TAHOE FOREST HOSPITAL DISTRICT

2017-05-09 Board Quality Committee Meeting

Tuesday, May 9, 2017 at 12:00 pm

Human Resources Conference Room - Tahoe Forest Hospital

10024 Pine Avenue, Truckee, CA 96161

Meeting Book - 2017-05-09 Board Quality Committee Meeting

05/9/17 Board Quality Committee

AGENDA

ITEMS 1 - 4: See Agenda

5. APPROVAL OF MINUTES

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.2. Patient & Family Centered Care (PFCC)

6.2.2. Patient Experience Presentation

Jean Steinberg

6.4. Healthcare Facilities Accreditation Program (HFAP) Survey

No related materials.

6.5. Medical Staff Quality Committee

No related materials.

6.6. Quadruple AIM

No related materials.

6.7. Board Quality Education

No related materials.

ITEMS 7 - 9: See Agenda

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE AGENDA

Tuesday, May 9, 2017 at 12:00 p.m.
Human Resources Conference Room, Tahoe Forest Hospital
10024 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL
Alyce Wong, RN, Chair; Charles Zipkin, M.D., Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE
This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. APPROVAL OF MINUTES OF: 3/14/2017 ..... **ATTACHMENT**

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Quality Committee Charter and 2017 Focus ..... ATTACHMENT
Review and approve the *Board Quality Committee Charter and 2017 Focus*

6.2. Patient & Family Centered Care (PFCC)

6.2.1. Patient & Family Advisory Council Update ..... ATTACHMENT
An update will be provided related to the activities of the Patient and Family Advisory Council (PFAC).

6.2.2. Patient Experience Presentation
Update on a past patient experience presentation and discuss potential patients that may be interested in sharing their healthcare story at an upcoming TFHD Board of Directors or Board Quality Committee meeting.

6.3. Credentialing & Peer Review Process ..... ATTACHMENT
Review the Medical Staff credentialing, privileging, and peer review process to gain an understanding of this function.

6.4. Healthcare Facilities Accreditation Program (HFAP) Survey
Provide a summary report on the triennial HFAP accreditation survey conducted April 24-28, 2017.

6.5. Medical Staff Quality Committee (MSQAC)
Discuss the option of having two Board members attend the open session bimonthly MSQAC meeting instead of having a separate Board Quality Committee meeting.

6.6. Quadruple Aim

Discuss plan to obtain physician and staff engagement information with a goal to improve the experience of providing care.

6.7. Board Quality Education

6.7.1. Future Board Quality Education

Discuss any topics for future board quality education.

6.7.2. Hospital Quality Institute Conference

Discuss attendance at the Hospital Quality Institute Annual Conference on November 1-3, 2017, in Monterey, CA.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE

The date and time of the next committee meeting will be confirmed for Tuesday, July 11, 2017, at 12:00 p.m.

9. ADJOURN

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

TAHOE FOREST HEALTH SYSTEM

QUALITY COMMITTEE
DRAFT MINUTES

Tuesday, March 14, 2017 at 12:00 p.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER
Meeting was called to order at 12:03 p.m.

2. ROLL CALL
Board: Alyce Wong, RN, Chair; Charles Zipkin, M.D., Board Member

Staff: Harry Weis, Chief Executive Officer; Crystal Betts, Chief Financial Officer; Judy Newland, Chief Operating Officer; Janet Van Gelder, Director of Quality and Regulations; Dr. Peter Taylor, Medical Director of Quality; Dr. Shawni Coll, Chief Medical Officer; Dr. Joshua Scholnick, Vice Chief of Staff; Trish Foley, Patient Advocate; Martina Rochefort, Clerk of the Board

Other: Nancy Woolf, Patient and Family Advisory Council member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
No changes were made to the agenda.

4. INPUT – AUDIENCE
No public comment was received.

5. APPROVAL OF MINUTES OF: 1/23/2017
Clerk of the Board was directed to change "authority" to "responsibility" under item 6.2.

Director Wong approved the Quality Committee minutes of January 23, 2017 with the change noted above, seconded by Director Zipkin.

