

This policy applies to: <input checked="" type="checkbox"/> <i>Stanford Hospital and Clinics</i> <input checked="" type="checkbox"/> <i>Lucile Packard Children’s Hospital</i>	Date Written or Last Revision: May 2010
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I. PURPOSE

To establish mechanisms for reviewing relevant data that will serve as the basis for decisions regarding licensed health care providers file and to ensure adverse information is carefully reviewed before recommendation for appointment or reappointment.

II. POLICY STATEMENT

It is the policy of Stanford Hospital and Clinics (“SHC”) and Lucile Packard Children’s Hospital (“LPCH”) to ensure all licensed health care providers are reviewed and ranked according to issues identified in their file.

III. FILE REVIEW

When all of the information has been gathered, the file is triaged by a Credentialing Coordinator and designated as Category 1 or Category 2. This is a method of triaging files to ensure that potentially adverse information is fully reviewed before recommending the provider for appointment or reappointment. A provider’s file is identified as Category 1 or Category 2 based on the following:

Category 1 – All verification and evaluation of credentials file is complete with no issues needing further discussion and verification documents are received with no adverse response

Category 2 – Additional evaluation by Department Head/Service Chief/Division Head and Credentials Committee(s) is required based on issues as indicated below. The Credentials Committee Chair can assess files prior to the full Credentials Committee meeting and make an assessment on whether or not the file should be presented to the full committee for review (See Appendix A):

1. General Issues:

- The applicant has experienced voluntary or involuntary termination of medical staff membership, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care organization
- The applicant has held a substantial number (more than five) of medical licenses across the United States
- Unsatisfactory peer reference or prior affiliation information
- Disciplinary actions or reports filed by any verification organization (NPDB, MBC, State Licensing Board, or a state or federal regulatory agency or there has been a criminal conviction etc.)
- One malpractice claim in the past two years which is still pending or resulted in a settlement or any and all history of malpractice cases on new applicants
- Review of any “yes” answers on attestation questions

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- Derogatory or questionable information obtained from any source
- There are gaps in time for which the applicant has not accounted
- There are discrepancies between information the applicant submitted and information received from other sources.

2. Issues Specific to Reappointment:

- Health issues identified in reapplication, e.g., inability to perform essential functions, illegal drug use
- Additional privileges requested or privileges the applicant requested vary from those requested by other practitioners in the same specialty
- Activity not consistent with Medical Staff category
- QA data referencing quality of care issues
- Peer references and/or prior affiliations indicate potential problems (e.g., difficulty with interpersonal relationships, minor patient care issues, etc.)

Completed application packets including all verifications and supporting documents will be forwarded to the appropriate Department Head/Service Chief/Division Head for review and recommendation to the Credentials Committee(s). All Category 2 files will be individually reviewed by the Credentials Committee Chair and/or the Credentials Committee(s) prior to being recommended to the respective Medical Executive Committee (MEC) of each facility.

A report must be drafted for the Credentials Committee(s) documenting the concerns, if the Department Head/Service Chief/Division Head does not wish to approve the application for appointment or reappointment based on:

- Perceived medical disciplinary cause or reason, indicating the potential for a provider's conduct to be detrimental to patient safety or to the delivery of patient care; or
- Perceived conduct or professional competence which affects or could affect adversely the health or welfare of a patient or patients,

IV. APPROVAL PROCESS

There is a Credentials Committee at each hospital which will meet monthly, but may meet more frequently or be canceled as determined by the Chairman. The membership of these committees will be at least eight (8) members of the general Medical Staff at each facility who shall be chosen to ensure representation from major clinical areas. In addition, the SHC committee will have a medical staff member from Psychiatry, Chief of Staff, and the Vice Chief of Staff. All of these members vote on matters coming before

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the committee. Thirty percent (30%) of the voting membership (but no less than [3]) of this committee shall be considered a quorum. Recommendation will be made in a nondiscriminatory manner and not based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patient in which the practitioner specializes. Each committee member will be asked to sign a Confidentiality Statement.

After receiving Clinical Department/Service review, the application packet may be reviewed by the Credentials Committee Chair prior to each full Credentials Committee Meeting (review may also occur electronically) then processed through the Credentials Committee(s), Medical Executive Committee (MEC), and Hospital Board(s) of Directors at each applicable facility for final approval. If an application for appointment or reappointment is deferred at any of these levels due to a need for further information, the Credentials Office will assist in the follow-up process. Upon request and/or as a follow up to the credentialing process as outlined above, the provider will be informed of the status of their appointment or reappointment throughout the credentialing process. Any and all requests for further information will be made in writing and forwarded to the provider via internal mail system, email and/or regular mail methods.

When the appointment or reappointment has been approved by the Board(s) of Directors, the Credentials Office will send a letter or email confirmation to each provider indicating that their request for appointment or reappointment has received final approval from the respective Board of Directors within 60 days of final approval. At this time, the Credentialing database is updated and information is maintained on an online roster assessable by the medical group.

