Policy: Physician Proctoring by External Providers

ORGANIZATIONAL: Affects two or more departments.							
Folder	Organizational Choices: Medical Staff			**Sub-Folder** (If Applicable)	Click here to enter text.		
Original Effective Date	9/27/2016	**Scope**	*What departments does this policy apply to? State "All" as is may apply to the entire organization.* *Medical Staff and Procedural Departments*				
Approved (Approver/ Date)	MDRC 01/18/18; Medical Executive Committee 01/23/18						
Last Reviewed/ Revised Date	12/28/2017	**OSHA Category** (If Applicable)	Choose an item.	**Standard** (If Applicable)	*MS 08.01.01*	**Number of pages**	11

PURPOSE:
To define the process for the Medical Staff, Medical Staff Services personnel, and personnel in procedural areas regarding requests for, and verification and approval of, non-privileged physician proctors.

SKILL LEVEL:
Medical Staff members, Physician proctors, Medical Staff Services personnel, procedural area personnel.

GUIDELINES:
Physician proctors (who may also be referred to as preceptors) who do not hold privileges at Southeast Hospital may be invited to observe a Medical Staff member carry out a defined number of procedures and provide a subsequent evaluation. Prior to doing so, the proctor/preceptor must complete and return documentation as per *Appendix E and Appendix F.* The proctor/preceptor must be approved by the President of the Medical Staff or his/her designee after Medical Staff Services personnel have performed the required verifications as per *Appendix D.*

No external proctor/preceptor may function and no cases may be scheduled by the Medical Staff member without signed authorization, with the exception of those proctors who will exclusively perform retrospective chart reviews (for example, Board examiners).

Proctors who perform retrospective chart reviews will be required to complete a HIPAA compliance form *(Appendix F)*. If also observing in the operating room, TB test results within the last year (refer to *Tuberculosis Screening and Reporting Policy)* and a current influenza vaccine, if visiting during the designated flu season (October - April), must be provided.

The proctor/preceptor is responsible to the Hospital, not to the medical staff member, to make written recommendations regarding the knowledge and skill of the medical staff member to carry out the proposed procedure(s). The proctor/preceptor shall submit a written report using the appropriate form as provided by Medical Staff Services.

As an observer, the proctor/preceptor may scrub in, but may not be involved in patient care. As may any physician, the proctor/preceptor may intervene in cases of emergency, to save the patient from harm.

Non-physician company representatives who observe procedural cases must follow the "Company Vendor Sales Representatives" policy.

PROCEDURE:

- At minimum, 30 days prior to the planned procedure(s), the Medical Staff member requesting proctoring and/or direct preceptorship must notify Medical Staff Services and complete the Request for Additional Privileges form (including the name and contact information of the proctor/preceptor) as per *Appendix A.* Processing may take up to 60 days, and is subject to final approval by the Hospital Board of Directors.

- For new procedures (where new equipment and/or techniques will be utilized), specific credentialing criteria for the procedure must be submitted and go through the Hospital's current approval process. The Credentials Committee will determine the need for and circumstances of the proctoring and/or preceptorship process, including number of cases to be observed, qualifications of the proctor(s)/preceptor(s), and all other pertinent matters.

- Prior to providing proctoring/direct preceptorship, the external proctor/preceptor must provide a notarized copy of his/her driver's license, proof of licensure, and current malpractice insurance coverage. The proctor/preceptor must also provide verification of immunizations including a TB test within the last year (refer to *Tuberculosis Screening and Reporting Policy)* and a current influenza vaccine if visiting during the designated flu season (October - April).

    - For proctors who will complete retrospective chart reviews, only, Medical Staff Services will verify medical license and ensure receipt of signed HIPAA form *(Appendix F)*, proof of immunization including a TB test within the last year (refer to *Tuberculosis Screening and Reporting Policy)* and a current influenza vaccine if visiting during the designated flu season (October - April).

- Medical Staff Services personnel will verify licensure and training (via AMA, AOIA, or other appropriate primary source verification), and query both the National Practitioner Data Bank (NPDB) and Office of the Inspector General (OIG). Medical

Staff Services personnel will request a letter from the proctor/preceptor's primary practice location showing that he/she is on staff and in good standing.