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION
6.1. Quality Committee Charter and 2017 Focus
Director of Quality and Regulations reviewed the Quality Committee charter and proposed 2017 focus.

General Counsel advised via email that a charter is not required for the committee.

Director Wong recommended dropping charter at this time.

Director Wong moved to defer the approval of the charter until after the board retreat.

Director Wong moved approval of the Quality Committee's 2017 Focus, seconded by Director Zipkin.

6.2. Patient & Family Centered Care (PFCC)
6.2.1. Patient & Family Advisory Council Update
Due to the blizzard in February, PFAC was cancelled so there is nothing new to report.

Director Wong hopes the PFAC will find additional family members to come speak.

6.2.2. TIMED ITEM – 12:15 PM - Patient Experience Presentation

The Quality Committee received a presentation from a husband regarding his wife's care at Gene Upshaw Memorial Cancer Center and Tahoe Forest Hospital.

Mr. Joslin joined the meeting at 12:13 p.m.

Mr. Joslin shared the story of his wife's journey through cancer. He felt a "a hand-off/road map" is needed after a cancer diagnosis is given.

Mr. Joslin discussed the perception of hospice. "Hospice means death." He felt their meeting with Dr. Brooks Rohlen could have happened sooner. He would like to see more cohesion between physicians.

Mr. Joslin departed the meeting at 12:43 p.m.

Discussion was held about current work that is developing on a palliative care program.

CNO has been working on palliative care with Bev Schnobrich on the inpatient side. Dr. Heifetz is also working on the palliative care program.

Director Zipkin suggested patients be referred to "palliative care" instead of "hospice." COO stated the industry on a national level is moving from using "hospice."

COO added that a follow up phone call needs to happen after patients receive a diagnosis.

CEO commented that we owe a roadmap to our patients.

Nancy Woolf suggested having the physician sit down with the patient and scratch a plan out on a piece of paper. There is something valuable about having notes to take home.

Director Zipkin said the Patient Advocate should let Mr. Joslin know that hospice has a volunteer program if he is interested.

6.3. Healthcare Facilities Accreditation Program (HFAP) Survey

Director of Quality and Regulations provided an update on preparation for the unannounced triennial HFAP accreditation survey.

Staff is diligently preparing for the unannounced survey.

There will be two separate surveys for Tahoe Forest Hospital and Incline Village Community Hospital.

6.4. Medical Staff Quality Committee (MSQAC)

The committee discussed the option of having two Board members attend the open session bimonthly Medical Staff Quality Assurance Committee meeting instead of having a separate Board Quality Committee meeting.

The District's General Counsel, in conjunction with Medical Staff's attorney, will weigh in on whether or not the Quality Committees can be combined.

Discussion was held on what topics each of the Quality Committees review.

Dr. Coll will join the call with legal counsel.

This topic will be added to the agenda for the next Quality Committee meeting.

6.5. Quadruple AIM

Employee Engagement Survey is conducted through Human Resources.

The Patient Safety Survey will go out at the end of April or beginning of May.

Medical Staff Services is working on a physician satisfaction survey. They would like to offer incentive prizes for physicians to complete the survey which will be conducted by Press Ganey.

COO suggested changing "satisfaction survey" to "engagement survey".

CMO stated quality of care comes from engaged physicians and staff.

Directed Wong inquired what the Personnel Committee does with survey data.

6.6. Board Quality Education

The Quality Committee discussed the Governance Institute white paper on *Maximizing the Effectiveness of the Board's Quality Committee: Leading Practices and Lessons Learned*.

Director Wong commented this was a great article. It reinforces the idea there should be a Quality Committee. The Quality Committee is doing the job expected.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

None.

8. NEXT MEETING DATE

The date and time of the next committee meeting was confirmed for Tuesday, May 9, 2017, at 12:00 p.m.

9. ADJOURN

Meeting adjourned at 1:35 p.m.

Board Quality Committee Focus 2017

Approved March 14, 2017

1. Monitor quality, service and patient safety metrics and support processes, with a focus on outliers, to achieve top decile performance and measurable improvement.

