Medical Staff Services

Report to the JCC May 2016

ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

Regulatory Expectations of Governing Body:CMS

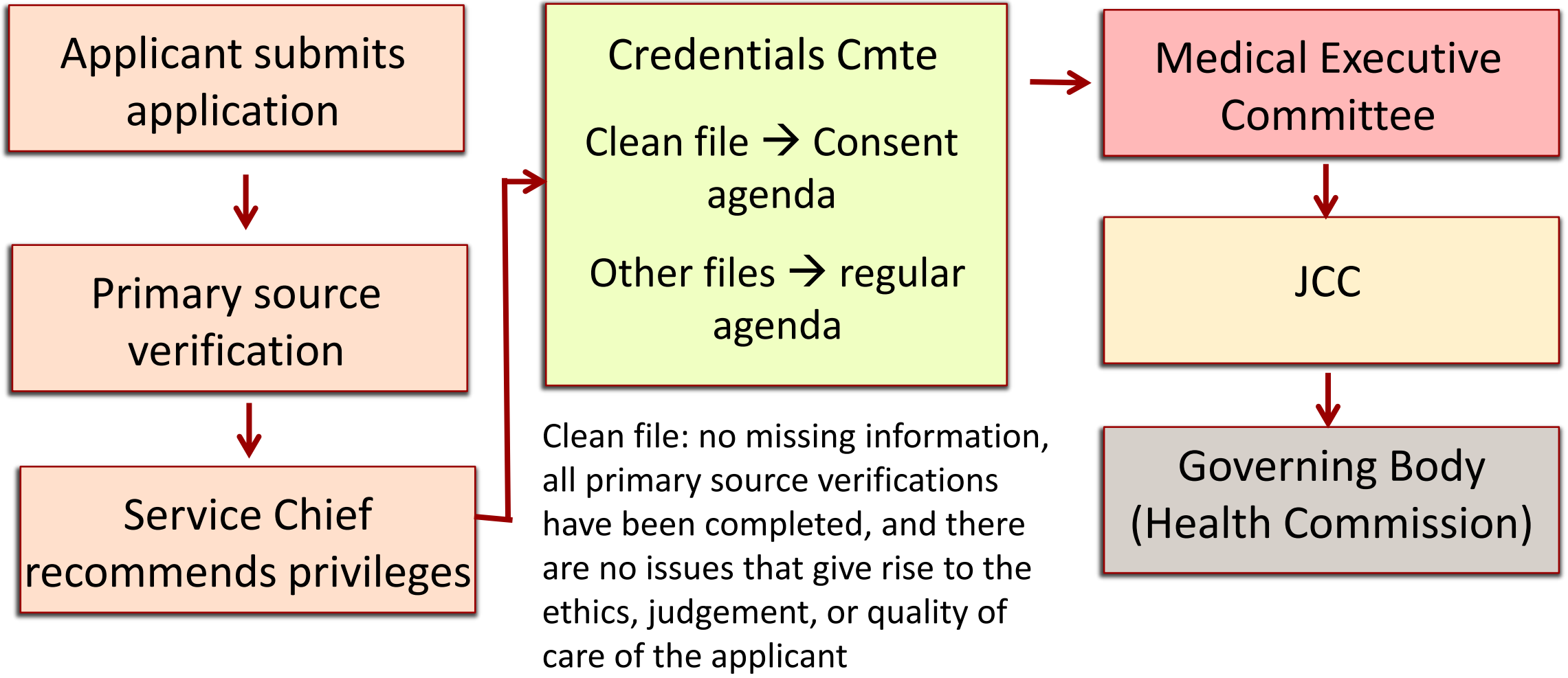
- **§ 482.12 Condition of participation: Governing body**
  - (a) *Standard: Medical staff.* The governing body must:
    - (1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;
    - (2) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff;
    - (4) Approve medical staff bylaws & other medical staff rules & regulations;
    - (5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;
    - (6) Ensure the criteria for selection are individual character, competence, training, experience, & judgment;

Regulatory Expectations of Governing Body:Title 22

§ 70701 Governing body

- The governing body shall:
- (1) Adopt written bylaws in accordance with legal requirements and its community responsibility which shall include but not be limited to provision for:
- (B) Appointment and reappointment of members of the medical staff
  - Per Governing Body Bylaws, The GB delegates to JCC the appointment and reappointment of members of the medical staff and the delineation of Clinical Privileges
- (G) Preparation and maintenance of a complete and accurate medical record for each patient

