Sample Free Clinic Documentation for the Federal Tort Claims Act (FTCA) Free Clinic Program Application

Medical malpractice coverage for volunteers and staff is necessary for clinics to provide the best quality health care to patients, but oftentimes the cost of this coverage is so high that it limits the scope of services provided.

The Health Resources and Services Administration (HRSA) administers the Free Clinic Program of the Federal Tort Claims Act (FTCA), providing medical liability coverage at no cost to Free Clinics' volunteer health care professionals, staff, board, officers, employees and/or contractors. In order to receive coverage, Free Clinics must apply to HRSA on behalf of such individuals.

The National Association of Free & Charitable Clinics (NAFC) has compiled sample documents used in FTCA-deemed Free Clinics, in order to provide guidance to other Free Clinics looking to receive future liability coverage under the FTCA Free Clinic Program. The sample documents are listed in the order that they are asked for within the "Calendar Year 2016 Federal Tort Claims Act (FTCA) Deeming Application for Free Clinics" which can be accessed at: http://bphc.hrsa.gov/ftca/pdf/pal_2015-04_.pdf

The following sample documents are meant to serve as guidance. When applying for FTCA Free Clinic liability coverage, readers are strongly urged to make sure that their own submission documents are specific to their individual clinics.

To apply for FTCA Free Clinic Program liability coverage, please contact HRSA at freeclinicsFTCA@hrsa.gov or call the Office on Quality and Data at (301) 594-0818.

The NAFC would like to thank The Free Clinic of Simi Valley in Simi Valley, CA and the Lake County Free Clinic in Painesville, OH for their support of this compilation and lent documents to be used as general guidance when applying for this program.

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CLINIC NAME	***Practitioner Credentialing and Verification Policy***

Purpose of Policy

The purpose of this policy is to establish a credentialing process for the purpose of validating and evaluating the credentials and competencies of licensed and certified staff as a basis for volunteering (new or continued), employment (new or continued), or a change in assignment.

Policy

The Clinic's credentialing program shall apply to all licensed professional, volunteer and paid, and to certified professionals volunteer and paid. Licensed and certified volunteers apply for privileges or scope of services. This process will clarify who is authorized to perform what tasks and services, and assure (to the extent possible) that persons are practicing within the scope of their licensure or certification, training and experience. This process applies to both LIPs (Licensed Independent Practitioners) and non-LIPs.

Procedures

<u>License/Certification Verification</u>

The Clinic shall use the following procedures:

1. All professionals who are either licensed or certified must be credentialed at the time they begin their volunteer commitment with the Clinic. At the time the application forms are given to the applicant, he/she is informed that failure to provide full disclosure and/or truthful information on the application is grounds for denial of an application for privileges.

2. Prior to the time the practitioner begins work, information pertaining to their credentials will be gathered. At the time of application, new volunteers will be made aware of the Clinic policy of verifying credentials annually; documentation of this agreement will be maintained in each practitioner's confidential file. Also in the file will be the results of credentialing inquiries and current copies of all relevant licensure or certification.

3. The Clinic shall gather the following information as Primary Source Verification:

    - Verification through CVO of credentials/licensure – the Clinic will utilize the Ohio E-License online system and the NPDB for all queries and will provide information including licensure and education.
    - Statement of fitness from practitioner attesting to his ability to perform the duties required at the Clinic.

4. The Clinic shall gather the following information as appropriate as Secondary Source Verification:
    - Copy of current government-issued ID
    - DEA registration
    - Hospital admitting privileges
    - Immunization/TB results
    - CPR training

Responsibility for Verification

The Clinic's Executive Director is responsible for overseeing that credentialing activities are implemented properly, effectively and fairly. The Executive Director must ensure that the credentialing tasks are conducted privately, and must make sure that the program is implemented in accordance with applicable laws and guidelines. It is the responsibility of the Executive Director to make sure the Clinic and the licensed or certified staff qualifies for FTCA liability coverage.

This responsibility includes, but is not limited to:

- Verifying the credentials of all licensed and certified volunteers
- Maintaining files and information in a confidential manner
- Carrying out telephone conversations and conferences in private
- Receiving confidential information directly (via mail, e-mail, or facsimile)
- Maintaining confidentiality
- Establishing systems for tracking the mailing and receipt of requests for information including time frames for re-credentialing and renewing items such as licenses, registrations, etc.
- Making recommendations to the Executive Director and the Credentialing Committee
- Maintaining a confidential file on each licensed or certified volunteer which includes, among other contents, all information/documentation related to credentialing.

