Executive Committee. Each committee shall maintain a permanent file of the minutes of each meeting. Access to the minutes of committee meetings shall be in accordance with the Hospital Rule regarding the protection of the confidentiality of Medical Staff records.

R. Radiation Safety Committee

i. Composition

a. Radiologist, as Chairman.

b. Radiology Department Manager.

c. Radiotherapist.

d. Radiation Physicist.

e. Operating Room Supervisor.

ii. Duties (mandated by the Nuclear Regulatory Commission [NRC])

a. Oversee use of radioactive pharmaceuticals.

b. Review personnel radiation dosimetry and other technical aspects of the use of radiopharmaceuticals.

c. Oversee devices which produce ionizing radiation (x-ray equipment).

d. Oversee the safe application and utilization of ionizing

radiation equipment, with NRC guidelines.

iii. Meetings

The Committee shall meet at least on a quarterly basis.

S. Regulatory Review Committee

Oversight Committee to ensure quality, safe medical practice.

i. Composition

The membership of the Regulatory Review Committee shall be chaired by the Past President of the Medical Staff, Chairman of the Performance Improvement Council, Medical Director, Vice President, Operations/Chief Nursing Officer/or designee and VP/COO/or designee

ii. Quorum

Three members present constitute a quorum.

iii. Duties

The Committee shall identify all deficiencies, practice issues and discuss regulatory reporting requirements. The Chairman of the Regulatory Review Committee shall notify the appropriate department Chief who shall then be responsible to communicate to the individual physician that he/she is the subject to a mandated report.

iv. Meetings

The Regulatory Review Committee shall meet at least quarterly.

T. Transfusion Committee

i. Composition

a. Representatives of major clinical departments.

b. Director of the Blood Bank.

c. Nursing.

d. Supervisor of the Blood Bank.

e. Director of Continuity of Care.

f. Administration.

ii. Duties

a. The Committee reviews all aspects of the transfusion of blood, blood components, and blood derivatives.

b. Standards of transfusion practice are developed by the Committee, as are audit criteria for screening of medical charts.

c. In addition, the Committee reviews the performance of the transfusion service and the Blood Bank, and the performance of the blood supplier (Red Cross).

d. The Committee stays abreast of developments in technical and legal aspects of transfusion therapy.

iii. Meetings

The Committee shall meet in January, May and September.

U. TRAUMA PERFORMANCE IMPROVEMENT AND PATIENT SAFETY COMMITTEE

i. Composition

The committee membership will consist of the Trauma Medical Director who shall be the Chair, Representatives from the Department of Surgery, Anesthesia, Orthopedics, Emergency Medicine, Radiology as well as the VP of Operations and CNO, Nursing Director of the Emergency Department and the Trauma Program Manager.

ii. Purpose

Purpose of this committee is to monitor and improve care of the injured patients that seek treatment at Lowell General Hospital. The committee members review the trauma program management and care of the Trauma Patient across the continuum. Patients are identified and referred to the Trauma Performance Improvement and Patient Safety Committee based on quality of care indicators established by the Lowell General Hospital Trauma Committee and indicators required by the American College of Surgeons Committee on Trauma.

The State of Massachusetts designation process for operating as a Trauma Center requires compliance with the American College of Surgeons Committee on Trauma verification guidelines and a certificate of verification in order to participate in the State Trauma Point of Entry.

iii. Meetings

The Committee will meet quarterly.

V. TRAUMA OPERATIONAL PERFORMANCE PROCESS SYSTEMS COMMITTEE

i. Composition

The multidisciplinary committee will consist of members of the medical staff and representatives of the hospital's and program related support services. The Trauma Medical Director will be the Chair.

ii. **Purpose**

Purpose of this committee is to address, assess and correct global trauma program and system issues or concerns. It includes all program-related services that are supportive in the care and management of the trauma patient. Its work is to correct overall program deficiencies in order to optimize patient care and quality.

iii. **Meetings**

The Committee will meet quarterly.

W. UTILIZATION REVIEW COMMITTEE

i. Composition

The Utilization Review Committee must consist of two or more practitioners. At least two of the members of the committee must be doctors of medicine or osteopathy. Members also shall consist of the Lowell General Hospital Physician Advisor, Vice President of Medical Affairs, Director of Quality/Case Management and the Case Management Leader.

The committee reviews cannot be conducted by any individual who has a direct financial interest in the hospital or was professionally involved in the care of the patient whose case is to be reviewed.

ii. Duties

a. To ensure high quality, patient focused care and effective utilization of our services and facilities.

b. To review all patients on preadmission, admission and on a concurrent basis for Severity of Illness and Intensity of Services.

c. To monitor professional services delivered to our patients following the Performance Improvement Plan.

d. To issue Medicare and Medicaid Notices of Non Coverage for patients who do not meet inpatient criteria.

c. Monitor all Notices of Non Coverage for Medicare and Medicaid patients.

d. To Monitor all patients Length of Stay.

e. To monitor discharge planning provided to our patients for timeliness, appropriateness and patient satisfaction.

f. To monitor all transfers into and out of Lowell General Hospital.

g. To monitor delay days in regards to Patient and Family delays, Discharge Placement delays, Department Delays, Physician treatment delays and Physician Utilization Delays.

h. To monitor third party payer denials and appeals.

iii. Meetings

The Utilization Review Committee will meet at least quarterly. Special meetings of this committee may be called when deemed necessary by the Chair. Minutes shall be distributed to the membership prior to scheduled meetings.

The Utilization Review Committee will report to the Performance Improvement Committee quarterly and on a PRN basis.

LOWELL GENERAL HOSPITAL

MEDICAL STAFF MEETINGS

TITLE: Meetings of the Medical Staff

PURPOSE: To define the meeting procedure requirements of the medical staff.

OBJECTIVES: (1) To define the various meeting procedure requirements of the medical staff, quorum, actions, agenda, and minutes

(2) To assure that each meeting of the Medical Staff, its committees and members receives a uniform understanding of its meeting requirements.

