NEW HANOVER REGIONAL MEDICAL CENTER

POLICY ON PRACTITIONER ACCESS TO CONFIDENTIAL FILES

Approved by the Board of Trustees
November 17, 2020

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1. SCOPE OF POLICY, DEFINITIONS, AND GENERAL PRINCIPLES

1.A ***Scope of Policy.*** This Policy applies to all Confidential Files maintained by New Hanover Regional (the "Medical Center").

1.B ***Definitions.***

(1) "Confidential File" means any file, paper or electronic, containing credentialing, privileging, EPP/peer review, health, or quality information related to a Practitioner. The Confidential File is distinct from personnel files the Medical Center maintains in its role as an employer, which are not governed by this Policy.

(2) "EPP Specialists" means the clinical and non-clinical staff who support the EPP/peer review process. This may include, but is not limited to, staff from the quality department, Medical Staff office, human resources, and/or patient safety department.

(3) "EPP/peer review" means the evaluation of professional practice/peer review process and includes all activities and documentation related to reviewing issues of clinical competence, professional conduct, care management, and health status.

(4) "Medical Staff Leader" means any Medical Staff Officer, Department Chair or committee chair.

(5) "Practitioner" means any individual who has been granted clinical privileges, Medical Staff membership, and/or a Medical Staff status by the Board, including, but not limited to, members of the Medical Staff and Advanced Practice Professionals.

1.C ***General Principles.***

(1) ***General Rules Regarding Access to Confidential Files by a Practitioner.***

(a) ***Medical Center Record.*** The Confidential File is a confidential and proprietary business record of the Medical Center. As such, access to the Confidential File is governed by this Policy.

(b) ***Personal Review of Information.*** Subject to the rules set forth in this Policy, Practitioners may review and make notes of information in their Confidential File. Practitioners may not designate another individual to review the Confidential File on

their behalf, and may not be accompanied by any other individual when reviewing their Confidential File.

(c) ***Copies.*** Practitioners may not copy, digitally image, or otherwise record any information from their Confidential File. Smart phones and other devices capable of copying or making digital images of information must remain with EPP Specialists while a Practitioner reviews documents. Except as otherwise set forth in this Policy, EPP Specialists may provide copies or summaries to the Practitioner only with the written permission of the Vice President for Medical Affairs ("VPMA").

(d) ***Documents Previously Sent to the Practitioner.*** Upon the request of a Practitioner, the EPP Specialists may copy and provide to the Practitioner any routine or sensitive documents contained in the Confidential File that: (i) had previously been sent by the Practitioner to the Medical Center, or (ii) had previously been sent by the Medical Center to the Practitioner. The written permission of the VPMA is not required for the EPP Specialists to make or disclose such copies.

(e) ***Alterations and Deletions.*** Practitioners may not alter or delete any information in their Confidential File. As described in Section 1.C(2) below, Practitioners may submit a request to the VPMA to alter or delete information in their Confidential File that is factually inaccurate.

(f) ***Logistics of Review.*** The format (e.g., paper or electronic), location, and other conditions relating to a Practitioner's review of the Confidential File will be determined by the VPMA, using the provisions of this Policy for guidance. The review will generally occur in the Medical Staff Office or other location where the Confidential File is maintained, with a EPP Specialist available to provide assistance as needed. The Confidential File may not be removed from the Medical Center without the written permission of the VPMA. The Leadership Council will be notified of any request for access made pursuant to this Policy.

(g) ***Medical Staff Hearings.*** A Practitioner shall be entitled to copies of documents that are not redacted pursuant to this Policy if those documents were used as the basis for an adverse professional review action that entitles the Practitioner to a Medical Staff hearing. The provision of such copies shall be subject to any rules set forth in the Medical Staff Bylaws or related policies.

(2) ***Alterations and Deletions at the Request of the Practitioner.***

(a) Practitioners may submit a request to the VPMA to alter or delete information in their Confidential File.

(b) The VPMA shall make the alteration or deletion only if the Leadership Council determines that the information in question is factually inaccurate. By way of example and not limitation, information is factually inaccurate if it pertains to the wrong individual (e.g., a Practitioner with the same name) or if it reflects an error in calculation (e.g., improper calculation of infection or complication rates).