Initial appointment of Medical Staff members



Clean file: no missing information, all primary source verifications have been completed, and there are no issues that give rise to the ethics, judgement, or quality of care of the applicant

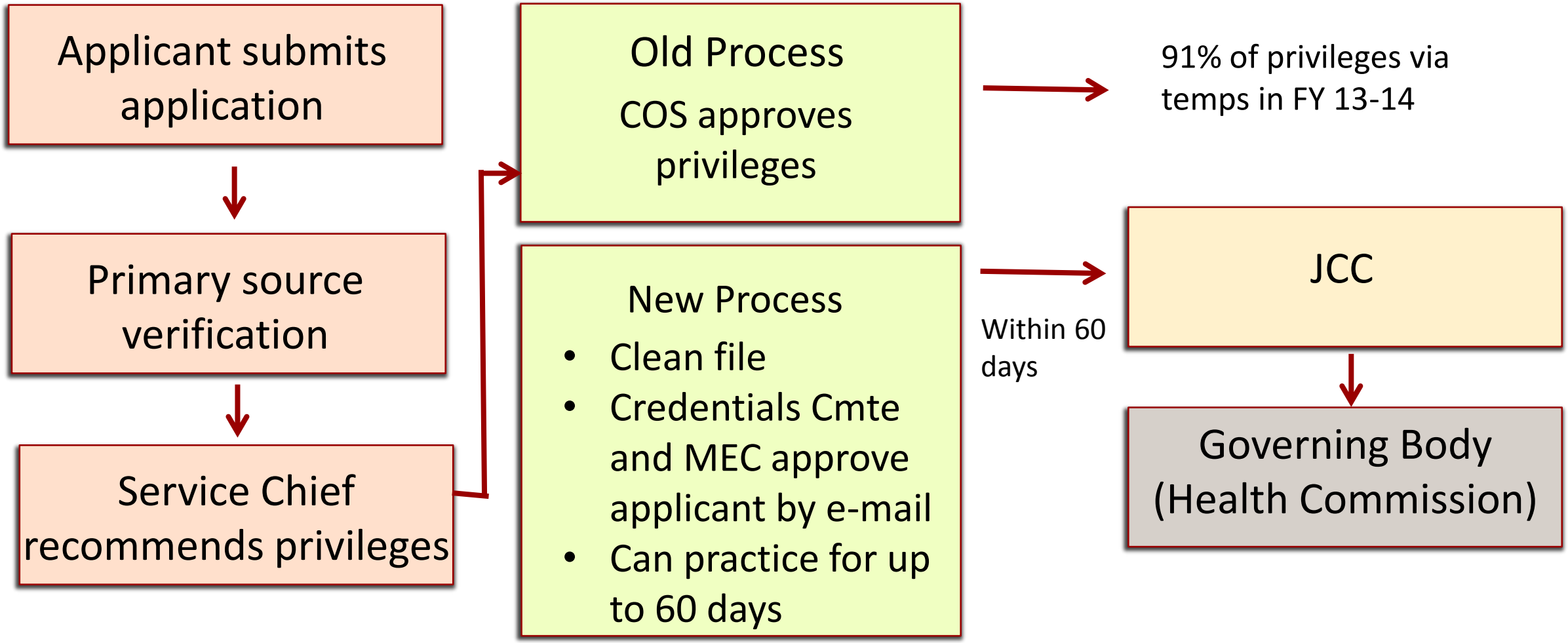
Proctoring

- Proctoring may consist of concurrent &/or retrospective observations of clinical competence.
- All new appointees to the Medical Staff & existing members requesting additional privileges, regardless of specialty or category of membership, shall be assigned a Proctor by the Clinical Service Chief & complete a period of proctoring.
- The Proctor must have unrestricted privileges to perform the evaluation(s) that he/she will proctor.
- The Clinical Service Chief will submit a form to the Credentials Committee attesting to the satisfactory completion of proctoring.
- Documentation of the proctoring will reside in the Clinical Service Office.