PROCEDURE AND RESPONSIBILITIES:

I. Notice

Written or oral notice stating the place, day, and hour of any special meeting or of any regular meeting, not held pursuant to resolution, shall be given to each member of the Active and Honorary Staffs not less than fourteen days before the time of such meeting, by the person(s) calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States Mail, addressed to each member at his address as it appears on the records of the Hospital, with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

II. Quorum

The presence of 10% of the total membership of the Active Staffs at any regular or special meeting of the Medical Staff shall constitute a quorum.

III. Manner of Action

The action of a majority of the voting members present at a meeting at which a quorum is present shall be the action of the Staff. Exceptions to this rule include actions taken in regards to proposed new or amended Medical Staff Bylaws, which require two-thirds majority of the voting members present when proper notice has been served; and 90% majority when proper notice has not been served.

IV. Agenda

The President of the Medical Staff is responsible for preparing the agenda. This duty may be delegated to another member of the Medical Executive Committee. When possible, the agenda shall be provided to the members of the Staff and shall serve as the meeting notice.

At all regular meetings of the Medical Staff, the recommended order of business shall be:

A. Call to order.

B. Acceptance of the minutes of the last regular meeting of the Medical Staff.

C. Report of all Medical Committee meetings since the last regular meeting of the Medical Staff.

D. Communication/Information.

E. Old business.

F. Report of the President of the Hospital and/or the Medical Director.

G. Reports of departments.

H. Reports of committees.

I. Review of quality assurance/ CQI activity.

J. New business.

K. Adjournment.

V. Minutes

Minutes of each Medical Staff meeting shall be prepared by the Secretary and shall include a record of the attendance of the members and the vote taken on each matter. The minutes shall be signed by the Secretary and retained in a permanent file. Access to the minutes of Medical Staff meetings shall be in accordance with the Hospital's policy regarding the protection of the confidentiality of Medical Staff records.

LOWELL GENERAL HOSPITAL

DEPARTMENT/SECTION/SERVICE MEETINGS

TITLE: Department, Section and Service meetings of the Medical Staff

PURPOSE: To define the meeting procedure requirements of the medical staff for Departments, Service, or Section.

OBJECTIVES: (1) To define the various Department, Section, or Service meeting procedure requirements of the medical staff, quorum, actions, agenda, and minutes

(2) To assure that each meeting of the Medical Staff, its Departments, Services, or Sections receive a uniform understanding of meeting requirements.

PROCEDURE AND RESPONSIBILITIES:

I. Notice

Written or oral notice stating the place, day, and hour of any special meeting of any regular meeting, not held pursuant to resolution, shall be given to each member of the department/section/service not less than fourteen days before the time of such meeting, by the person(s) calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States Mail, addressed to each member at his address as it appears on the records of the Hospital, with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

II. Quorum

The presence of 10% of the Active Medical Staff members in good standing of a department/section/service, but not less than two members, shall constitute a quorum at any meeting.

III. Manner of Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of the department/section/service. Action may be taken without a meeting by unanimous consent, in writing, setting forth the action so taken, signed by each member entitled to vote thereat.

IV. Agenda

The chief of each department/section/service is responsible for preparing the agenda. This duty may be delegated to another member of the department/section/service. When possible, the agenda shall be provided to the department/section/service members with the meeting notice. Exhibit 1 is a sample agenda for Medical Staff department/section/service meetings.

V. Minutes

Minutes of each department/section/service meeting shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. Minutes shall also include the conclusions, recommendations, actions taken, and results of actions taken pursuant to quality assurance activities. The minutes shall be signed by the presiding chief and copies thereof shall be promptly submitted to the Medical Executive Committee. Each department/section/service shall maintain a permanent file of the minutes of each meeting. Access to the minutes of department/section/service meetings shall be in accordance with the Hospital's policy regarding the protection of the confidentiality of Medical Staff record.

EXHIBIT 1

SAMPLE AGENDA FOR MEDICAL STAFF
DEPARTMENT/SECTION/SERVICE MEETINGS

I. Call to order.

II. Reading and/or acceptance of the minutes of the last regularly scheduled meeting.

III. Continuous Quality Improvement Business

A. Indicator activity.

B. Monitoring and evaluation activity which may include:

1. Medical records
2. Infection control
3. Blood usage review
4. Pharmacy and therapeutics
5. Utilization review
6. Surgical case review
   a. Reports from Ambulatory Care Committee (invasive procedures).
   b. Reports from Pathology (cases that produce tissue).

c. Individual departmental monitoring of non-tissue cases.

7. Other monitoring activity reports for CQI.
   a. Critical care.
   b. Oncology.
   c. Prenatal services.
   d. Trauma.
   e. Continuing medical education.
   f. Results of patient satisfaction survey.
   g. Cardiac cath.

C. Trend reports.

D. Mortality review.

IV. Old business. (Reports by responsible individuals that action plans from previous meetings were carried out.)

V. New business.

VI. Educational presentation.

VII. Adjournment

LOWELL GENERAL HOSPITAL
HOSPITAL POLICY AND PROCEDURE MANUAL

Title: Disruptive Behavior	**Policy Number: HP-M-A-5** Page 1 of 6
Endorsed by:	**Date Revised:** 1/19
Nurse Practice Council Date: 3/19	**Supersedes:** 4/15
Policy Review Committee Date: 2/19	**Date Discontinued:** N/A
Approved: Date:_	**Initial Effective Date:** 11/24/99

I. PURPOSE:

To define a mechanism by which any Medical Staff or Medical Ancillary Staff member who reportedly engages in disruptive behavior will be dealt with in a consistent manner.

To define a mechanism by which hospital employees, patients or visitors may report disruptive behavior attributable to any Medical Staff or Medical Ancillary Staff for review and follow-up by leadership as appropriate.