(c) Reported concerns regarding a Practitioner's clinical performance or behavior shall not be deleted simply because the applicable committee decides that the care provided was appropriate or the behavior did not warrant an intervention. Similarly, information shall not be altered or deleted simply because it is old or reflects an opinion with which the Practitioner disagrees.

(d) Any request by a Practitioner to alter or delete information will be maintained in the Confidential File, regardless of whether the request is granted.

(3) ***Disputes.*** Any dispute regarding access to information in a Practitioner's Confidential File shall be resolved by the VPMA and the Medical Staff President, after discussing the matter with the Practitioner.

(4) ***Request from Attorney or Threatened/Pending Legal Action.*** Medical Center counsel shall be consulted if a request for access is received from a Practitioner's attorney or if legal action is otherwise threatened or pending.

(5) ***Documentation Added to Confidential File.*** A copy of all communications sent to a Practitioner regarding credentialing, privileging, or EPP/peer review matters shall be included in the Practitioner's Confidential File. Practitioners may respond in writing to any such communications and the Practitioner's response shall be maintained in the Practitioner's Confidential File along with the original communication.

(6) ***Non-Retaliation.*** Practitioners may not retaliate against any individual for: (i) providing information; or (ii) otherwise being involved in the collection or review of any information that is included in a Confidential File.

(7) ***Confidentiality.*** Consistent with the confidential and privileged status of the Confidential File under state law, a Practitioner may not disclose or discuss information from the Confidential File except as follows: (i) to

other Practitioners and/or Medical Center employees who are directly involved in credentialing, privileging, and peer review activities concerning the Practitioner, and/or (ii) to any legal counsel who may be advising the Practitioner. The Practitioner may not share or discuss information from the Confidential File with any other individual without first obtaining the express written permission of the Leadership Council or VPMA.

(8) ***Former Practitioners and Non-Privileged Practitioners.*** Individuals who no longer have clinical privileges or Medical Staff appointment at the Medical Center, or who have never been granted clinical privileges, are not entitled to access their Confidential File as set forth in this Policy. However, the Medical Center may disclose information from the Confidential File directly to other health care providers, health plans or other organizations where the Practitioner is applying for privileges, participating status, employment or other affiliation if the Practitioner signs an authorization and release from liability form acceptable to the Medical Center.

(9) ***Delegation of Functions.***

(a) When a function under this Policy is to be carried out by a member of the Administrative Team, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Medical Center employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(b) When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual as set forth above.

(10) ***Violations.*** Violations of this Policy constitute unprofessional conduct. Such violations include, but are not limited to, copying, making digital images of, altering, or deleting information from the Confidential File, retaliating against those who are believed to have submitted information, or disclosing confidential information. Violations by Practitioners who maintain appointment or clinical privileges will be reviewed pursuant to the Medical Staff Professionalism Policy. Violations by individuals

without appointment or privileges may result in a report to the applicable state licensing board.

2. LEVELS OF ACCESS

2.A *Routine Credentialing, Privileging, and EPP/Peer Review Documents.*

(1) ***Definition.*** The following are routine credentialing, privileging, and EPP/peer review documents ("routine documents"):

(a) applications for appointment, reappointment, clinical privileges, or permission to practice, and requested changes in staff status or clinical privileges, with all attachments;

(b) information gathered in the course of verifying education, training, experience, and similar information included on applications for appointment, reappointment, permission to practice, clinical privileges, or changes in staff status (however, this does not include information obtained from references or other third parties who provide the information with an expectation of confidentiality, as described in Section 2.B below);

(c) quality profiles, Ongoing Professional Practice Evaluation ("OPPE") reports, or other quality data reports;

(d) Informational Letters prepared in accordance with the Evaluation of Professional Practice Policy;

(e) routine correspondence between the Medical Center and the Practitioner; and

(f) routine affiliation verifications.