2. Monitor the Patient Safety Culture Survey plan for improvement progress.

3. Support the Quadruple Aim, including improving the experience of providing care and workforce engagement.

4. Provide appropriate resources to assist the Patient & Family Advisory Council (PFAC) improvement initiatives.

5. Provide direction on how to best educate the community about the TFHD quality and service metrics (i.e., web site, public speaking, social media, quarterly magazine, newspaper articles, etc.).

6. Support the Epic electronic health record implementation with a focus on quality, service, and patient safety.

Quality Committee Charter

Approved January 22, 2014

Tahoe Forest Hospital District is committed to performance excellence, to delivering the highest quality care and service, and to exceeding the expectations of our patients, physicians, employees, and community. This committee will provide leadership, oversight, and accountability for organization wide quality improvement processes and programs. We will regularly assess the needs of our stakeholders, evaluate proposed quality initiatives, openly debate options, and assure the production of an organization wide strategic plan for quality. We will set expectations, facilitate education, and support the monitoring of the quality of care, service excellence, risk reduction, safety enhancement, performance improvement, and healthcare outcomes. Because of our efforts Tahoe Forest Hospital District will be the best place to receive care, the best place to work, the best place to practice medicine, and a recognized asset to all in our community.

G. Quality Committee

1. The Committee membership shall be comprised of a minimum of two members of the Board of Directors as appointed by the Board President and two (2) members of the Tahoe Forest Hospital Medical Staff as appointed by the Medical Executive Committee. {Recommend Chief of Staff or designee and Chairperson of the Quality Assessment and Improvement Committee}

2. The Committee shall meet a minimum of four (4) times per calendar year.

3. The Committee is accountable to the Board of Directors for the following:

a. Provide oversight for the organization-wide Quality Assessment and Performance Improvement Plan;

b. Set expectations of quality care, patient safety, environmental safety, and performance improvement throughout the organization;

c. Ensure the provision of organization-wide quality of care, treatment, and service provided and prioritization of performance improvement throughout the organization;

d. Monitor the improvement of care, treatment, and services to ensure that it is safe, beneficial, patient-centered, customer-focused, timely, efficient, and equitable;

e. Oversee and be accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities;

f. Ensure the development and implementation of ongoing education focusing on service excellence, performance improvement, risk-reduction/safety enhancement, and healthcare outcomes.

H. Community Benefit Committee

1. The Committee shall comprise two (2) Board Members.
2. The Committee shall meet at least 4 times a year and additionally as needed.
3. The Committee shall have the following responsibilities pursuant to the policies of the Board of Directors:
   a. Ensure Health System strategic planning and stated goals include community and population health initiatives to improve health, decrease costs, and improve the patient experience.
   b. Provide advice and input in the deployment of the tri-annual Community Health Needs Assessment (CHNA).

Tahoe Forest Hospital District
Board Quality Committee Charter

Draft

The Board Quality Committee was established by the Tahoe Forest Hospital District Board of Directors to assist the Board in fulfilling its oversight and accountability for the organization-wide Process Improvement and Quality Assurance Programs. The committee considers operational and clinical quality, patient safety, patient and family engagement/satisfaction, and risk management, regulatory preparedness and compliance across the continuum of care in the organization.

Membership

The Committee membership shall be comprised of a minimum of two members of the Board of Directors as appointed by the Board President and two members of the Tahoe Forest Hospital Medical Staff as appointed by the Medical Executive Committee. (Recommended Chief of Staff or designee and the Chairperson of the Quality Assessment and Improvement Committee)

Meetings

The committee shall meet a minimum of four times per calendar year.

