SUMMA HEALTH SYSTEM
Department of Psychiatry Rules and Regulations

The Department of Psychiatry is organized to provide accountability for professional performance and ethical conduct of its members to the Summa Health System Board and to strive toward continual improvement of the quality of patient care delivered in the Department consistent with the recognized standards of professional care and resources available; to provide educational opportunities to its members to continually advance professional knowledge; to provide ongoing review of patient care practices; and to provide a means through which the Department may participate in the Hospital's policy-making and planning processes.

The Department of Psychiatry shall be organized as follows:

I. Officers of the Department
   A. Department Chair
      1. The Department Chair shall be appointed by the Hospital Board and shall meet the qualifications as outlined for a Department Chair in the Summa Health System Medical Staff Bylaws.
      2. Duties of the Department Chair are outlined in the Summa Health System Medical Staff Bylaws.
      3. Removal of a Department Chair is outlined in the Summa Health System Medical Staff Bylaws
   B. Department Vice Chair – as applicable
      1. The Vice Chair shall be a member of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in at least one clinical area within the Department.
      2. The Vice Chair shall be appointed by the Chair of the Department and approved through the Medical Executive Committee.
      3. Duties of the Vice Chair shall be:
         a. Act as presiding officer, or representative, at any meeting as designated by the Chair.
         b. Assist Department Chair in the development, implementation, evaluation and monitoring of the Department quality review programs.
         c. As appropriate, review credentials applications, conduct clinical interviews, and make recommendations to the Department Chair regarding the clinical privileges to be exercised within the Department by members of, or applicants to, the Medical Staff in the Department.
         d. Evaluate the clinical work performed in the Department, as assigned.
         e. Conduct investigations and submit reports and recommendations to the Department Chair regarding clinical privileges to be exercised within the Department by members of, or applicants to, the Medical Staff in the Department.
         f. Perform such other duties commensurate with the office that may be requested by the Department Chair.
      4. Vice Chair shall serve the same term as the Department Chair until his/her successor is chosen, unless he/she resigns or is removed from office.
      5. Removal of a Vice Chair may be initiated by:
         a. Removal of a Vice Chair shall be at the discretion of the Department Chair, and reported to the Medical Executive Committee.
         b. Removal of a Vice Chair does not constitute adverse action and shall not entitle the member removed to any hearing or appeal rights regarding the issue of removal.
   C. Division Chiefs – as applicable [see Department Addendum]
      1. Division Chiefs shall be members of the Active Staff of the Department of Psychiatry.
      2. Division Chiefs shall be qualified by training, board certification in the appropriate specialty or subspecialty, experience and demonstrated current ability in the clinical area included within their division.
      3. Appointment of Division Chiefs:
         a. By the Department Chair, or
         b. Division members shall select a leader acceptable to the Department Chair,
c. Upon acceptance by the Department Chair, the nominee will be presented to the Department membership for their information.
d. The Department Chair shall notify the Medical Executive Committee, for their information, of the decision of the Department.

4. Each Division Chief shall serve a minimum term of two years unless he/she resigns prior to the end of the term, or is removed from office.
5. Duties of the Division Chief, or designee, shall be:
a. Act as presiding officer at any division meeting, and keep accurate records of the proceedings.
b. Assist in the development and implementation, in cooperation with the Department Chair, of a program to carry out the quality review, evaluation and monitoring function assigned to the division.
c. Review credentials applications, conduct clinical interviews, and make recommendations to the Department Chair regarding the clinical privileges to be exercised within his/her division by members of, or applicants to, the Medical Staff in the Department of Psychiatry.
d. Evaluate the clinical work performed in the division.
e. Conduct investigations and submit reports and recommendations to the Department Chair regarding the clinical privileges to be exercised within his/her division by members of, or applicants to, the Medical Staff in the Department.
f. Perform such other duties commensurate with the office that may from time to time be requested by the Department Chair.
g. May serve as education coordinator for the division for education of residents and students and shall coordinate the continuing medical education of attending and ancillary staff.

6. Removal of a Division Chief may be initiated by:
a. Removal of a Division Chief shall be at the discretion of the Department Chair.
b. Removal of a Division Chief does not constitute adverse action and shall not entitle the member removed to any hearing or appeal rights regarding the issue of removal.

D. Residency Program Director /Fellowship Director
1. Appointment process:
a. A Department Chair may appoint residency and fellowship directors, or form a departmental search committee.
b. The ACGME requires that residency and fellowship directors be approved by the Graduate Medical Education Committee (GMEC).
c. The GMEC approved candidate is then referred to the Medical Executive Committee for approval.
d. The Designated Institutional Official (DIO) for Graduate Medical Education is required to submit GMEC-approved program director appointments into the ACGME WebAds data system, and then that appointment is reviewed by the respective RRC, which has final approval authority over the appointment.