(2) ***Access to Routine Documents.*** A Practitioner shall be permitted to review routine documents subject to the rules set forth in Section 1.C above. Practitioners must schedule a specific time to review routine documents, providing at least three (3) business days advance notice so the EPP Specialists and/or VPMA can properly prepare the documents.

2.B *Sensitive Credentialing, Privileging, and EPP/Peer Review Documents.*

(1) ***Definition.*** Any document that is not a routine document as defined above is a sensitive credentialing, privileging, and EPP/peer review document ("sensitive document"). Sensitive documents include, but are not limited to, the following:

(a) reported concerns or incident reports concerning the Practitioner submitted by Medical Center employees or other Practitioners;

(b) evaluations or reports completed as part of the credentialing and privileging processes by Department Chairs and other internal reviewers;

(c) documentation created pursuant to the FPPE Policy to Confirm Practitioner Competence and Professionalism;

(d) evaluations or reports completed as part of the EPP/peer review process by internal reviewers, proctors, monitors, or external reviewers;

(e) non-routine affiliation verifications, and all peer references prepared by the Medical Center;

(f) e-mails and other electronic communication, memos to file, correspondence, notes and other documents that reflect the deliberative process of Medical Staff Leaders and Medical Center personnel related to credentialing, privileging, or EPP/peer review. Such documents are sensitive because Medical Staff Leaders and Medical Center personnel must be willing to engage in open, candid discussions about sensitive issues and explore all available options to effectively and constructively resolve concerns;

(g) correspondence between the Practitioner and the Medical Center related to the EPP/peer review process;

(h) reports and minutes of peer review committees pertaining to the Practitioner (information in such reports and minutes not pertaining to the Practitioner shall be redacted);

(i) correspondence from references and other third parties, including, but not limited to, letters of reference, confidential evaluation forms, and other documents prepared by external sources concerning the Practitioner's training, clinical practice, professional competence, conduct, or health;

(j) notations of telephone conversations concerning the Practitioner's qualifications with references and other third parties, including date of conversation, identification of parties to the conversation, and information received and/or discussed;

(k) correspondence setting forth formal action by the Credentials Committee, Leadership Council, Committee for Professional Enhancement ("CPE"), Medical Executive Committee, or any other committee performing EPP/peer review, including, but not limited to, letters of guidance or education, follow-up letters to collegial intervention discussions, letters of warning, or reprimand,

consultation requirements, Voluntary Enhancement Plans, or final adverse actions following completion or waiver of a hearing and appeal;

(l) all documentation in the Practitioner's confidential health file, including reported concerns related to health, Health Status Assessment Forms and related evaluations of a Practitioner's health; and

(m) results of queries to the National Practitioner Data Bank.

If there is any doubt about whether a document is routine or sensitive, it shall be treated as sensitive.

(2) ***Access to Sensitive Documents.***

(a) As a condition of being granted access to sensitive documents, the Practitioner must:

(i) provide at least seven (7) business days' advance notice so the sensitive documents can be properly prepared for review, as described in this Section;

(ii) sign the Request to Access Confidential File form set forth as **Appendix A** to this Policy; and

(iii) schedule a specific time to review the file when a Medical Staff Leader or the VPMA will be available to answer any questions raised by the Practitioner during his/her review.

(b) The EPP Specialists and VPMA will determine the manner in which sensitive documents will be made available to the Practitioner, subject to the following rules:

(i) Except for correspondence that has already been exchanged with a Practitioner, a sensitive document will be summarized or redacted by the VPMA or the EPP Specialists so that the identity of any individual who prepared or submitted the document, or who provided information relevant to the matter, can no longer be ascertained.

(ii) In determining which option to use – summary or redaction – the VPMA or the EPP Specialists should consider the number of documents that would need to be redacted, the resources needed to complete the redactions, and the probability that an individual who prepared or

submitted the document could be identified despite the redactions.

(iii) The Practitioner shall not be told the identity of any individual who prepared or submitted a sensitive document, unless:

(A) the individual specifically consents to the disclosure; or

(B) information provided by the individual is used to support an adverse professional review action that results in a Medical Staff hearing.

