WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Organization of the Medical Staff MS 100.00

EFFECTIVE DATE: December 2, 1997 Page 1 of 1
REVIEWED/REVISED DATE: 8/04, 8/05, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 01.01.01

Purpose: To outline the structure and organization of the Medical Staff.

Policy: It is the policy of WCRH, that, as a specialized hospital, the Medical Staff as a whole is designated as the Department of Pediatrics.

Procedure:

1. Pursuant to Article 3 of the Bylaws of the Medical Staff, because all patients are pediatric and are admitted for the purpose of rehabilitation, the Medical Staff shall be organized as the Department of Pediatrics.

2. The Medical Director shall serve as the Chairman of the Department of Pediatrics and shall be responsible for fulfilling the leadership role and responsibilities of the Department.

3. All members of the Medical Staff will be required to qualify for at least the minimum level of Pediatric Privileges and may seek additional consulting privileges in the area of specialty.

_____ _____
Medical Director Date Administrator Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Medical Staff Responsibilities of the Medical Director — MS 101.00

EFFECTIVE DATE: December 2, 1998 **Page:** 1 of 1
REVIEWED/REVISED DATE: 8/04, 8/05, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 01.01.01

PURPOSE: To establish the responsibilities of the Medical Director of WRCH as senior medical executive and department leader.

POLICY: The Medical Director of WCRH shall oversee the clinical organization of the Hospital and the quality of care provided by all professional departments in coordination with Administration, Medical Executive Committee and the Chief Executive Officer. The Medical Director is the physician appointed by the Governing Body to act on its behalf on clinical matters as set forth in Section 3.3-1 of the Medical Staff Bylaws. The status of the Medical Director as administrator is unrelated to his/her role as a member of the Medical Staff. The Medical Director must be a member of the medical staff with admitting and clinical privileges.

PROCEDURE: Please refer to the Medical Staff Bylaws Section 3.3-1 and Policy and Procedure MS 101.01 for clarification of duties of the Medical Director of WCRH and the Physician-in-Chief of WRCH.

_____ _____

Medical Director Date Administrator Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
Medical Staff Manual

SUBJECT: Medical Director Responsibilities **NO: 101.01**

EFFECTIVE DATE: 12/2/97 **PAGE 1 of 3**

REVIEWED/REVISED: 12/8/02, 6/11/03; 2/17/04; 05/05; 02/06; 4/06; 3/07, 7/08, 3/10, 10/11, 6/12, 9/14, 4/17, 10/17, 10/20, 10/23

TJC Standard: MS 01.01.01

Purpose: To outline the administrative and clinical responsibilities of the Medical Director of WCRH.

Policy: It is the policy of WCRH that, upon appointment, a Medical Director be responsible for the direction, provision and quality of medical/clinical services provided.

Procedure: The Medical Director is responsible for the direction, provision, and quality of medical services provided to patients. When absent, he/she will designate in writing a physician to act in his/her absence. Responsibilities will be as follows:

1. Shall be responsible for the administrative duties of the Department of Pediatrics including, but not limited to, planning, budgeting, surveillance of professional performance, coordination and integration of medical services, development of policies and procedures, staffing and education.

2. Assists in developing and maintaining the job descriptions for the medical staff and assigning duties based upon education, training, competencies, and job descriptions as well as lead and develop medical staff members.

3. In conjunction with the Chief Operating Officer and Administrator develops and provides day-to-day administration of the Pediatric Department including:

    a. Medical Staff Bylaws
    b. Medical Staff Policies and Procedures
    c. Credentialing System
    d. Medical Staff committees and teams
    e. Clinical Program development

4. In conjunction with the Director of Quality/Risk Management, shall participate in the hospital's performance improvement and risk management activities.

5. Shall work to ensure hospital compliance with Medicare, Medicaid, JCAHO, and state and federal licensure requirements.

6. In conjunction with the Chief Operating Officer and Administrator, shall participate in program development activities to include public appearance, educational presentations to targeted audiences and attendance local and national professional conferences and meetings.

7. When required following focused peer review decision, will implement changes to improve identified LIP performance.

8. Shall provide input into the evaluation/supervision of the clinical director/department level staff.

9. Shall coordinate 24-hour physician services for patient care.

10. Shall oversee the provision of direct medical and rehabilitation care to patients within the hospital including:

    a. Coordination of daily rounds and team meetings
    b. Coordination of interdisciplinary care plan for each patient, including projected patient goals
    c. Act as hospital liaison to Utilization Review and Peer Review Organizations regarding approval/continuation of patient care at an acute level of service.

11. Shall review all patient admissions for medical appropriateness and discharge coordination.

12. In conjunction with the Director of Quality/Risk Management, shall participate in the hospital's performance improvement and risk management activities.

13. Shall reinforce implementation of policies and procedures for infection control and medical emergencies.

14. Shall coordinate program evaluation for tracking patient outcomes.

15. Shall represent the hospital in its referral, program development and marketing activities to include public appearances and educational presentations to targeted audiences.

16. Shall serve as advisor for clinical matters and ensure the highest level of client satisfaction with working with the following departments:
    a. Therapies (PT, OT, SLP, TR, RT)
    b. Neuropsychology/Psychology

c. Nursing
d. Social Services
e. Case Management

17. Shall ensure timely dictation of medical information that might be requested by referral services.

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Medical Director	Date	Administrator	Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Physician Coverage MS 200.00

EFFECTIVE DATE: December 2, 1997 Page 1 of 1
REVIEWED/REVISED DATE: 8/04, 8/05, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 03.01.01, 03.01.03

POLICY: Each attending physician is responsible for providing coverage during the time when the physician is not on site.

PROCEDURE:

1. Each physician is responsible for admission and treatment of patients needs to provide telephone coverage after hours and on weekends.

2. The physician is responsible for notifying the Director of Nursing how he/she may be contacted.

3. A physician may provide coverage by sharing responsibilities with a group of physicians as long as each covering physician is an active member of the medical staff with appropriate delineation of privileges. The physician is responsible for providing a schedule to the Director of Nursing.

