SANTA ROSA MEMORIAL HOSPITAL

POLICY ON
PRACTITIONER ACCESS
TO
CONFIDENTIAL FILES

TABLE OF CONTENTS

PAGE

1. SCOPE OF POLICY AND GENERAL PRINCIPLES

1.A ***Scope of Policy.*** This Policy applies to all practitioners who provide patient care services within Santa Rosa Memorial Hospital (the "Hospital").

1.B ***General Principles.***

(1) ***Practitioner Access to Confidential Files.*** The Medical Staff Bylaws and related documents specifically encourage the use of collegial and educational efforts to address questions or concerns that arise regarding a practitioner's clinical practice or professional conduct. Consistent with those collegial and educational efforts, practitioners may review the certain contents of their confidential credentials and quality files (hereafter referred to collectively as "confidential file") and make notes about it, in accordance with this Policy.

(2) ***Correspondence Added to Confidential File.*** All correspondence sent to a practitioner regarding credentialing, privileging, or PPE/peer review matters shall be contained in the practitioner's confidential file. Practitioners may respond in writing to any such correspondence and the practitioner's response shall be maintained in the practitioner's confidential file along with the original correspondence.

(3) ***Corrections and Deletions at the Request of the Practitioner.*** Practitioners may request corrections and deletions of information in their confidential file. The Chief Medical Officer, or his or her authorized representative, shall make the correction or deletion only after the Medical Executive Committee or the Chief of Staff have determined that good cause exists for the correction or deletion. For purposes of this Policy, "good cause" means that the information in question is factually inaccurate. "Good cause" does not exist simply because information is old or because it reflects an opinion with which the practitioner disagrees. Complaints or reports regarding the practitioner that the Medical Staff evaluated but was not able to substantiate or found it to be unsubstantiated shall not be deleted under this paragraph, but shall remain in the practitioner's file with a statement attached reflecting the findings of the evaluation.

(4) ***Misstatements or Omissions on Application Forms.*** Any individual who plays a role in the credentialing or professional practice evaluation process and who becomes aware of a potential misstatement or omission on an application form for appointment or reappointment submitted by a practitioner shall notify the Credentials Committee. The misstatement or omission will then be handled in accordance with Section 2.C.2 of the Credentialing Policy.

(5) ***Removal of Documents from the File/Copies.*** Under no circumstances may practitioners remove their confidential file (or any portion of it) or make copies of the file or any document in it without the express written permission of the Chief of Staff and the Chief Medical Officer.

(6) ***Non-Retaliation.*** Retaliation against any individual who reports a concern about quality or patient safety or professional conduct is considered inappropriate conduct and will be addressed in accordance with the Medical Staff Professionalism Policy.

(7) ***Disputes.*** Any dispute regarding access to information in a practitioner's confidential file shall be resolved by the Chief Medical Officer and the Chief of Staff, after discussing the matter with the practitioner involved.

2. LEVELS OF ACCESS

2.A *Routine Credentialing and PPE/Peer Review Documents.*

(1) ***Definition.*** The following are considered routine credentialing and PPE/peer review documents at the Hospital:

(a) applications for appointment, reappointment, or permission to practice, and requested changes in staff status or clinical privileges, with all attachments (except for confidential reference information obtained from third parties as described in Section 2.C below);

(b) information gathered in the course of verifying, evaluating, or otherwise investigating applications for appointment, reappointment, permission to practice, or changes in staff status or clinical privileges (except for confidential reference information obtained from third parties as described in Section 2.C below);

(c) quality profiles, Ongoing Professional Practice Evaluation ("OPPE") reports, or other quality data reports;

(d) routine correspondence between the Hospital and the practitioner; and

(e) information concerning the practitioner's meeting attendance record and compliance with other citizenship requirements.

(2) ***Access.*** A practitioner shall be permitted access to routine credentialing and PPE/peer review documents, provided the practitioner (i) schedules a specific time to review the file with a representative of Medical Staff Administration present, and (ii) acknowledges that no information can be removed or altered as described in Section 1.B of this Policy.

2.B ***Sensitive Internal Documents.***

(1) ***Definition.*** The following are considered sensitive internal documents at the Hospital:

(a) reported concerns or incident reports concerning the practitioner prepared by Hospital employees, other practitioners, contractors, patients or visitors;

(b) confidential correspondence, memos to file, and notes prepared by Medical Staff Leaders and Hospital personnel related to collegial intervention efforts or other progressive steps with the practitioner;

(c) periodic review and appraisal forms completed by the appropriate Service Chair, including those completed at the time of appointment, reappointment, or renewal of permission to practice;

(d) professional practice evaluation forms completed as part of the professional practice evaluation process or the initial evaluation to confirm competence;

(e) evaluations or reports from proctors, monitors, and external clinical reviewers;

(f) confidential reports and minutes (redacted) of peer review committees pertaining to the practitioner; and

(g) correspondence setting forth formal Service, Credentials Committee, Leadership Council, Professional Practice Evaluation Committee ("PPEC"), or Medical Executive Committee action, including, but not limited to, letters of guidance, warning, or reprimand, terms of probation, or consultation requirements.

(2) ***Access.*** A practitioner shall be permitted access to sensitive internal documents as follows:

(a) The practitioner must first sign the Request to Access Confidential File Form set forth as **Appendix A** to this Policy.