Accountability

The Committee is accountable to the Board of Directors for the following:

1. Provide oversight for the organization-wide Quality Assessment and Performance Improvement Plan.
2. Set expectations of quality care, patient safety, environmental safety and performance improvement throughout the organization.
3. Ensure the provision of organization-wide quality of care, treatment and services provided and prioritizing of performance improvement throughout the organization.
4. Monitor the improvement of care treatment and services to ensure that it is safe, beneficial, patient-centered, customer focused, timely efficient and equitable.
5. Oversees and accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs and subsequent quality improvement activities.
6. Ensures the development and implementation of ongoing education focusing on service excellence, performance improvement, risk-reduction/safety enhancement and healthcare outcomes

2017 PFAC PROCESS IMPROVEMENT LOG

The identified topics are noted on this log and the information is forwarded to the responsible Director/Manager for their review and follow up.

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
1st Quarter 2017				
1/17/17	Laboratory Services Emergency Department Hand Cleaning Signage Wellness Community Resources	Vern Barnes Sharon Sutich John Rust PFAC PFAC	Guest speakers Vern Barnes, Sharon Sutich, and John Rust. Vern and Sharon provided an update for on-line scheduling of laboratory appointments and discussed ways to increase participation. The lab administers a single question survey to inquire about services and anything that can be done to improve experiences. Feedback from the group included the importance of Spanish speaking staff and ways for patients to understand what labs they are having done and what orders say from the physicians (i.e. whether they need to fast). John relayed year end Press Ganey scores for the Emergency Department which were favorable! We discussed patient perceptions and how outliers can drastically affect survey results; also acknowledging how the same experience can elicit different responses or expectations. Areas for process improvements include noise reduction at the nurse's station, keeping patients informed about delays, and utilizing private rooms when possible to address privacy. We revisited the hand washing signage discussed in November for patient rooms and it was identified that the inpatient white boards do include signage that is adequate for patient rooms. Staff will be reminded to review this information with patients. There was discussion about how to involve/include Incline Village Community Hospital (IVCH) patients and families in the PFAC.	Continued focus on noise reduction in ED; use of private rooms when possible Relayed information to Jan Iida for consideration

2017 PFAC PROCESS IMPROVEMENT LOG

The identified topics are noted on this log and the information is forwarded to the responsible Director/Manager for their review and follow up.

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
1/17/17	(continued)		It was determined perhaps quarterly focus groups at IVCH may be helpful to provide information about the services and also obtain feedback for process improvements. We also discussed how important it is for the Wellness Neighborhood to educate our clinics on ways for patients to seek services for depression. Other items: PFAC member Nancy Woolf accepted the opportunity to be a representative on the Board Quality Committee! Also, we have a new member, Sandra Dorst, who will be joining us once her orientation is complete!	Relayed information to Maria Martin
2/21/17	Meeting Cancelled (weather)			

2017 PFAC PROCESS IMPROVEMENT LOG

The identified topics are noted on this log and the information is forwarded to the responsible Director/Manager for their review and follow up.

3/21/17	Community Health and Wellness Extended Care Center Home Health/Hospice IVCH Whiteboards	Maria Martin/ Eileen Knudson Sarah Jane Stull Max Hambrick	Maria and Eileen provided an overview of programs that offer access to services for high risk patients including care coordination and transitional care (hospital to home). New programs include orthopedic, perinatal, and wound care coordination, as well as a diabetic prevention program. They were also awarded a grant a year ago that funds projects related to pain management, blood pressure guidelines/education, and counseling services for mental health. A challenge has been getting the information out to the community. Feedback and ideas from the group highlighted the use of social media including podcasts, a 'did you know' email to patients/community members, and the hospital website/facebook page. Sarah Jane relayed the services that are provided by the Extended Care Center including long term care, post operative rehabilitation, and hospice. She asked for input about a wait list process for long term care; the current process is in order of chronology and spots are held if families decline the need for service when a bed becomes available. The group discussed options for a wait list that may include assessing patient needs more regularly and offering available beds based on a priority assessment of needs. Also, it was suggested to benchmark best practice and consider what other rural hospitals are doing. Max spoke about Home Health/Hospice and clarified the difference in services based on geographical regions. This can be affected by the amount of services needed and the staff required to implement the services.	Relayed ideas to Marketing

2017 PFAC PROCESS IMPROVEMENT LOG

The identified topics are noted on this log and the information is forwarded to the responsible Director/Manager for their review and follow up.

