Hartford Hospital
A Hartford HealthCare Partner

Medical Staff Services
Office: 860-972-2585
Fax: 860-545-3755

VISITING (NON-OBSERVATIONAL) TEMPORARY PRIVILEGES

When there is an important patient care, treatment or service need. Specifically, temporary privileges may be granted for situations such as the following: the care of a specific patient; when a proctoring or consulting physician is needed, but is otherwise unavailable; or, when necessary to prevent a lack or lapse of services in a needed specialty area.

1. The HH physician requesting the visiting practitioner MUST receive approval from the appropriate Department Chair(s) prior to the procedure.

2. Visiting (Non-Observational) Temporary Privileges are granted for no more than 60 days.

3. The following documentation is required by the Medical Staff Office (MSO), **two weeks** prior to the day of the procedure, in order to grant access:
   - Visiting (Non-Observational) Temporary Privilege Application
     (If ANY requested information on application is missing, your request will be deemed incomplete and unable to process.
   - Current licensure from state or country
     (It should be noted that Connecticut law provides that no person may practice medicine or surgery without a license from the State of Connecticut. However, the Department of Public Health will not object to a physician being brought into the State on a truly temporary, one-time basis, to ASSIST or CONSULT, under the supervision of a properly licensed and credentialed Connecticut physician. Assuming that the physician has a valid medical license somewhere.)
   - CT Controlled Substance license(if applicable)
   - Federal DEA license
   - Copy of Delineation of Privileges or Privilege Control List from his/her primary institution
   - Completed signed Authorization/Release from physician (attached)
   - Malpractice coverage information (including carrier terms/limits)
   - Confidentiality Agreement (attached)
   - HIPAA Training Protocol and Certification (attached)
   - Copy of a government issued ID (drivers license)
   - Proof of flu vaccination or exemption.
   - Proof of PPD vaccination or exemption.
   - Name and Contact information for current Hospital's Department Chief – for verification of competency.
   - Name and contact information of all hospitals practiced at the previous two years – for verification of good standing.

4. MSO will process the above and forward to the Department Chair for recommendation.
5. President of the Medical Staff makes recommendation to approve by signing form.
6. Hospital President signs memo to grant temporary privileges.
7. FPPE – to be completed by HH physician requesting visiting practitioner and returned to the Medical Staff Office by fax at (860)545-3755.

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VISITING (NON-OBSERVATIONAL) TEMPORARY PRIVILEGED ACCESS TO HH APPLICATION FORM

NAME:

Last Name:_____First Name:_____Middle I:____Title:_____

GENDER: Female____ Male____ Date Of Birth:_____ SS#_____

CURRENT ADDRESS:

Organization:_____

Number/Street:_____City:_____State:_____Zip:_____

Tel:_____Fax:_____Cell:_____

E-mail:_____

Contact Person:_____Phone:_____

Current Department Chief Name:_____ Fax: _____

LICENSE/EDUCATION:

State License Number:_____State of Licensure:_____

Medical/Professional School:_____Year Of Grad:_____

ROLE DESCRIPTION:

_____

_____

_____

Please indicate if the role requires special expertise/certification _____Yes _____No (If yes, enclose documentation - certifications)

DATE(S) of HH access: _____ to _____**Name of HH Privileged Physician**:_____

To be completed by Department Chair

I hereby authorize that the above stated individual may have access to Hartford Hospital for the duties and dates described above.

_____ _____
Department Chair Signature Date

_____
Department Chair Name (Printed)

CONSENT AND RELEASE

I hereby apply for hospital staff appointment, clinical privileges, and membership to ICP/HPHO as requested. I am willing to make myself available for interviews in regard to this application. As an applicant, I have the burden of producing adequate information for proper evaluation of my application. I also understand that I am required to provide the hospital(s) or its authorized representatives with updated current information regarding all questions on this application form as such information becomes available and such additional information as may be requested by the hospital or its authorized representatives. Failure to produce this information or additional information will prevent my application from being evaluated and acted upon.

Information given in or attached to this application is accurate and fairly represents the current level of my training, experience, capability and competence to exercise the clinical privileges requested. As a condition to making this application, any misrepresentation or misstatement in, or omission from this application, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application resulting in denial of appointment and clinical privileges. In the event that appointment or privileges have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of such appointment or privileges.