2. Duties of the Residency Program Director:
a. Management and supervision of all aspects of the residency training program.
b. Recruitment and selection of residents.
c. Medical direction of all facilities utilized for the express purpose of education.
d. Recruiting, maintaining and supervising a highly competent faculty teaching staff for resident education.
e. Ensuring that all aspects of the residency program are in full compliance with applicable accreditation standards.
f. Working with the Department Chair to implement mutually supportive activities between the residency program and the departmental membership.

3. Removal of a Program Director:
a. Removal of a Program Director shall be at the discretion of the Department Chair.
b. The Designated Institutional Official (DIO), or the

c. Graduate Medical Education Committee may recommend removal.
d. Removal of a Program Director must be reported to the Medical Executive Committee.
e. Removal of a Program Director does not constitute adverse action and shall not entitle the member removed to any hearing or appeal rights regarding the issue of removal.

II. Department Meetings
A. The Department will meet on a regular basis at a time and place designated by the Department Chair with appropriate consideration of membership needs. Department meetings may be canceled at the discretion of the Department Chair.

B. Conduct of Business
1. Department business shall be conducted under generally accepted parliamentary rules of order.
2. A quorum will be required for the conduct of all business requiring the placing of motions and the taking of a vote.
3. A quorum shall be specifically defined in the department addendum.
4. Unless otherwise stated in these rules, passage of all items to be voted upon requires a simple majority of voting members present or responding by email.
5. In the absence of a quorum, the administrative business of the Department may be conducted. Such business would include reports of committees, dissemination of information and all other routine matters not requiring a vote.
6. An Executive Session of the Department meeting may be called as determined by the Department Chair. At Executive Sessions, members shall include Active Staff members of the Department and a recording secretary.

C. Voting Rights
1. Active Staff
   An active staff member may vote on any matter presented at a Department meeting and any departmental committee meeting of which he/she is a member.
2. All Other Staff Categories
   These categories of membership may only vote on matters presented to department committees to which the member has been appointed.

D. Absent Voting Members
1. In anticipation of an issue to be voted upon in his/her absence, a voting member may register his/her vote by written or oral proxy.
2. Proxy votes are to be registered with the Department Chair or designee.

E. Members with active admitting privileges are required to attend a minimum of 50 percent of department meetings. Failure to meet the attendance requirement, as defined, without excuse satisfactory to the Dept Chair or designee, may be grounds for corrective action as described in the Summa Medical Staff Bylaws.

F. Executive session of the Department meeting may be called as determined by the Chair. At Executive Sessions, members shall include Active Staff members of the Department and a recording secretary.

III. Departmental Committees
A. The Department Peer Review Board shall serve as a standing committee. (Refer to Peer Review Committee Addendum)

B. Other standing and ad hoc committees may be formed at the discretion of the Department Chair to attend to necessary Department functions.

IV. Division Meetings
A. Division meetings shall be held at the discretion of the Division Chief, as needed and appropriate. Members shall be notified at least three days prior to the meeting by telephone, an electronic message or written notice.

B. Attendance requirements for division meetings are at the discretion of the Department Chair. Failure to meet the defined attendance requirement, without excuse satisfactory to the Division Chief may be grounds for corrective action as described in the Summa Medical Staff Bylaws. Meeting attendance is reviewed during reappointment.
C. A quorum for a division meeting shall be defined as those present.

D. Minutes of the division meeting shall be recorded and forwarded to the Department Chair. Any pertinent information should be reported during the Department meeting.

V. Appointment and Clinical Requirements [see Department Addendum]

A. In addition to the qualifications outlined in the Summa Medical Staff Bylaws, members of the Department must meet the following general requirements:

1. Must be certified by a primary board or hold appropriate sub-specialty certification within their field of practice where a specialty board exists, or become board certified within five (5) years of appropriate residency and/or fellowship training completion or within the amount of time specific by the applicant's specialty, whoever is less. The certification must be recognized by the American Board of Medical Specialties or the American Osteopathic Association. If a period of clinical practice is required prior to certification examination, the five (5) year interval shall begin at the completion of the practice period.

2. Must maintain an office and residence within a reasonable distance of the hospital.

3. Must provide additional documentation and information for credentialing as requested by the Department Chair and/or Division Chief.

4. Must demonstrate a commitment to participate as appropriate in the clinical, educational and service activities of the Department, including consults and care of the uninsured at Summa Health System.

B. Scope of Practice

The scope of practice is defined in Attachment A.

C. Terms of Appointment

1. All appointments shall be made by the Summa Health System Board in accordance with the procedures set forth in the Credentialing Appointment/Reappointment Policy and the Summa Health System Medical Staff Bylaws.