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
3/21/17	(continued)		Max discussed a challenge with response rates to surveys that will hopefully be increased as it was determined a registration and mailing issue was affecting the number of people who were receiving surveys. There was a group discussion about how to educate the community about the services Hospice provides and how to increase the notion that the service offers comfort care and quality of life vs. a perception that once you accept the service it is only about a potential time frame of survival. We also reviewed a whiteboard that will soon be utilized at the Incline Village Community Hospital Emergency Department with a goal of keeping patients informed during their stay. Suggestions included adding wait times vs. 'expected' times, including a personal goal for the visit, asking if there is anything else one might need, and having a yes/no box for food allowed or if a patient could be mobile during the visit. Thank you to PFAC members: Nancy for attending the Board Quality Committee meeting this month and Doug for filming a TV segment about PFAC!	Relayed suggestions to Jan Iida
2nd Quarter 2017				

2017 PFAC PROCESS IMPROVEMENT LOG

The identified topics are noted on this log and the information is forwarded to the responsible Director/Manager for their review and follow up.

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
4/18/17	2 Year Anniversary Celebration!!! Cancer Center/Navigator Program BETA Healthcare Group/HEART	PFAC Karen Aaron Deanna Tarnow	Acknowledged 2 years of PFAC!!!!! Karen reviewed the services provided at the Cancer Center including, but not limited to, Medical Oncology, Radiation Oncology, lab services, financial counseling, and our affiliation with UC Davis.	

2017 PFAC PROCESS IMPROVEMENT LOG

The identified topics are noted on this log and the information is forwarded to the responsible Director/Manager for their review and follow up.

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
4/18/17	(continued)		She discussed her role as Nurse Navigator and being the 'point person' to answer questions and guide patients through their care, with the intention to facilitate continuity of care and meet patient needs. A challenge has been transportation for patients who live in outlying areas and also ensuring patients are informed of her role. Feedback from the group highlighted the notion of a FACT Sheet with the main responsibilities of her role (she is currently revising one and will send to the PFAC for review). Ideas for transportation included connecting with community groups to see their availability and Karen is also working with the American Cancer Society on this issue. Deanna introduced the HEART (healing, empathy, accountability, resolution, and trust) Program offered by BETA Healthcare Group that supports healing of both the patient and caregiver after an adverse event happens. The goal is to be transparent, timely, and thorough when communicating with patients and families. This is a program we may enroll in next year! Other topics discussed included the process for refunds from the billing office and how to best communicate to patients what the refunds are for, or what date of service they are related to. We also reviewed a nursing rounds card to place in patients' rooms in the evening if patients are sleeping when the nurse is rounding. Suggestions will be forwarded to the Chief Nursing Officer.	Relayed information to Patient Financial Services

2017 PFAC PROCESS IMPROVEMENT LOG

The identified topics are noted on this log and the information is forwarded to the responsible Director/Manager for their review and follow up.

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
3rd Quarter 2017				
July/August	NO MEETING-Summer!		.	
4th Quarter 2017				
12/19/17	NO MEETING-Holiday			