The intent of this policy is to ensure that the professional conduct of our Medical Staff and Medical Ancillary Staff is in compliance with the Medical Staff Bylaws and Rules and Regulations. Lowell General Hospital maintains "zero tolerance" for instances of disruptive behavior that may adversely affect the health, safety and welfare of patients, visitors and hospital staff.

II. SCOPE: All Hospital Personnel

III. POLICY:

All members of the hospital community are expected to adhere to acceptable principles in matters of personal conduct. A high degree of personal courtesy and integrity must be exhibited in all dealings with each other as well as with patients, vendors and others with whom we come in contact. This involves a sincere respect for the rights, beliefs and feelings of others regardless of their position and requires the use of commonly accepted standards of courtesy.

Examples of courteous behavior include but are not limited to:

1.) A demonstration of respect for individuals through the use of appropriate language and tone of voice and the avoidance of using obscene, abusive, demeaning or threatening language or gestures.
2.) Respect for the personal and professional privacy of individuals by utilizing appropriate locations for interactions.
3.) Demonstration of a positive, cooperative attitude toward each other.

Examples of disruptive behavior include but are not limited to:

1.) Disregard for bylaws, rules and regulations, or policies or procedures applicable to all members of the Medical Staff and Medical Ancillary Staff.
2.) Direct or tacit refusal to comply with the reasonable instructions or performance of a duty or assignment of a superior, including the Chief Medical Officer, Department Chair/Chief or duly authorized officer of the Medical Staff or Hospital.
3.) Failure to work in a harmonious or cooperative manner with other members of the Medical Staff and/or any other member of the Hospital's professional or administrative staff.
4.) Threatening, intimidating or coercing any member of the Medical Staff, any Hospital employee, any Hospital patient, or any Hospital visitor, including verbal or physical threat, intimidation or coercion, or any related disorderly conduct.
5.) Use of abusive language and unnecessary shouting in a patient care setting, in public or in a general work area.
6.) Throwing objects at or in the direction of another person.
7.) Any act, conduct, or omission which is detrimental to patient care (whether to a specific patient or to patients generally), or which interferes with the orderly operation of the Hospital.
8.) Non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply incompetence.
9.) An intimidating or abusive management style which might include, but not limited to, racial, gender or sexual discrimination or harassment.

IV. PROCEDURE:

1.) Submission of a Complaint:

a.) Any medical staff member, employee, or agent of the hospital, patient or visitor may file a complaint against a Medical Staff and/or Medical Ancillary Staff regarding perceived disruptive conduct.

b.) Patients or visitors who wish to file a complaint against a Medical Staff and/or Medical Ancillary Staff for perceived disruptive behavior may be directed to the Patient Relations department at (978) 937-6458. The complaint will be processed pursuant to the hospital's Resolution of Complaints policy.

c.) Hospital employees or other Medical Staff members may report disruptive behavior by accessing the hospital's electronic safety reporting system and completing a Professional Conduct report. Alternatively, disruptive behavior may be reported via utilization of the *Healthcare Practitioner Reporting Form.* Both the electronic safety reporting system and the Healthcare Practitioner Reporting form are accessible thru the WIRE.

d.) The report must include documentation of the perceived disruptive conduct and will include:

- The date and time of the behavior in question
- The circumstances which precipitated the situation

- Whether the behavior involved a patient and if so the patient's name and medical record number
- A description of the behavior limited to factual, objective and observed acts as much as possible
- The consequences, if any, of the disruptive behavior as it relates to patient care, employee safety, and/or hospital operations.
- Corroboration by another individual is desirable, if possible

e.) Any record of any immediate action taken to remedy the situation including date, time, place, action, and names(s) of those intervening.

2.) **Procedure upon completion of a Complaint:**

a.) Upon receipt of an electronic filing of a Professional Conduct safety report, the report will be processed by Risk Management and forwarded to the Chief Medical Officer (or designee) and the designated Chief of Service.

b.) If completed on a Healthcare Practitioner Reporting form, the form should be forwarded directly to the Executive Vice President of Operations with a copy to the appropriate Vice President.

c.) The Chief Medical Officer (or designee) and the Chief of Service are responsible for investigating the described event as expeditiously as possible and informing the Chief Operating Officer and/or Vice President of Operations depending on the nature and seriousness of the complaint.

d.) The Chief is responsible for informing the involved Medical Staff or Medical Ancillary Staff member of the Complaint and obtaining his/her perspective. The Chief will also advise that the involved provider she may not approach the individual that completed the report.

e.) In the event a complaint is filed against a Chief of a Department, the complaint will be addressed by the President of the Medical Staff.

f.) In the event that further action is required, the Chief Operating Office or Chief Medical Officer will call a fact-finding meeting that will consist of: the Chief Operating Officer, the Chief Medical Officer, the President of Medical Staff and the Department Chief (as stated above.)

g.) The results of the meeting will be presented to the Medical Executive Committee if the fact finding committee so recommends. The process, deliberations of meetings and any reports created as a by-product of the proceedings will be in accordance with the Medical Staff Bylaws and confidentiality is assured pursuant to M.G.L.CIII, Section 205.

h.) The findings of all fact-finding committee results will be filed in the peer review file for the person under review.

V. CORRECTIVE ACTION

A. Pursuant to the Medical Staff Bylaws, corrective action may include but is not limited to: warning letters, admonitions, reprimands, probation, requirement for consultation, or reduction, suspension, or revocation of privileges, or a formal complaint to the Board of Registration in Medicine.

B. All completed reports with follow-up will be reviewed by the Patient Care Assessment Coordinator and forwarded to the Director of Quality and Risk for tracking and trending, including placement in the Medical Staff or Medical Ancillary Staff members' peer review file.

VI. NON-RETALIATION:

Lowell General Hospital is committed to maintaining a fair and just environment. Staff members, patients or visitors who appropriately report instances of perceived disruptive behavior attributable to Medical Staff or Medical Ancillary staff shall not be subject to retaliation for reporting.