2. All initial appointments are provisional for one (1) year.

3. During the provisional period, each appointee's performance and clinical competence shall be monitored by the Department Chair, or their designee. At the conclusion of the provisional period, the Department Chair shall review the appointee's performance with regard to:
   a. quality of patient care
   b. relationship with physicians, patients, and other health care personnel
   c. ethical conduct
   d. physical and mental health
   e. compliance with the Summa Health System Medical Staff Bylaws, Department Rules and Regulations, and Hospital policies
   f. timely completion of medical records
   g. board certification status

4. The Department Chair shall submit a written report regarding the appointee to the Credentials Committee for approval. The report must include a recommendation for permanent appointment or continuation of the provisional appointment for a one (1) year period of time.

D. Professional Practice Evaluations

All appointees will be subject to professional practice evaluations.

1. Initial appointments and new privileges will merit a Focused Professional Practice Evaluation (FPPE), as determined by the Department Chair and/or designee and established in Department rules and regulations, in accordance with bylaws and available standards, and approved by the Medical Executive Committee. Final report will be submitted to the Medical Staff Credentials Committee for approval.

2. All medical staff appointees will have Ongoing Professional Practice Evaluations (OPPE), at an interval not less than every 6 months. Specifications are determined by the Department Chair and/or designee and established in Department rules and regulations, in accordance with bylaws and available standards, and approved by the Medical Executive Committee. This information will be submitted to the Medical Staff Credentials Committee, to be used in the reappointment process.
3. When a practitioner's clinical competence, practice behavior, or performance of privileges indicate the need for a period of focused performance monitoring, a targeted FPPE will be developed and implemented by the Department Chair and/or designee, in accordance with bylaws and available standards, and approved by the Medical Executive Committee. The result of the FPPE will be handled in accordance with Medical Staff Policy 1.29.

E. Revocation, Suspension or Limitation of Department Membership
Membership in the Department may be revoked, restricted, or suspended as outlined in Article V of the Summa Medical Staff Bylaws.

VI. Amendments

These Rules and Regulations may be amended at any regular Department meeting. The proposed amendment must be sent to each voting member at least seven (7) days before the scheduled meeting. Providing a quorum is present, a two-thirds (2/3) majority vote shall be required for adoption of each amendment proposed. Approval of these amendments shall be subject to approval of the Medical Executive Committee and the Summa Health System Board.

VII. Matters Not Addressed by the Departmental Rules and Regulations

The Bylaws, Policies and Procedures of the Medical Staff shall serve as a reference until the Department Rules and Regulations can be amended to address such matters.

VIII. Appendices to the Rules and Regulations of the Department include:
A. Scope of Practice
B. Delineation of Privileges
C. Peer Review/Quality Improvement Program

IX. Medical Staff Definitions (Refer to the Medical Staff Bylaws)

X. Ethics and Ethical Relationships

The Principles of Medical Ethics are consistent with those outlined in the Medical Staff Bylaws.
APPENDIX A

Department of Psychiatry
Summa Health System

Psychiatry
SCOPE OF PRACTICE
Privileges in the Department of Psychiatry include diagnostic/therapeutic procedures associated with the scope of training/experience in clinical psychiatry. Privileges are defined within the limits of the license. Inpatients require admission by a psychiatrist who is an active member of the Department of Psychiatry of Summa Health.

Psychology
SCOPE OF PRACTICE
Privileges in Psychology include diagnostic/therapeutic procedures associated with the scope of training/experience in clinical psychology. Privileges are defined within the limits of the license.

Addiction Medicine
SCOPE OF PRACTICE
Privileges in Addiction Medicine include diagnostic/therapeutic procedures associated with the scope of training/experience in addiction medicine. Privileges are defined within the limits of the license/certification.
APPENDIX B

Department of Psychiatry
Summa Health System

DELINEATION OF PRIVILEGES
DEPARTMENT OF PSYCHIATRY

Summa Health

DOCUMENTATION OF COMPETENCY
For applicants, documentation of competence requires a letter from their former Program Director, or current Chief of Service/Department Chair, attesting to clinical competency and training in the procedures requested. The numbers of procedures performed and outcomes may be requested as documentation of clinical competency. At re-appointment, documentation of competency includes a review of volume and quality reports.

NAME:

<table>
<thead>
<tr>
<th>PRIVILEGE</th>
<th>REQUESTED (Initial)</th>
<th>DOCUMENTATION REQUIRED</th>
<th>DOCUMENTATION RECEIVED</th>
<th>RECOMMENDED (Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric evaluation and management including treatment planning</td>
<td>No</td>
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<tr>
<td>Physical evaluation and management</td>
<td>No</td>
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<tr>
<td>Diagnostic studies/laboratory tests</td>
<td>No</td>
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<tr>
<td>Psychopharmacotherapy</td>
<td>No</td>
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<tr>
<td>Psychotherapy:</td>
<td>No</td>
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<tr>
<td>Individual</td>
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<td>Group</td>
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<tr>
<td>Consultation Liaison Psychiatry</td>
<td>No</td>
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<tr>
<td>Electroconvulsive Therapy (ECT) (see ECT privilege form)</td>
<td>Yes</td>
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</table>

I _______________________________ hereby request the above initialed privileges in the Department of Psychiatry. I attest to having the required education and experience to perform the procedures indicated, and I agree to provide documentation of competency as required.