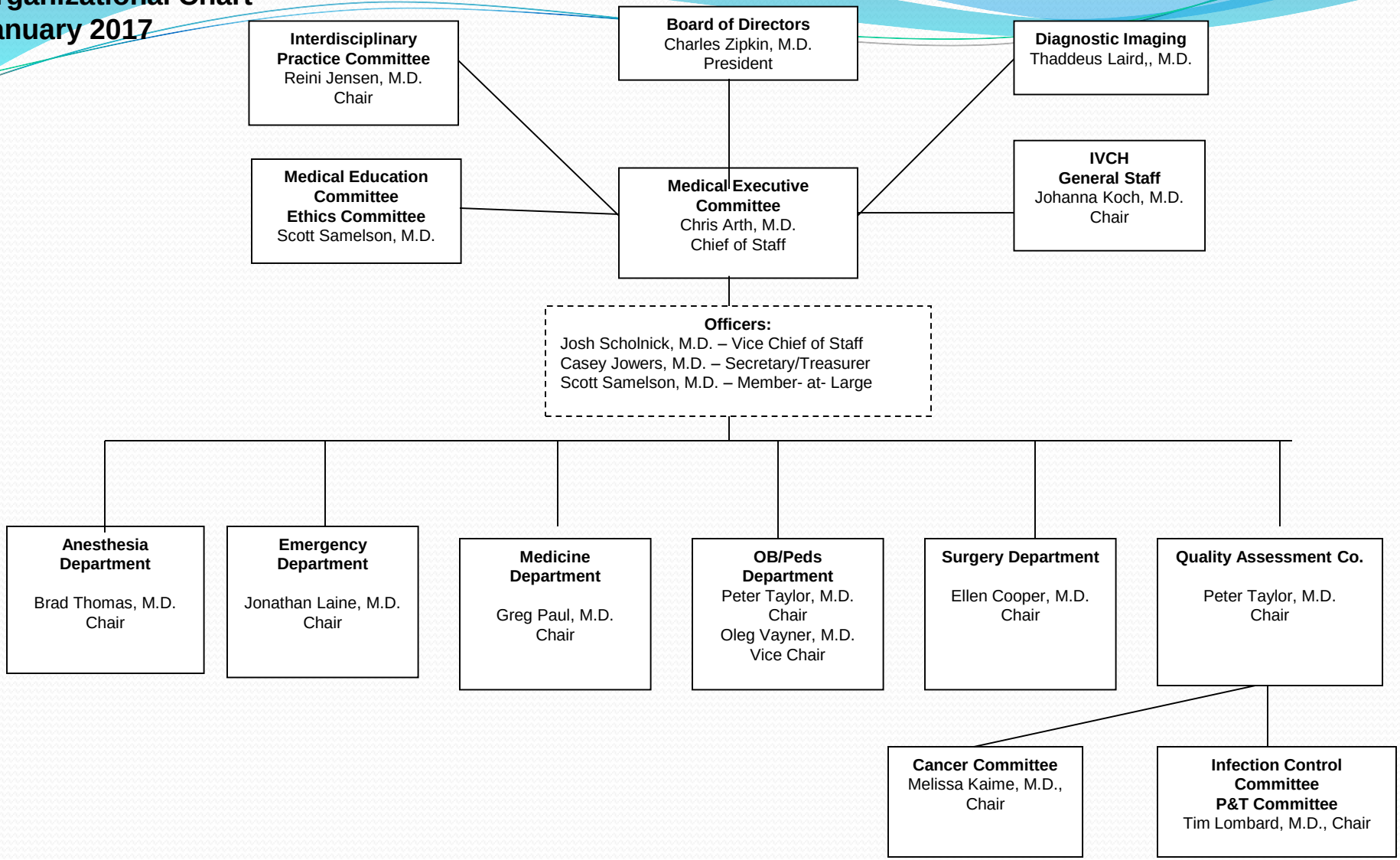
CREDENTIALING PRIVILEGING & PEER REVIEW PROCESS

TAHOE FOREST HOSPITAL SYSTEM

Tahoe Forest Hospital

Incline Village Community Hospital

Tahoe Forest Hospital District Medical Staff Organizational Chart January 2017



Definitions

1) **Credentialing** – a standardized process of inquiry which validates the candidates identity, background, education and training

2) **Privileging** – a standardized process determining the boundaries of each applicant's clinical knowledge, skills, competency, and as granted by the governing board to render specific professional, diagnostic, therapeutic, medical, surgical l, or dental services in a TFHS facility or in connection with its programs

3) **Appointment** – determining whether a candidate will be a member of the medical or staff and if so, in what membership category

4) **Peer Evaluation** – Formal documentation received during the initial & re-appt for staff privileges process.

5) **Peer Review** – A participatory process that monitors important aspects of care provided by a hospital's individual practitioners. Results of peer review are used in the medical staff reappointment process as well as for ongoing professional practice evaluation. When the results of peer review indicate a need for performance improvement at the individual and/or aggregate levels, appropriate quality improvement activities are undertaken to ensure that improvement occurs.

