UPMC
POLICY AND PROCEDURE MANUAL

POLICY: HS-MS0008 *
INDEX TITLE: Medical Staff

SUBJECT: Practitioner Access to Confidential Files
DATE: April 1, 2024

This Policy applies to the following United States based UPMC facilities, including any providers who practice therein:

[Check all that apply]

☒ UPMC Children's Hospital of Pittsburgh	☒ UPMC Pinnacle Hospitals
☒ UPMC Magee-Womens Hospital	☒ Harrisburg Campus
☒ UPMC Altoona	☒ West Shore Campus
☒ UPMC Bedford	☒ Community Osteopathic Campus
☒ UPMC Chautauqua	☒ UPMC Carlisle
☒ UPMC East	☒ UPMC Memorial
☒ UPMC Hamot	☒ UPMC Lititz
☒ UPMC Horizon	☒ UPMC Hanover
☒ Shenango Campus	☒ UPMC Muncy
☒ Greenville Campus	☒ UPMC Wellsboro
☒ UPMC Jameson	☒ UPMC Williamsport
☒ UPMC Kane	☒ Williamsport Campus
☒ UPMC McKeesport	☒ Divine Providence Campus
☒ UPMC Mercy	☒ UPMC Cole
☒ UPMC Northwest	☒ UPMC Somerset
☒ UPMC Passavant	☒ UPMC Western Maryland
☒ Main Campus	
☒ Cranberry	
☒ UPMC Presbyterian Shadyside	
☒ Presbyterian Campus	
☒ Shadyside Campus	
☒ UPMC Western Psychiatric Hospital	
☒ UPMC St. Margaret	

Provider-based Ambulatory Surgery Centers

☒ UPMC Altoona Surgery Center
☒ UPMC Children's Hospital of Pittsburgh North
☒ UPMC St. Margaret Harmar Surgery Center
☒ UPMC South Surgery Center

Free-Standing Ambulatory Surgery Facilities:

☐ UPMC Hamot Surgery Center (**JV**)
☐ Hanover SurgiCenter
☐ UPMC Specialty Care York Endoscopy
☐ Susquehanna Valley Surgery Center

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☒ UPMC Center for Reproductive Endocrinology and Infertility
☒ UPMC Digestive Health and Endoscopy Center
☒ UPMC Surgery Center – Carlisle
☒ UPMC Surgery Center Lewisburg
☒ UPMC Pinnacle Procedure Center
☒ UPMC West Mifflin Ambulatory Surgery Center
☒ UPMC Community Surgery Center
☒ UPMC Leader Surgery Center

☐ West Shore Surgery Center **(JV)**

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POLICY ON PRACTITIONER ACCESS TO CONFIDENTIAL FILES

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POLICY ON PRACTITIONER ACCESS TO CONFIDENTIAL FILES

1. SCOPE OF POLICY

(a) This Policy applies to the Confidential Files maintained by a Participating UPMC Hospital or its Medical Staff. For purposes of this Policy, the specific Participating UPMC Hospital where the Policy is being applied (e.g., the hospital that is receiving a request for access) will be referred to as "the Hospital" and any individuals or committees referenced in the Policy will refer to individuals and committees at the same Hospital.

(b) A Confidential File is any file, paper or electronic, containing credentialing, privileging, PPE/peer review, health, quality, or utilization information related to a Practitioner.

(c) The Confidential File is distinct from personnel files the Hospital maintains on individuals in their role as employees, which are not governed by this Policy.

2. REVIEW OF CONFIDENTIAL FILES

2.A ***Personal Review of Information.*** 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 another individual when reviewing their Confidential File.

2.B ***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 Vice President of Medical Affairs ("VPMA"), using 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 PPE Specialist or the VPMA available to provide assistance as needed. The Confidential File may not be removed from the Hospital without the written permission of the VPMA.

2.C ***Scheduling Review.*** Practitioners must:

(1) schedule a specific time to review their Confidential File when either a PPE Specialist or the VPMA is available to be present during the review; and

(2) provide at least ten (10) business days' advance notice so a PPE Specialists or VPMA can properly prepare the documents.