VII. APPENDICES: LGH Healthcare Practitioner Reporting Form

VIII. POLICY TRACKING RECORD:

Reviewed/Revised: 3/00; 3/03; 10/04; 10/08; 4/12; 5/15; 1/19

THIS REPORT IS CONFIDENTIAL AND USED FOR PEER REVIEW PURPOSES ONLY

LOWELL GENERAL HOSPITAL
HEALTHCARE PRACTITIONER REPORTING FORM

This form is to be utilized whenever a Medical Staff and/or Medical Ancillary Staff performs in a manner that is inconsistent with the expected standards of practice. A Medical Staff and/or Medical Ancillary Staff may be any individual involved in the care of patients.

PATIENT:_____ MR#:_____

ATTENDING MD:_____ DATE OF REPORT:_____

NAME OF PERSONNEL (if applicable):_____

PRACTITIONER IN QUESTION:_____

DATE/TIME OF INCIDENT:_____ LOCATION:_____

Part I: Must be completed by employee/immediate Supervisor within 24 hours of incident and forwarded to Exec. VP of Operations with copy to appropriate VP.

PART I. NATURE OF COMPLAINT:
Check off all that apply:

☐	PROFESSIONAL MISCONDUCT	☐	UNLAWFUL DISCRIMINATION
☐	SEXUAL MISCONDUCT	☐	IMPAIRED BY DRUGS/ALCOHOL
☐	RUDE/DISCOURTEOUS BEHAVIOR	☐	FAILURE TO SUPERVISE STAFF

☐
OTHER:_____

Describe your complaint here. Include, if appropriate, circumstances that precipitated the situation, description of behavior (limit to factual, objective data as much as possible), consequences, if any, disruptive behavior to patient care or hospital operations, record any action taken to remedy the situ names of persons, if any intervening. (please use additional paper if needed)

_____

_____

_____

_____

_____

_____

SIGNATURE OF REPORTER

Side 2

LOWELL GENERAL HOSPITAL
HEALTHCARE PRACTITIONER REPORTING FORM

Part II: To be completed by VP of Operations. Include any action taken, date of action taken, and follow- up if indicated.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Part III: The person initiating the report is responded to in a timely manner.

_____
SIGNATURE

NOT TO BE DISTRIBUTED

PATIENT CARE ASSESSMENT PROGRAM

LGH has established and maintains a qualified Patient Care Assessment Program that complies with the requirements of 243 CMR 3.00 et seq. and that has been approved by the Massachusetts Board of Registration in Medicine. The Patient Care Assessment Committee has been delegated the responsibility for the development, maintenance and support of this program. The Committee monitors and coordinates the Medical Staff Performance Improvement Program, the Medical Staff Credentialing function, the Hospital and Medical Staff Utilization Review Program and the authorization and monitoring of all aspects of the Patient Care Assessment Program. The Committee has representation from, and serves as liaison among, The Board of Trustees, the Medical Staff and Hospital Management. Specific responsibilities include:

- To oversee and approve the goals and priorities for performance improvement in accordance with the Hospital's mission, vision, strategic plan and available resources;

- To annually review, assess, and modify the Hospital's Performance Improvement Plan and its performance;

- To encourage ongoing activities that shall improve the quality of patient care by reducing or eliminating risks/hazards, improve patient satisfaction and customer service, reduce duplication of effort, and most importantly, study and improve processes, outcomes, and individual performance;

- To encourage continuing education of all persons involved in Performance Improvement;

- To ensure and facilitate communication, cooperation and the sharing of knowledge of activities and findings with the Board of Trustees, Medical Staff and Administration.

- To provide periodic reports to the Board of Trustees of the findings, actions, and results of actions from the Performance Improvement Program.

- To review compliance of the hospital with Joint Commission on Accreditation of Healthcare Organization Standards, Board of Registration in Medicine Regulations, State Regulations pertaining to Licensure and Federal Regulations pertaining to the Hospital.

PHYSICIAN HEALTH POLICY

Policy

It is the policy of the Medical Staff and Hospital to be sensitive to a practitioner's health or condition that may adversely affect that practitioner's ability to provide safe, competent care to patients. The concern is for high-quality patient care always, but it is accompanied by compassion for the practitioner whose abilities may be diminished in some way due to age or illness. To address such potential concerns, the Hospital and Medical Staff create a Physician Health Committee. That Physician Health Committee is comprised of three active medical staff members including the Past President, Chief of Psychiatry and the Vice President of Medical Affairs. The Physician Health Committee shall be expanded as necessary to address the particular situation before it.

Purpose

To address a practitioner's health or condition that may adversely affect the practitioner's ability to provide safe, competent care to patients with a process that provides education about practitioner health, addresses prevention of physical, psychiatric, or emotional illness, and facilitates confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition. The purpose of this process is to identify and manage matters of physician health that is separate from the medical staff disciplinary function.

Procedures

1. The medical staff and allied health practitioner staff shall be educated on the existence and nature of this policy and the Physician Health Committee through articles in the medical staff newsletter, and/or continuing medical education lectures.

2. The Physician Health Committee may receive a referral from the practitioner whose health is at issue, the Credentials Committee, Administration, the Board of Directors, or any concerned individual. The reporter articulate the nature of the concern and the reasons in support of it in writing.

3. The report shall be directed to the Physician Health Committee Chair, who shall immediately direct whatever brief investigation is necessary to understand the nature of the concern. That may include meeting with the individual who filed the report.

4. The practitioner whose health or behavior is in question shall be invited to meet with the Physician Health Committee.

a) The practitioner be apprised of the nature of the meeting and of the opportunity to be accompanied by a practitioner who may be treating the condition at issue.

b) The representative accompanying the practitioner shall not be a lawyer. The purpose of this Physician Health Committee and this meeting is to discuss what, if any, problems exist and to work mutually towards a solution in the best interest of the practitioner's health and patient care.