- The President of the Medical Staff or his/her designee shall review and approve the proctor verification form and attached documentation as per Appendix D prior to the proctor/preceptor's attending the case. The President may make inquiry from other sources in a similar manner as for applications to the Medical Staff. Where the President is the applicant, the President-Elect or Secretary of the Medical Staff may serve in his/her stead.

- Prior to the initiation of the proctoring/direct preceptorship process, the applicant for new privileges must agree in writing as per *Appendix B* **or** *Appendix C* as applicable (choice of form is based on employment status) to hold harmless the Hospital, its medical staff and other staff members, and the proctor(s)/preceptor(s), when acting in good faith, from any legal proceedings arising from any recommendation(s) that may result from the proctoring process.

- The President of the Medical Staff or his/her designee shall notify the proctor/preceptor, the medical staff member and the appropriate Hospital staff, such as the Surgical Services Director, Cardiovascular Services, etc., upon the proctor/preceptor's approval, after reviewing the "Non-Privileged Physician Proctors Verification" form (Appendix D) and supporting documentation. The "Non-Privileged Physician Proctors Verification" form (Appendix D) shall be accompanied by the appropriate credentialing criteria document, where applicable.

- Any emergency interventions by the proctor/preceptor shall be documented and form part of the proctor/preceptor's report, and shall be documented by the attending procedural physician in the medical record.

- The proctor/preceptor's report shall include the factual observations obtained, with a recommendation regarding the ability of the Medical Staff member to perform the procedure. This may be positive or may embody recommendations for additional training or experience and repeat mentoring, or any other appropriate recommendation. The report, along with the President's recommendation, shall be forwarded to the Credentials Committee for consideration.

REFERENCES:

The Joint Commission (2016) MS.08.01.01: The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance.

Pelletier, S. Proctoring conundrums: How to credential an OR observer (2007), retrieved from http://www.hcpro.com/content.cfm?content_id=75377 on 12/14/2017

Attachments:

Appendix A: Request for Additional Privileges Form
Appendix B: Proctoring Agreement Form – Employed Physicians
Appendix C: Proctoring Agreement Form – Non-Employed Physicians
Appendix D: Non-Privileged Physician Proctor Verification Form
Appendix E: Non-Privileged Physician Proctor Information Form
Appendix F: HIPAA Compliance Form

REQUEST FOR ADDITIONAL PRIVILEGES

NAME/TITLE _____

DEPARTMENT _____

SECTION _____

REQUESTED PRIVILEGE _____

Will a surgeon preceptor/proctor (such as a physician representative of a company) be present for any case(s)?

Yes/No (*Circle one**)

*If yes, please provide preceptor contact information below and sign attached proctoring agreement.

Preceptor Name/Title: _____
Company Name: _____
Email/Phone: _____
DATE REQUIRED: _____

_____ _____
Signature Date

Please submit request to:

Medical Staff Services
SoutheastHEALTH
1701 Lacey Street
Cape Girardeau, MO 63701
Phone: 573-651-5535
Fax: 573-986-5978
Email: lsaupe@sehealth.org

** Upon receipt of this request, Medical Staff Services will provide the criteria for obtaining this privilege and ask you to submit documentation of experience and/or training.*
***Please note this privilege will not be in effect until the request has gone through the full approval process*

AGREEMENT TO PROCTORING REQUIREMENTS
RELEASE AND HOLD HARMLESS

The undersigned **employed physician** has applied for new or additional privileges at Southeast Hospital. As a condition thereof, I have been asked to demonstrate my competency and skill to perform such procedures by performing a pre-determined number of procedures before a qualified proctor (which may also be referred to as a direct preceptor), who shall report his/her findings to the appropriate Department or Section Chair and to the Credentials Committee, Medical Executive Committee, and Hospital Board of Directors.

I understand that for each such procedure I will be the physician in charge of the patient's care and treatment and the proctor is only there to observe. However, if in the proctor's sole judgment and discretion an emergency situation arises which necessitates the proctor's intervention in order to save the patient from harm, the proctor may intervene. Such intervention will form part of the proctor's report. As the physician in charge, I will document any such intervention by the proctor in the medical record.