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2.D *Access to Sensitive Documents.*

(1) ***Signed Form.*** If any of the documents the Practitioner wishes to review are Sensitive Documents (as defined in Section 7), the Practitioner must sign the ***Request to Access Confidential Fil***e form set forth as ***Appendix A*** to this Policy prior to accessing the documents.

(2) ***Redaction and Summary of Sensitive Documents Prior to Review.***

(a) Sensitive Documents will be redacted or summarized by the VPMA or a PPE Specialist 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.

(b) In determining which option to use – redaction or summary – the VPMA or a PPE Specialist 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.

(c) Summaries of Sensitive Documents should provide sufficient information to permit a Practitioner to understand:

(1) the nature of the document;

(2) the date it was prepared;

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

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

(3) ***No Disclosure of Attorney Documentation.*** Documentation in a Confidential File that is subject to the attorney-client privilege or that is deemed to be attorney work product of Hospital counsel will not be summarized or provided to the Practitioner in redacted form, nor will the existence of such documentation be disclosed to the Practitioner.

3. OBTAINING COPIES OF CONFIDENTIAL FILES

3.A ***No Copies May Be Made by Practitioners.*** 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 PPE Specialists while a Practitioner reviews documents.

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3.B *Copies by the Hospital.*

(1) After a Practitioner has reviewed the Confidential File, the Practitioner may request copies of documents that were made available to the Practitioner during the review.

(2) The VPMA and Medical Staff President will decide whether the Practitioner's request for copies will be granted. In making this decision, the VPMA and Medical Staff President may consider all relevant factors including the sensitivity of the documentation, the Practitioner's stated purpose for obtaining copies, confidentiality and retaliation risks, the resources needed to make the copies, and whether the documents are available to the Practitioner from other sources. The VPMA and Medical Staff President will act on the Practitioner's request within 10 business days of receiving it. If the VPMA and Medical Staff President disagree about whether the Practitioner's request for copies should be granted, the matter will be referred to the Hospital President for decision.

4. ALTERATIONS TO CONTENT OF CONFIDENTIAL FILES

4.A *Alterations and Deletions at the Request of the Practitioner.*

(1) Practitioners may not alter or delete any information in their Confidential File.

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

(3) 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).

(4) Reported concerns regarding a Practitioner's clinical performance or behavior shall not be deleted simply because the applicable Medical Staff 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.

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

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4.B ***Response of Practitioners.*** Practitioners may respond in writing to any documentation in their Confidential File. The Practitioner's response shall be maintained in the Confidential File along with the original communication.

5. CONFIDENTIALITY AND NON-RETALIATION

5.A ***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:

(1) to other Practitioners and/or Hospital employees who are directly involved in credentialing, privileging, and peer review activities concerning the Practitioner; and/or

(2) 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 written permission of the Leadership Council or VPMA.

5.B ***Non-Retaliation.*** Practitioners may not retaliate against any individual who either provided information that was included in the Confidential File or was involved in the review of that information.

6. ADDITIONAL PROVISIONS

6.A ***Hospital Record.*** The Confidential File is a confidential and proprietary business record of the Hospital. As such, access to the Confidential File is governed by this Policy.

6.B ***No Disclosure of Identities.*** As noted previously, the Practitioner shall not be told the identity of any individual who prepared or submitted a Sensitive Document, or who provided additional information relevant to the Sensitive Document, unless:

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

(2) the information provided by the individual is used during a Medical Staff hearing to support an adverse professional review action that has been recommended by the Medical Executive Committee. For purposes of a Medical Staff hearing, the Practitioner shall be entitled to unredacted copies of any documents that were considered by the Medical Executive Committee. The provision of such copies shall be subject to any rules set forth in the Medical Staff Credentials Policy or related policies.

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6.C ***Former Practitioners and Non-Privileged Practitioners.*** 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 Hospital 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 Hospital.

6.D ***Request from Attorney or Threatened/Pending Legal Action.*** Hospital 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.

6.E ***Violations.*** Violations of this Policy 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 to unauthorized individuals. 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.