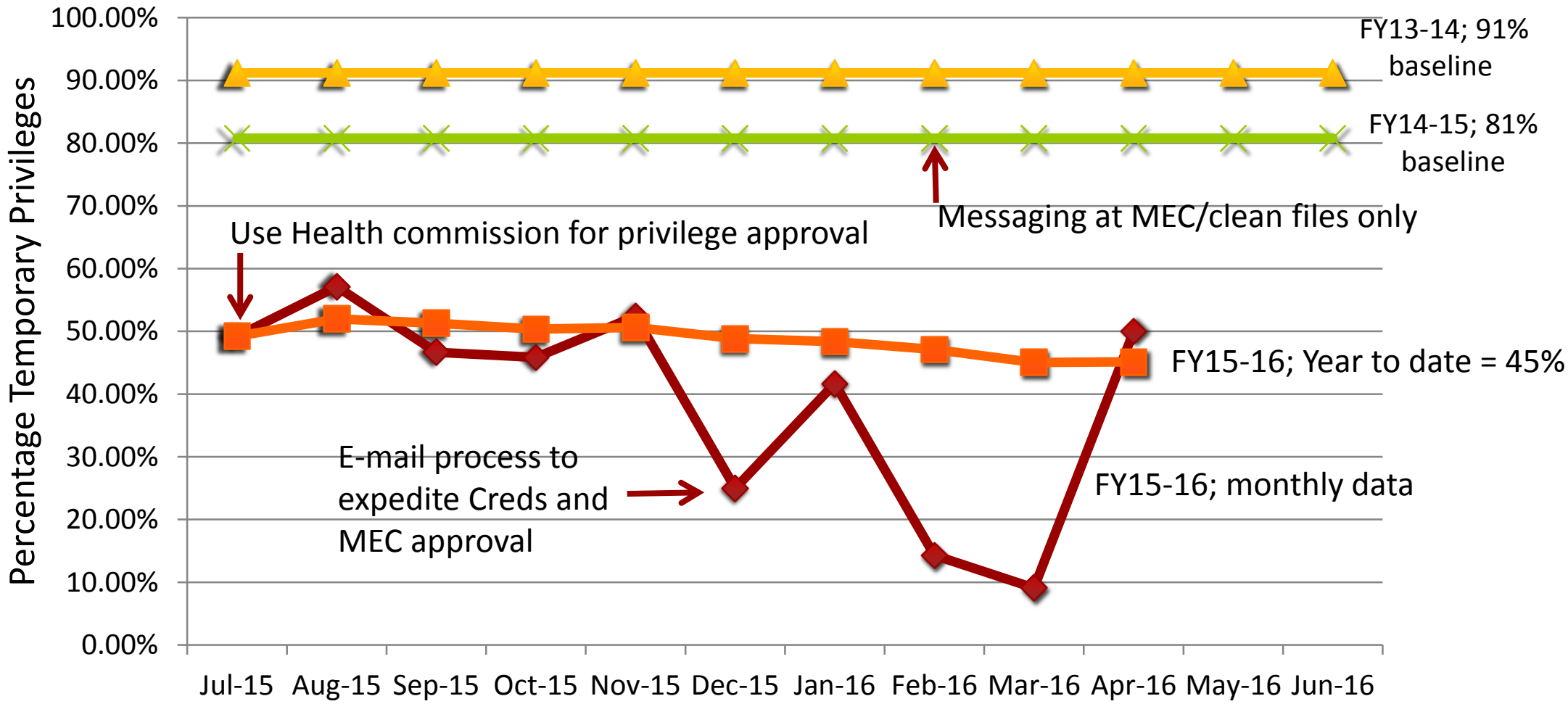
Initial Appointments Of Credentialed Providers Per Year

7/15 – 6/16	194
7/14 – 6/15	200
7/13 – 6/14	225
7/12 – 6/13	167
7/11 – 6/12	183

Temporary privilege process



Temporary Privileges Granted



OPPE Process

- Every six months
- The Service Chiefs or designee will submit written summation of the OPPE findings on the approved OPPE cover sheet to the Medical Staff Office for presentation to & review by the Credentials Committee Chair.
- The Chair will determine if significant findings should be submitted for review at Credentials Committee &/or the Medical Executive Committee.
- The OPPE cover sheet will become part of the practitioner's credentials file & will be included in the decision to continue current privilege(s), recommend changes to current privilege(s), or recommend a Focused Professional Practice Evaluation (FPPE).
- Pre-determined thresholds, that trigger Credentials Committee review exist for the following organization metrics: A) deaths rated preventable, or possibly or probably preventable; B) two consecutive 'marginal ratings by the Service Chief or designee in the same metric; C) two consecutive 'unacceptable' ratings in the same metric (these will require FPPE and notification to the Chair of Credentials Committee)

Reappointments

Reappointment Application

At least 5 months prior to the end of the 2 year appointment period, the provider is emailed an application for reappointment. Previously submitted information will populate the reappointment application.