For any denied applications, the information will be reviewed by Medical Executive Committee (MEC) to ensure that applications are not being denied based on discrimination as noted above.

Any application still pending after 45 days based on information not received from the applicant will be placed in an inactive status. The applicant may have to ability to reapply at a later day.

A. III. RELATED DOCUMENTS

- Stanford Hospital and Clinics Medical Staff Bylaws, Rules and Regulations
- Lucile Packard Children's Hospital Medical Staff Bylaws, Rules and Regulations
- Credentials Policies and Procedures

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I. IV. DOCUMENT INFORMATION

A. Legal Authority/References
JCAHO Standards
NCQA Standards
Title 22 Regulations

B. Author/Original Date

This Policy was authored by the Director, Medical Staff Services in May, 2006.

C. Gatekeeper of Original Document

The Director, Medical Staff Services (or designee), who will be responsible for initiating its review and revision. The Policy will reside in the Credentials Policy and Procedure Manual, a copy of which is kept in the Credentials Department and in the Medical Staff Office.

D. Distribution and Training Requirements

The distribution and training requirements for this Policy will be handled through the Credentials Department.

E. Requirements For Review and Renewal

This Policy will be reviewed and/or revised every three years or as required by change of law or practice.

F. Review and Revision History

Revision – September, 2000 (Approved by HCC 9/18/00), 3/02, 12/02, 7/03, 6/05, 10/06, 10/07, 3/10

G. Local Approvals

Credentials Committee (2) – 3/02, 7/03, 6/05, 10/06; 11/07, 4/10
LPCH Policy Committee – 4/10
Medical Executive Committee (2) – 4/02, 8/03, 7/05, 11/06, 12/07, 5/10

Hospital Board Approvals (2)

4/02, 8/03, 7/05, 11/06, 12/07, 5/10

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**Direct inquiries to:
Director, Medical Staff Services, (650) 497-8920
SHC and LPCH**

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APPENDIX A

Credentiaing and Privileging Policy for LIP's
Follow up and Status
What Constitutes Cat II files

ISSUE	LPCH	SHC
Any open or closed Claims history for new appointments even if the pay out was \$0 and even if the applicant was dismissed from the claim.	These will be reviewed by Credentials Committee Chair and discussed at the full meeting as necessary. Any file with more than 1 open/closed claim will be reviewed by the full committee.	These will be reviewed by Credentials Committee Chair and discussed at the full meeting as necessary
Any Claims not discussed or not closed in the past two years for reappointments	These will be reviewed by the full Committee	These will be reviewed by Credentials Committee Chair and discussed at the full meeting as necessary
No/Low volume	These will be assessed by the Chair and determined if full committee review is necessary	a. These will be managed by policy or bylaws. If volume criteria is not met, then notification will be sent to the provider, Service Chief and Deputy Chief (for community physicians). Use standard letter that currently exists. b. These will also be reviewed by the Credentials Committee Chair and discussed at the full meeting as necessary
Pending items (i.e., x-ray certificate when required, OH&S, Teaching Appointment)	These will be flagged and reviewed by the full Committee, but not treated as a CAT II	a. Files that are pending items (i.e., x-ray certificate when required, OH&S, Teaching Appointment, DEA, and DEA without CA Address). For those who are not willing to obtain a DEA or get a CA address, policy will be followed and a letter will be sent stating policy. b. These will be reviewed by Credentials Committee Chair and discussed at the full meeting as necessary

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ISSUE	LPCH	SHC
No clinical Activity for previous two years	These will be assessed by the Chair and determined if full committee review is necessary	Review as CAT II at Full Meeting
MBC 805 report (exclude MBC report for non change of address. This will be reviewed by Committee Chair)	Review as CAT II at Full Meeting	Review as CAT II at Full Meeting
Peer Reference with a rating of less than 3 on a 1 to 5 scale	Review as CAT II at Full Meeting	Review as CAT II at Full Meeting
Provider attests to previous drug use or criminal activity/background check	Continue to refer to Well Being Committee These will be assessed by the Chair and determined if full committee review is necessary	Review as CAT II at Full Meeting Continue to refer to Well Being Committee
When privilege criteria has not been met, but privileges <u>have been</u> approved by service chief.	Review as CAT II at Full Meeting	Refer Service Chief to Chair of Credentials
When privilege criteria has been met, and privileges <u>have not been</u> approved by service chief	These will be assessed by the Chair and determined if full committee review is necessary	Refer Service Chief to Chair of Credentials
FPPE implemented as a result of Peer Review	Review as CAT II at Full Meeting	Review as CAT II at Full Meeting
Reappointment zero cases for particular privilege proctor assigned	These will be assessed by the Chair and determined if full committee review is necessary	These will be assessed by the Chair and determined if full committee review is necessary
Reappointment new privilege been requested and proctor has been assigned	These will be assessed by the Chair and determined if full committee review is necessary	These will be assessed by the Chair and determined if full committee review is necessary