St. David's South Austin Medical Center

Policy on Practitioner Access to Confidential Files

MEC Approved: 4/12/19
Board Approved: 4/18/19

(REPLACES POLICY ON CONFIDENTIALITY OF PEER REVIEW RECORDS AND THE MANAGEMENT AND MAINTENANCE OF PRACTITIONER FILES)

TABLE OF CONTENTS

PAGE

1. SCOPE OF POLICY, DEFINITIONS, AND GENERAL PRINCIPLES 1
- 1.A Scope of Policy 1
- 1.B Definitions 1
- 1.C General Principles 2
  - (1) General Rules Regarding Access to Confidential Files by a Practitioner 2
  - (2) Alterations and Deletions at the Request of the Practitioner 3
  - (3) Disputes 4
  - (4) Request from Attorney 4
  - (5) Correspondence Added to Confidential File 4
  - (6) Non-Retaliation 4
  - (7) Confidentiality 4
  - (8) Former Practitioners and Non-Privileged Practitioners 5
  - (9) Violations 5
  - (10) Maintenance and Retention of Confidential Files 5
  - (11) Delegation of Functions 6

2. LEVELS OF ACCESS 6
- 2.A Routine Credentialing, Privileging, and PPE/Peer Review Documents 6
  - (1) Definition 6
  - (2) Access to Routine Documents 6
- 2.B Sensitive Credentialing, Privileging, and PPE/Peer Review Documents 7
  - (1) Definition 7
  - (2) Access to Sensitive Documents 8

APPENDIX A: Request to Access Confidential File

POLICY ON PRACTITIONER ACCESS TO CONFIDENTIAL FILES

1. SCOPE OF POLICY, DEFINITIONS, AND GENERAL PRINCIPLES

1.A ***Scope of Policy.*** This Policy applies to all Practitioners who provide patient care services at St. David's South Austin Medical Center (the "Hospital").

1.B ***Definitions.***

(1) ***"Confidential File"*** means any file, paper or electronic, containing credentialing, privileging, PPE/peer review, or quality information related to a Practitioner.

(2) ***"Medical Staff Leader"*** means any Medical Staff Officer, Department Chairperson, Division Director, or committee chairperson.

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

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

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

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

(a) ***Hospital Record.*** The Confidential File is a confidential and proprietary business record of the Hospital, similar to patient medical records. As such, access to the Confidential File is governed by this Policy.

(b) ***Review and Note Taking.*** Practitioners may review information in their Confidential File as set forth in this Policy. They may also make notes regarding such information and discuss it with Hospital personnel and Medical Staff Leaders.

(c) ***Copying or Imaging.*** Except as otherwise set forth in this Policy, Practitioners may not copy, digitally image, or otherwise record any information from their Confidential File, nor may Hospital staff make such copies or images, without the written permission of the Chief Medical Officer ("CMO"). Smart phones and other devices capable of copying information must remain with Medical Staff Services Department personnel while documents are being reviewed.

(d) ***Previous Correspondence with Practitioner.*** Upon the request of a Practitioner, Hospital staff 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 Hospital, or (ii) had previously been sent by the Hospital to the Practitioner. The written permission of the CMO is not required for Hospital staff 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 CMO 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 CMO using the provisions of this Policy for guidance. The review will generally occur in the Medical Staff Services Department or other location where the Confidential File is maintained, with a representative of the Medical Staff Services Department available to provide assistance as needed. The Confidential File may not be removed from the Hospital without the written permission of the CMO.

(g) ***Medical Staff Hearings.*** Notwithstanding any other provision in this Policy, a Practitioner shall be entitled to a non-redacted copy of any document that was used as the basis for an adverse professional review action that entitles the Practitioner to a Medical Staff hearing, subject to any rules set forth in the Medical Staff Bylaws, Credentials Policy, or related policies.

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

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

(b) The CMO shall make the alteration or deletion only if: (i) the MEC determines that the information in question is factually inaccurate; and (ii) the alteration or deletion is consistent with applicable record retention policy.[1] 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 CMO and the President of the Medical Staff, after discussing the matter with the Practitioner.

(4) ***Request from Attorney.*** Operations Counsel shall be consulted if a request for access is received from a Practitioner's attorney.

(5) ***Subpoenas.*** All subpoenas of confidential files and related records will be referred to Operations Legal Counsel and Risk Management. Information will be released only upon approval by Operations Legal Counsel and Risk Management.

---

[1] See the Atlas Information Lifecycle Management site for more information about record retention.

(5) ***Correspondence Added to Confidential File.*** All formal and routine correspondence sent to a Practitioner regarding credentialing, privileging, or PPE/peer review matters shall be included in the Practitioner's Confidential File. Practitioners may respond in writing to any such correspondence and the Practitioner's response shall be maintained in the Practitioner's Confidential File along with the original correspondence.

(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 Texas law, a Practitioner may not disclose or discuss information from the File ***except*** as follows: (i) to other Practitioners and/or Hospital 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 Chief Medical Officer.

