

JERSEY SHORE UNIVERSITY MEDICAL CENTER

DEPARTMENT OF PSYCHIATRY

RULES & REGULATIONS

A. QUALIFICATIONS TO BECOME A MEMBER OF THE PSYCHIATRIC DEPARTMENT

1. INITIAL CREDENTIALING, PSYCHIATRISTS

Completion of three years approved Psychiatric Residency plus approval by the Psychiatry Department, Credentials Committee of the Medical Staff, the Executive Committee of the Medical Staff, and the Board of Trustees is required to become a member of the active Psychiatric Staff.

2. PROVISIONAL STATUS AND RECREDENTIALING

All new members will be in a provisional status according to the Medical Staff Bylaws. Members will be recredentialed every two years according to Medical Staff Bylaws.

3. SCOPE OF PRACTICES

The scope of practices will be those generally associated with the practice of psychiatry. These include:

- (a) diagnosis of mental illness and substance abuse in children, adolescents, adults and geriatric patients.
- (b) treatment of mental illness and substance abuse including individual, family and group cognitive or dynamic therapy, behavioral rehabilitation, behavior therapy and psychotropic medication prescribing.
- (c) supervision of multidisciplinary treatment including assessments, treatment planning and discharge planning.
- (d) consultative services for patients being treated outside of the department as well as to the JSUMC community as a whole.

4. GRANTING OF PRIVILEGES

Privileges granted in each of the above areas is dependent on certification, training, work experience as well as peer recommendation. The Chairman, in consultation with the Department, will make recommendations for specific privileges. Core privileges in the Department includes the diagnosis and treatment of mentally ill and substance abusing patients in an outpatient setting. The

following criteria will be used for more specific diagnostic and treatment modalities:

(a) Physical Examination

Current competence as evidenced by the performance of at least 25 comprehensive physical examinations in the past year.

(b) Inpatient Attending

Current competence as evidenced by having attended to at least 24 adult psychiatric inpatients over the previous 2 years.

(c) Consultations to Hospitalized patients

Current competence as evidenced by performing at least 24 hospital consultations in the previous 2 years.

(d) Services to Minors

Psychiatrists who routinely provide outpatient or consultative services to children under the age of 18 must have completed a two year approved fellowship in child and adolescent psychiatry. Adult psychiatrists may provide consultation services to hospitalized minors. However, it should be done in collaboration with a child and adolescent psychiatrist on staff at JSUMC.

(e) Biofeedback

Either a certificate of training or evidence from residency training of skill acquisition.

(f) Medically Managed Detoxification

Experience with JSUMC detoxification protocol as evidenced by treating at least 12 patients with protocol over previous 2 years.

(g) Electroconvulsive Therapy

Either a certificate of training or evidence from residency training of skills acquisition plus current competence as evidenced by performing 25 treatments per a year. All applicants for electroconvulsive therapy must be proctored for a minimum of twelve procedures before being permitted to practice independently.

B. MEETINGS OF THE DEPARTMENT

1. The Department will meet at least every other month to discuss Departmental business.

The Chairman will set a regular date and place for the meetings. All active and provisional members will have voting status. The Chairman of the Department will conduct the meeting and may invite other individuals to attend as appropriate.

2. A quorum for the meeting will be considered constituted if 50% of the voting members are present.
3. All members of the Department must provide an excuse for non-attendance. Members are required to attend at least 50% of the Department meetings.

C. OFFICERS OF THE DEPARTMENT

1. The Department shall elect a Chairman, a Vice Chairman and a representative to the Nominating Committee on an annual basis. The term of office will be for one year beginning January 1st. The Chairman must be a member of the active staff with attending and consultative privileges. The Vice Chairman will act in the Chairman's stead during periods of absence.