(iv) Any summaries of sensitive documents that may be prepared should provide sufficient information to permit a Practitioner to understand:

(A) the nature of the document;

(B) the date it was prepared;

(C) the purpose for which it was prepared;

(D) who prepared it (in general terms, without revealing the person's identity); and

(E) the general nature of the comments in the document.

Adopted by the Medical Executive Committee on November 9, 2020.

Approved by the Board on November 17, 2020.

APPENDIX A

REQUEST TO ACCESS CONFIDENTIAL FILE

I have asked to review information from my confidential Medical Staff file. I understand that the Medical Center and Medical Staff Leaders need to take appropriate steps to maintain the confidentiality of this information under North Carolina and federal law, as well as to ensure a professional, non-threatening environment for all who work and practice at the Medical Center. Accordingly, as a condition to reviewing this information, I agree to the following:

1. My access to my confidential Medical Staff file is governed by the ***Policy on Practitioner Access to Confidential Files*** (the "Policy"). I understand that, pursuant to the Policy, I may not copy, digitally image, or otherwise record any information from the file without the express written permission of the Vice President for Medical Affairs ("VPMA"). I will leave my smart phone or similar electronic device capable of copying or making digital images with the EPP Specialists while I review information in my file. Also, I may not alter or delete any information in my file. Instead, I may request the Medical Center to alter or delete factually inaccurate information pursuant to the process set forth in the Policy.

2. I will maintain all information that I review in a ***strictly confidential*** manner. Specifically, I will not disclose or discuss this information ***except*** to the following individuals: (i) my physician colleagues and/or Medical Center employees who are directly involved in credentialing, privileging, and evaluation of professional practice activities concerning me, and/or (ii) any legal counsel who may be advising me. I will not share or discuss this information with any other individual without first obtaining the express written permission of the Leadership Council or VPMA.

3. I understand that this information is being provided to me as part of the Medical Staff's and Medical Center's policy of attempting to utilize Initial Mentoring Efforts and Progressive Steps, where possible, to address any questions or concerns that may arise with my practice. In addition to discussing these matters directly with the Medical Staff and Medical Center leadership, I understand that I may also prepare a written response and that this response will be maintained in my file.

4. I understand that the Medical Center and the Medical Staff have a responsibility to provide a safe, non-threatening workplace for my physician colleagues and for Medical Center employees. I therefore agree that:

    (a) ***I will <u>not approach and discuss</u> the information that I review from my file with any individual who I believe may have provided the information, because even well-intentioned conversations with such individuals can be perceived as intimidating. I understand that any such discussions will be viewed as retaliation and a violation of the Medical Staff Professionalism Policy.***

(b) ***I also will <u>not engage</u> in any other retaliatory or abusive conduct with respect to these individuals. This means that I will not confront, ostracize, discriminate against, or otherwise mistreat any such individual with respect to any information that the individual may have provided.***

5. I understand that any violation of the Policy constitutes unprofessional conduct. Such violations include, but are not limited to, copying, altering, or deleting information from the Confidential File, retaliating against those who I believe may have submitted information in the File, or disclosing information from the File. Any such violations will be reviewed pursuant to the Medical Staff Professionalism Policy. If I do not maintain appointment or clinical privileges at the Medical Center, any violation of the Policy may result in a report to the applicable state licensing board.

By signing this Agreement, I understand that I am ***<u>not waiving</u>*** any of the rights or privileges afforded me under the Medical Staff Bylaws and related documents. I remain free to raise legitimate concerns regarding the care being provided, or the conduct being exhibited, by a nurse or other Medical Center employee, another physician, or the Medical Center itself. ***<u>However, like everyone else, I must use the established and confidential Medical Staff and administrative channels in order to register any such concerns</u>.*** These channels are part of the Medical Center's ongoing performance improvement and evaluation of professional practice activities, and permit the appropriate Medical Staff or Medical Center leadership to fully review and assess the matter and take action to address the issue, as may be necessary.

_____ _____

[Name] [Date]

Note: This form shall be retained in the Practitioner's confidential file. A copy shall be provided returned to the Practitioner for reference.