4. If a physician is unavailable to the hospital staff after hours, the Medical Director will be contacted.

_____ _____

Medical Director Date Administrator Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

Subject: Pulmonary Services for Children with Ventilator Needs. MS 201.00

Effective date: December 10, 2002 Page 1 of 1
Reviewed/Revised: 8/04, 8/05, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 03.01.01, 03.01.03

Purpose: To ensure highest quality of medical care for children who are ventilator dependent.

Policy: It is the policy of the Medical Staff of WCRH that all children who receive invasive and noninvasive ventilatory assistance be assessed and managed by a Pediatric Pulmonologist or Intensivist who are skilled in ventilator management.

Procedure:

1. When a patient with invasive or noninvasive ventilatory assistance is admitted to WCRH a consult shall be made to the Pediatric Pulmonologist or his/her designee.

2. Children with ventilatory needs are co-managed by the Attending Physician and the Pulmonologist.

_____ _____
Medical Director Date Administrator Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

Subject: Nurse Practitioner Role at WCRH **MS 202.00**

Effective date: August 15, 2005 **Page 1 of 1**
Reviewed/Revised: 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 03.01.01, 03.01.03

Purpose: To establish the role of a Pediatric Nurse Practitioner at WCRH.

Policy: The Pediatric Nurse Practitioner at WCRH shall operate in accordance with the Medical Staff Bylaws and Rules and Regulations of the Medical Staff at WCRH and the Statues and Regulations of the New Jersey Board of Nursing.

Procedure:

1. The nurse practitioner shall be credentialed and privileged as an Allied Health Professional member of the WCRH Medical Staff with a sponsoring (affiliated) physician.

2. The nurse practitioner shall operate within his/her scope of practice. The nurse practitioner may perform an initial history and physical examination, perform a follow-up examination, evaluate and manage common deviations from established illness, order laboratory and diagnostic tests, and with the sponsoring physician, write progress notes and order medication, treatments and devices.

3. The sponsoring physician (affiliated physician) shall review all evaluations and interventions and co-sign the nurse practitioner's notes and orders within 24 hours.

4. The attending physician is responsible for the medical care and treatment of his/her patient.

5. The sponsoring physician must be available electronically at all times.

_____ _____
Medical Director Date Administrator Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Sedation MS 203.00

EFFECTIVE DATE: December 1, 2001 Page 1 of 1
REVIEWED/REVISED DATE: 8/04, 8/05, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 03.01.01, 03.01.03

Purpose: To ensure patient safety through appropriate administration and monitoring of patients who receive mild sedation.

Policy: It is the policy of WCRH that all patients who receive mild sedation or anxiolytics are safely medicated and monitored.

Procedure:

1. Moderate sedation (conscious sedation) and deep sedation are not performed at WCRH.

2. Mild sedation and anxiolytics, defined as the state of sedation, in which patients respond normally to verbal commands, can be prescribed by any physician who has active staff privileges.

3. When a child receives a medication for the purpose of mild sedation, he is monitored for progression to moderate sedation, as defined by depression of consciousness, during which a patient can respond to verbal commands, either alone or with light tactile stimulation by nursing staff.

4. If a child who has been sedated demonstrates evidence of moderate sedation, he is monitored with a pulse oximeter for the duration of his sedation.

5. When procedures, which require moderate or deep sedation, are performed at another hospital, it is the responsibility of that hospital to administer and monitor the child. When the child returns to our hospital, he will be assessed for the level of sedation, and appropriate monitoring will be done based on his clinical exam.

_____ _____
Medical Director Date Administrator Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: **REPORTING OF MEDICALLY IMPAIRED DRIVERS** **MS 205.00**

EFFECTIVE DATE: May 5, 2003 **Page: 1 of 1**
REVIEW/REVISED: 8/04, 8/05, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

PURPOSE: To provide guidelines for the reporting of medically impaired drivers to the appropriate state agencies responsible for the licensing of operators of motor vehicles.

POLICY: It is the policy of WCRH to identify drivers who may be medically impaired and report them to the appropriate state agency.

PROCEDURE:

1. The physician shall make a determination at the team conference as to whether, in his/her opinion a patient of age can safely operate a motor vehicle. This decision will be based on state regulations and:
    - Patient physical and medical status
    - Cognitive/perceptual abilities
    - Results of screening assessment (predrivers evaluation) if available
    - Rancho Level if patient has a traumatic brain injury. Patients with a Rancho Level 5 or above should be evaluated for driver safety.
2. If the physician determines that the patient cannot safely operate a motor vehicle, the social worker shall be responsible to obtain the appropriate forms required for that state.
3. The physician is responsible for completing and signing the forms. If no form is available, the physician shall write a letter to the appropriate state agency.
4. The physician along with the social worker is responsible for notifying the patient and family of state regulations regarding impaired drivers.

Medical Director Date Administrator Date

WEISMAN CHILDREN'S REHABILITTION HOSPITAL
MEDICAL STAFF MANUAL
POICY AND PROCEDURE

Subject: Graduate Medical Education **MS 206.00**

Effective date: January 1, 2002 **Page 1 of 2**
Review/Revision Date: 8/04, 8/05, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 04.01.01

Purpose: To safeguard patient care and enhance medical education by setting standards for the supervision and evaluation of students in graduate medical education.

Policy: Licensed individual practitioners (LIP) who have appropriate clinical privileges will supervise students in graduate medical education programs, provide performance evaluations for individual students and communicate regularly to the Medical Executive Committee.

Procedure:

1. Students/residents in good standing in accredited graduate medical education programs are eligible to participate in a clinical rotation at WCRH. This rotation is one month in length and the student may continue to have clinical responsibilities at the sending institution such as call and clinic experience.

2. During the rotation at WCRH the resident may perform responsibilities as listed in the job description. Unsupervised responsibilities for the second or third year residents include physical examination and history taking, daily patient rounds, venous and arterial blood sampling. All other procedures must be directly supervised. The resident may document the initial history and physical examination and progress notes in the patient chart and may write orders that do not include controlled substances.