By applying for appointment, clinical privileges and/or membership, I accept the following conditions during the processing and consideration of my application, regardless of whether or not I am granted membership, appointment or privileges and for the duration of such appointment or reappointments as I may be granted:

A. I extend absolute immunity to indemnity and hold harmless and release from any and all liability, the hospital, its authorized representatives and any third parties, as defined in subsection C below, for any good faith acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, performed, made, requested or received by the hospital and its authorized representatives to, from, or by any third party, including otherwise privileged or confidential information, relating, but not limited to, the following:
   (1) Applications for appointment or clinical privileges, including temporary privileges;
   (2) Periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;
   (3) Proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary sanction;
   (4) Summary suspensions;
   (5) Hearings and appellate reviews;
   (6) Medical care evaluations;
   (7) Utilization review;
   (8) Any other hospital, medical staff, department, service or committee activities;
   (9) Matters or inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and
   (10) Any other matter that might directly or indirectly have an effect on my competence, on patient care or on the orderly operation of this or any other hospital or health care facility.

The foregoing shall be privileged to the fullest extent permitted by law. Such privilege shall extend to the hospital and its authorized representatives and to any third parties.

B. I specifically authorize the hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my satisfaction of the criteria for initial and continued appointment to the medical staff, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the hospital and its authorized representatives upon request. The hospital has my permission to provide a copy of this authorization to said third parties.

C. The term "hospital and its authorized representatives" means the hospital corporations and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the hospital: the members of the hospital Board and their appointed representatives, the Chief Executive Officer or his designees, the members of the hospital's credentialing committee, the hospital's medical staff committee, other employees of the hospital, consultants to the hospital, the hospital attorney or designees and all appointees to the medical staff, the Hartford HealthCare Credentialing Verification Organization. The term "third parties" means all individuals, including appointees to the hospital medical staff and appointees to the medical staff of other hospital or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether hospital, health care facilities or not, from whom information has been requested by the hospital or its authorized representatives or who have requested such information from the hospital and its authorized representatives.

CONSENT AND RELEASE (CONTINUED)

I acknowledge that:

1. Medical staff appointment and clinical privileges at the hospital are not a right of every licensed professional who makes application for the same;
2. My request will be evaluated in accordance with prescribed procedures defined in the hospital and its medical staff bylaws, rules and regulations;
3. All hospital and medical staff recommendations relative to my application are subject to the ultimate action of the hospital Board, whose decision shall be final;
4. If appointed, my initial appointment and clinical privileges shall be provisional for the time period determined by the Board;
5. I have the responsibility to keep this application current by informing the hospital, through the Chief Executive Officer or Credentialing Verification Organization, of any change in the areas of inquiry contained herein, including but not limited to any change in my professional liability insurance coverage, the filing of a lawsuit against me, any disciplinary or other action by a government entity, or professional organization or licensing board, and any change in my medical staff status at any other hospital; and
6. Reappointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support for the hospital, as evidenced by admission, treatment and continuous care and supervision of patients for whom I have responsibility and acceptable performance of all responsibilities related thereto as well as the other factors deemed relevant by the hospital. Reappointment and continued clinical privileges shall be granted only on formal application, according to hospital and its medical staff bylaws, rules and regulations and upon final approval of the hospital Board.

I agree to participate in the Hospital's Organized Health Care Arrangement (the "OHCA") between the Hospital and its Medical Staff for the sole purpose of complying with the federal law known as HIPAA. As a participant of the Hospital's OHCA, I agree to comply with all policies relating to protecting patient privacy, including but not limited to policies setting forth my obligations as a participant of the Hospital's OHCA.

I have received and have had an opportunity to read a copy of the bylaws of the hospital and such hospital policies and directives as are applicable to appointees to the medical staff, including the bylaws and rules and regulations of the medical staff presently in force. I specifically agree to abide by all such bylaws, policies, directives and rules and regulations as are in force during the time I am appointed or reappointed to the medical staff or exercise clinical privileges at the hospital.

If appointed and/or granted clinical privileges, I specifically agree to:

1. Refrain from fee splitting or other inducements relating to patient referral;
2. Refrain from delegating responsibility for diagnoses or care of hospitalized patients to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised;
3. Refrain from deceiving patients as to the identity of any practitioner providing treatment or services;
4. Seek consultation whenever necessary or required;
5. Abide by generally recognized ethical principles applicable to my profession;
6. Provide continuous care and supervision as needed to all patients in the hospital for whom I have responsibility; and
7. Accept committee assignments and such other duties and responsibilities as shall be assigned to me by the hospital Board and Medical Staff.