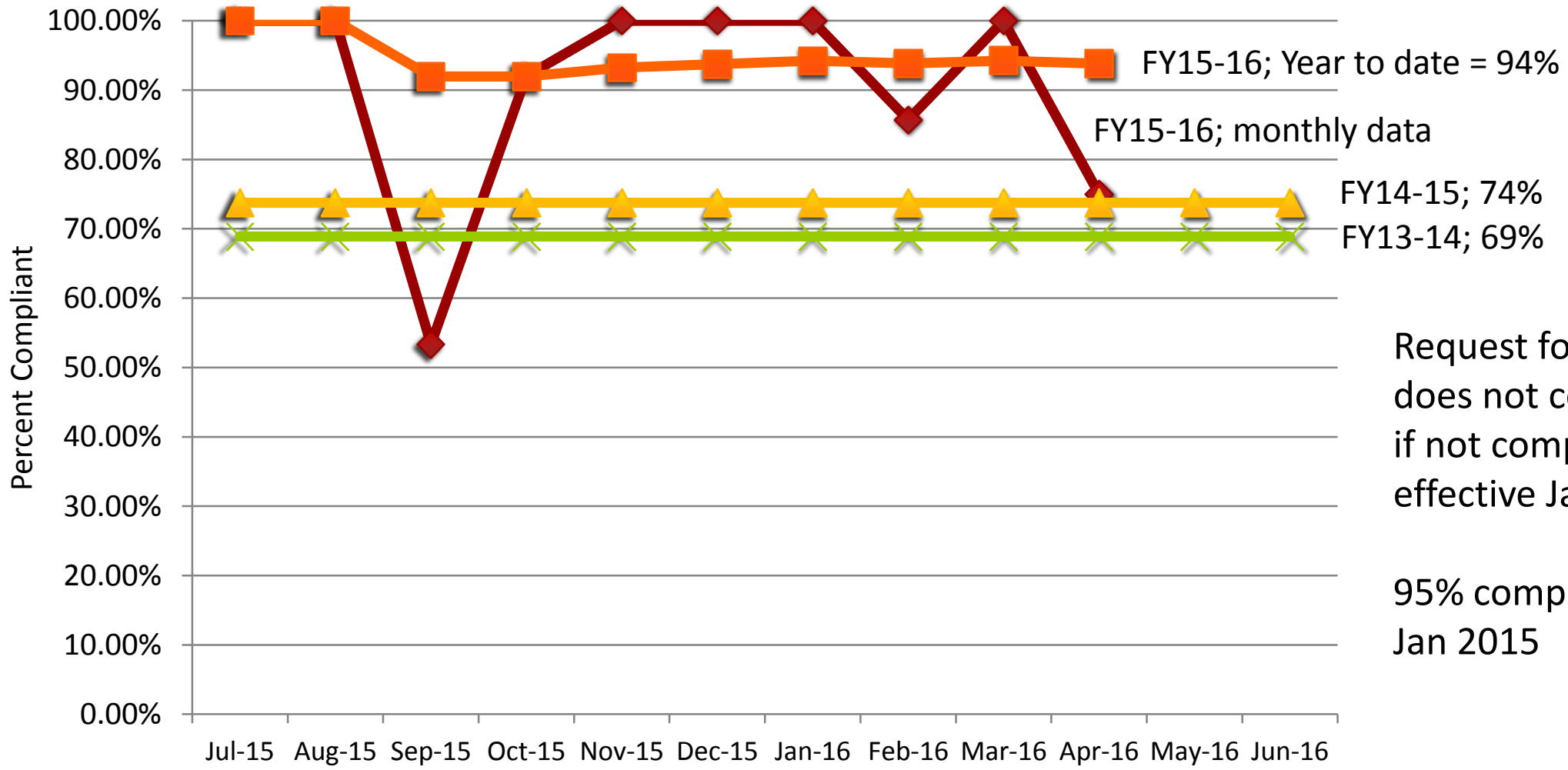
Reappointment Performance Monitoring

The results of performance monitoring, evaluation, and identified opportunities to improve care & service are documented in this file. Data Summary sheets & Reappointment grids delineating that the reappointment criteria for each privilege has been met is provided as evidence of the practitioner's current competence & suitability for continued medical staff membership.