3. The LIP responsible for supervising the student/resident must co-sign all resident orders, progress notes, and initial history and physical examination forms. The LIP is responsible for separate written documentation, establishing that the LIP has also examined the patient, summarizing the pertinent examination and treatment plan and stating that the LIP is in agreement with the assessment and plan of care that the student/resident has documented.

4. Students/residents in graduate medical education programs are formally evaluated at the end of the clinical rotation, typically one month in length.

A written evaluation is coordinated with the appropriate LIP at WCRH and forwarded to the graduate medical education coordinator at the sending institution. The student/resident is provided informal feedback throughout the rotation and is provided the opportunity to review the educational experience with the LIP responsible for supervision.

5. The Medial Executive Committee reviews the educational program as needed but at least on a yearly basis and forwards its review to the Governing Body.

6. Full responsibility for the care of the patient remains with the LIP.

7. Patients and their families have the right to refuse care provided by a student/resident.

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Medical Director Administrator

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Medical Staff Role in Quality Assurance MS 300.00

EFFECTIVE DATE: September 1, 1999 Page 1 of 2
REVIEWED/REVISED DATE: 8/04, 8/05, 6/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 05.01.01, 05.01.03 The organized medical staff has a leadership role in hospital performance improvement activities to improve quality of care, treatment, and services and patient safety.

Purpose: To ensure Medical Staff participation in the measurement, assessment and improvement of the patient care process.

Policy: It is the policy of WCRH that the Medical Staff and Medical Director have a leadership role and actively participate in the Hospital's Performance Improvement Program.

Procedure:

1. The Medical Director and Medical Staff will be active participants in the Performance Improvement Committee.

2. The Medical Director is responsible for the Quality Indicators to be used to screen closed medical records for appropriate medical care.

3. The Executive Committee of the Medical Staff will review the quality indicators as part of the recredentialing and reappointment process on a regular basis to assess their reliance, effectiveness and validity.

4. Medical Staff member's competence, skills, and professional judgment will be assessed on an ongoing basis through the review of open and closed medical records.

5. All Medical Staff Performance will be evaluated on an ongoing basis through the use of quality indicators as well as on a biannual basis querying other hospitals where physicians have staff privileges and requesting assessment of the practitioner's abilities at each of the facilities where the member has clinical privileges.

6. Medical Staff performance will include but not be limited to:

    - Medical Assessment
    - Use of medications
    - Use of Blood/Blood components
    - Operative and other procedures
    - Efficiency of practice and patterns
    - Departures from established patients of clinical process
    - Coordination of care
    - Accurate, timely, legible completion of medical records

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Medical Director	Date	Administrator	Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Credentialing MS 400.00

EFFECTIVE DATE: May 1, 1999 Page 1 of 2
REVIEWED/REVISED DATE: 8/04, 8/05, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 06.01.01, 06.01.03, 06.01.05, 06.01.07, 06.01.09 The hospital collects information regarding each practitioner's current license status, training, experience, competence and ability to perform the requested privilege.

Purpose: To establish a mechanism for the evaluation of the qualifications of physicians, dentists and other licensed independent practitioners.

Policy: It is the policy of the Medical Staff and the Governing Body of WRCH to evaluate the credentials and qualifications of current and prospective members of the Medical Staff in order to ensure the quality of care provided to the patients of WRCH.

Procedure:

1. The Medical staff authorizes the Medical staff services professional to act on its behalf to obtain and verify the information necessary for a thorough, objective evaluation of the credentials, qualifications and competencies of practitioners seeking appointment/reappointment by the Medical Executive Committee and the Governing Body.

2. The information required of each applicant is set forth in Article IV, VI and VII of the Medical Staff Bylaws.

3. The Medical Staff services professional will be responsible for obtaining the necessary information and promptly processing each application for appointment/reappointment.

4. The Medical Executive Committee, upon recommendation of the Medical Director, will evaluate the information submitted and verified and make a recommendation to the Governing Body with respect to medical staff membership and appropriate clinical privileges to be granted.

5. The Governing Body, upon recommendation of the Medical Executive Committee will consider the information and recommendation and make a final decision with respect to medical staff membership and appropriate clinical privileges to be granted.

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Medical Director Date	Administrator Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL

MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Procedure for Handling Applications To Medical Staff — MS 401.00

EFFECTIVE DATE: April 2002 — Page: 1 of 3
REVIEWED/REVISED: 4/04, 8/05, 2/06, 4/06, 8/06, 3/07, 9/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 06.01.01, 06.01.03, 06.01.05, 06.01.07, 06.01.09

PURPOSE: To ensure that WCRH responds to applications to the Medical Staff efficiently and on a timely basis.

POLICY: It is the policy of WCRH that applications to the Medical Staff be handled in a time-efficient, responsive and accurate manner.

PROCEDURE:

1. When a request for application to Medical Staff is made, the Medical Staff Coordinator mails a copy of the application for Medical Staff membership and a copy of delineation of privilege that is appropriate to the doctor's subspecialty.

2. If a request for membership to the Medical Staff fills the criteria for temporary privileges, the Medical Staff services professional mails a copy of the application for temporary privileges.

3. The applicant must provide the following information necessary to complete the application:

    a. completed, and signed application form and request for privileges;
    b. copy of current NJ state license, CDS and DEA certificate;
    c. copy of the facesheet of the current professional liability insurance policy or certificate of insurance;
    d. copies of certificates or letters confirming completion of an approved residency/training program or other educational curriculum;
    e. copies of certificates or letters from appropriate specialty board(s) stating board status-i.e., board qualification or board certification, or recertification; and
    f. names and addresses of two professional references that have recently worked with the applicant and directly observed his or her professional performance over a reasonable period of time. At least one reference must be an individual practicing in a field similar to that of the applicant and one reference must be from an individual working in Pediatrics.

g. statement that no health problems exist that could affect his or her ability to perform the privileges requested, including PPD status
h. a current picture hospital ID card **or** a valid picture ID issued by a state, federal or regulatory agency

4. If all required information is not received within 45 days of receipt of the application, the hospital will consider the application incomplete and the medical staff service professional will suspend further processing. The hospital will send one reminder notice to the applicant after receipt of the application, noting missing items or information.