I agree to immediately notify **Hartford HealthCare Affiliates and Subsidiaries** if any information contained in my application has changed. I further agree that the foregoing obligation shall be a continuing obligation so long as I hold Medical Staff membership and/or privileges at the hospital(s).

Signature: _____ Date: _____

Print Name: _____

Hartford HealthCare

Hartford HealthCare Corporation
CONFIDENTIALITY AGREEMENT

I understand that in the course of providing my services at Hartford HealthCare Corporation (HHC), I may have access to Protected Health Information and Proprietary Information.

"Protected Health Information" means any information that is created or received by an HHC organization relating to a patient's past, present or future physical or mental health or condition, the provision of health care to a patient, or the past, present or future payment for the provisions of health care to a patient.

"Proprietary Information" means company personnel records, employee health records, administrative and financial information, marketing materials, business plans and practices, forms, agreements, policies, guidelines, inventions, know how, software systems and products, and any other data, documents and information owned by, maintained by, or in the custody or possession of HHC organizations regardless of form or storage media.

By signing this document, I agree:

1. To abide by all HHC policies, procedures and guidelines relating to the use, access and protection of Protected Health Information and Proprietary Information, as amended from time to time.

2. To hold in strictest confidence all Protected Health Information and not to disclose or discuss Protected Health Information with any other third party, including friends or family, except as permitted by HHC policies, procedures and guidelines and in accordance with state and federal laws.

3. To use Protected Health Information and Proprietary Information only in connection with the performance of my duties on behalf of the organization, and to not remove Protected Health Information and/or Proprietary Information from the HHC premises except as permitted by my position in accordance with HHC policies, procedures and guidelines and in accordance with state and federal laws.

4. That I will not discuss Protected Health Information where unauthorized persons can overhear the conversation.

5. That I will access Protected Health Information and Proprietary Information for the sole purpose of performing my approved job function and will not access Protected Health Information and Proprietary Information at the request of others who do not have a need or right to have access to such Protected Health Information and Proprietary Information.

6. That I will not leave my computer terminal unattended while on-line or share or lend my user password or authentication code or device with any other person.

7. To ensure that all Protected Health Information is retained and destroyed according to state and federal laws.

8. That I have read and understand the provisions of the Hartford HealthCare Medical Staff/HIPAA/Patient Information Privacy Training and Hartford HealthCare Medical Staff/HIPAA/Information Security Training.

I understand that:

9. Access to and use of Protected Health Information is subject to regular audit and monitoring.

10. The restrictions described in this Agreement are in force at all times and in all locations (including remote access).

11. If I fail to comply with the terms of the Agreement, I may be subject to disciplinary action, up to and including termination from my position.

12. A patient's right to confidentiality of Protected Health Information is protected by state and federal laws and HHC policies, procedures and guidelines.

13. If I violate this Agreement, I may, as an individual, be subject to civil or criminal legal action for which I will not be provided defense counsel or insurance coverage by HHC.

14. I understand that my obligations under this Agreement shall survive termination of my position and termination of this Agreement.

Signature: _____ Company: _____

Name (Print or type): _____ Department: _____

Date: _____ Employee Number: _____

VPMA Council 4-28-2016
Form eff. Date: May 16, 2013

Hartford Hospital
A Hartford HealthCare Partner

HIPAA TRAINING PROTOCOL FOR GUEST PRACTITIONER ACCESS TO HH

You have been extended an opportunity to observe a medical/surgical/diagnostic procedure at Hartford Hospital. The hospital is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy and Security Regulations within that law require that you be in complete compliance with the intentions of the law. The Office of Civil Rights has been given the authority to enforce the privacy regulations. Both civil and criminal penalties are associated with these regulations.

Among the many regulations there are several with which you must become familiar and obey.

HIPAA creates new rules that all 50 states must follow to protect health information. Protect means that only people who are allowed or need the information access it. Patient information protected by HIPAA is called Protected Health Information (PHI).

Confidentiality must be maintained for any information related to diagnosis, treatment, medical history and prognosis of the patient.

Confidentiality must also be maintained for any individually identifiable information, such as social security number, medical record or account number, address, etc.

PHI exists in spoken, written and electronic formats and through visual observation.

In summary, Protected Health Information (PHI) is anything you see or hear that lets you know about the health of a specific patient as well as personal identifiers.