Temporary Privileging

In rare instances, the Clinic is able to grant temporary privileges to a practitioner prior to completing verification of credentials according to the procedures listed above. These instances include situations such as the need for a practitioner to provide important services to a patient on a short-term or emergency basis (e.g., fill in for practitioner who becomes ill or unable to provide

care). Though the preference would be to avoid these situations, practitioners may be granted temporary privileges when the following has been completed:

- Licensure verified (can be done by phone)
- Verification of current competence in scope of patient care services to be provided at the Clinic (can also be verified by phone)

Temporary privileges are not to be granted for non-urgent reasons (e.g., insufficient information provided by practitioner to complete the verification process, Clinic staff did not finish verification in timely manner).

Communication of Credentialing Findings

1. The Executive Director will review the results of inquiries and determine a status for each practitioner according to the following options:

    a. Grant or renew status/privileges without changes.
    b. Change (expand or decrease) status/privileges.
    c. Deny or terminate status/privileges.

2. Recommendations shall be presented by the Executive Director to the Medical Director for approval.

3. If the Executive Director and Medical Director recommend making an adverse decision, the applicant must be notified in writing of the proposed decision and the stated reasons for it, and be given an opportunity to provide additional information.

4. The Executive Director will forward the necessary information to the Clinic's Board of Directors. The authority for final action on the recommendation to grant privileges to licensed and certified practitioners lies with the Clinic's Board of Directors. The Board is responsible for the final action to accept, modify or deny the privileges recommended. In the event that a meeting is not scheduled prior to the start date of the practitioner, the Board President may approve the recommendation on behalf of the Board until it can be approved by the full Board at the next meeting.

5. Adverse action taken against a physician, dentist, or registered nurse that concerns professional competence or conduct which is based on formal peer review and is in effect for 30 days or longer must be reported to the NPDB and the state medical, dental or nursing licensing board within 30 days of the final action.

Credentialing Activities After Board Action

Once the Board has approved a practitioner for privileges or scope of practice, signed documentation from the verification and recommendation process is placed in the practitioner's file and the practitioner is notified of the decision.

Re-credentialing Procedures

1. The Clinic re-credentials practitioners annually: this involves updating the volunteer's file consistent with his or her current role and assignment, additional training, and documented competencies.

2. Re-credentialing does not require verification of original education, qualifications and references; rather, it includes documentation of additional training and continuing education, along with changes in request for scope of practice privileges, verification of current licensure or certification status, statement of lack of privileges at another health care facility, and peer reviews (if applicable).

3. Each practitioner will update the information required to perform a licensure/certification verification.

4. Database inquiries are performed in the same manner as detailed above in License/Certification Verification Procedures.

5. Routine and/or special evaluations conducted by the applicant's supervisor should be included in the re-credentialing file. Any special reports concerning the applicant, both positive and negative, also should be included.

6. If adverse information is received from any source, the Executive Director will notify the Medical Director. The Executive Director and Medical Director should consider the most appropriate manner in which to advise the applicant of the adverse information, and provide an opportunity for the applicant to explain or refute the adverse or questionable findings.

7. If warranted, the adverse information may be investigated; after the investigation is concluded, the results/recommendations will be placed in the practitioner's credentialing file and the applicant will be notified of the outcome of this investigation.

Re-credentialing Activities After Board Action

As in credentialing, once the Board has approved a practitioner for privileges or scope of practice, signed documentation from the verification and recommendation process is placed in the practitioner's file and the practitioner is notified of the decision.

Special Re-credentialing Considerations

If a volunteer's scope of practice changes significantly during the credentialed period, re-credentialing should take place at the time of the change, and then again during the following annual review.

Confidentiality

All credentialing and privileging activities are to be considered confidential.

Credentialing Program Evaluation

The credentialing program will be periodically reviewed to make sure that it is accomplishing its goals. If needed, adjustments will be made to the program. These adjustments and improvements will be reported to the Clinic's Board of Directors.

Attachment

Certification of Ability to Perform Volunteer Role

CLINIC NAME **CLINIC POLICIES & PROCEDURES**	Page 4 of 21
	Supersedes Date:
	Original Date: February 10 2014
	Version: 01
	Policy Section: HR
Credentialing and Privileging	

PURPOSE

The CLINIC NAME has in place a credentialing process for the purpose of validating and evaluating the credentials and competencies of licensed and certified staff as a basis for volunteering, continued volunteering or a change in assignment. Involved in this process are the Clinic's Governing Board, Credentialing Committee, Executive Director, and the Credentialing Coordinator.

RESPONSIBLITIES

Governing Board

The Clinics' Governing Board is ultimately responsible for the management and quality of Clinic services. The Board must determine that appropriate quality management and credentialing

programs are in place to assure the Clinic's eligibility for "deemed status" coverage under the FTCA.

The Governing Board will receive reports at its meetings from the Credentialing Committee or its designee and make final decisions concerning the granting or denying of privileges. In instances when volunteers have successfully completed the credentialing process yet there is not an upcoming board meeting, the governing board may grant or deny privileges via electronic or phone communications with a review at the next scheduled board meeting.