5. The Medical Staff Coordinator will then verify the information provided from the primary source

6. The verifications will include the following:

   a. Information from all prior and current malpractice insurance carriers concerning claims, suits, and settlements (if any) during the past five years;
   b. Administrative and clinical references from all significant past practice settings for the previous 10 years;
   c. Verified documentation of the applicant's past clinical work experience;
   d. Verification of licensure status in all current or past states of licensure;
   e. Information from the AMA Physician Profile
   f. Verification of completion of medical/osteopathic/dental school and residency/fellowship programs; and
   g. Information from the National Practitioner Data Bank.

7. If there is delay in obtaining required information, the Medical Staff Coordinator will request assistance from the applicant. If the applicant fails to adequately respond to a request for assistance within 30 days of the hospital's request, the hospital will terminate the application process.

8. Where the application file is completed and verified, it will be presented to the Medical Director and his/her recommendation is made.

9. When the Medical Staff office has obtained the above items, it will summarize the file on an Administrative Review form and present the file to the appropriate department chair and the credentials committee chair.

10. The application is then reviewed at the next routine Medical Executive Meeting and a recommendation made.

11. The application is then reviewed at the next Board of Director’s Meeting and a final recommendation is made.

12. A letter is sent to the applicant informing him/her of the decision for admission to the Medical Staff or reason for privilege denial.

13. An application for reappointment to the Medical Staff is mailed approximately 4-

6 months prior to the two year anniversary (10/01, 10/03, 10/05, etc.). The process for reappointment is the same as for initial appointment.

14. Information regarding each practitioner's scope of privileges is updated as changes in clinical privileges for each practitioner are made.

15. The Medical Staff Coordinator at WCRH is responsible for periodic up-keep of Medical Staff files to ensure licensure, CDS, DEA and malpractice are valid.

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Medical Director	Date	Administrator	Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Primary Source Verification MS 402.00

EFFECTIVE DATE: May 1, 1998 Page 1 of 1
REVIEWED/REVISED: 8/04, 8/05, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 06.01.07 The organized medical staff reviews and analyzes information regarding each requesting practitioner's current licensure status, training, experience, current competence, and ability to perform the requested privilege.

Purpose: To establish guidelines for the verification of information submitted by applicants.

Policy: It is the policy of the Medical Staff of WCRH to verify, through appropriate primary and secondary sources, the information provided by applicants for medical staff membership and clinical privileges.

Procedure:

1. The Medical Staff Coordinator shall verify the following information from the primary source or by obtaining a current AMA Master Profile.

    - Education
    - Training
    - Board Status
    - Licensure(s)
    - DEA
    - Hospital Affiliations
    - Insurance Coverage
    - Professional liability claim history

_____ _____
Medical Director Date Administrator Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF SERVICES MANUAL
POLICY AND PROCEDURE

SUBJECT: National Practitioner Data Bank Queries MS 402.01

EFFECTIVE DATE: May 5, 1998 Page 1 of 1
REVIEWED/REVISED DATE: 8/04, 8/05, 2/06, 7/08, 3/10, 10/11, 6/12, 3/13, 10/17, 10/20, 10/23

TJC Standard: MS 06.01.13 The hospital queries the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.

Purpose: To establish a procedure for queries to the National Practitioner Data Bank. To verify the professional liability claim status and current disciplinary record of all applicants to the Medical Staff.

Policy: It is the policy of the Medical Staff at WCRH to query the NPDB at time of appointment and reappointment and in conjunction with granting clinical privileges.

Procedure:

1. The Medical Staff Coordinator will request a report form the NPDB for all physicians, dentists, and other licensed independent practitioners as appropriate in conjunction with the initial appointment, reappointment, temporary privileges, and change in privileges or new privilege requested.

2. The Medical Director, Medical Executive Committee and the Governing Body will review the information received from NPDB as part of the evaluation of the practitioners' credentialing information.

_____ _____

Medical Director Date Administrator Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Criteria for Clinical Privileges MS 403.00

EFFECTIVE DATE: September, 1998 Page 1 of 2
REVIEWED/REVISED DATE: 8/04, 8/05, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

Purpose: To establish a mechanism for the granting of clinical privileges and to ensure the practitioners granted clinical privileges provide services within the scope of the privileges granted.

Policy: It is the policy of Weisman Children's Rehabilitation Hospital/Voorhees Pediatric Facility and its Medical Staff that all practitioners who are permitted by law and by the Hospital to provide patient care services independently in the hospitals have delineated clinical privileges.

Procedure:

1. The Medical Director of WCRH in conjunction with the Medical Executive Committee, shall establish criteria for the granting of hospital-specific clinical privileges within the Department of Pediatrics as well as for each specialty services.

2. Applicants for clinical privileges have the burden of demonstrating their ability, qualifications, (physical and mental) and competence to perform the clinical privileges requested.

3. The Medical Director of WRCH shall make a recommendation on the applicants' request to the Medical Executive Committee which also considers the request and makes a recommendation for the granting, denial, modification, restriction on monitoring of clinical privileges to the Hospital's Governing Board which the Governing Board makes a final determination.

4. Requesting practitioners are notified regarding the granting decision.

5. Hospital staff are provided with access to the delineation of privileges of each Medical Staff member in order to ensure that all practitioners practice within the scope of privileges granted.

6. Ongoing review of the quality of patient care as part of Medical Staff QA/PI also serves as a check to ensure that practitioners do not exceed the scope of the privileges.

7. Questions regarding the scope of any practitioner's privileges should be reported immediately to the Medical Director or the Medical Staff services professional.