D. ADMINISTRATIVE DIRECTION AND ACCESSIBILITY OF PATIENTS FOR TEACHING

The medical administrative direction of the service is the responsibility of the Chairman, Department of Psychiatry. All patients admitted to the inpatient or outpatient psychiatric service will be freely accessible to medical students, interns, psychiatric residents/fellows, social work students and psychology interns for teaching purposes. Any exceptions to this will be noted in the chart by the attending physician.

E. INPATIENT UNIT

1. WHO MAY ADMIT TO THE PSYCHIATRIC INPATIENT UNIT

Only members of the Active or Regional Psychiatric staff with admitting privileges may admit. Patients will be admitted or transferred to the Psychiatric Unit only after consultation with a member of the Active Psychiatric Staff and his/her acceptance of the patients on his/her service.

2. SUITABILITY OF PATIENTS

Patients admitted to the unit must be voluntary or admitted under the auspices of a guardian unless referred to the Short Term Care Beds by an appropriate screening service. The Unit is designed as one element of service in the Community Mental

Health Center for short-term inpatient treatment (average length of stay 7-14 days but not to exceed 90 days).

3. USE OF RESTRAINTS/SECLUSION

Mechanical restraints, including isolation, shall not be applied in the care or treatment of any mentally ill, substance abusing or mentally retarded individual, unless required by his/her medical needs; every use of a restraint - and the reason therefore - shall be made a part of the clinical record. The safety of the patient is of paramount importance. Nothing should preclude the application of measures in an emergency situation that will afford immediate control of a violent or highly disturbed patient. The emergency nature of the measures will be fully recorded in the clinical record. (Refer to hospital and departmental policies and procedures for specific implementation protocols.)

4. ADMISSION DIAGNOSIS

All patients must have a primary diagnosis of mental illness according to the American Psychiatric Association's current Diagnostic and Statistical Manual (DSM, AXIS I-II) excluding substance abuse. Active substance abusers may be admitted if they have a valid acute non-substance abuse mental illness that would warrant hospitalization.

5. MEDICAL CLEARANCE

The admitting psychiatrist is responsible for assuring the medical stability of his/her patient prior to admission.

6. AGE LIMITATIONS

Children under the age of 18 will not be admitted to the Psychiatric Inpatient Unit. Exceptions can be made for unique circumstances with the permission of the Chairman of the Department.

7. AT RISK PATIENTS

All patients admitted to the psychiatric service, who are deemed to be at risk for injury to self, others or property, will be subject to special precautions. Immediately upon admission, the nurse in charge will be informed by orders of the need for suicide precaution. This will be immediately written in the patient's chart. The attending psychiatrist will recommend additional special nursing care where when indicated.

8. ADMITTING PROCEDURES

Patients may be admitted to the inpatient unit in several ways:

- (a) Patients admitted from the Crisis services will be screened by the psychiatrist covering the Crisis unit. The psychiatrist will provide sufficient admitting orders to cover the patient until they can be seen by an inpatient attending.
- (b) Any psychiatrist on staff at JSUMC may directly admit a patient by determining bed availability and providing admitting orders. The admitting psychiatrist is responsible for assuring that the patient is medically stable.
- (c) Any request for transfer of a patient from another facility or the admission of a patient by a non- psychiatrist will be referred to the psychiatrist covering the inpatient unit. If accepted for admission, the inpatient psychiatrist will provide admission orders.
- (d) A patient in a medical or surgical bed may be transferred to the inpatient unit following consultation by a psychiatrist. The consulting psychiatrist is responsible for notifying the inpatient unit of the transfer and providing admission orders.