5. If the practitioner declines to meet with the Physician Health Committee and there continues to be a concern about the practitioner's health or ability to care for patients safety and competency, that question shall be forwarded to the Medical Executive Committee for investigation in accordance with the policy.

6. The practitioner and the Physician Health Committee shall discuss the nature of the problem, what if any modifications of the practitioner's practice is appropriate, and what if any accommodations can be made to enable the practitioner to continue clinical practice.

7. If the extent of the practitioner's illness or limitation is not easily ascertainable, the Physician Health Committee shall require the practitioner to submit to an appropriate evaluation by an internal or external resource for diagnosis and treatment of the condition or concern individual or entity mutually acceptable to the practitioner and the Physician Health Committee at the practitioner's expense. If the practitioner declines such evaluation, the Physician Health Committee work shall be concluded and it shall direct this matter to the Medical Executive Committee for investigation.

8. Once accommodations or limitations upon the practitioner's practice have been agreed upon, they shall be put in writing and maintained in the practitioner's confidential peer review file. All members of the Medical Executive Committee shall be informed that there is an agreement.

9. All ongoing monitoring that is required shall be the responsibility of the Physician Health Committee or the person or entity to whom the responsibility is delegated by the Physician Health Committee.

10. State and Federal law shall dictate the extent to which any report needs to be filed with the state and federal agencies otherwise peer review protections shall apply.

11. The extent to which any patient notice of the conditions, limitations or accommodations is required shall be dictated by the situation and agreed upon by the Physician Health Committee and the practitioner.

12. Throughout the process, all parties shall avoid speculation, conclusions, gossip and any discussion of this matter with anyone outside those described in this policy.

13. In the event of an apparent or actual conflict between this policy and the bylaws, rules and regulations, plans, or other policies of the Hospital or its Medical Staff, including the due process section of those bylaws, polices and procedures, the provisions of this policy shall control.

LOWELL GENERAL HOSPITAL
HOSPITAL POLICY AND PROCEDURE MANUAL

Title: FOCUSED PROFESSIONAL PRACTICE EVALUATION POLICY	**Policy Number: HP-M-A-19**
	Page 1 **of Total Pages** 5
Endorsed by:	**Date Revised:** 5/18/2018
_____ - _____	**Supersedes:** 3/18/2009
Medical Executive Committee - 7/18/12	**Date Discontinued:**
Approved: Arthur Lauretano, MD - 7/17/2018 Date	**Initial Effective Date:** March 2009

I. PURPOSE
To establish a systematic process to evaluate and confirm the current competency of a practitioner's performance of privileges at Lowell General Hospital.

II. SCOPE
Active and Affiliate Medical Staff, Medical Staff Office Personnel, Regulatory Compliance Staff

III. DEFINITIONS:
Focused Professional Practice Evaluation (FPPE) describes the special monitoring process Lowell General Hospital undertakes for its active and affiliate medical staff to ensure they provide safe and quality patient care. The monitoring process varies according to whether a practitioner is newly privileged, is requesting additional privileges, is identified as a practitioner who does not have documented evidence of competently performing the requested privilege at Lowell General Hospital, or is identified because a question has arisen regarding a currently privileged practitioner's ability to provide safe, high quality patient care. An FPPE is a time-limited period during which the hospital evaluates and determines a practitioner's professional performance.

IV. POLICY:
It is the Policy of Lowell General Hospital to conduct appropriate monitoring of the care delivered by its medical staff and to promote safety and high quality health care for its patients.

An FPPE shall occur in the following circumstances:

A. All newly privileged Medical Staff or Affiliate Medical Staff shall be subject to an FPPE as described in the Procedure at Section V(A);

B. All current Medical Staff or Affiliate Medical Staff member seeking new privileges shall be subject to an FPPE, as described in the Procedure at Section V(A); and

C. Any current Medical Staff or Affiliate Medical Staff member when there are concerns regarding the practitioner's provision of safe, high quality care shall be subject to an FPPE, as described in the Procedure at Section V(B).

All findings and information associated with any FPPE shall be considered confidential and protected pursuant to CMR 243, M.G.L. c. 112 s 5, and M.G.L. c. 111, s 203.

V. PROCEDURE:

A. NEW MEMBERS OF THE MEDICAL STAFF & NEWLY REQUESTED PRIVILEGES

1.) An FPPE is required for all new members of the Medical Staff and is accomplished through review of all hospital-based outpatient procedures and all inpatient admissions. Outpatient and inpatient episodes of care are reviewed by screening all coded medical record descriptors for specific complication and mortality codes listed in standard coding texts and other internally generated quality/safety reports. The physician-specific rate of the occurrences for all episodes of care is compared to peer physicians from the same specialty or sub-specialty. Quality data from other appropriate Hospital and Medical Staff Committees may also be considered.

2.) The FPPE shall begin with the applicant's first admission or performance of the newly requested privilege. The duration of the focused review shall be for a minimum of three months or until at least 5 episodes of care are available for review. The period of focused evaluation shall not exceed one year unless requested by practitioner and approved by a medical staff leader (Department Chief, Section Chief). If upon completion of the focused evaluation described in #1, the review reveals that the physician-specific rate of occurrences compares with peer physicians from the same specialty or sub-specialty, it will be deemed to contain no outliers and the FPPE shall be deemed complete.

3.) If significant outliers are identified through the initial evaluation described in #1, the FPPE shall continue and expand to encompass, but not be limited to, one or more of the following:

a.) Retrospective or prospective chart review,
b.) Discussion with other individuals involved in the care of each patient,
c.) Monitoring clinical practice patterns,
d.) Proctoring,
e.) Simulation,
f.) External Peer Review.

4.) Focused evaluation as outlined in #3 above will be conducted by a medical staff leader (Department Chief, Section Chief) or designee from within the department or section. A minimum of five (5) additional cases shall be reviewed. The

continued evaluation will be specific to the privilege in question and shall not be related to existing privileges in good standing.