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Medical Director	Date	Administrator	Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Expedited Credentialing MS 404.00

EFFECTIVE DATE: July 1, 2004 Page 1 of 1
REVIEWED/REVISED DATE: 8/05, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 06.01.11 An expedited governing body approval process may be used for initial appointment and reappointment to the medical staff and when granting privileges when criteria for that process are met.

Purpose: To provide an expedited credentialing process for LIPs that are eligible.

Policy: It is the policy of WCRH that qualified LIPs may receive privileges in an expedited manner.

Procedure:

1. LIPs with completed applications are considered for expedited credentialing unless they are ineligible based on the following:
    a. The applicant submits an incomplete application.
    b. The Medical Executive Committee makes an adverse or limited recommendation.
    c. There is a current or previously successful challenge to licensure or registration.
    d. Medical staff membership at another institution has been involuntarily terminated.
    e. Clinical privileges have been involuntarily limited, reduced, denied or lost.
    f. There is an excessive pattern of adverse professional liability actions against the LIP.
2. When the Medical Executive Committee reviews and makes a positive recommendation regarding privileging, the application is then reviewed by a committee consisting of two voting members of the Governing Body.
3. The members of the Governing Body who are responsible for reviewing applications for expedited privileging shall be appointed by the President of the Governing Body.
4. The committee shall have the responsibility to review and grant privileges to the LIP as representatives of the full governing body.

_____ _____
Medical Director Date Administrator Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Medical Staff Peer Review MS 405.00

EFFECTIVE DATE: April 15, 2003 Page 1 of 1

REVIEWED/REVISED DATE: 8/04, 8/05, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 08.01.03 Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

PURPOSE: To document the mechanism by which the WCRH Medical Staff is involved in performance improvement and peer review.

POLICY: The Medical Staff at WCRH has a leadership role in performance improvement activities as outlined in the Medical Staff Performance Improvement Plan and participates in Peer Review.

PROCEDURE:

1. The Medical Staff Performance Improvement Plan is agreed upon at the Medical Staff Executive Committee. Performance improvement activities and peer review occur quarterly and member of the medical staff are active member of the WCRH Performance Improvement Committee.
2. Current assessment of physician quality of care includes the Quality Screening Tool and Unplanned Transfer Review.
3. Charts are selected randomly for quality screens or chosen for review because of an unplanned transfer. Charts are assessed by a committee of attending physicians (peers), then reviewed by the Medical Director.
4. The attending physician of record is notified of any concerns regarding quality of care and comment is encouraged.
5. Any discrepancy between the assessment and the attending physician is addressed at the Medical Staff Executive Committee, which shall operate as a Peer Review Committee.
6. If consensus cannot be reached, an independent review may be requested.
7. Concerns regarding quality of care are addressed though the WCRH Medical Staff Bylaws Article 11.
8. Peer review information is used at the time of recredentialing.

_____ _____

Medical Director Date Administrator Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Temporary Privileges MS 406.00

EFFECTIVE DATE: September, 1998 Page 1 of 2
REVIEWED/REVISED DATE: 8/04, 8/205, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 06.01.13 Under certain circumstances, temporary clinical privileges may be granted for a limited period of time.

Policy: It is the policy of WCRH to grant temporary privileges to LIP's under the circumstances outlined in the Medical Staff Bylaws 7.2 in an efficient manner.

Procedure:

1. Temporary privileges may be requested in the following two situations.

    a. To fulfill an important patient care, treatment and service need that requires a practitioner's immediate authorization to practice.
    b. When an applicant for new privileges with a complete application is awaiting review and approval by the medical staff executive committee and the governing body.

2. For temporary privileges to meet an important patient care need:

    a. Medical Director is responsible to determine if a specific patient care need warrants providing temporary privileges.
    b. The applicant must submit a completed application
    c. The Medical Staff Coordinator shall verify current license and competence.
    d. The CEO with the recommendation of the Medical Staff president shall grant temporary privileges not to exceed 120 days.
    e. The full application shall be processed in the time frame specified in the Medical Staff Bylaws.

3. For temporary privileges granted while awaiting full approval:

    a. The applicant is responsible for submitting a complete application
    b. The Medical Staff Coordinator shall verify license, relevant training, experience, current competency and ability to perform requested privileges, and current health status. NPDB query is performed and reviewed.
    c. The applicant must have not currently or previously successful challenge to license or registration. The applicant must not have been subject to involuntary termination of medical staff membership at another institution

or been subject to involuntary limitation, reduction, denial or loss of clinical privileges.

d. The CEO with the recommendation of the Medical Staff president shall grant temporary privileges not to exceed 120 days.
e. Clinical privileges and Medical Staff membership shall be reviewed and granted by the Medical Executive Committee and Governing Body as outlined in the Medical Staff Bylaws and Policies and Procedures.

_____ _____

Medical Director Date Administrator Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

Subject: Disaster Privileging of Licensed Independent Practitioners — MS 407.00

EFFECTIVE DATE: 12/10/02 — Page 1 of 2
REVIEWED/REVISED: 05/23/04, 8/05, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

Standard: The organization may grant disaster privileges to volunteers eligible to be licensed independent practitioners.

Purpose: To provide for necessary medical services provided by LIP following the activation of the hospital emergency plan.

Policy: It is the policy of the medical staff of WCRH to grant disaster privileges to identified Licensed Independent Practitioners (LIP) during disasters when the hospital is unable to meet immediate patient needs following activation of the emergency management plan.

Procedure:

1. In the event of a disaster following the activation of the emergency management plan, the administrator in charge or his designee shall determine if there are sufficient LIPs on site to handle the immediate patient needs. If there are insufficient staff to meet the acute medical needs, the administrator may, based on need and identification, grant emergency medical privileges to LIPs.