Signature: _______________________________ Date: _________________

Division Chief: _______________________________ Date: _________________

Department Chair: _______________________________ Date: _________________
**Electroconvulsive Therapy**

**Description:** Electroconvulsive Therapy (ECT) is a psychiatric treatment in which seizures are electrically induced in anesthetized patients for therapeutic effect.

<table>
<thead>
<tr>
<th>Request</th>
<th>Check the “request” checkbox to indicate privileges requested below.</th>
<th>Dept Chair Rec</th>
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<tbody>
<tr>
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<tr>
<td>☑</td>
<td>Electroconvulsive Therapy</td>
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<tr>
<td>☑</td>
<td>Performance of Electroconvulsive Therapy</td>
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</tbody>
</table>

**QUALIFICATIONS**

**Basic Training**

The practitioner performing ECT must provide documentation of instruction in and clinical supervision of the performance of ECT during residency training. Alternatively, documentation of successful completion of a recognized course (APA approved) in administration and use of ECT may be substituted. All psychiatrists performing ECT must be familiar with and follow the recommendations of the Task Force on ECT of the American Psychiatric Association, as described in *The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging (2e, 2001, APA Press)*, as well as the relevant Summa policy and procedures.

**Continuing Competence**

Initial privileges to perform ECT may be granted after the Department Chair or another member of the Psychiatry department with ECT privileges has observed a minimum of 10 treatments performed by the applicant (or additional cases if indicated by the observing physician) to ensure competence in the procedure. Observation may be repeated after a prolonged gap (over six months) in performing the procedure. Continuing competence is also assured through ongoing monitoring by the department.

**Clinical Experience (Reappointment)**

Practitioner must document evidence of a minimum of 10 treatments during the two year reappointment period.

**Additional Qualifications**

Practitioner must be a member of the Active Staff.

AND

Practitioner must utilize Summa Health as his/her primary hospital affiliation.

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G:\Psychiatry\Delineation of Privileges\ECT 2015.docx

I ____________________________, hereby request the above initialed privileges in the Department of Psychiatry. I attest to having the required education and experience to perform the procedures indicated, and I agree to provide documentation of competency as required.

Signature: ___________________________________________ Date: ________________

Division Chief: ______________________________________ Date: ________________

Department Chair: _____________________________________ Date: ________________
DELINEATION OF PRIVILEGES
DEPARTMENT OF PSYCHIATRY

Summa Health

DOCUMENTATION OF COMPETENCY
For applicants, documentation of competency requires a letter from their former Program Director, or current Chief of Service/Department Chair, attesting to clinical competency and training in the procedures requested. The numbers of procedures performed and outcomes may be requested as documentation of clinical competency. At re-appointment, documentation of competency includes a review of volume and quality reports.

NAME:

<table>
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<tr>
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<th>DOCUMENTATION REQUIRED</th>
<th>DOCUMENTATION RECEIVED</th>
<th>RECOMMENDED (Initial)</th>
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<tbody>
<tr>
<td>A. Neuro Psychology</td>
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<td>No</td>
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<tr>
<td>B. Psychological testing</td>
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<tr>
<td>C. Psychotherapy</td>
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<tr>
<td>D. Research</td>
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PSYCHOLOGY
I hereby request privileges for the following diagnostic and therapeutic modalities in the Department of Psychiatry, Section of Psychology, and I attest to having the required education and I will practice only within the bounds of my training.

I _______________________________________, hereby request the above initialed privileges in the Department of Psychology. I attest to having the required education and experience to perform the procedures indicated, and I agree to provide documentation of competency as required.

Signature: ____________________________________________ Date: _____________

Division Chief: ________________________________________ Date: _____________

Department Chairman: _________________________________ Date: _____________
DELINEATION OF PRIVILEGES  
DEPARTMENT OF PSYCHIATRY

Summa Health

DOCUMENTATION OF COMPETENCY
For applicants, documentation of competency requires a letter from their former Program Director, or current Chief of Service/Department Chair, attesting to clinical competency and training in the procedures requested. The numbers of procedures performed and outcomes may be requested as documentation of clinical competency. At re-appointment, documentation of competency includes a review of volume and quality reports.

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<tr>
<th>PRIVILEGE</th>
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<th>DOCUMENTATION REQUIRED</th>
<th>DOCUMENTATION RECEIVED</th>
<th>RECOMMENDED (Initial)</th>
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<tr>
<td><strong>ADDITION MEDICINE AND SUBSTANCE ABUSE</strong></td>
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<td>Admit Patients to Ignatia Hall</td>
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<td>Biopsychosocial assessment of addictive conditions</td>
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<td>Consultative services related to addictive conditions</td>
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<tr>
<td>Educational interventions related to Addictive conditions:</td>
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<td>Family</td>
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<td>Medical assessment of patient</td>
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<td>Medical management of conditions related to dependence, abuse, withdrawal and complications of adding substances</td>
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<tr>
<td>Psychosocial Treatment of conditions related to dependence, abuse, withdrawal and complications of adding substances</td>
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<tr>
<td>Supervision/consultation/educational services to members of multidisciplinary team (nurses, counselors, social workers, etc)</td>
<td>No</td>
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I ________________________________, hereby request the above initialed privileges in the Department of Psychiatry. I attest to having the required education and experience to perform the procedures indicated, and I agree to provide documentation of competency as required.