(8) ***Former Practitioners and Non-Privileged Practitioners.***

(a) Individuals who no longer have clinical privileges or Medical Staff appointment at the Hospital, or who have never been granted clinical privileges, are not entitled to access their Confidential File as set forth in this Policy. However, the CMO may, in his or her discretion, grant access to such individuals.

(b) In deciding whether to grant access, the CMO may consider any relevant factor, including: (i) the individual's rationale for requesting access; (ii) staff and resource limitations; and (iii) the potential for heightened risk to the confidentiality of the information if the individual is not bound by the confidentiality requirements in the Medical Staff Bylaws and related documents.

(c) If the CMO decides to grant access to individuals covered by this section, the CMO may use the provisions of this Policy as guidance, or may provide more limited access (e.g., no access to documentation about behavioral concerns). In addition, the CMO may impose conditions prior to granting access, such as the individual's execution of a confidentiality agreement.

(9) ***Violations.*** Violations of this Policy by Practitioners constitute unprofessional conduct. Such violations include, but are not limited to, copying, 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 Practitioners without appointment or privileges may result in a report to the applicable state licensing board.

(10) ***Maintenance and Retention of Confidential Files.*** Specific requirements regarding the manner in which Confidential Files are maintained (e.g., location of

paper files, software programs to access electronic information, etc.) shall be determined by Hospital management. The retention of Confidential Files shall be governed by applicable record retention policy and state-specific retention schedules.[2]

(11) ***Delegation of Functions.*** When a function under this Policy is to be carried out by a member of Hospital management, by a Medical Staff Leader, 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 Hospital 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 as required by this Policy.

2. LEVELS OF ACCESS

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

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

(a) Requests For Consideration ("RFCs"), Re-credentialing Requests for Consideration ("R-RFCs"), 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 Professional Practice Evaluation Policy;

(e) routine correspondence between the Hospital 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 Medical Staff Services Department and/or CMO can properly prepare the documents.

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

---

[2] See the Atlas Information Lifecycle Management site for more information about record retention.

(1) ***Definition.*** Any document that is not a routine document as defined above is a sensitive credentialing, privileging, and PPE/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 Hospital 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 PPE/peer review process by internal reviewers, proctors, monitors, or external reviewers;

(e) non-routine Affiliation Verifications, and all Peer References;

(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 Hospital personnel related to credentialing, privileging, or PPE/peer review. Such documents are sensitive because Medical Staff Leaders and Hospital 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 Hospital related to the PPE/peer review process;

(h) reports and minutes of peer review committees pertaining to the Practitioner;

(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 Medical Executive Committee or Medical Care Evaluation Committee ("MCEC") action, including, but not limited to, letters of guidance or education, follow-up letters to collegial intervention discussions, letters of warning, or reprimand, consultation requirements, Performance Improvement 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 CMO will be available to answer any questions raised by the Practitioner during his/her review.

(b) The Medical Staff Services Department and CMO 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, any sensitive document that would reveal the identity of the individual who prepared or submitted it will be summarized or redacted by the CMO or the Medical Staff Services Department so the individual's identity can no longer be ascertained.
(ii) In determining which option to use – summary or redaction – the CMO or the Medical Staff Services Department 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;
(B) the Medical Executive Committee determines that an exception must be made in a particular situation to ensure an appropriate review (in these instances, the individual in question will be given prior notice that the disclosure will be made and informed that no retaliation will be permitted against the individual); or
(C) 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.

APPENDIX A

REQUEST TO ACCESS CONFIDENTIAL FILE

I have asked to review information from my confidential Medical Staff file. I understand that the Hospital and Medical Staff Leaders need to take appropriate steps to maintain the confidentiality of this information under Texas and federal law, as well as to ensure a professional, non-threatening environment for all who work and practice at the Hospital. 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 Chief Medical Officer. Also, I may not alter or delete any information in my file. Instead, I may request the Hospital 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 consistent with its privileged status. Specifically, I will not disclose or discuss this information ***except*** to the following individuals: (i) my physician colleagues and/or Hospital employees who are directly involved in credentialing, privileging, and peer review 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 Medical Executive Committee or Chief Medical Officer.
3. I understand that this information is being provided to me as part of the Medical Staff's and Hospital's policy of attempting to utilize collegial intervention 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 Hospital 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 Hospital and the Medical Staff have a responsibility to provide a safe, non-threatening workplace for my physician colleagues and for Hospital employees. I therefore agree that:
   (a) ***I will <u>not 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 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. *[<u>As applicable</u>: If I do not maintain appointment or clinical privileges at the Hospital, 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 also remain free to raise legitimate concerns regarding the care being provided, or the conduct being exhibited, by a nurse or other Hospital employee,

another physician, or the Hospital itself. ***However, like everyone else, I must use the established and confidential Medical Staff and administrative channels in order to register any such concerns.*** These channels are part of the Hospital's ongoing performance improvement and peer review activities, and permit the appropriate Medical Staff or Hospital leadership to fully review and assess the matter and take action to address the issue, as may be necessary.

_____ _____

[Name] [Date]

Note: After this agreement is signed, a copy shall be returned to the Practitioner for reference.