2. Disaster medical privileges can be requested verbally by any LIP in the case of a disaster.

3. When disaster privileges are requested the administrator shall require one of the following forms of identification:
    a. a current picture hospital ID card
    b. a current license to practice and a valid picture ID issued by a state, federal or regulatory agency.
    c. Identification that the individual is a member of the Disaster Medical Assistance Team.

d. Identification that the individual has been granted authority to render patient care in emergencies having been granted by a federal state or municipal entity.
e. Identification of the LIP by an individual who is a current member of the WCRH medical staff and who has personal knowledge of qualifications.

4. Following identification, the administrator may grant disaster privileges depending on need and qualifications.

5. If the administrator is unavailable, disaster privileges may be granted by the President of the Medical Staff or the Medical Director.

6. Individuals who receive disaster privileges will be identified by a temporary badge stating name and qualifications. The Disaster Team Leader or designee will direct and supervise the LIP in care provision.

7. As soon as the disaster is under control and the situation stabilized, the privileging process for temporary privileges as per the Bylaws and Medial Staff Policy and Procedures shall be initiated.

_____ _____

Medical Director Date Administrator Date

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Focused Professional Practice Evaluation MS 408.00

EFFECTIVE DATE: 1/08 Page 1 of 7
REVIEWED/REVISED DATE: 7/08, 3/10, 10/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 08.01.01 The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance.

PURPOSE: To allow the organized medical staff to focus evaluation on a specific aspect of a practitioner's performance (1) when a practitioner has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence in the hospital's setting; or (2) if questions arise regarding a practitioner's professional practice during the course of the Ongoing Professional Practice Evaluation.

POLICY: Focused Professional Practice Evaluation ("FPPE") is required when there is concern regarding the practitioner's current competency, either due to data from the ongoing peer review, a specific event or observation or the practitioner is not yet a member of the medical staff of WCRH.

Definition of Proctoring: For purposes of this policy, proctoring is a focused evaluation to confirm an individual practitioner's current competence at the time when he or she requests new privileges, either at initial appointment or as a current member of the medical staff. In addition to specialty-specific issues, proctoring also will address the six general competencies of physician performance.

Practitioners requesting membership but not exercising specific privileges do not need to be proctored. FPPE for medical staff members for existing privileges based on trends or patterns of performance identified by FPPE or because of infrequent use of a specific privilege are outside the scope of this policy.

Proctoring Methods: Proctoring may be performed using prospective, concurrent, or retrospective approaches. Specialists who most often provide cognitive care, as opposed to procedural care, are usually evaluated prospectively or retrospectively. Prospective proctoring and concurrent proctoring are the preferred methods of evaluating practitioners who request privileges to perform various procedures. The appropriate proctoring methods for an individual practitioner shall be determined annually by the medical executive committee.

Duration of Proctoring Period: The medical staff may take into account the practitioner's previous experience in determining the approach and extent of proctoring needed to confirm current competence. The practitioner's experience may fall into on of the following classes:

1. A recent training program graduate from a facility.
2. A practitioner with experience of less than 2 years at another medical staff
3. A practitioner with experience of greater than 2 years at another medical staff.

Practitioners in classes 1 and 2 would be candidates for the full proctoring program. Practitioners in class 3 would be candidates for limited proctoring, unless concerns exist regarding the recent frequency of use of the requested privileges.

Medical Staff's Ethical Position on Proctoring: The proctor's role is typically that of an evaluator, not of a consultant or mentor. A practitioner serving solely as a proctor, for the purpose of assessing and reporting on the competence of another practitioner, is an agent of the hospital. The proctor will receive no compensation directly or indirectly from any patient for this service, and he or she will have no duty to the patient to intervene if the care provided by the proctored practitioner is deficient or appears to be deficient. The proctor or any other practitioner, however, may nonetheless render emergency medical care to the patient for medical complications arising form the care provided by the proctored practitioner. The hospital will defend and indemnify any practitioner who is subjected to a claim or suit arising from his or her acts or omissions in the role of proctor.

Responsibilities of the Proctor: Proctors must be members in good standing of the active medical staff of WCRH and must have unrestricted privileges to perform any procedure or provide medical management to be concurrently observed. The proctor will do the following:

1. Directly observe the procedure being performed or concurrently observe medical management for the medical admission and complete appropriate sections on the proctoring form.
2. Retrospectively review the completed medical record following discharge and compete appropriate sections of the proctoring form.
3. Monitor the practitioner being proctored from admission through discharge, including:
    a. history and physical
    b. diagnosis and justification
    c. proposed treatment or procedure and its indications
    d. continuity of care provided to the patients
    e. appropriateness of procedures, tests and medications prescribed
    f. appropriate use of consultants
    g. appropriateness of length of stay
    h. adequacy of progress notes
    i. discharge summary
    j. timely completion of medical records

k. appropriately signed consents
l. technical skills/knowledge (as appropriate)
m. management of complications

4. Ensure the confidentiality of proctoring results and forms. The proctor will deliver the completed proctoring form to the medical staff office.
5. Submit a summary proctor report at the conclusion of the proctoring period.
6. If, at any time during the proctoring period the proctor has concerns about he practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), the proctor will promptly notify the Medical Director and may recommend that one of the following occur:
    a. The Medical Director intervenes and adjudicates the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient.
    b. The Medical Director reviews the case for possible peer review at the next medical executive committee meeting.
    c. Additional or revised proctoring requirements may be imposed upon the practitioner until the proctor can make an informed judgment and recommendation regarding the clinical performance of the individual being proctored.