(b) The practitioner may review sensitive internal documents that have already been provided to the practitioner (e.g., follow-up letters to collegial intervention, correspondence regarding official committee action, reports from external reviewers, etc.) in the presence of an appropriate Medical Staff Leader and may request copies of those

documents (subject to any reasonable charges). (Medical Staff Leader is defined in the Organization Manual.)

(c) Sensitive internal documents that have not been provided to the practitioner (e.g., reported concerns, confidential notes maintained by Medical Staff Leaders, proctor reports, credentialing appraisal forms, etc.) shall be summarized in a manner that does not reveal who prepared or submitted the document, and the summary shall be reviewed with the practitioner by an appropriate Medical Staff Leader or the CMO. The summary shall be retained in the practitioner's confidential file.

(d) The practitioner shall not be told the identity of any individual who prepared or submitted a sensitive internal document, unless:

(i) the individual specifically consents to the disclosure (however, the Medical Staff is not obligated to make this request of the individual);;

(ii) the Chief of Staff and the Chief Medical Officer determines that an exception should be made in a particular situation; or

(iii) the information is the basis for an adverse professional review action that entitles the individual to a hearing pursuant to the Medical Staff Bylaws.

(e) In accordance with the Medical Staff Professionalism Policy, an appropriate Medical Staff Leader or the CMO may also prepare a summary of a sensitive internal document and provide it to the practitioner to obtain the practitioner's input or in preparation for a meeting with the practitioner about the matter.

2.C ***Sensitive External Documents.***

(1) ***Definition.*** The following are considered sensitive external documents at the Hospital:

(a) confidential correspondence from references and other third parties, including, but not limited to, letters of reference, confidential evaluation forms, and other documents concerning the practitioner's training, clinical practice, professional competence, or conduct at any other health care facility, residency or fellowship training program;

(b) results of National Practitioner Data Bank ("NPDB") queries; and

(c) notations of telephone conversations concerning the practitioner's qualifications with references and other third parties, including date of conversation, identification of parties to the conversation, and information received and/or discussed.

(2) ***Access.*** A practitioner shall be permitted access to sensitive external documents in accordance with the same terms and conditions as for sensitive internal documents (Section 2.B(2)). An exception applies to the results of queries to the NPDB. Per requirements of federal law, the Hospital will not share these results with the practitioner; instead, the practitioner should request his or her own information directly from the NPDB.

2.D ***Practitioner Explanation/Response***

The practitioner may submit a written explanation or response to any of the documents or summaries he or she reviews for inclusion in the file.

2.E ***Medical Staff Hearings.*** Notwithstanding this policy, a practitioner who is entitled to and requests a hearing under the Hearing and Appeals Procedures Article of the Medical Staff Bylaws shall be entitled to review or receive documents in the manner detailed in that Article.

APPENDIX A

REQUEST TO ACCESS CONFIDENTIAL FILE

I have asked to review information from my confidential Medical Staff file. I understand that the Hospital and Medical Staff Leadership need to take appropriate steps to maintain the confidentiality of this information under California and federal law, as well as to ensure a professional, non-threatening environment for all who work and practice at the Hospital. Accordingly, as a condition to reviewing this information, I agree to the following:

1. I will maintain all information that I review in a ***strictly confidential*** manner. Specifically, I will not disclose or discuss this information ***except*** to the following individuals: (i) my physician colleagues and/or Hospital employees who are directly involved in credentialing and peer review activities concerning me, and/or (ii) any legal counsel who may be advising me. I will not share or discuss this information with any other individual without first obtaining the express written permission of the Hospital.

2. I understand that this information is being provided to me as part of the Medical Staff's and Hospital's policy of attempting to utilize collegial intervention and progressive steps, where possible, to address any questions or concerns that may arise with my practice. In addition to discussing these matters directly with the Medical Staff and Hospital leadership, I understand that I may also prepare a written response and that this response will be maintained in my file.

3. I understand that the Hospital and the Medical Staff have a responsibility to provide a safe, non-threatening workplace for my physician colleagues and for Hospital employees. I therefore agree that ***I will <u>not directly discuss</u> the information that I review from my file with any individual who may have provided the information, <u>nor</u> will I engage in any other retaliatory or abusive conduct with respect to these individuals***. This means that I will not directly approach, confront, ostracize, discriminate against, or otherwise mistreat any such individual with respect to any information that the individual may have provided.

4. I understand that any retaliation by me, as described in the previous paragraph, is a very serious matter and cannot be tolerated. Any such conduct by me will be grounds for immediate referral to the Medical Executive Committee for review and possible disciplinary action pursuant to the Medical Staff Bylaws and related documents.

By signing this Agreement, I understand that I am ***<u>not waiving</u>*** any of the rights or privileges afforded to me under the Medical Staff Bylaws and related documents.

I also understand that I am fully permitted to raise any question or concern that I may have regarding the care being provided by a nurse or other Hospital employee, another physician, or the Hospital itself. ***However, I understand that I must use the established and confidential Medical Staff and administrative channels in order to register any such concerns.*** These mechanisms are part of the Hospital's ongoing performance improvement and peer review activities, and permit the appropriate Medical Staff or Hospital leadership to fully review and assess the matter and take action to address the issue, as may be necessary.

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_____, M.D. Date

Board approved: May 22, 2018