SAINT JOSEPH
Regional Medical
Center

Version #: 3

Title: **Access to Credentials/Peer Review File**

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POLICY:

1. There will be two separate files maintained for each member of the Medical Staff or Medical Associate granted clinical privileges. These files will be secured and maintained separately in the Medical Staff Office. The files will contain the following information:
   A. Credentials File Contents:
      1) Application and reappointment information, signed release forms, privileging forms
      2) Verification of current licensure, DEA certificate, malpractice insurance face sheet and other certification as appropriate
      3) Continuing Medical Education records
      4) Curriculum Vitae
      5) References from other practitioners and facilities regarding the practitioner's current competency
      6) Health status documentation
      7) Miscellaneous information
   B. Peer Review File Contents:
      1) Medical record review forms
      2) Correspondence to and from peer review committee
      3) Results of special reviews
      4) Relevant incident reports or other documentation regarding situations requiring trending or investigation
      5) Reappointment Profiles and procedural documentation

PROCEDURE:

A. Access to Credentials/Peer Review Files
   1) Access to the credentials or peer review files shall be for the sole purpose of discharging medical staff responsibilities and subject to the guidelines of confidentiality. Access shall be limited to the President of the Medical Staff, Service Chief, Medical Executive/Credentials Committee and the Board of Directors as needed to discharge its lawful obligation and responsibilities.
   2) A practitioner shall be granted access to his own credentials or peer review file, subject to the following procedure:
      a) Requests to review a file shall be made to the Medical Staff Coordinator. The review will take place in the Medical Staff Office during normal office hours.

b) The practitioner shall have access to the contents of both files, excluding references from other practitioners/healthcare facilities received as a part of the credentialing process.

c) A practitioner may receive a copy of only those documents provided by or addressed personally to them. A written summary of all information, including peer review committee findings, proctoring reports, patient and/or other complaints, etc. shall be provided to the practitioner by the President of the Medical Staff or his designee.

3) Information contained in the credentials file may be disclosed to other parties with the practitioner's consent. Information will only be released upon receipt of a Release of Information form signed and dated within the last six months.

B. Insertion of Information

1) Any person may provide information to the Medical Staff about the conduct, performance or competence of practitioners. Such information shall be confined to acts, demeanor or conduct reasonably likely to be:

a) Detrimental to patient safety or to the delivery of quality patient care within the hospital

b) Unethical

c) Contrary to the Medical Staff Bylaws or Rules & Regulations

d) Below acceptable professional standards

2) Adverse information deemed important for credentialing purposes shall be reviewed by both the President of the Medical Staff and the appropriate Service Chief and a recommendation made to:

a) Exclude the information from the credentials and peer review file

b) Provide a written summary of the adverse information to the practitioner and offer an opportunity for rebuttal before it is entered into the credentials or peer review file

c) Insert the information in the credentials or peer review file along with a notation that a request has been made to the Medical Executive/Credentials Committee for an investigation as outlined in the Medical Staff Bylaws.

3) The above recommendation will be forwarded to the Medical Executive/Credentials Committee which, when so informed, may either ratify or initiate contrary actions to the decision by a majority vote.

4) Information utilized in the course of an investigation shall remain in the peer review file.

5) Corrective action or restriction of clinical privileges, as recommended by the Medical Executive/Credentials Committee and acted upon by the Board of Directors, shall be included in the file.

C. Request for Correction, Deletion or Addition to Information in the Credentials and Peer Review files

1) When a practitioner has reviewed his/her file as provided according to this policy, he or she may address a written request to the President of the Medical Staff for correction or deletion of information in his or her file. Such requests shall include a statement of the basis for the action requested.

2) The President of the Medical Staff shall review requests for correction or deletion of information within thirty (30) days and shall recommend to the Medical Executive/Credentials Committee whether or not to honor this request.

3) The Medical Executive/Credentials Committee shall make a final decision by majority vote. The practitioner shall be notified in writing within two (2) weeks of the decision of the Medical Executive/Credentials Committee.

4) A practitioner, with notification to the Medical Executive/Credentials Committee, shall have the right to add to his/her own credentials or peer review file a brief statement responding to any information contained in the file.

References/Standards:

- Policy Origin Date: March 1999
- Review Date: March 2005
- Revised Date:
- Effective Date: March 19999
- Reviewed/Recommended By: Medical Executive Committee