9. DISCHARGES

Patients will receive one of four types of discharge:

- (a) Regular
- (b) AMA
- (c) Transfer to another facility, voluntary
- (d) Transfer to another facility, involuntary

10. RESPONSIBILITIES OF ADMITTING PSYCHIATRIST

The admitting psychiatrist will be professionally responsible for the overall care of his/her patients as follows:

- (a) All patients must undergo a comprehensive admission assessment by a psychiatrist or advanced practice nurse within 24 hours of admission.
- (b) All necessary and immediate orders such as medications, suicide precautions, emergency medical or surgical consultations, etc., will be called into the nursing staff at the time arrangements are made for admission. These will then be confirmed in writing by the attending psychiatrist within 24 hours after admission.
- (c) A brief admitting note will be typed into the on-line medical record at the time of the admission interview documenting:

1. Reason for admission
 2. Any/all acute behavioral problems
 3. Any/all acute medical problems
 4. Immediate treatment plan
- (d) A complete psychiatric evaluation will be dictated at the time of the admission interview. This will contain:
1. Chief complaint
 2. History of present illness (presenting behavioral symptoms, evolution of symptoms to date, treatment(s) provided to date, current psychosocial stressors)
 3. Past psychiatric history (previous episodes, including all hospitalizations, outpatient treatments, dates, providers, as well as secondary illnesses/problems)
 4. Substance abuse history (use and abuse of nicotine, alcohol, prescription drugs and illicit drugs with dates, amounts, medical, psychosocial and legal consequences of use)
 5. Personal history (history of significant life events including family of origin, schooling, marriage, children and any major traumas including physical and sexual abuse)
 6. Social history (current social environment including family, friends, leisure activities, religion)
 7. Occupational history (types of work, duration of jobs, military experience, vocational skills)
 8. Family history of medical and psychiatric illnesses
 9. Medical history (current medical problems, treating physicians, medications, significant past illnesses, past hospitalizations, past surgeries)
 10. Physical exam (if appropriate)
 11. Review of symptoms (including symptoms of depression, mania, psychosis, anxiety, panic, stress disorder, substance abuse, learning disability, attention deficit, dissociation, eating disorder, sexual dysfunction, personality disorder)

12. Mental status exam: a) appearance, b) affect, c) thoughts and perceptions, d) thought processes, e) insight, f) cognitive including consciousness, orientation, concentration, language, recent/remote memory, fund of knowledge, abstract reasoning, and judgment.
 13. Functional Assessment (any limitations that would impair recovery including difficulties with ADL, managing money, complying with treatment, physical handicaps, lack of schooling/training)
 14. Five Axes diagnoses (may refer to above for Axes III and IV)
 15. Summary statement repeating highlights of above with interpretation including reference to competency and dangerousness
 16. Initial treatment plan (therapies, consultations, referrals, follow up dates (outpatient) or discharge date (inpatient))
- (e) The medical history and physical examination is part of the attending psychiatrist's responsibility. He/she may do this as part of his/her examination. A medical consultation by a JSUMC medical staff member may serve in lieu of the medical history and physical. The medical history and physical examination must be completed and noted on the patient's chart within 24 hours of the patient's admission. Patients with known histories of serious physical disorder or suspicious symptoms or abnormal vital signs must be examined as soon as possible.
- (f) In cases of readmission, the psychiatrist may refer to the previous psychiatric evaluations as long as he/she has personally verified that the information is in the record, is accurate and is available.
- (g) The attending psychiatrist will be expected to see his/her patients as frequently as is deemed necessary. All patients must be seen by the attending psychiatrist or his designee at least once a day, seven (7) days a week.
- (h) The attending psychiatrist or his/her designee must type a progress note at least once a day documenting significant changes in the patient's condition or treatment plan.
- (i) All orders should be computer entered except for telephone orders or preadmission orders.
- (j) The attending psychiatrist or his/her designee will be responsible for dictating a discharge summary at the time of discharge This summary must include:
1. Diagnoses on discharge (DSM, Axis I-V)

2. Condition on discharge (including any disability)
3. Prognosis
4. A narrative summary that includes:
 - a. Reason for admission
 - b. Pertinent physical and laboratory finding(s)
 - c. Course in hospital
 - d. Aftercare plans (psychiatrist, therapist, treatment program, living situation)
 - e. Medication(s) at discharge including amount prescribed and an indication that the patient was properly educated
 - f. Assessment of lethality

(k) In addition to the dictated summary, the attending physician or his/her designee must type a brief discharge note on the day of discharge that includes:

- discharge medication(s)
- follow-up plan
- assessment of dangerousness

(l) The attending psychiatrist will be responsible for arranging coverage by another member of the attending psychiatric staff, if for any reason he/she is unable to provide continuous care for his/her patient.