Signature: ____________________________ Date: ________________

Division Chief: ____________________________ Date: ________________

Department Chair: ____________________________ Date: ________________
APPENDIX C

Department of Psychiatry
Summa Health System
Ongoing Professional Performance Evaluation (OPPE),
Focused Professional Practice Evaluation (FPPE), and Peer Review

This Policy is adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the Bylaws also apply to the policy and procedures described herein.

SCOPE

Applies to all credentialed members of the Department of Psychiatry.

EXCEPTION:

No volume providers with medical staff membership and without clinical privileges per Joint Commission clarification are exempt from the Ongoing Professional Performance Evaluation and Focused Professional Practice Evaluation requirements contained within this document.

I. PURPOSE:

To assure that the hospital, through the activities of its medical staff, assesses the ongoing professional practice and competence of its medical staff, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competence, practice, and the quality of patient care;

To define those circumstances in which an external review or focused review may be necessary

To address identified issues in an effective and consistent manner.

“Professional Practice Evaluation” is considered an element of the peer review process and the records and proceedings relating to this policy are confidential and privileged to the fullest extent permitted by applicable law.

II. DEFINITIONS

Peer:

For purposes of this policy, the term “Peer” refers to any practitioner who possesses the same or similar knowledge and training in a medical specialty as the practitioner whose care is the subject of review.

Individual Case Review:

The process outlined for peer review of a particular case identified with a potential quality of care issue.

Ongoing Professional Practice Evaluation:

The ongoing process of data collection for the purpose of assessing a practitioner’s clinical competence and professional behavior. Information gathered during this process is factored into decisions to maintain, revise, or revoke an existing privilege(s) prior to or at the time of the two-year membership and privilege renewal cycle.

Focused Professional Practice Evaluation:

The time-limited evaluation of practitioner competence in performing a specific privilege. The process is consistently implemented as a means to verify clinical competence for all initially requested privileges, for a newly requested privilege, and whenever a question arises regarding a practitioner’s ability to provide safe, high-quality patient care.
FPPE is not considered an investigation or corrective action as defined in the Medical Staff Bylaws and is not subject to the Bylaws provisions related to the corrective action process.

FPPE affects only the privileges for which a relevant concern has been raised and related privileges for which the same concern would apply. Other existing privileges in good standing should not be affected by the decision to initiate FPPE.

Peer Review

Peer Review is the process by which a practitioner, or committee of practitioners, examines the work of a peer and determines whether the practitioner under review has met accepted standards of care in rendering medical services. The professional or personal conduct of a physician or other healthcare professional may also be investigated. Individual Case Review, Ongoing Professional Practice Evaluation, and Focused Professional Practice Evaluation are components of peer review.

Practitioner Proctoring:

The personal presence of an assigned practitioner who does not have a treatment relationship with the patient, who is designated to provide clinical teaching or to monitor the clinical performance of another practitioner to facilitate quality of care to patients, as required for purposes of credentialing, reappointment, quality improvement, FPPE, or corrective action.

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

A. Initiation of FPPE

FPPE will be initiated in the following instances:

- Upon initial appointment;
- When a new privilege is requested by an existing practitioner;
- When a question arises through the OPPE process, individual case review, or other peer review process regarding a currently privileged practitioner’s ability to provide safe, high-quality patient care. For example, when a trigger is exceeded and preliminary review indicates a need for further evaluation.

A recommendation of FPPE may be made by:

- The Credentials Committee;
- A Department of the Medical Staff;
- The Chair of the Department;
- A special committee of the medical staff;
- The MEC

The FPPE monitoring plan for a new practitioner, or newly requested privilege(s) will be specific to the requested privileges or group of privileges.

FPPE is not considered an investigation as defined in the Medical Staff Bylaws and is not subject to the bylaws provisions related to investigations. If FPPE results in an action plan to perform an investigation, the process identified in the Medical Staff Bylaws would be followed.

