COVENANT MEDICAL CENTER

POLICY ON PRACTITIONER ACCESS TO CONFIDENTIAL FILES

Adopted by the Medical Staff: August 13, 2019
Approved by the Board: August 29, 2019

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1. SCOPE OF POLICY, DEFINITIONS, AND GENERAL PRINCIPLES

1.A *Scope of Policy.* This Policy applies to all Practitioners who provide patient care services at (the "Hospital").

1.B Definitions.

(1) "Medical Staff Leader" means any Medical Staff Officer, department chair, section chief, and committee chair.

(2) "Practitioner" means any individual who has been granted clinical privileges and/or membership by the Board, including, but not limited to, members of the Medical Staff and Allied Health Professionals.

1.C General Principles.

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

(2) ***Rules Regarding Access to Files.*** Practitioners may be given a reasonable opportunity to inspect their confidential file, make notes regarding it, and discuss the contents with Hospital or Medical Staff Leaders. However, no information in the file may be photocopied, digitally imaged or recorded, altered, or removed from the file without the express written permission of the Chief of Staff, Chief Medical Officer or the Chief Executive Officer ("CEO"), except that documents submitted by the Practitioner to the Hospital may be copied and provided to the Practitioner without the need for written permission as described in this subsection.

(3) ***Correspondence Added to Confidential File.*** All correspondence sent to a Practitioner regarding credentialing, privileging, or 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.

(4) ***Corrections and Deletions at the Request of the Practitioner.*** Practitioners may request corrections and deletions of information in their confidential file. Except as otherwise provided, the Chief of Staff or the Vice Chief of Staff shall make the correction or deletion only after the Leadership Council has 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.

(5) ***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 Chair of the Centralized Credentials Committee. The Centralized Credentials Committee shall provide notice to the Practitioner and invite the Practitioner to provide a written response. The Centralized Credentials Committee shall determine whether any action with respect to the Practitioner's clinical privileges is appropriate as set forth in the Medical Staff Credentials Policy, or if information should be added to the Practitioner's confidential file to clarify the issue.

(6) ***Non-Retaliation.*** Retaliation by a Practitioner against any individual who reports a concern about quality or patient safety or professional conduct is 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 of Staff and the Chief Medical Officer, after discussing the matter with the Practitioner involved. Hospital counsel may be consulted for assistance, and shall be consulted if a request for access is received from a Practitioner's attorney.

(8) ***Delegation of Functions.*** When a function under this Policy is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(9) ***Former Practitioners.*** Individuals who no longer have clinical privileges or Medical Staff appointment at the Hospital are not entitled to access their confidential files as set forth in this Policy. However, the Chief of Staff and the Chief Medical Officer may, in their discretion, grant access to such former Practitioners. In deciding whether to grant access, the Chief of Staff and the Chief Medical Officer may consider any relevant factor,

including: (1) the former Practitioner's rationale for requesting access; (2) staff and resource limitations; and (3) the potential risk to the confidentiality of the information, in light of the fact that the former Practitioner is no longer bound by the confidentiality requirements in the Medical Staff Credentials Policy and related documents. If the Chief Medical Officer and Chief of Staff decide to grant access to a former Practitioner, they may use the provisions of this Policy as guidance, or they may provide more limited access (e.g., no access to documentation about behavioral concerns).

2. LEVELS OF ACCESS

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

(1) ***Definition.*** The following are considered routine credentialing and professional practice evaluation ("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;

(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) results of queries to the National Practitioner Data Bank;

(d) quality profiles, Ongoing Professional Practice Evaluation ("OPPE") reports, Focused Professional Practice Education ("FPPE") reports, and other quality data reports;

(e) routine correspondence between the Hospital and the Practitioner; and

(f) 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 the Medical Staff Office present, and (ii) reviews and acknowledges the rules regarding access to files described in Section 1.C(2) 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 or other Practitioners;

(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 Department Chair, including those completed at the time of appointment, reappointment, or renewal of permission to practice;

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

(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 Centralized Credentials Committee, Leadership Council, CoPE, or Medical Executive Committee action, including, but not limited to, letters of guidance, warning, or reprimand, terms of probation, consultation requirements, performance improvement plans, or final adverse actions following completion or waiver of a hearing and appeal.

(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 Files form set forth as **Appendix A** to this Policy. The Practitioner must also review and acknowledge the rules regarding access to files described in Section 1.C(2) of 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 or the Chief Medical Officer.

(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 Chief Medical Officer. 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;

(ii) the Leadership Council, an appropriate Medical Staff Leader, or 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 Credentials Policy.

(e) In accordance with the Medical Staff Professionalism Policy, an appropriate Medical Staff Leader or the Chief Medical Officer 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.

(f) The Practitioner may submit a written explanation or response to such documents or summaries for inclusion in the file.

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) 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 (see Section 2.B(2)).

2.D ***Medical Staff Hearings.*** As set forth in the Medical Staff Credentials Policy, a Practitioner shall be entitled to a copy of any document that was used as the basis for an adverse professional review action that entitles the individual to a Medical Staff hearing.

Adopted by the Medical Executive Committee on_____, 2019.

Approved by the Board on_____, 2019.

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 Leaders need to take appropriate steps to maintain the confidentiality of this information under Texas 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 not discuss the information that I review from my file with any individual who may have provided the information, nor will I engage in any other retaliatory or abusive conduct with respect to these individuals***. This means that I will not 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 will not 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 Credentials Policy and related documents.

By signing this Agreement, I understand that I am ***not waiving*** any of the rights or privileges afforded to me under the Medical Staff Credentials Policy 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.

_____ _____

[Name] Date

Note: After this agreement is signed, a copy shall be returned to the Practitioner for reference.