Hospital Orientation Requirement Compliance

7/13 – 6/14	12.3 %	Request for privileges does not come to JCC if not completed
7/14 – 6/15	100 %	
7/15 – 5/15	100 %	

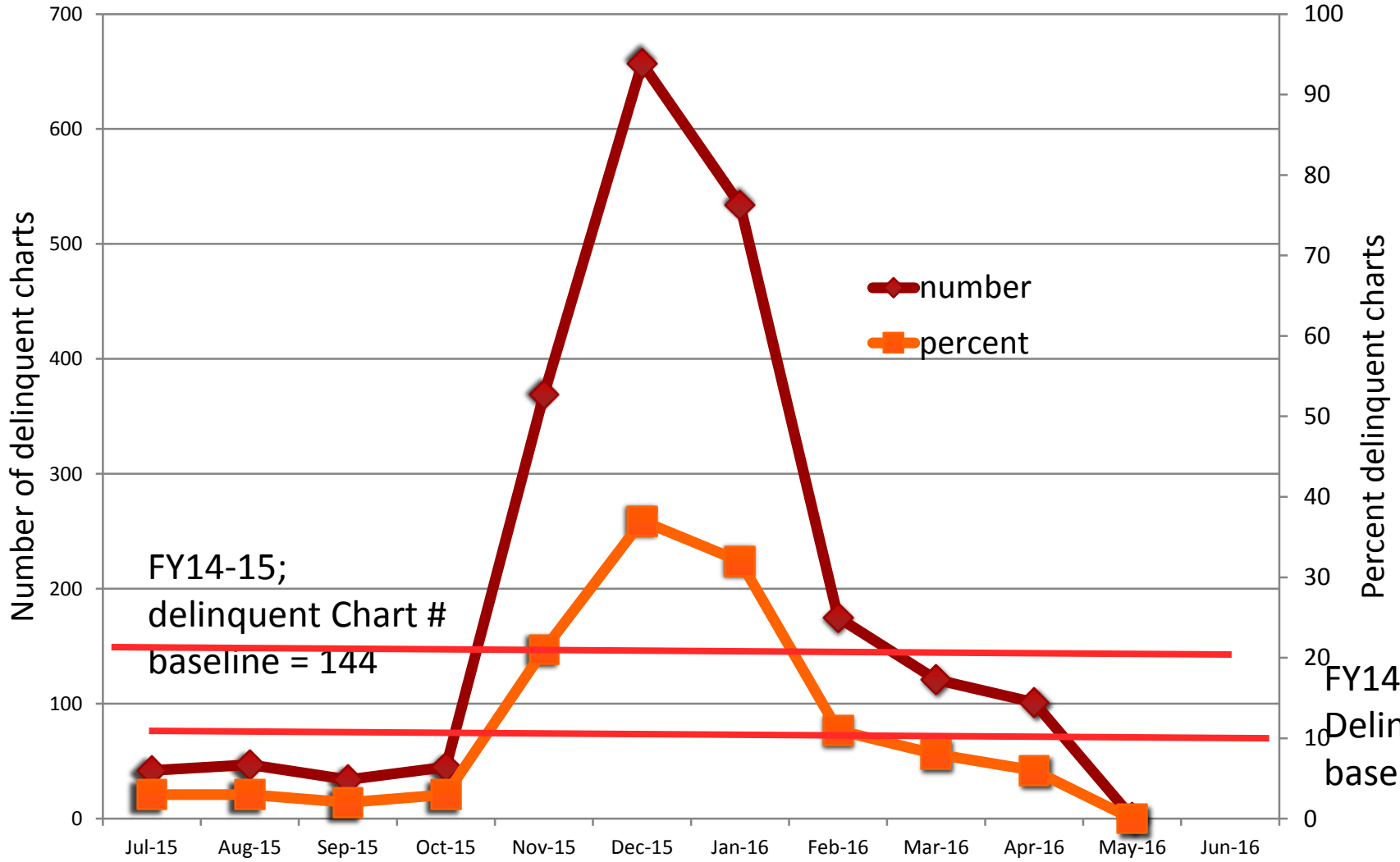
TB Compliance by Fiscal Year: Initial appt. and reappt.