11. ELECTROCONVULSIVE THERAPY - ECT.

If ECT is provided, the attending physician must either be privileged to administer ECT or make arrangements with a psychiatrist who is privileged. All ECT will be performed in conjunction with the Department of Anesthesiology.

12. THERAPEUTIC LEAVES

Any leave from the Unit must be of short duration and for therapeutic reasons only. All patients must return to the Unit by 9:00 p.m. Should the patient not return by midnight, the attending psychiatrist must be notified. The patient should be discharged AMA unless there are extenuating circumstances. Proper notification should be made to all other concerned agencies whenever absence from the Unit is a reason for concern.

13. TREATMENT PLAN - DIAGNOSTIC CATEGORIES AND RECOGNIZED FORMS OF TREATMENT FOR DIAGNOSTIC CATEGORIES

Admitting or provisional diagnoses, as formulated by the attending physician, shall be recorded and reviewed throughout the period of evaluation and treatment of the patient. These shall be rendered in standard nomenclature as provided in the American Psychiatric Association's current DSM. Treatment will be provided according to the standards of the American Psychiatric Association and the Department of Psychiatry. Treatment planning will be multidisciplinary. Each patient's treatment plan will be reviewed at the multidisciplinary treatment team meeting within 72 hours of admission and at least once a week thereafter. The admitting physician must either attend the treatment planning meetings or arrange for his/her input at the meeting.

14. CONTINUITY OF CARE

The Department of Psychiatry has the responsibility, through its attending psychiatrists, for planning aftercare measures with the patient and significant persons in his/her personal life and social environment. It will, through the attending physician and psychiatric social service, work to effect a smooth transition to an aftercare program.

15. INVOLUNTARY TREATMENT

(a) Use of Medications

When a patient on the Inpatient Psychiatric Unit constitutes an imminent danger to themselves or others, they may be involuntarily medicated if and only if medication is anticipated to significantly reduce the risk of harm. Any individual who requires repeated involuntary medication should be referred for involuntary treatment.

(b) Commitment for Involuntary Treatment

Involuntary treatment can be facilitated through the Monmouth Medical Center Screening Service or by a two physician certificate. Patients who are deemed to be in need of involuntary treatment will be required to stay at JSUMC until a screener evaluates them. If the screener and their consulting psychiatrist agree with the need for involuntary treatment, the patient will be committed according to New Jersey Screening Law. If the screener does not believe the patient meets the standard for commitment, the attending psychiatrist must discharge the patient, arrange for voluntary hospitalization or arrange for a two physician "alternate route" commitment.

(c) Refusal to Participate in Treatment

Refusal to participate in treatment or obey ward rules is also considered grounds for transfer or discharge of patients who are not in immediate danger to themselves or others.

16. **INFORMED CONSENT**

All patients must be fully informed of their rights in writing at the time of admission. All patients must be fully informed and provide consent for all procedures. Patients must be involved in all aspects of their care. Family surrogates will be involved in treatment decision making when there is any question of a patient's competency.

F. OUTPATIENT SERVICES

JSUMC operates psychiatric outpatient services for adults and children. Patients referred to a member of the medical staff for an initial assessment will undergo the same comprehensive evaluation as for an inpatient.