I agree to abide by the Southeast Hospital policy on Physician Proctoring by External Providers. I hereby release and agree to hold Southeast Hospital and its board of directors, administrators, managers, employees, agents and servants harmless from and against any and all damages or claims, actions, causes of action arising out of or otherwise attributable to: (i) actions (favorable or adverse) on this Request for Additional Privileges, provided that such actions are made in good faith; and (ii) the proctoring process.

_____
Medical Staff Member Signature

_____ _____
Witness Date

AGREEMENT TO PROCTORING REQUIREMENTS
RELEASE AND HOLD HARMLESS

I, _____, the undersigned **physician,** have applied for new or additional privileges at Southeast Hospital. As a condition thereof, I have been asked to demonstrate my competency and skill to perform such procedures by performing a pre-determined number of procedures before a qualified proctor (which may also be referred to as a direct preceptor), who shall report his/her findings to the appropriate Department or Section Chair and to the Credentials Committee, Medical Executive Committee, and Hospital Board of Directors.

I understand that for each such procedure I will be the physician in charge of the patient's care and treatment and the proctor is only there to observe. However, if in the proctor's sole judgment and discretion an emergency situation arises which necessitates the proctor's intervention in order to save the patient from harm, the proctor may intervene. Such intervention will form part of the proctor's report. As the physician in charge, I will document any such intervention by the proctor in the medical record.

I agree to abide by the Southeast Hospital policy on Physician Proctoring by External Providers and Medical Staff Bylaws. I hereby agree to defend, hold harmless and indemnify Southeast Hospital and its officers, directors and employees against any and all third party claims, causes of action, demands, losses, judgments, damages and expenses incidental to the defense thereof including reasonable attorneys' fees and court costs arising out of or resulting from any negligent or wrongful act or omission by me. Additionally, I hereby release from liability and agree to hold harmless Southeast Hospital and its officers, directors and employees for their actions performed in connection with evaluating the Request for Additional Privileges, provided that such actions are made in good faith, and made in accordance with the Medical Staff Bylaws.

_____
Physician Signature Date

_____
Witness Date

Non-Privileged Physician Proctor Verification

PROCTOR NAME: _____

MEDICAL STAFF MEMBER NAME: _____

PROCEDURE: _____

Anticipated Date(s) of Proctoring: _____

Verification (attach documentation of each of the following):

✓	**Items to be Provided by Physician Proctor/Preceptor**
	Notarized copy of driver's license (verification of identity)
	Copies of Medical License(s) in state(s) where currently practicing
	Current Malpractice Insurance Certificate
	TB Test Result (within past 12 months – refer to Tuberculosis Screening & Reporting Policy)
	Proof of Influenza Vaccination (if on site October – April)
	Proctor/Preceptor Information Form, including signed authorization to release information
✓	**Items to be Verified by Medical Staff Services**
	National Practitioner Data Bank
	Medical License(s) in state(s) where currently practicing
	Letter of good standing from current institution
	OIG
	AMA/AOIA Profile to illustrate education/training

Verified by:

_____ _____

Medical Staff Services Date

Approved by:

_____ _____

(check one): Date

□ President, Medical Staff
□ President-Elect, Medical Staff
□ Secretary, Medical Staff

FOLLOW UP

Notify Medical Staff member and procedural area manager of approval
Provide appropriate IPPE/Preceptor or Proctor review forms to procedural area manager
Scan verification form and related documents into shared drive

Date Received_____
Anticipated Procedure Date(s)_____

Non-privileged Physician Proctor/Preceptor Information Form

Medical Staff Services Department
Phone: 573-651-5535
Fax : 573-986-5978

INSTRUCTIONS:

- Please submit the following documentation, along with this form, by email to Laura Saupe, Medical Staff Services Manager, lsaupe@sehealth.org, or Fax to (573) 986-5978:
  - Curriculum Vitae (CV)
  - Notarized copy of driver's license or government issued photo ID
  - Copies of Medical License(s) in state(s) where currently practicing
  - Current malpractice insurance certificate
  - TB Test Result (within past 12 months – refer to attached TB policy and questionnaire)
  - Proof of influenza vaccination (if on site October – April)
  - Signed authorization for release of information (see next page) – Medical Staff Services will request a letter of good standing from your current institution
- Please complete the below information in its entirety and submit with the above documentation. Failure to do so will delay processing. Cases are unable to be scheduled by the SoutheastHEALTH Medical Staff Member requesting proctoring/preceptorship without receipt of all required documentation, processing and verification by Medical Staff Services, and authorization by the President of the Medical Staff.