Therefore, in your capacity as an observer, you must never attempt to access PHI, never remove PHI from its source and never reveal PHI to <u>any</u> person. You may engage in confidential private conversations about your experience but only with your hospital preceptor.

In order to participate in an observation capacity, you must sign a separate confidentiality statement and sign the next page of this protocol. Signing these documents will indicate that you have read the HIPAA information provided by Hartford Hospital and you agree to uphold the directions the hospital provides to help safeguard the confidentiality of our patients' protected health information.

Thank you in advance for your cooperation.

Certification of HIPAA Training for Guest Practitioner Access to HH

I have read and understand the HIPAA Training materials listed above. Further, I understand that I am expected to maintain the confidentiality of all protected health information to which I am exposed.

_____
Signature

_____
(Print Name)

Hartford Hospital
Focused Professional Practice Evaluation (FPPE)
EVALUATION FORM

TO BE COMPLETED BY SUPERVISING/PROCTORING PHYSICIAN/ DIVISION DIRECTOR AND/OR CHIEF

Practitioner: **Dept/Section:**

Appointment Date: **Staff Status:** Visiting Temporary Privileges

Reason for the FPPE – *select the appropriate box:*

- ☐ Supervision of new Medical Staff Practitioner
- ☐ Proctoring of new clinical privilege – Name of privilege: _____
- ☐ Focused review of practitioner with existing privileges as requested by Division Director

- **Practitioners Privileges – (per application)**

Type of review – please *check all that apply noting volume and details as requested:*

	Yes	No
Chart Review / Interpretation Review (Radiology, Pathology, other tests) - **minimum of 5 cases**	☐	☐
Procedure Review (Surgery, Interventional, Obstetrics, Anesthesia) - **minimum of 5 cases**	☐	☐

Type of procedures(s): _____

(use separate sheet for details as needed or required)

	Yes	No
Prospective:	☐	☐
Retrospective:	☐	☐

	Yes	No
Direct observation of patient interaction or direct feedback -**minimum of 5 cases**	☐	☐
Significant Issues in overall performance	☐	☐

Qualitative response: _____

FOR PEDIATRIC PRACTITIONERS ONLY –Care of newborn infants - One time requirement of three hours of continuing education in breastfeeding within six months of initial appointment:

Met requirement

Yes	No
☐	☐

****PRIVILEGED AND CONFIDENTIAL RECORDS AND PROCEEDINGS OF A MEDICAL PEER REVIEW COMMITTEE**
Under Connecticut State Statute 19a-17B Section (4) for evaluating and improving the quality of health care rendered.

Competencies Reviewed – *check all that were reviewed:*

Competency	Yes	No	NA
PATIENT CARE: Was care safe, timely, effective and efficient?			
MEDICAL KNOWLEDGE: Did medical knowledge demonstrate/reflect up to date standards of care?			
PRACTICE BASED LEARNING: Was care reflective of evidence based medicine?			
INTERPERSONAL AND COMMUNICATION SKILLS: Was there evidence of effective and appropriate communication?			

PROFESSIONALISM: Was there compliance with code of conduct and ethics?			
SYSTEMS BASED PRACTICE: Was there cooperation with and participation in the multidisciplinary healthcare team?			
DOCUMENTATION AND ADMINISTRATIVE COMPLIANCE: Compliance with CPOE, dictation, legibility, authentication and medical record completion requirements?			

RECOMMENDATION

NEW MEDICAL STAFF MEMBERS SUPERVISION (based on FPPE1 outlined above)

- ☐ Recommend approval of ALL granted privilege(s)
- ☐ Recommend additional period of supervision (after 6 months of provisional status)
- ☐ Recommend removal or discontinuation of previously granted privileges (comment below)

COMMENTS:

Supervising Physicians signature: _____
Printed Name: _____
Date: _____

NEW PRIVILEGE PROCTORING (based on FPPE1 outlined above)

- ☐ Recommend approval of ALL granted privilege(s)
- ☐ Recommend additional period of proctoring (comment below)
- ☐ Recommend not approving requested privilege(s) (comment below)

COMMENTS:

Supervising Physicians signature: _____
Printed Name: _____
Date: _____

Division Director – Agree with Above and Recommend

- ☐ Granting of all provisionally approved or requested privilege(s)
- ☐ Non-approval of granted or requested privileges as noted below
- ☐ Extension of supervision or proctoring as noted below
- ☐ Promotion from provisional status to: _____

COMMENTS:

Division Director and/or Chief signature: _____
Printed Name: _____
Date: _____