Credentialing Committee

The Credentialing Committee shall be comprised of licensed professionals generally under the leadership of the dental/medical director. The committee or its designee is responsible for reviewing all credentialing and re-credentialing files and making recommendations to the Governing Board concerning the granting of privileges. In order to make these recommendations the committee may seek additional references or information.

Executive Director

The Clinic's Executive Director is responsible for overseeing that credentialing programs are implemented properly, effectively and fairly. The Executive Director must ensure that the Clinic's Credentialing Coordinator has the resources to complete the credentialing tasks privately, and must make sure that the program is implemented consistent with applicable laws and guidelines. It is the responsibility of the Executive Director to make sure the Clinic and the licensed or certified staff qualify for FTCA liability coverage.

As the director of the Clinic, the Executive Director has the authority to review all documentation and attend all meetings of the Clinic's Credentialing Committee.

Clinic's Credentialing Coordinator

The volunteer coordinator of the Clinic shall be the "Clinic's Credentialing Coordinator" and is responsible for completing and overseeing all credentialing processes. This coordinator must have the ability to:

- Maintain the files and information in a confidential manner
- Carry out telephone conversations and conference in private
- Receive unopened mail directly
- Receive confidential facsimile information directly
- Maintain confidentiality
- Establish systems for tracking the mailing and receipt of requests for information including time frames for re-credentialing and renewing items such as licenses, registrations etc.
- Make recommendations to the Executive Director and the Credentialing Committee
- Verify the credentials of all licensed and certified volunteers

- Maintain a credentialing file on each licensed or certified volunteer

SCOPE

The Clinic's credentialing program shall apply to all licensed professionals, volunteer and paid, and to certified professionals, volunteer and paid. Licensed and certified volunteers apply for privileges or scope of services. This process will clarify who is authorized to perform which tasks and services, and assures (to the extent possible) that persons are practicing within the scope of their licensure or certification, training and experience.

PROCEDURES

The Clinic will use the following procedures in the credentialing and privileging program:

5. All volunteers who are either licensed or certified must be credentialed at the time they begin their volunteer commitment with the Clinic. At the time the application forms are given to the applicants, the applicants are informed that failure to provide full disclosure and/or truthful information on the application is grounds for denial of an application for privileges.

6. At the time the Licensed Individual Practitioner (LIP) begins volunteer service, information as to their credentialing and privileging status will be obtained from the Credentials Verification Organization (CVO). The Clinic then has 120 days in which to gather secondary source verification information.

7. All licensed dental and medical practitioners will complete The CLINIC NAME's "Licensed Independent Practitioner Standard Credentialing Form". An example of this form is contained in Appendix A. Certified dental and medical volunteers will complete the Clinic's "Certified Volunteers Credentialing Form". An example of this for is contained in Appendix A.

8. All applicants will complete an informed consent. The informed consent form authorizes Clinic representatives to request confidential information concerning the applicant and should be attached to each application.

9. Primary Source Verification and Secondary Source Verification
    a. The CLINIC NAME will use HOSPITAL SYSTEM as the Clinic's (CVO) for primary source verification of LIP'S and Certified Professionals.
    b. The Clinic will, however, maintain individual credentialing files on each professional volunteer that will include:

        1. Identification
        2. Current License
        3. DEA Registration
        4. DPS Registration

5. Immunization and PPD Status
6. Life Support Training
7. Current C.V.

10. As soon as an application and the attachments are received, the Clinic Credentialing Coordinator must review the application to be certain that all questions have been answered in full. A signed "Consent to Release" form must be included with the application to authorize the Clinic to secure information from the CVO. (See attached form)

11. The Clinic Credentialing Coordinator shall prepare and maintain a Credentialing File on each volunteer.

12. Credentialing Files are to be marked and stored according to their status:
    a. Active
    b. Inactive
    c. Withdrawn Application/Application Denied

13. Upon receipt of the application, the Credentialing Coordinator will contact the applicant for any missing or incomplete information.

14. The Clinic Credentialing Coordinator determines the application is complete when all information requested has been received or accounted for and summarized in the Credentialing Report.

    a. The Credentialing Report is a summary of the completed credentialing process. The Credentialing Report includes a summary of the findings of the investigation and the recommendation to be made to the Credentialing Committee. (An example of the credentialing the report is available in Appendix A.)
    b. This form is used to document the progress of the application and credentialing through the various stages of review and recommendations. (An example of this form is in Appendix A.)

COMMUNICATION OF CREDENTIALING FINDINGS

6. The Executive Director reviews the recommendations of the Clinic Credentialing Coordinator to determine that they are appropriate to the findings. The Executive Director or his /her designee is responsible for forwarding the necessary information to the Clinic Credentialing Committee for review.