G. EMERGENCY SERVICES

1. The Department of Psychiatry will provide 24 hour emergency psychiatric consultation to the Crisis Center, the hospital and the emergency department.
2. The on-call psychiatrist will be immediately available by phone and must be available in person at JSUMC within thirty minutes if required. It is the responsibility of the Psychiatrist on call to provide back-up coverage if he/she will not be available at any time. Any problems will be reported to the Chairman of the Department of Psychiatry.
3. In the event that the on-call psychiatrist cannot be reached, the Chairman of the Department of Psychiatry will be called. If he/she is unavailable, the Vice Chairman will be called.
4. Patients who are in need of involuntary psychiatric hospitalization will be referred for involuntary treatment as outlined in Section 15.

H. CONSULTATION ON CRIMINAL AND CIVIL CASES

If a psychiatric consultation is requested on a patient facing criminal or civil proceedings, the consulting psychiatrist will be responsible for advising about the diagnosis, management or treatment of the patient while they are at JSUMC. They are not required to render a legal opinion or provide continuing care, expert testimony, etc.

I. MEDICAL ANCILLARY SERVICES

The Department recognizes the use of advanced practice nurses to provide psychiatric services in collaboration with an attending psychiatrist. Advanced

practice nurses can be privileged to perform any activity permitted by law in the State of New Jersey. Actual privileges will be determined on a case by case basis according to the nurse's education, training, experience and credentials, the criteria for privileging psychiatrists (A 3 above) as well as the supervising physicians willingness and ability to provide oversight. All advanced practice nurses must meet criteria for health professional affiliates as specified in the Medical Staff Bylaws and enter into an appropriate collaborating agreement.

To qualify as a collaborating physician, a psychiatrist must:

1. Countersign all admission assessments and all discharge summaries.
2. Countersign all inpatient consultations.
3. Review inpatient evaluations, recommendations and treatments on a daily basis.
4. Review initial consultations, recommendations and treatment recommendations on a daily basis.
5. Review outpatient evaluations, recommendations and treatments once a week
6. Have face to face supervision at least three times a week (when inpatients are being seen by the advanced practice nurse) and once every two weeks for outpatients.
7. Must be immediately available by phone (within ½ hour) at all times the advanced practice nurse is seeing patients.

J. THE REGIONAL MEDICAL STAFF

The category of regional medical staff is created for psychiatrists who have admitting privileges at another facility and who provide on-call coverage at JSUMC including weekend and holiday coverage.

They are not expected to provide on-going attending or consultative services once the on-call period has ended.

Members of the regional medical staff will be required to pay dues but are not required to attend departmental meetings, medical staff meetings or participate in mandatory on-call. They are required to participate in Quality Improvement activities.

Members of the regional staff will be privileged according to the guidelines for Regional Medical Staff in the Bylaws.

K. THE CONSULTING STAFF

- (a) Psychiatrists with unique capabilities not found among the active staff may be granted consulting privileges.

- (b) Psychiatrists may be granted consulting privileges if they are part of a teaching program but will not be attending to or consulting on any patients.
- (c) Psychiatrists who are required to interview patients as a responsibility of the New Jersey screening service for involuntary treatment may also be granted consulting privileges.

L. PROHIBITED TREATMENT

The following treatment modalities are prohibited from being employed by members of the Department of Psychiatry.

1. Adversive behavioral modification
2. Denial of nutritional care
3. Corporal punishment
4. Fear eliciting procedures
5. Seclusion or restraint for punitive purposes
6. Psychosurgery

M. PSYCHOLOGY SECTION

1. Definition of Section

There will be a section of the Department of Psychiatry for the purpose of privileging, credentialing, and monitoring the care provided by licensed independent practitioners of psychology. All individuals requesting privileges as psychologists at Jersey Shore University Medical Center will make application according to the Medical Staff Bylaws. If appointed, they will become members of the Section of Psychology. The Section will develop and implement a quality improvement plan to monitor the care provided by all members of the Section.