5.) If at any time during the FPPE, a question arises as to the practitioner's competence to exercise the affected privileges resulting in concern about imminent threat to patient safety, review by the Department/Section Chief, President-Elect of the Medical Staff, Chief Medical Officer, and Chief Nursing Executive with input from the Regulatory Compliance Office shall occur. Additional performance monitoring requirements may be put into place and a report shall be made to the Medical Executive Committee. In such circumstances, if the practitioner's lack of competence immediately threatens a patient's life or is likely to cause immediate serious injury to a patient, the practitioner shall be subject to summary suspension pursuant to Section 7.2 of Lowell General Hospital's Medical Staff Bylaws.

6.) At the end of the period of focused evaluation described in #1 above, in the event that the practitioner's activity has not been sufficient to appropriately evaluate his/her competence either:

a.) The practitioner shall voluntarily resign the relevant privilege(s), or
b.) The practitioner shall submit for approval a written request for an extension of the period of focused evaluation by providing a letter of explanation describing the circumstances suggesting that an extension is appropriate, or
c.) If the practitioner has recent significant volume of the privileges in question at another local hospital, external peer references specific to the procedures will be obtained.

7.) The Credentials Committee is charged with the responsibility of monitoring compliance with this Policy. The Credentials Committee shall therefore receive regular status reports on the progress of practitioners undergoing FPPE for new privileges as well as any issues or problems involving the implementation of this Policy.

8.) The Credentials Committee will report any practitioners with continued performance concerns to the Medical Executive Committee for discussion and action as appropriate.

B. <u>CURRENTLY PRIVILEGED PRACTITIONERS</u>

1.) The FPPE process may be initiated upon approval by the Medical Executive Committee after concerns arise regarding a medical staff member's provision of safe, high quality care. An FPPE may be triggered by a specific or single incident, a sentinel/adverse event, evidence of trends in clinical practice, or other circumstances indicating that patient safety may be compromised. Examples of evidence that may trigger an FPPE include, but are not limited to:
a.) information obtained from ongoing evaluation/peer review activities,

b.) other evidence suggesting that a practitioner's performance does not fall within the accepted practice guidelines or standards of care;
c.) significant adverse events;
d.) medical errors and misses; and
e.) staff or patient/family complaints.

Such evidence shall be brought to the attention of the Medical Executive Committee who shall be responsible for approving an FPPE for currently privileged practitioners.

2.) Information for this evaluation may be derived from but not limited to the following:

a.) Retrospective or prospective chart review
b.) Discussion with other individuals involved in the care of each patient
c.) Monitoring clinical practice patterns
d.) Proctoring
e.) Simulation
f.) External Peer Review

3.) If proctoring is required, the following guidelines should be used:

a.) Proctors must be in good standing of the active medical staff of Lowell General Hospital.
b.) The Proctor must have unrestricted privileges to perform any procedure to be concurrently observed.
c.) Proctors will be mutually agreed upon between the Department Chair and the physician being proctored.
d.) The Proctor may be a member of the same practice group as the physician being proctored.
e.) Proctor shall directly observe the procedure being performed, concurrently observe medical management or retrospectively review the completed medical record following discharge.
f.) The Proctor will submit a summary report at conclusion of proctoring period.
g.) If at any time during the proctoring period the Proctor has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient, the Proctor shall promptly notify the Department Chair and President of the Medical Staff.
h.) Concurrent proctoring is one method of evaluation for competency for procedures that may be used. The Proctor is not a mentor or a consultant. The Proctor is an agent of the hospital. The Proctor shall receive no compensation from any patient for this service. The Proctor, or any practitioner, however, should nonetheless render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner. The hospital will defend and indemnify any practitioner who is subjected to a claim or suit arising from his or her acts or omissions in the role of Proctor.

4.) External peer review will be solicited under the following circumstances, as determined by the Chief Medical Officer.

a.) Other members of the Medical Staff lack the professional expertise necessary to review the practitioner's performance, or
b.) When there is concern regarding competition between the practitioner under review and other practitioners on the Medical Staff who would be considered appropriate peers to perform the review, or
c.) Other circumstances exist that could compromise the review as determined by the Chief Medical Officer.

5.) Continued adverse findings associated with the FPPE may prompt a need for Corrective Action. Corrective Action shall proceed as detailed in Section 7 of the Medical Staff bylaws. However, an FPPE is not required to be conducted prior tot the commencement of corrective action proceedings or the institution of a summary suspension under the Medical Staff Bylaws.
6.) An FPPE is not a disciplinary or corrective action as defined in Section 7 of Lowell General Hospital's Medical Staff Byulaws and in no event does a decision to perform an FPPE entitle the affected practitioner access to the hearing and appellate review procedures outlined in the Medical Staff Bylaws.

VI. REFERENCE(S):

The Joint Commission Hospital Accreditation Standards 2018
CMS Conditions of Participation last accessed May 2018
CMR 243, M.G.L. c. 112 s 5, and M.G.L. c. 111, s 203. last accessed May 2018
Medical Staff Bylaws

VII. ATTACHMENTS:

A. Monitoring Form – Cognitive Privileges
B. Monitoring Form – Procedures

VIII. POLICY TRACKING RECORD:

3/09; 6/12; 5/13 Policy Adopted and Integrated at the Saints Campus, 7/2018

Lowell General Hospital

Complete connected care℠

Monitoring Form - Cognitive Privileges

Individual Proctored: _____	Privilege: _____
MR #: _____	Condition: _____

Type of Review: O Direct/Concurrent O Retrospective

You have been asked to proctor this physician to evaluate the quality of care provided. As such, it is your responsibility to report any poor or significant substandard performance made by the physician immediately to the Chair of the Department.

Evaluate in terms of completeness and accuracy	Acceptable	Marginal	Not acceptable	N/A
1. H&P are complete, accurate and on the chart.				
2. The diagnosis is consistent with the H&P.				
3. The orders are appropriate.				
4. Consultation is used appropriately.				
5. Ancillary Services are used appropriately.				
6. Abnormal tests are recognized/followed up.				
7. Complications are managed appropriately.				
8. Case management is consistent with the problem.				
9. Drug and therapeutic regimens meet accepted standards.				
10. Plans for follow up are documented.				
11. Interaction with colleagues and staff.				
12. Interaction with patients.				