B. Timeframe for Collection and Reporting

The period of FPPE must be time-limited. Time-limited may be defined by;

- A specific period of time;
- A specific volume (number of procedures/admissions)
The medical staff may take into account the practitioner’s previous experience in determining the approach, extent, and time frame of FPPE needed to confirm current competence. The practitioner’s experience may be individualized based upon one of the following experience/training examples:

1. Recent graduate from a training program affiliated with the facility, where the requested privileges were part of the training program (competence data is available)
2. Recent graduate from a training program at another facility, where the requested privileges were part of the training program (competence data is not available)
3. A practitioner with regular experience exercising the requested privilege of fewer than two years on another medical staff
4. A practitioner with regular experience exercising the requested privilege of more than five years at another medical staff

FPPE shall begin with the applicant’s first admission(s) or performance of the newly requested privilege. FPPE should optimally be completed within three months, or a suitable period based upon volume. The period of FPPE may be extended as necessary at the discretion of the Department Chair but may not extend beyond the first biennial reappointment.

C. Methods for Conducting FPPE/Communication to the Practitioner

FPPE may be accomplished by:

1. Chart reviews, both concurrent and/or retrospective (see Attachment A)
2. Simulation
3. Discussion with the involved practitioner and/or other individuals involved in the care of the practitioner’s patients
4. Direct observation/proctoring
5. For dependent AHP’s, FPPE methods may include review or proctoring by the sponsoring physician.
6. Internal or external peer review.

The terms of all FPPE shall be communicated in writing to the affected practitioner, including the following:

- The cause for the focused monitoring
- The anticipated duration
- The specific mechanism by which monitoring will occur (i.e. chart reviews, proctoring, peer observation, etc.)

D. Performance Monitoring Criteria and Triggers

Monitoring criteria, including specific performance elements to be monitored, as well as thresholds or triggers, are developed and approved by the medical staff or medical staff department/committee. The triggers are defined as potentially unacceptable levels of performance. Triggers to consider include, but are not limited to:

- A single egregious case or evidence of a practice trend
- Patient/staff complaints
- Non-compliance with Medical Staff Bylaws, Rules and Regulations
- Failure to follow approved clinical practice guidelines
- Unprofessional behavior or disruptive conduct

If the results for a practitioner exceed thresholds established by the Medical Staff, outliers may be forwarded for peer review after initial screening by Quality Management.
E. Conclusion of FPPE

At the conclusion of the initial FPPE, findings will be reviewed by the responsible Department, for decision and recommendation. Decisions may include moving forward with OPPE, extending the period of FPPE, development of a performance improvement plan, or recommending to limit or suspend the privilege. Such recommendations are reported to and approved by the Medical Executive Committee and Board of Trustees. For recommendations resulting in restriction, suspension, revocation of specific privileges or other limitation on privileges, the processes pursuant to the Medical Staff Bylaws will apply.

Each practitioner will be notified of their performance and outcome(s) following FPPE. A letter is forwarded to the Medical Staff member including, but not limited to, the following:

- Findings and outcome of FPPE
- Specific actions, if any, that need to be taken by the Practitioner to address any quality concerns and the method for follow-up to ensure that the concerns have been addressed; and
- If the focused review is complete or will continue (duration will be specific if the focused review will continue)
- The period of initial FPPE is completed and the practitioner will move into OPPE
- The period of FPPE for a specific privilege is completed and the practitioner will continue with OPPE

At the end of the period of focused evaluation, in the event that the practitioner's activity/volume has not been sufficient to meet the requirements of FPPE:

- The practitioner may voluntarily resign the relevant privilege(s), or
- The practitioner may submit a written request for an extension of the period of focused evaluation, or
- If the practitioner has sufficient volume of the privileges in question at another local facility, external peer references specific to the privilege/procedure will be obtained.
- FPPE may be extended at the discretion of the responsible medical staff department or committee.

The practitioner is not entitled to a hearing or other procedural rights for any privilege that is voluntarily relinquished.

Results of FPPE are maintained in the Practitioner's official file.

F. Performance Improvement Plan

If FPPE outcomes identify the need for an improvement plan, the plan will be drafted by the responsible medical staff department, committee or chair. The written improvement plan and supporting FPPE outcomes should be presented to the Medical Executive Committee for approval. The involved Practitioner should also be offered the opportunity to address the Committee and respond to the findings before the improvement plan is finalized and implemented.

Methods identified to resolve performance issues shall be clearly defined. Examples of improvement methods may include:

- Necessary education
- Proctoring and/or mentoring
- Counseling
- Practitioner Assistance Program
- Suspension or revocation of privilege, subject to the provisions of the Bylaws.

Following approval by the Medical Executive Committee (MEC), the Department or Committee Chair, or Chief of Staff will meet with the Practitioner to communicate the improvement plan. If the Practitioner agrees with the plan, the written document should be signed by the Practitioner and forwarded to the
Practitioner’s official file. If the Practitioner does not agree with the plan and/or refuses to implement the improvement plan, the outcome will be reported to the Department Chair and/or Medical Executive Committee for resolution.

**ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)**

A. **Timeframe for Collection and Reporting**

OPPE will be initiated and reported on all providers with clinical privileges. Results of OPPE will be reported for review and/or action every three to six months if possible, and in no event less frequently than every nine months.