6) **Performance Indicator/Measure -** A clearly defined statement describing Information to be collected for purposes of improving processes and outcomes of care.

7) **Quality Assurance -** Systematic monitoring and evaluation of the various aspects of a project or service.

8) **Quality Improvement -** The practice of continuously assessing and adjusting performance using statistically and scientifically accepted procedures.
An ongoing process to measure and improve performance.

9) **QA+QI (OPPE – Ongoing Professional Practice Evaluation) –** A screening tool to evaluate all practitioners who have been granted privileges and to identify those clinicians who might be delivering an unacceptable quality of care. [Note: May also be used to identify those who have no quality of care issues.]

Credentialing's Triple Aim

- Protect the patient
- Facilitate clinical practice
- Support organizational goals

Granting clinical privileges requires:

First , that the requestor is qualified to apply

Second , the requestor has direct or relevant recent Experience (training, experience, judgment)

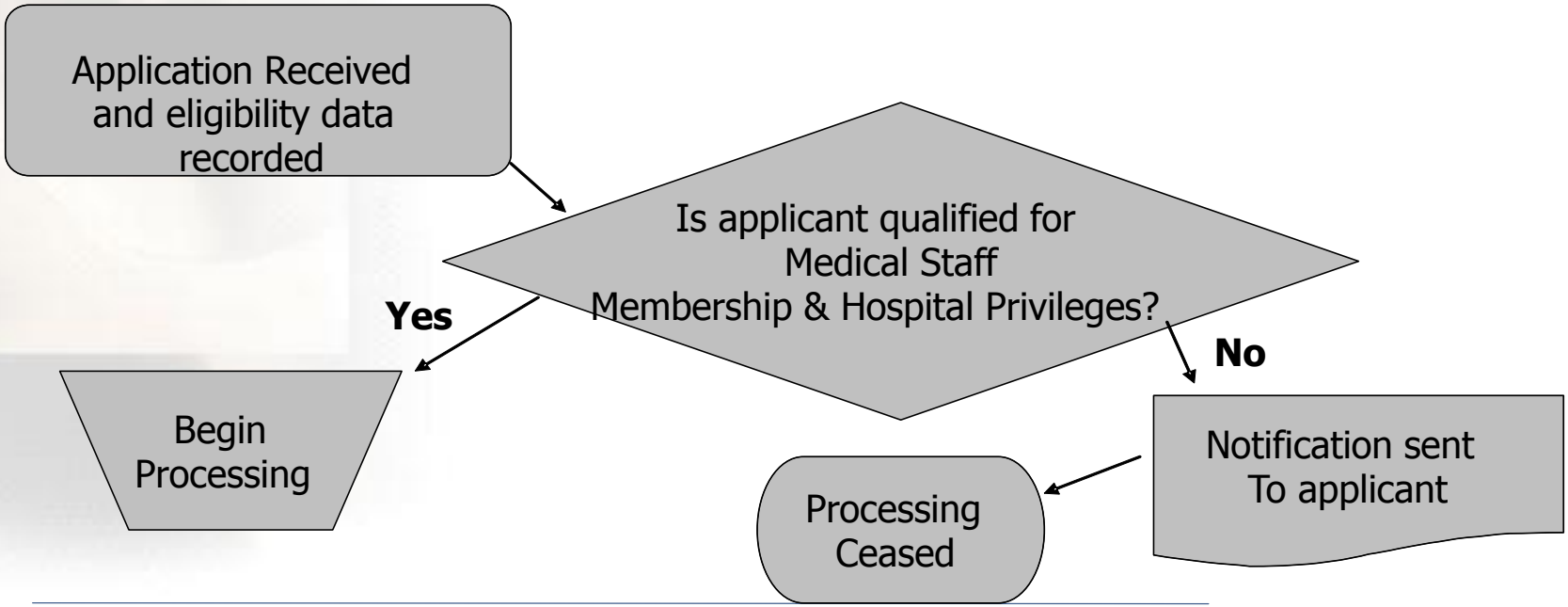
Third , the experience has been of acceptable quality (competency)