2. Initial Credentialing

All applicants for credentialing must meet the standards for psychologists outlined under Article III of the Medical Staff Bylaws. Psychologists are, however, excluded from the requirement for authorization to prescribe medications including the lack of a requirement to have a current Federal and State registration for prescribing controlled. They are also exempt from the requirement for board certification (Article III, 3f).

3. Provisional Status and Recredentialing

Psychologists will be initially admitted to a provisional status according to the Medical Staff Bylaws. Removal from provisional status will be contingent on approval by the Chairman of Psychiatry upon a formal recommendation by the Chief of the Section of Psychology.

4. Scope of Practices

The scope of psychologists' inpatient privileges will be consultative in nature. They will not be granted admitting privileges. In the Outpatient Service, psychologists can be privileged as primary behavioral health care providers. Psychologist's practice is restricted to the areas of their clinical expertise. These include:

(a) Patient Management Privileges

- provide, coordinate and evaluate psychological care
- participate in the development of multidisciplinary treatment plans under the direction of a psychiatrist
- supervise psychology staff and psychology trainees including Psychology Interns
- enter consultation notes on charts

(b) Clinical Assessment Privileges

- behavioral assessment
- biobehavioral and psychophysiological assessment
- neuropsychological examination
- mental status examination
- intellectual assessment
- personality assessment
- psychoeducational assessment
- vocational assessment

(c) Clinical Treatment Privileges

- individual psychotherapy
- group psychotherapy
- family psychotherapy
- behavior modification
- hypnosis
- biofeedback
- psychological rehabilitation services

(d) Consulting Privileges

- consultation liaison to other services, as needed
- professional development services within the facility
- program planning and evaluation

5. Granting of Privileges

Privileges granted in each of the above areas is dependent on certification, training, work experience and peer recommendations. The Chief of the Section of Psychology will make recommendations to the Chairman of Psychiatry for specific privileges. The Section will be responsible for continuing development of criteria for privileges. The following criteria will be used for specific procedures/treatment modalities:

- (a) neuropsychological testing, biofeedback, hypnosis, rehabilitation of brain injury: certification of specialty training in the area plus current competence as evidenced by ongoing assessment/treatment.

6. Officers of the Section

The Section of Psychology will have a Section Chief and Associate Chief appointed by the Chairman of the Department of Psychiatry. The Section Chief will be responsible for convening quarterly meetings of the Section. The Section Chief will be responsible for preparing minutes and reporting to the Department of Psychiatry. The Section Chief will serve as an ex-officio member of the department and will attend all departmental meetings.

7. Continuing Education Requirements

All members of the Section of Psychology must complete 10 hours of approved continuing education credits in a two year period.

8. Renewal of Privileges:

In order to remain in the Section all psychologists must be able to demonstrate that he or she has either:

- 9. Provided psychological services, on an inpatient, outpatient, or consultative basis, to at least 8 JSUMC patients in the past 12 months.

OR

- 10. Has participated in the training for psychology pre-doctoral interns (i.e. seminars, grand rounds, supervision, observation).

N. CONSULTATIONS BY PSYCHIATRISTS

- 1. Consultations will be performed within the following time frames:

- (a) Emergent consultations must be seen as soon as possible, typically within 1-2 hours

- (b) Urgent consultations must be seen within 12 hours
 - (c) Routine consultations must be seen within 24 hours
2. The individual requested to perform the consultation must do so or make alternative arrangements. If no physician has been designated, the psychiatrist on call is obligated to perform the consultation.
 3. In general consultations should be deemed to be routine. Urgent or emergent consultations are appropriate when there is a need for immediate behavioral management (i.e. suicidal, homicidal, violent, or assaultive), immediate diagnostic assistance (i.e. drug intoxications/withdrawal versus other causes of delirium), immediate treatment recommendations (i.e. acute psychosis, drug detoxification) or issues of involuntary treatment.
 4. There must be a typed progress note for all new consultations that delineates pertinent findings and treatment recommendations. The note should include 5 Axis diagnoses. In addition, a comprehensive consultation note must be dictated including the items listed in E 10c, above.
 5. All consultations will be followed up and a typed progress note entered as long as an unstable psychiatric condition remains.