B. **Indicators for Review**

The type of data to be collected and related thresholds, or triggers, is determined by individual medical staff committees/departments and approved by the Medical Staff. Indicators may change as deemed appropriate by the department and/or medical staff and should be reviewed and approved on an annual basis. Data collected should not be limited to negative/oulier trending data. Good performance data should also be considered.

1. The Department will select indicators based upon their clinical service.
2. The Medical Staff may consider using the six areas of “General Competencies” developed by the Accreditation Council for Graduate Medical Education (ACGME). These include:
   a. Patient care
   b. Medical/clinical knowledge
   c. Practice-based learning and improvement
   d. Interpersonal and communication skills
   e. Professionalism
   f. Systems-based practice

3. Thresholds/triggers for performance must be defined for the selected indicators. Triggers are defined as unacceptable levels of performance within the established defined criteria and are used to identify those performance outcomes that could trigger FPPE. Triggers to consider include, but are not limited to:

   Defined number of events occurring
   Defined number of individual peer reviews with adverse determinations
   Elevated infection, mortality, and/or complication rates
   Sentinel events
   Small number of admissions/procedures over an extended period of time
   Increasing lengths of stay in comparison to peers
   Patterns of unnecessary diagnostic testing/treatments
   Failure to follow approved clinical practice guidelines

C. **Oversight and Reporting**

The review of performance data and any recommendation(s) for action, if necessary, will be the responsibility of one of the following:

- The specific Medical Staff Department; and/or
- The Chair of the Department
D. Results and Reporting of Data Analysis

Data are analyzed and reported to determine whether to continue, limit, or revoke any existing privilege(s). The results of the individualized practitioner report are referenced in the MEC meeting minutes, maintained in the Practitioner’s official file and incorporated into the two-year reappointment process.

During the course of OPPE, FPPE may be triggered by the following special circumstances:

- A single egregious case or evidence of a practice trend
- Exceeding the predetermined thresholds established for OPPE
- Patient/staff complaints
- Non-compliance with Medical Staff Bylaws, Rules and Regulations
- Elevated infection, mortality and/or complication rates
- Failure to follow approved clinical practice guidelines
- Unprofessional behavior or disruptive conduct

If unprofessional behavior or disruptive conduct is identified as a possible concern, the Disruptive Practitioner Policy will be initiated as a component of the OPPE.

At the completion of the review period, the results of OPPE (the practitioner profile report) will be communicated to the individual practitioner. The original report will be maintained in the Practitioner’s official file.

**INDIVIDUAL CASE REVIEW PROCESS**

Cases identified with potential quality of care issues are referred to the Department Chair for review. Quality Management is responsible for coordinating the Peer Review Process.

Cases may be identified through OPPE, FPPE, case management, risk management, audits, sentinel events, clinician referrals, allegations of suspected substance abuse or disruptive behavior and other sources. All cases should be initially screened by the Quality Management department utilizing medical staff approved screening criteria, prior to forwarding for physician review. If there are no potential quality of care issues identified following the quality management screening, the case is closed, the findings are documented and trending is performed in Quality Management.

If potential quality of care issues are identified through Quality Management screening, the following process for peer review shall be implemented:

**A. Reviewer Selection & Duties**

Reviews are completed by the Department Chair and/or Committee

The designated reviewer may not review a case where he/she participated in the care.

**B. Reviewer Disqualification & Replacement**

If a reviewer does not feel he/she can adequately review a medical record due to a conflict of interest or believes he/she is not qualified to address a certain issue, the reviewer may discuss the issue with the Chairperson of the Committee, Department Chief or Chief of Staff. If the Chair concurs, the Chair shall reassign the record(s) to another reviewer. If a member has reviewed a record that needs to be presented but is unable to attend the meeting, the member shall report to the Chair so that the presentation may be reassigned to another Committee member or presented by the Chairperson. If the chairperson is the practitioner subject to review, the record review will be assigned to another Active Staff member by the Chief of Staff.
C. Communication to Involved Practitioner

This will follow the Summa Heath System Medical Staff Bylaws.

**DOCUMENTATION OF PEER REVIEW ACTIVITIES:**

Reports of OPPE and FPPE and individual case review findings and recommendations shall be presented to the MEC. The MEC may adopt the recommendations of the Medical Staff Department/Committee and/or make further recommendations, including recommendation for further investigation and/or Corrective Action in accord with the Medical Staff Bylaws.

Results of OPPE, FPPE and Peer Review outcomes shall be documented and maintained in the Practitioner’s official file and referenced at reappointment.

G:\Psychiatry\Policies and Procedures\APPENDIX C OPPE FPPE.docx
DEPARTMENT ADDENDUM
I.C.

Psychiatry
• Inpatient Division
• Outpatient Division
• Geriatric Division
• Consultation/Liaison Division

Psychology
• General Psychology Division
• Traumatic Stress Division

Addiction Medicine Division

II.B.3.

Quorum shall be defined as the number of active department members present at a regularly scheduled meeting of the department.

V.A.