Request for privileges does not come to JCC if not completed; effective Jan 2015.

95% compliant since Jan 2015

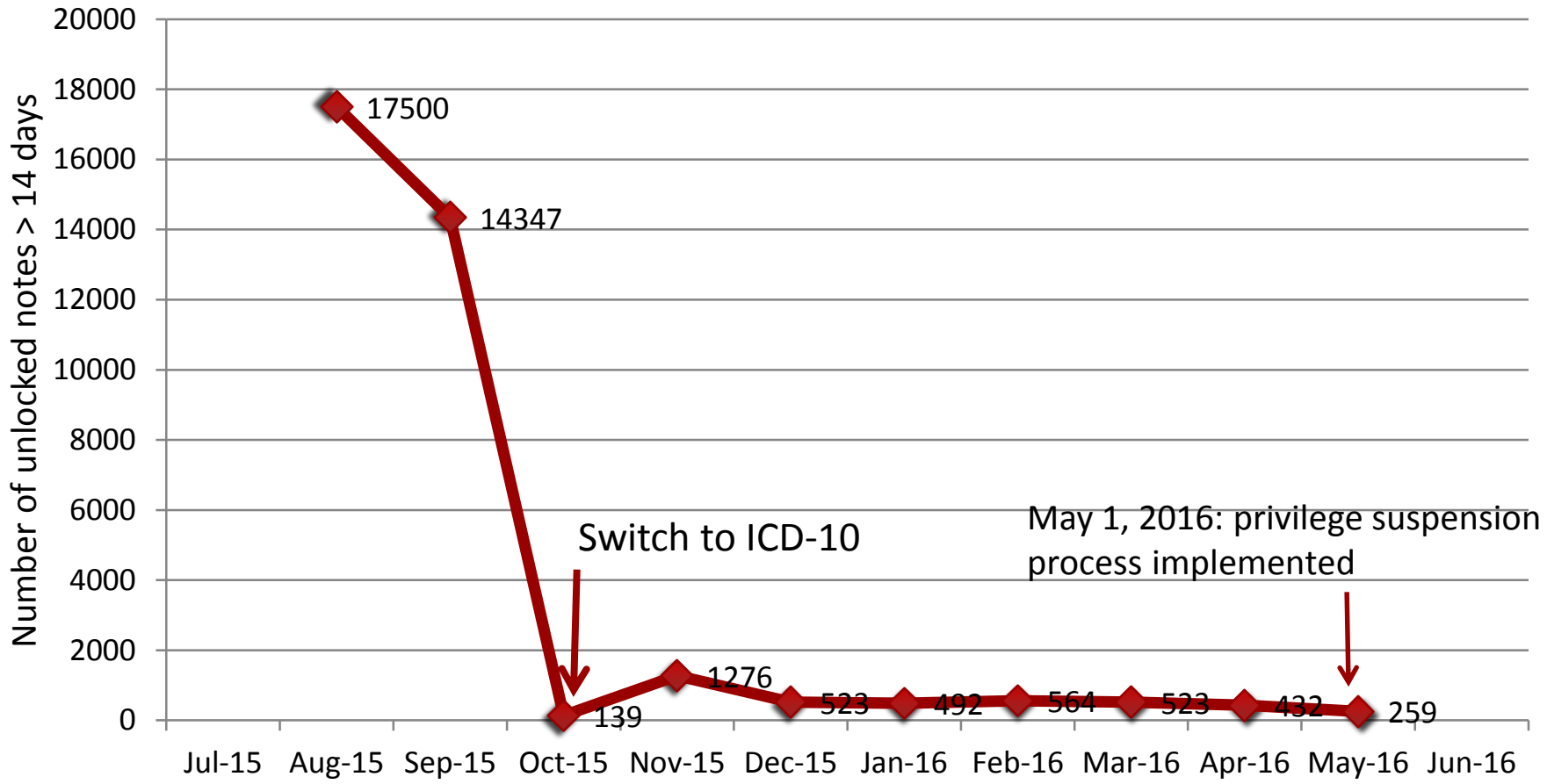
Delinquent paper medical records



Feb 2015: messaging privilege suspension for delinquent charts. Decrease from 20-30% to 3-5%