7. DEFINITIONS

7.A ***Routine Documents.*** The following are routine credentialing, privileging, and PPE/peer review documents ("Routine Documents"):

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

(2) 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, which are considered Sensitive Documents);

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

(4) information letters prepared in accordance with the Professional Practice Evaluation Policy;

(5) routine correspondence between the Hospital and the Practitioner; and

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(6) routine affiliation verifications.

7.B ***Sensitive Documents.*** 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:

(1) reported concerns or incident reports concerning the Practitioner submitted by Hospital employees or other Practitioners;

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

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

(4) evaluations or reports completed as part of the PPE/peer review process by internal reviewers, proctors, monitors, or external reviewers, and all correspondence regarding these activities;

(5) non-routine affiliation verifications, and all peer references prepared by the Hospital;

(6) 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;

(7) correspondence between the Practitioner and the Hospital related to the PPE/peer review process;

(8) reports and portions of minutes of peer review committees pertaining to the Practitioner and maintained in the Practitioner's file;

(9) 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;

(10) notations of telephone conversations concerning the Practitioner's qualifications with references and other third parties, including date of

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conversation, identification of parties to the conversation, and information received and/or discussed;

(11) correspondence setting forth formal action by the Credentials Committee, Leadership Council, Professional Practice Evaluation Committee ("PPEC"), Medical Executive Committee, or any other committee performing PPE/peer review, including, but not limited to, letters of guidance or education, follow-up letters to collegial counseling discussions, letters of warning, or reprimand, consultation requirements, performance improvement plans, or final adverse actions following completion or waiver of a hearing and appeal;

(12) 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

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

If there is any doubt about whether a document is a Routine Document or a Sensitive Document, it shall be treated as a Sensitive Document.

7.C ***Other Definitions.***

Unless otherwise indicated below, the terms used in this Policy are defined in the Medical Staff Credentials Policy.

(1) "PPE Specialists" means a member of the PPE Specialists Committee at a Participating UPMC Hospital. This may include, but is not limited to, a Quality Department RN Reviewer, VPMA, applicable Department Chair, representatives from Medical Staff Services, and/or representatives of the Wolff Center who work on behalf of the Participating UPMC Hospital.

8. AMENDMENTS

(a) The Medical Staffs and Board at each Participating UPMC Hospital have independently adopted this Policy as their own by voting to approve it for use at each of their respective facilities. In doing so, the Participating UPMC Hospitals have delegated to the Medical Review Council the authority to develop and adopt amendments to this Policy.

(b) Notice of any amendments will be provided to the Medical Executive Committees at each Participating UPMC Hospital for their information. Any amendments to this Policy will take effect immediately upon receiving notice of the changes from the Medical Review Council.

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(c) If any Medical Executive Committee has concerns about an amendment, they may bring the concern to the attention of the Medical Review Council. The Medical Executive Committee may also recommend to its Board that the Hospital opt out of this Policy and reestablish its own.

SIGNED: Donald M. Yealy, MD
Senior Vice President, UPMC and Chief Medical Officer, UPMC Health Services
ORIGINAL: April 1, 2024
APPROVALS:
Policy Review Subcommittee: March 13, 2024
Executive Staff: March 29, 2024 (effective April 1, 2024)
PRECEDE:
SPONSOR: UPMC Medical Staff Services

*** With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

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APPENDIX A

REQUEST TO ACCESS CONFIDENTIAL FILE

I have asked to review information from my confidential Medical Staff file. I understand that the UPMC ___________ and its Medical Staff Leaders need to take appropriate steps to maintain the confidentiality of this information under state 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 Vice President of Medical Affairs ("VPMA"). I will leave my smart phone or similar electronic device capable of copying or making digital images with a PPE Specialist while I review information in my file. 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. 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 professional practice evaluation 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 Hospital'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 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 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.***

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(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 to unauthorized individuals. Any such violations will be reviewed pursuant to the Medical Staff Professionalism Policy.

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 Hospital employee, another physician, or the Hospital 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 Hospital's ongoing performance improvement and professional practice evaluation 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: This form shall be retained in the Practitioner's confidential file. A copy shall be provided to the Practitioner for reference.

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