In addition to the qualifications outlined in the Summa Medical Staff Bylaws, members of the Department must meet the following general requirements:
5. Staff categories are active or affiliate. Active staff category is required for admitting privileges. Active staff are also required to participate in the department on call rotation. [see attached Psychiatry on-call policy and responsibilities]

INITIAL APPOINTMENT FOR PSYCHOLOGISTS
1. Meets the general requirements as outlined in the Summa Medical Staff Bylaws.
2. Graduate of an APA-approved training program or equivalent program leading to an Ed.D., Ph.D., or Psy.D. Degree in Psychology.
3. One year post-doctoral internship in a clinical psychology JCAHO-approved inpatient psychiatric facility and/or clinical psychology internship program approved by the American Psychological Association.
4. A written recommendation from the program director of each training program and/or current institution in which the applicant has participated. These recommendations shall address the applicant's clinical competence as a consultant in psychology, ability to work and get along with other healthcare professionals, ethical character, procedural skills, proficiency in psychological assessment, clinical judgment, knowledge of recent psychology literature, and commitment to teaching.
5. Completion of an interview with the Chief of the Section of Psychology (or designee) and/or the Chairman of the Department of Psychiatry (or designee) in accordance with the Medical Staff Bylaws.

ADDITIONAL PRIVILEGES
1. For privileges in Neuropsychology, Forensic Evaluation, Hypnosis, Biofeedback, Pain Management or Therapy for Sexual Dysfunction, specific documentation of training, experience and competency is required.
REAPPOINTMENT
1. Letter from the Department Chairman or Section Chief of the psychologist's primary hospital certifying adequate activity levels and addressing overall clinical competency, the absence of quality of care problems, educational contribution, and physical and mental health status.
2. Psychologists within the Section of Psychology are expected to follow current guidelines for mandatory Continuing Medical Education set forth by the Ohio Board of Psychology.
3. Meet the general qualifications for reappointment as set forth in the Medical Staff Bylaws.

INITIAL APPOINTMENT FOR ADDICTION MEDICINE
1. Meets the general requirements as set forth in Article III of the Medical Staff Bylaws.
2. Shall have obtained Certificate of Added Qualifications from the American Board of Addiction Medicine (ABAM), American Society of Addiction Medicine or obtain the Certificate of Added Qualifications in Addiction Psychiatry from the American Board of Psychiatry and Neurology (ABPN), or other accrediting bodies recognized by the American Board of Specialists.

   OR

3. Completion of American Board of Addiction Medicine (ABAM) or American Board of Psychiatry and Neurology (ABPN), approved fellowship and attain respective certifications within two years of completing fellowship.
4. Completion of an interview with the Chief of the Division of Addiction Medicine or designee and/or the Chairman of the Department of Psychiatry or designee in accordance with the Medical Staff Bylaws

REAPPOINTMENT
1. Letter from the Department Chairperson of the physician’s primary hospital certifying activity levels and addressing overall clinical competency, the absence of quality of care problems, educational/service contribution, and physical and mental health status.
2. Shall obtain twenty-five (25) hours of Category I CME credit in Addiction Medicine every two years.
3. Shall obtain the Certificate of Added Qualifications prior to the expiration of the second reappointment period (4 years).
DEPARTMENT OF PSYCHIATRY
ON-CALL POLICY AND RESPONSIBILITIES

OBJECTIVE: The psychiatry on-call system was created to provide the Emergency Department (ED) access to an attending psychiatrist to help in the assessment of treatment of patients with a psychiatric emergency.

GUIDELINES:

I. On-Call Responsibilities
   a. Psychiatrists who have admitting privileges at Summa are required to take call. Call begins each day at 8 a.m. and continues until 8 a.m. the following day.
   b. Exemptions from call:
      i. Physicians 65 and older
      ii. At the discretion of the department chair

II. Obligations and responsibilities of the psychiatrist on-call.
   a. Be available by telephone to respond to calls from the ED. When paged, it is expected that the psychiatrist return the call within 20 minutes.
   b. If the psychiatrist on-call expects to engage in any activity where he/she may not be available for a specific time, the psychiatrist on-call is obligated to find another psychiatrists from the admitting staff at Summa Health System for him/her for those specific hours that he/she is not available and to notify ED, psychiatric units, and the administrator on-call on the specifics of time, name of the coverage psychiatrist and how he/she can be reached for the specific hours that psychiatrist will be covering.
   c. Patients seen in the ED are assessed by the Emergency Medicine Attending Physician. The psychiatrist on-call helps in this assessment by providing his/her expertise, which should be guided by the clinical needs of the patient and what is in the patient’s best interest. If there is a clinical indication for the patient’s admission to one of the psychiatric units, it is expected that the psychiatrist on-call admit the patient to his/her service and be responsible for managing the patient’s care. The psychiatrist on-call is expected to admit the patient to his/her service regardless of whether the psychiatrist on-call is or is not on a particular insurance/managed care panel.