Responsibilities of Practitioners Being Proctored: The practitioner being proctored will do the following:

1. Notify the proctor of each case in which care is to be evaluated and, when required, do so in sufficient time to enable the proctor to observe or review the case concurrently. In an emergency, the practitioner may admit and treat the patient and must notify the proctor as soon as is reasonably possible of the emergency.
2. Provide the proctor with information about the patient's clinical history; pertinent physical findings; pertinent lab and x-ray results; the planned course of treatment or management; and direct delivery of a copy of all histories and physicals, consultations, and discharge summaries documented by the proctored physician to the proctor.
3. Will have the prerogative of requesting from the Medical Director a change of proctor if disagreements with the current proctor may adversely affect his or her ability to complete the proctorship satisfactorily. The matter will be submitted to the Medical Executive Committee for recommendation and final action.
4. Inform the proctor of any unusual incident(s) associated with his or her patients.
5. Ensure documentation of the satisfactory completion of his or her proctorship, including the completion and delivery of proctorship forms and the summary proctor report to the medical staff office. The proctoring period will automatically extend for up to three months if the summary proctor report is not completed and submitted at the end of the initial proctoring period. If the summary proctor report is not completed and submitted to the medical staff office at the end of a proctoring period extended under this subparagraph five, the privileges of a provisional appointee subject to proctoring, or the additional or new privileges that are the subject of proctoring for any other member of the medical staff shall

be automatically suspended. Failure to obtain submission of a completed summary proctor report before the time for submission of the physician's next reappointment application shall be treated as a voluntary relinquishment of the privileges that were subject to proctoring.

Responsibilities of Medical Director: The Medical Director shall be responsible for the following:

1. Assigning proctors.
2. Helping establish a minimum number of cases or procedures to be proctored and determining the times when the proctor must be present.
3. Identifying the names of medical staff members eligible to serve as proctors.
4. Reviewing the medical records of the patients) treated by the practitioner being proctored if, at any time during the proctoring period, the proctor notifies the medical director that he or she has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), based on the recommendation of the proctor. The medical director shall then do one of the following:
    a. Intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient;
    b. Refer the case(s) to the next medical staff committee meeting for peer review;
    c. Recommend to the Medical Executive Committee that one of the following occur:
        (1) Additional or revised proctoring requirement be imposed on the practitioner;
        (2) Corrective action will be undertaken pursuant to a corrective action plan.

Responsibilities of the Medical Staff Office/Quality Department: The medical staff office/quality department shall do the following:

1. Send a letter to the practitioner being proctored and to the assigned proctor containing the following information:
    a. A copy of the privilege form of the practitioner being proctored
    b. The name, address and telephone numbers of both the practitioner being proctored and the proctor.
    c. A copy of the proctoring policy and procedure
    d. Proctoring form to be completed by the proctor
2. Develop a mechanism for tracking all admissions or procedures performed by the practitioner being proctored.
3. Provide information to appropriate hospital departments about practitioners being proctored, including the name of the proctor and a supply of proctoring forms as needed.
4. Contact both the proctor and practitioner being proctored on a monthly basis to ensure that proctoring and chart review are being conducted as required.

5. Provide regular status reports to the medical director related to the progress of all practitioners required to be proctored, as well as any issues or problems involved in implementing the policy and procedures.
6. Periodically submit a report to the Medical Executive Committee of proctorship activity for all practitioners being proctored.
7. At the conclusion of the proctoring period, submit a summary proctor report to the Medical Director and the Medical Executive Committee.

Proctoring Methods Available: Proctoring may use a combination of the following methods to obtain the best understand of the care provided by the practitioner:

1. Prospective proctoring: Presentation of cases with planned treatment outlined for treatment concurrence or review of case documentation for treatment concurrence.
2. Concurrent proctoring: Real-time observation of a procedure. May also be used for real-time observation of the patient's clinical history and physical and review of treatment orders.
3. Retrospective evaluation: Review of case record after care has been completed. May also involve interview of personnel directly involved in the patient's care.

Sources of Data: Proctoring data can be obtained for all dimensions of practitioner competence from multiple data sources. Data may be individual (i.e. case specific) or aggregate "rate" data from multiple cases. Data may be derived from information specifically obtained for FPPE or ongoing peer review.

FPPE data may include the following:

1. Personal interaction with the practitioner by the proctor
2. Detailed medical record review by the proctor
3. Interview of hospital staff interacting with the practitioner
4. Surveys of hospital staff interacting with the practitioner
5. Chart audits by non-medical staff personnel based on medical staff-defined criteria for initial appointees.

The data obtained by the proctor will be recorded in an approved proctoring form to ensure consistency.

Ongoing peer review data may include the following:

1. Routine chart audits by non-medical staff personnel for important clinical functions.
2. Data abstracted for external comparative databases used to evaluate current medical staff members (if any)
3. Incident Reports
4. Findings of cases identified for review by medical staff peer review committees
5. Patient satisfaction surveys

Data Analysis: The proctor will review both the case-specific and aggregate data and will provide the credentials committee with an interpretation about whether the practitioner's performance was acceptable, whether the proctor needs additional data to complete the evaluation or whether the practitioner's performance was unacceptable. For aggregate rate data, the medical staff will determine the acceptable target.

Each specialty will define the appropriate methods to determine what constitutes practitioners' current competency. The specialty will describe these methods in brief proctoring plan submitted to the credentials committee for approval. The plan will be reviewed and updated annually and will include the types of proctoring to be used, the data sources and collection methods employed and the method of evaluating the data.

Procedure for Outlining the Proctoring Process:

The specific steps that both the proctor and the practitioner being observed must perform are displayed in the attached Form entitled: "Outlining the Proctoring Process".

Results and Recommendations: At the end of the proctoring period, the proctor will provide a summary report to the medical director that shall include one or more of the following:

1. Whether a sufficient number of cases done at WCRH or at another local hospital have been presented for review to evaluate properly the clinical privileges requested.
2. If a sufficient number of cases have NOT been presented for review, whether in the proctor's opinion the FPPE period should be extended for an additional period.
3. If sufficient treatment of patients has occurred to evaluate the clinical privileges requested properly, the proctor shall make his or her report concerning the appointee's qualifications and competence to exercise these privileges.
4. Make a recommendation for permanent membership and clinical privileges as requested or recommend an additional one year of proctoring, or NOT recommend permanent membership and clinical privileges as requested.
5. If this is a recommendation by the Medical Executive Committee to terminate the practitioner's appointment or additional clinical privileges due to questions about qualification, behavior or clinical competence, the practitioner shall be entitled to the hearing and appeal process outlined in the medical staff by-laws.