Personal Information – to be used for primary source verification purposes		
Last Name	First Name	Middle Name or Middle Initial
Other Names By Which You Have Been Known Professionally or During Training	Degree	NPI
Home Street Address	Home City/State/Zip	
Home Phone Number	Cell Phone Number	E-Mail Address
Date of Birth	Sex ☐ Male ☐ Female	Social Security Number
Primary Hospital Affiliation	Primary Hospital Address	Primary Hospital Phone Number
Company Affiliation (Manufacturer of Equipment/Device)	Device Manufacturer Sales Representative Name	Device Manufacturer Sales Representative Phone Number and/or Email Address
Name of Medical Staff Member to be Proctored/Preceptored	State(s) of Licensure	License Number(s)

_____

Signature Date

Authorization for Release of Information: My signature has been affixed below. A photocopy or fax of this statement shall be as binding as the original.

I hereby authorize the release to Southeast HEALTH of all relevant information regarding my medical/professional education, training, credentials, qualifications, and past and current professional practice (to include medical malpractice claims, actions against licensure, etc.).

I hereby release from liability all representatives of Southeast HEALTH facilities, their respective Medical Staff and their authorized representatives for their acts performed in good faith and without malice in connection with evaluating my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to Southeast HEALTH, their respective Medical Staff or their authorized representatives, in good faith and without malice concerning my professional qualifications, present and past medical malpractice activities, including otherwise privileged or confidential information.

I furthermore authorize and consent to Southeast HEALTH representatives providing other hospitals, medical associations, licensing boards or other organizations with information considered relevant and hereby release them from liability for so doing.

_____

Signature Date

_____

Printed Name and title

SOUTHEASTHEALTH

HIPAA CONFIDENTIALITY AGREEMENT

While at SoutheastHEALTH, you may have access to Confidential Information. The purpose of this Agreement is to help you understand your obligations regarding confidential information. As an employee/volunteer/student/contractor or other individual performing or observing services at Southeast, you are expected to be trained and qualified to perform your responsibilities, and to understand and acknowledge significant obligations. This includes but is not limited to obligations to maintain the confidentiality of Protected Health Information ("PHI"), as required by the Health Insurance Portability and Accountability Act ("HIPAA") and its regulations and other federal and state laws that were established to protect the confidentiality of medical and personal information. These laws provide, generally, that such information may not be disclosed except as permitted or required by law or unless authorized by the patient. Southeast has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information.

CONFIDENTIALITY STATEMENT

I understand that I may be working with, or otherwise have access to confidential patient information, quality assurance, medical and other sensitive or private information. This information may include, but is not limited to, incident reports, medical reports, evaluation records, medical records, personnel information, verbal discussions, electronic communications including e- mail, and other information and data transmitted in written, verbal, electronic or other forms.

I acknowledge that it is my responsibility to respect the privacy and confidentiality of patient and other confidential information. I will not access, use or disclose patient or other confidential information unless I do so in the course and scope of fulfilling my duties for Southeast.

I understand I am not permitted to access the medical records or confidential information of my family members or friends.

I will safeguard all confidential information and PHI while I am fulfilling my duties at Southeast and will not disclose my password or authorization information that allows me to access confidential information to any other persons. I understand these obligations will continue after my affiliation with Southeast terminates.

I understand that I am required to immediately report any information about unauthorized activities, access, use or disclosure of confidential information to the Corporate Compliance Officer by calling 573-651-5505.

I understand and acknowledge that, should I breach any provision of this agreement, I may be subject to civil or criminal liability and/or disciplinary action consistent with applicable federal and state law, employment policies, contracts and processes.

Signature Printed Name Date