Please comment on any marginal or unacceptable findings.

Confidential Peer Review

Is there any other aspect of this evaluation and treatment with which you are uneasy or uncomfortable? O No O Yes (Please explain.)

Recommendation:
____Practitioner performed satisfactorily.
____Practitioner could benefit from additional proctoring of such cases. (Number suggested:_____)
____Practitioner should not attempt further care like this without additional training.

_____ _____
Proctor Date

Thank you. Please return this form to the Medical Staff Office.

Lowell General Hospital

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Monitoring Form – Procedures

Individual Proctored: _____ Privilege: _____
MR #: _____ Procedure: _____

Type of Review: ☐ Direct/Concurrent ☐ Retrospective

You have been asked to proctor this physician to evaluate the quality of care provided. As such, it is your responsibility to report any poor or significant substandard performance made by the physician immediately to the Chair of the Department.

Evaluate in terms of completeness and accuracy	Acceptable	Marginal	Not acceptable	N/A
Clinical indications appropriate				
Pre-Procedure				
Clinical Management				
Documentation				
Communications (Patient/Family)				
Intra-Procedure Phase & Technique				
Manual Dexterity, Approach to Procedure				
Technical Skills				
Management of Complications				
Completeness of Procedure				
Communication (Technical Staff)				
Post-Procedure				
Documentation of Procedure				
Discharge Instructions to Patient				
Overall Understanding & Performance of Procedure				

Please comment on any marginal or unacceptable findings.

Confidential Peer Review

Is there any other aspect of this evaluation and treatment with which you are uneasy or uncomfortable? ☐ No ☐ Yes (Please explain.)

Recommendation:
____Practitioner satisfactorily performs the procedure
____Practitioner could benefit from additional proctoring of such cases. (Number suggested:_____)
____Practitioner should not attempt further procedures like this without additional training.

_____ _____
Proctor Date

Thank you. Please return this form to the Medical Staff Office.

LOWELL GENERAL HOSPITAL
HOSPITAL POLICY AND PROCEDURE MANUALS

Title: Ongoing Professional Practice Evaluation (OPPE)	**Policy Number: HP-M-A-22** Page 1 of 3
Authored by: Erin M. Donovan Medical Executive Committee Date: _____ Credentials Committee Date: _____	**Date Revised:** 4/2018 **Supersedes: 10/2014** **Date Discontinued:** N/A
Approved: _____ Date: _____	**Initial Effective Date:** 5/2009

I. PURPOSE:

- To establish a systematic process that ensures the continued competence of practitioners.
- To identify potential practice trends that impact quality of care or patient safety so that they might be addressed in a timely manner.
- To foster an efficient evidence-based privilege renewal process.

II. SCOPE:

- Medical Staff members and Allied Health Professionals granted clinical privileges
- Medical Staff Services
- Regulatory Compliance

III. DEFINITIONS:

1.) Low Volume Provider – A practitioner who has less than 12 discharges, consultations or procedures per year depending on his or her specialty.

2.) Ongoing Professional Practice Evaluation (OPPE) – a process to evaluate all practitioners who have been granted privileges and to identify professional practice trends that impact quality of care and patient safety.

3. Ongoing Professional Practice Evaluation (OPPE) Report – A summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior.

4.) Practitioner – Member of the medical staff or an allied health professional who is credentialed for privileges.

IV. POLICY:

The LGH Medical Staff will ensure an evaluation of each practitioner's professional performance. Evaluations will be performed on an ongoing basis at least twice per year. Practitioners with identified performance issues will be addressed by the Medical Staff leadership and may be subject to a focused professional practice evaluation. The

information resulting from the ongoing professional practice evaluation will be used by the Credentialing Committee to determine whether to continue, revise or revoke any existing privilege(s).

Criteria used in the ongoing professional practice evaluation will be drawn from the following expectations:

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 demonstrate an ability to investigate and evaluate patient care practices by gathering and analyzing patient information.

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.

System-based Practice – Practitioners are expected to demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value."

As such, metrics to measure performance may include but not be limited to clinical quality and patient safety, utilization of resources, patient satisfaction, and other relevant criteria as determined by the Medical Staff.

The data used in the ongoing professional practice evaluation may be acquired through the following:

- Periodic chart review,
- Direct observation,
- Monitoring of diagnostic and treatment techniques,

- Discussions with other individuals involved in the care of patients including consulting physicians, assistants at surgery, and nursing and administrative personnel.

- Registries in which the hospital participates, and

- Business intelligence systems.

V. PROCEDURE:

1.) The Regulatory Compliance Department will prepare the OPPE reports for each practitioner.

2.) Criteria for the evaluation of practitioners will be developed in cooperation with the Department Chiefs, shared with the Department members and approved by the Medical Executive Committee. Practitioners' activity levels will also be reflected in the reports.

3.) In circumstances where a physician does not have sufficient volume to effectively measure his or her performance, the OPPE report will not be completed. The Medical Staff Office will ask the practitioner to provide documented evidence of quality performance from other facility(ies) in which he or she has similar credentials.

In the event, the practitioner is seeking *refer and follow* privileges and does not actively provide care in an acute setting, the practitioner will be asked to provide peer recommendations that speak to their patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal/communication skills, system-based practice and professionalism. An OPPE report will not be completed.

4.) The Department Chief will review each OPPE report for practitioners in his/her department.

5.) Chiefs may request additional information on a practitioner's performance via the Medical Staff Office or Regulatory Compliance Department. Examples may include results of quality reviews, drill down reports, etc. Alternately, the Chief may directly observe the practitioner, discuss the practitioner's care with other individuals involved in the care of the practitioner's patients (consultants, surgical assistants, nursing staff, etc.) or speak with the practitioner directly. If the Chief remains concerned with a practitioner's experience, he or she may request a Focused Professional Practice Evaluation through the Medical Executive Committee. (See the Focused Professional Practice Evaluation policy.)