Application for Appointment

TAHOE FOREST HEALTH SYSTEM

Step One Qualifications for Membership

"No one is permitted to practice without a ticket"



Privileging – Governing Regulations

- Privileges must be individually assessed
- Privileges granted and renewed on the basis of criteria that cite training and demonstrated competence
  - Not all practitioners in a specialty can be assumed to have equivalent competence
  - Some privileges may be performed by practitioners in more than one specialty (cross specialty lines)

AN APPLICATION IS INCOMPLETE IF:

- Supporting information is not supplied
- Questions or concerns are not resolved
- There are unexplained gaps in professional experience
- There are unanswered questions

Qualifications for Membership

1) Unrestricted Licensure in California and/or Nevada
2) Unrestricted DEA (CA and/or NV)
3) Not terminated from another staff for competency or behavioral concerns
4) Not excluded from CMS (Medicare)
5) Board Certification or Admissibility
6) Appropriate training and demonstrated current competence
7) Willingness to discharge the responsibilities of the medical staff
8) No felony convictions.
9) Request consistent with the hospital's mission and resources

FOCUSED PROFESSIONAL PRACTICE EVALUATION

- Assess privilege specific competence
- Proctoring
- Provide guidance
- Identify and address concerns:

Cases that fall out because of perceived problems, undesirable outcomes, or are part of a disturbing trend will be reviewed

CATEGORICAL REVIEW [Initial Applicants]
Category 1 (clean file-no issues)

a) Consecutively completed all training within 3 years of submitting application

b) Privileges requested are consistent with core as defined for that specialty

d) No suggestions of potential problems & no prior malpractice or disciplinary actions, licensure restrictions or any type of investigations in last 2 years

CATEGORICAL REVIEW [Initial Applicants]
Category 2 (changes)

a) Training not consecutive or completed training more than 3 years before receipt of application

b) Has greater than 4 current medical licenses

c) Has requested privileges that vary from those consistent with core for that specialty or varies substantially

d) Evaluation not received in prescribed format or negative responses

e) A Cat 1 application in which any of the recommendations of the chairmen vary

f) Applicant has a malpractice claims history

CATEGORICAL REVIEW [Initial Applicants] Category 3 (controversial)

a) Current or previously successful challenge to license or registration

b) Involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity

c) An unusual pattern of, or an excessive # of, professional liability actions, resulting in a final judgment against applicant

d) Practitioner who is currently or has previously participated in a health professionals assistance program

CATEGORICAL REVIEW [Reappointments]
Category 1 (clean file-no issues)

a) Requested privileges that are consistent with core

b) All references contain only favorable or neutral evaluations

c) No pending or past investigations or reports of disciplinary action

d) No questions raised about qualifications or privileges

e) No negative findings, e.g. quality of care, behavior, compliance with regulations

f) No malpractice claims in last 2 years

CATEGORICAL REVIEW [Reappointments]
Category 2, Cont'd

a) Applicant has requested privileges that vary from those consistent with the core privileges as defined for that specialty

b) Evaluation contained neutral or negative responses

c) Pending or past investigations or reports of disciplinary action

d) Questions have been raised by a member of the medical staff regarding applicant's qualifications for appointment or clinical privileges

e) Peer review information contains negative findings, regarding quality of care, behavior, or compliance with regulations.

CATEGORICAL REVIEW [Reappointments]
Category 2 (cont'd)

f) Has less than 20 hospital encounters in previous 2 years (low volume practitioner)

g) Any other concern raised by any person which may cause concern to the Credentials/MEC

h) Currently participating in a health professional's assistance or diversion program

CATEGORICAL REVIEW [Reappointments]
Category 3 (controversial)

<u>One or more of the following not previously reported:</u>

a) Current or previously successful challenge to any license or registration

b) Involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or entity

c) Unusual pattern of, or an excessive number of, professional liability actions, resulting in a final judgment against the applicant

The Power of the Pyramid

TAHOE FOREST HEALTH SYSTEM

QUESTIONS?