O. CONSULTATIONS BY PSYCHOLOGISTS

The same rules for psychiatric consultations (N, above) apply to psychologists although there is no provision for an on-call psychologist. Therefore all requests must be for a specific psychologist.

P. PSYCHIATRIC VERSUS PSYCHOLOGICAL CONSULTATIONS

The following situations must be referred to a psychiatrist.

- (a) any situation in which there is a significant possibility that the patient will require psychiatric hospitalization;
- (b) any situation in which there is a significant possibility that the patient would benefit from psychotropic medications (psychoses, mania, major depression, severe anxiety disorders, delirium, dementia and drug/alcohol intoxication or withdrawal);
- (c) any situation in which a patient is currently being maintained on a psychotropic medication;
- (d) any situation in which there is concern as to the patient's competence;
- (e) any situation in which the patient's medical condition may be causing psychiatric symptoms;

- (f) any situation in which there is the possibility of involuntary commitment, notably situations in which a patient presents an imminent danger to themselves or others as a result of a mental illness.

The Chairman of the Department of Psychiatry in collaboration with the Section Chief of Psychology will monitor requests for psychological consultation to assure adherence to these guidelines.

These guidelines do not preclude a psychology consultation in addition to a psychiatric consultation, if additional expertise is required.

Q. CRITERIA FOR REMOVAL FROM PROVISIONAL STATUS

All members of the Department of Psychiatry including psychiatrists, psychologists and advance practice nurses will initially be given provisional status. The Chairman of Psychiatry will make a recommendation for removal from provisional status based upon data from quality improvement activities and review of at least ten clinical records.

R. CRITERIA FOR DETERMINING MEDICAL STAFF RANK

All new active physician members of the Department will be given the rank of Assistant Attending. Elevation to a rank of Associate Attending will be based upon Board certification and two years active service at JSUMC. Additional criteria may include: academic affiliation, participation in JSUMC committees, and community service. Promotion to the rank of Full Attending requires five years continuous service at JSUMC plus contributions to the furtherance of JSUMC's Mission through such activities as teaching, research, continuous quality improvement and community service. The Chairman of the Department is responsible for making recommendations for promotions at the time of re-privileging.

S. CRITERIA FOR REPRIVILEGING

The Chairman, Department of Psychiatry will make recommendations for re-privileging based upon a review of credentials, quality improvement indicators, health status, malpractice litigation, completion of medical records and adherence to Departmental policies and procedures including clinical management protocols and attendance at Department and Medical Staff Meetings.

T. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

The Chairman of the department, in collaboration with the Outcomes Management Department will be responsible for conducting FPPE's. At minimum all FPPE's must include a review of at least ten (10) cases of every type of privilege being requested. The following circumstances will trigger an FPPE:

1. Any psychiatrist, psychologist or APN joining the Department.
2. Any psychiatrist or APN who is transitioning from primary activity in one service area (e.g. outpatient, inpatient or consultation) to another service area. This would apply to any individual who has not satisfied requirements to continue inpatient admitting privileges, consultation privileges, physical examination privileges, medically managed detoxification or ECT privileges.
3. Any psychiatrist, psychologist or APN returning from an LOA of 1 year or more.
4. Any psychiatrist, psychologist or APN who is requesting additional privileges.
5. Any psychiatrist, psychologist or APN where there has been an identified quality of care concern.

U. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

The Chairman of the Department must conduct an ongoing professional assessment of all active members of the department every six months. The ongoing assessment should include indicators of quality of care, resource utilization and patient outcomes.

Respectfully submitted,
Peter Q. Harris, M.D., Ph.D.
Chairman, Department of
Psychiatry
Revised: 12/12/09
Submitted for approval