6.) The Credentialing Committee will consider the OPPE report(s) at the time of reappointment for determining extension of existing privileges(s), revision of existing privilege(s) or revocation of existing privilege(s).

7.) The OPPE report will be filed in the practitioner's credentials file. A copy will be maintained in the Regulatory Compliance Department.

8.) All OPPE activities shall be conducted in a manner consistent with applicable confidentiality and peer review laws. The OPPE records and activities are confidential and shall not be disclosed except as required by law.

VI. REFERENCES:

The Joint Commission Hospital Accreditation Standards 2018

Systems-Based Practice: Improving the Safety and Quality of Patient Care by Recognizing and Improving the Systems in Which We Work; Julie K. Johnson, MSPH, PhD; Stephen H. Miller, MD, MPH; Sheldon D. Horowitz, MD
https://www.ahrq.gov/downloads/pub/advances2/vol2/Advances-Johnson_90.pdf

Exploring the ACGME Core Competencies: Practice-Based Learning and Improvement
https://lowellgeneral.ellucid.com/approval-process/2551/ax

VII. POLICY TRACKING RECORD:

5/2009, 4/2018

AMENDMENTS

AMENDMENT I	Medical Staff Committees – Utilization Review Committee Approved by the Medical Executive Committee 7/20/04 and the Board of Trustees 7/27/2004.
AMENDMENT II	Medical Staff Committees – Peer Review Council. Approved by the Medical Executive Committee 9/15/2004 Approved by the Board of Trustees 9/28/2004.
AMENDMENT III	Medical Staff Committees – Cancer Committee Organizational Structure Revision. Approved by the Medical Executive Committee 9/15/2004 Approved by the Board of Trustees 9/28/2004
AMENDMENT IV	Medical Staff Reappointment Policy and Procedure Removed CORI Checks. Approved by the Medical Executive Committee 9/15/2004 Approved by the Board of Trustees 9/28/2004
AMENDMENT IV	Addition of CORI POLICY Approved by the Medical Executive Committee 10/20/2004 Approved by the Board of Trustees 10/26/2004
AMENDMENT V	Replaced Disruptive Behavior Policy with Revision dated 10/28/2004 Approved by the Medical Executive Committee 11/17/2004 Approved by the Board of Trustees 12/23/2004
AMENDMENT VI	Revised Composition of Critical Care Committee to state a representative from Administration as needed. Approved by the Medical Executive Committee 10/18/2006 Approved by the Board of Trustees 10/24/2006
AMENDMENT VII	Medical Staff Appointment Policy & Procedure Section VB-1 Approved by the Medical Executive Committee 11/15/2006 Approved by the Full Medical Staff 12/7/2006 Approved by the Board of Trustees 12/19/2006
AMENDMENT VIII	Reappointment Policy and Procedure Section II Approved by the Medical Executive Committee 11/15/2006 Approved by the Full Medical Staff 12/7/2006 Approved by the Board of Trustees 12/19/2006

AMENDMENT IX Reappointment Policy and Procedures VIB
Approved by the Medical Executive Committee 11/15/2006
Approved by the Full Medical Staff 12/7/2006
Approved by the Board of Trustees 12/19/2006

AMENDMENT X Medical Staff Appointment Policy and Procedure Section IIN.
Approved by Medical Executive Committee 3/19/2008
Approved by the Board of Trustees 3/25/2008

AMENDMENT XI Medical Staff Appointment Policy and Procedure Section IIN.
Approved by Medical Executive Committee 4/16/2008
Approved by the Board of Trustees 4/22/2008

AMENDMENT XII Focused Professional Practice Evaluation Policy
Approved by Medical Executive Committee 3/18/2009
Approved by Board of Trustees 3/24/2009

AMENDMENT XIII Ongoing Professional Practice Evaluation Policy
Approved by the Medical Executive Committee 6/17/2009
Approved by the Board of Trustees 6/23/2009

AMENDMENT XIV Section II. Standing Committees; I. Medical Education And Library Committee
Approved by the Medical Executive Committee 11/17/2010
Approved by the Board of Trustees 12/21/2010

AMENDMENT XV Section II. Standing Committees: P. Perinatal Committee
Approved by the Medical Executive Committee 11/17/2010
Approved by the Board of Trustees 12/21/2010

AMENDMENT XVI Section II. Standing Committees, Medical Records Committee Disbanded
Approved by the Medical Executive Committee 3/14/2012
Approved by the Board of Trustees 3/21/2012

AMENDMENT XVI Section II. Standing Committees: Mortality & Morbidity Review Council – Approved by the Medical Executive Committee 9/18/2013
Approved by the Board of Trustees 9/2013

AMENDMENT XVII Section II. Standing Committees: Transfusion Committee

Approved by Medical Executive Committee 9/18/2013
Approved by Board of Trustees 9/2013

AMENDMENTXVIII Change the JCAHO to Joint Commission.
Approved by the Medical Executive Committee 3-2014
Approved by the Board of Trustees 3-2014

AMENDMENT XVIX Addition of Breast Program Leadership
Approved by Medical Executive Committee 2-2016
Approved by Full Medical Staff 3-2016
Approved by Board of Trustees 3-2016

AMENDMENTXX C. Cancer Committee
Approved by Medical Executive Committee 4-2017
Approved by Board of Trustees 4-2017

AMENDMENT XXI N. Medical Staff Peer Review
Approved by Medical Executive Committee 7-2017
Approved by Full Medical Staff 9-2017
Approved by Board of Trustees 9-2017

AMENDMENT XXII C. Cancer Committee
Approved by Medical ExecutiveCommittee 11-2017
Approved by Full Medical Staff – 12-2017
Approved by Board of Trustees 11-2017