May 1 2016: privilege suspension process implemented

Delinquent eCW medical records



Additional Information

For review but will not be presented

Initial Appointment

Submitted by applicant

- UCSF Faculty Appointment (if applicable)
- Requested Privileges/Protocols (Standardized Procedures)
- ID attestation per Joint Commission guidelines
- Agreement to abide by the Medical Staff Bylaws, Rules & Regulations
- Attestation questions regarding Actions/ Pending Actions, Liability Matters, Compliance with the Law & Health Status
- Medicare conditions for payment attestation
- Health Plan attestation forms
- Orientation and Occupational Health requirements/attestations
- Current Photo
- Current Curriculum Vitae (CV)

Primary Source verifications:

- California & all other state License(s)
- DEA Certificate and/or Furnishing certificate
- Evidence of Current Malpractice Coverage & Claims history
- Fluoroscopy Certificate (if applicable)
- CPR, BLS/ACLS, PALS (if applicable)
- Residencies, Fellowships;
- Hospitals & affiliations
- Board certification
- AMA profile
- NPDB & Sanctions
- NPI #
- Peer references

File Completion Timeline

- **Initial**

  Complex Files; Military, Foreign Graduates
  3-6 months

  Clean File/straight from
  Residency/Fellowship with AMA verified:
  1-2 months

  Clean Files/not AMA verified
  2-3 months

  With cases
  2-3 months

  Multiple Affiliation/ /Multiple Licenses
  3-4 months

- **Re-appointment**

  Only SFGH (Active Staff)
  1-2 months

  Multiple Hospital and Work Affiliation:
  2-4 months

Privileges

- The hospital has a clearly defined procedure for processing applications for the granting, renewal, or revision of clinical privileges, & the hospital has a process to determine whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privilege.

- Privileges are granted for a period not to exceed two years. All of the criteria used are consistently evaluated for all practitioners holding that privilege.

- Each enumerated privilege states prerequisite requirements, as well as criteria/data required for proctoring and reappointment.

- Evaluation of all of the following are included in the criteria for granting privileges:
  - Current licensure and/or certification, as appropriate, verified with the primary source
  - The applicant's specific relevant training, verified with the primary source
  - Evidence of ability to perform the requested privilege
  - Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
  - Peer and/or faculty recommendation
  - When renewing privileges, review of the practitioner's performance within the hospital

Temporary Privileges

Pending Application for Permanent Medical Staff Membership

- A. In the event that there is a compelling patient care need for which the Chief of the Clinical Service could not have anticipated, the Chief of Staff may grant temporary privileges to an applicant who has a clean application that has been approved by the Credentials Committee & the Medical Executive Committee & is pending the next meeting of the governing body for final approval.
- B. No person with temporary privileges may vote or hold office.
- C. Temporary privileges may be granted for a period not to exceed 60 days.

Application & Review

- The Chief of Staff, with the concurrence of the Chief Executive Officer, may grant temporary privileges after the following has been completed:
  - A. The Chair of the Credentials Committee has determined that the Applicant has a “clean application” as defined in the Definition section of these bylaws.
  - B. The Applicant has been approved by a quorum of both the Credentials Committee & the Medical Executive Committee. Such approval may be obtained through a vote via email.
  - C. The Chief of the Clinical Service provides the Chief of Staff with a compelling patient care need that could not have been anticipated and that requires that the services of the Applicant begin before the application can be approved at the next meeting of the Governing Body.

Ongoing Professional Practice Evaluation

Metrics

- Individual Clinical Services, with Medical Staff concurrence have determined the type of metrics to be monitored & evaluated, relevant to their specialty.
- The type of data to be collected may include, but is not limited to, high volume &/or high risk procedures.
- Continuing review of patient care & the professional performance of practitioners are the responsibility of the chiefs of service or designee as delineated in the medical staff bylaws.
- All OPPE that triggers additional comment or investigation will be reviewed to determine whether there are any performance improvement initiatives that need to be addressed related to organizational processes or clinical practices.
- Organizational metrics chosen for evaluation may include: 1) deaths 2) lengths of stay 3) re-admissions 4) transfusion data 5) other cases reviewed, patient complaints, unusual occurrences; sentinel events.
- Pre-determined thresholds, that trigger Credentials Committee review exist for the following organization metrics: A) deaths rated preventable, or possibly or probably preventable; B) two consecutive ‘marginal ratings by the Service Chief or designee in the same metric; C) two consecutive ‘unacceptable’ ratings in the same metric (these will require FPPE and notification to the Chair of Credentials Committee).