_____ _____

Medical Director Date Administrator Date

Weisman Children's Rehabilitation Hospital/Voorhees Pediatric Facility
Outline for the Proctoring Process

TASK	ACTIVITY	TIME FRAME	RESPONSIBILITY
Determine duration of proctoring period, volume and methods	Applicant classified regarding amount of proctoring required, based on applicant's experience and available data.	Within two weeks prior to privileges granted by board.	Medical Staff Committee
Assign Proctors	Members from appropriate specialty contracted and confirmed.	Within two weeks prior to privileges granted by board.	President of Medical Staff
Initiate Proctoring	Proctor and practitioner informed of proctoring plan	At orientation and activation of privileges	President of Medical Staff
Schedule proctoring sessions	Proctor and practitioner determine schedule (if concurrent methods used) and inform Medical Staff Office (MSO)	Within one week following privilege activation	Proctor, practitioner and MSO
Distribute proctoring forms	Forms for proctoring sent to proctor	Within one week following privilege activation.	MSO
Complete proctoring forms	Proctor submits completed forms to MSO	Monthly for duration of proctoring period	Proctor
Audit proctoring charts	Quality staff performs audits required by proctoring plan and submits data to MSO	Monthly for duration of proctoring period	Quality Staff as assigned
Obtain ongoing peer review	Quality staff submits data gathered to MSO	Monthly/Quarterly for duration of proctoring period	Quality Staff as assigned
Evaluate data	Proctor is provided with audit and Ongoing Peer Review data and provides interpretation	Monthly/quarterly for duration of proctoring period	MSO and Proctor
Proctor recommendation	Proctor provides MSO with overall assessment of proctoring data and recommendation to end or extend proctoring or terminate privileges	At end of initial proctoring period or volume, unless substantial concerns that required immediate action are raised earlier	MSO and Proctor
Recommendation	MSO provides Medical Director with proctor recommendation for medical director's approval.	MSO submits to medical director within one week of receiving proctor recommendation; Medical Director chair submits approval within two weeks	MSO and Medical Director
Final recommendation	Medical Staff Committee reviews proctor data and recommendation, submits final recommendation to Medical Executive Committee	At next schedule Medical Executive Committee meeting	MSO and Medical Director

10/11

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Ongoing Professional Practice Evaluation (*Maintaining Privileges)* MS 409.00

EFFECTIVE DATE: 1/08 Page 1 of 2

REVIEWED/REVISED DATE: 7/08, 3/10, 10/10, 10/11, 10/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 08.01.03 The Ongoing Professional Practice Evaluation information is factored into the decision to maintain existing privileges, to revise existing privileges or to revoke an existing privilege prior to or at the time of renewal.

PURPOSE: To establish a process designed to evaluate continuously a practitioner's performance. This ongoing evaluation allows the hospital to identify professional practice trends that impact on quality of care and patient safety. Such identification may require intervention by the organized medical staff.

POLICY: The Ongoing Professional Practice Evaluation ("OPPE") information is factored into the decision to maintain existing privileges, to revise existing privileges or to revoke an existing privilege prior to or at the time of renewal. Relevant information obtained from the OPPE will be integrated into performance improvement activities. If there is uncertainty regarding the practitioner's professional performance, the hospital's medical staff will follow the course of action defined in the medical staff by-laws for further evaluation of the practitioner.

Procedure: The criteria used in the ongoing professional practice evaluation may include the following:

1. Review of History and Physical and Chart Documentation
2. Pattern of pharmaceutical usage, including pain management
3. Requests for tests
4. Other relevant criteria as determined by the organized medical staff.

The information used in the OPPE may be acquired through the following:

1. Periodic chart review
2. Direct observation
3. Monitoring of diagnostic and treatment techniques
4. Discussion with other individuals involved in the care of each patient including consulting or covering physicians, nursing and administrative personnel.

_____ _____

Medical Director Date Administrator Date

Weisman Children's Rehabilitation Hospital/Voorhees Pediatric Facility
Physician Performance Report

Practitioner: _____

Reporting Period: _____

Activity Data

Admissions	
Consults	
Outpatient	
Total	

Performance Data	**Physician Data**	**Acceptable Performance**	**Comments**
Quality of History and Physical			
Medical Record Deficiencies			
Legibility			
Electronically authenticate verbal orders in timely manner			
Attendance at staff meetings			
Infection Control			
BLS			
PALS			
Medical/Clinical Knowledge			
Technical & Clinical Skills			
Clinical Judgment			
Interpersonal Skills			
Professionalism			
Communication Skills			
Grievances			
Pharmaceutical Usage			

WEISMAN CHILDREN'S REHABILITATION HOSPITAL
MEDICAL STAFF MANUAL
POLICY AND PROCEDURE

SUBJECT: Continuing Medical Education **MS 500.00**

EFFECTIVE DATE: November 1, 2004 **PAGE 1 of 1**
REVIEWED/REVISED: 6/05, 2/06, 3/07, 7/08, 3/10, 10/11, 6/12, 3/13, 9/14, 10/17, 10/20, 10/23

TJC Standard: MS 12.01.01 All licensed independent practitioners and other practitioners privileged through the medical staff process participate in continuing education.

Purpose: To identify how Medical Staff Continuing Medical Education is used as an adjunct to maintaining clinical skills and current competence.

Policy: It is the policy of WCRH that all LIPs participate in Continuing Medical Education.

Procedure:

1. LIPs participate in hospital sponsored educational activities.
    a. These activities relate to the nature of LIP clinical activities at this Hospital.
    b. These activities will be in accordance with the continuing education requirements for the LIP licensure.

2. Hospital sponsored educational activities are coordinated through the Program Development Committee.

3. Hospital sponsored educational activities are based on the findings of medical staff performance improvement activities.

4. LIPs continuing education is documented at the time of Reappointment.

5. Participation in continuing education is considered in decisions about reappointment or revision of clinical privileges.

_____ _____
Medical Director Date Administrator Date