7. The Credentialing Report and the Credentialing File are referred to the Credentialing Committee for review and recommendation. The Credentialing Committee, is responsible for making one of the following recommendations:

    a. To grant or renew status/privileges without changes
    b. To change (expand or decrease) status/privileges

c. To deny or terminate status/privileges

8. If the Committee **anticipates making an adverse recommendation**, the applicant must be notified in writing of the proposed adverse recommendation and the stated reasons, and be given an opportunity to provide additional information.

9. The Clinic's Credentialing Committee or its designee will forward the necessary information to the Clinic's Governing Board. The authority for final action on the recommendation to grant privileges to licensed and certified staff lies with the Clinic's Governing Board. The Board is responsible for the final action to accept, modify or deny the privileges recommended. The president or the secretary of the Board on behalf of the Board signs the Clinic Credentialing Report.

10. Adverse action taken against a physician, dentist, or registered nurse that concerns professional competence or conduct which is based on formal peer review and is in effect for 30 days or longer must be reported to the NPDB and the state medical, dental or nursing licensing board within 30 days of the final action

CREDENTIALING ACTIVITIES AFTER BOARD ACTION

Once the Board has approved a volunteer for privileges or scope of practice, several actions must be completed:

1. A signed copy of the credentialing report will be placed in the credentialing file.
2. Applicants are then notified of acceptance/rejection of application.
3. During the period between credentialing and re-credentialing, the Clinic Credentialing Coordinator should have in place a system to verify renewal of any dated or renewable authorizations. These verifications should be kept in each volunteer's credentialing file and will apply to re-credentialing:

    a. License/Certification Board Certification
    b. DPS Registration DEA Registration
    c. Malpractice Insurance CPR certification
    d. Re-credentialing due date.

RE-CREDENTIALING PROCEDURES

8. Re-credentialing does not require verification of original education, qualifications and references; rather, it includes documentation of additional training and continuing education, along with changes in request for scope of practice privileges, verification of current licensure or certification status, and any peer reviews.

9. Each licensed and certified volunteer must apply every two years for renewal of privileges through re-credentialing. Re-credentialing involves updating the volunteer's file consistent with his or her current role and assignment, additional training, and documented competencies.

10. Each practitioner will update the malpractice claims information on the Credentialing Application. If other information has changed substantially, practitioners will be required to complete a new form.

11. As soon as a re-credentialing application and attachments are received, the Clinic Credentialing Coordinator must review the application documents to be certain that the volunteer provided all information needed.

    a. The Credentialing Report is a summary of the completed credentialing process. The Credentialing Report includes a summary of the findings of the investigation and the recommendation to be made to the Credentialing Committee. (An example of the credentialing the report is available in Appendix A.)
    b. Clinic Credentialing Check List is used to document the progress of the re-credentialing through the various stages of review and recommendations. (An example of this form is in Appendix A.)

12. Primary Source Verification and Secondary Source Verification

    a. The CLINIC NAME will use HOSPITAL as the Clinic's Credentials Verification Organization (CVO) for re-credentialing LIP'S and Certified Professionals.

    b. The Clinic will however, update the credentialing file with the following:

        1. Identification
        2. Current License
        3. DEA Registration
        4. DPS Registration
        5. Immunization and PPD Status
        6. Life Support Training
        7. Current C.V.

13. Routine and/or special evaluations conducted by the applicant's supervisor should be included in the re-credentialing file. Any special reports concerning the applicant, both positive and negative, also should be included.

14. If adverse information is received from any source, the Clinic Credentialing Coordinator will immediately notify the Executive Director. If necessary the Executive Director will notify the Dental/Medical director. The Executive Director should consider the most appropriate manner in which to advise the applicant of the adverse information, and provide an opportunity for the applicant to explain or refute the adverse or questionable findings.

15. If the adverse information warrants an investigation, after the conclusion of this investigation the result/recommendations will be placed in the Practitioner's Credentialing File and the applicant will be notified of the outcome of this investigation.

COMMUNICATION OF RE-CREDENTIALING REPORTS

1. The Executive Director reviews the recommendations of the Clinic Credentialing Coordinator to determine that they are appropriate to the findings. The Executive Director, or his/her designee is responsible for forwarding the necessary information to the Clinic Credentialing Committee for review.

2. The re-credentialing Report and the Credentialing File are referred to the Credentialing Committee for review and recommendation. The Credentialing Committee, is responsible for making one of the following recommendations:

    a. To renew status/privileges without changes
    b. To change (expand or decrease) status/privileges
    c. To deny or terminate status/privileges

3. If the Committee **anticipates making an adverse recommendation**, the applicant must be notified in writing of the proposed adverse recommendation and the stated reasons, and be given an opportunity to provide additional information.

4. The Clinic's Credentialing Committee or its designee, will forward the necessary information to the Clinic's Governing Board. The authority for final action on the recommendation to grant privileges to licensed and certified staff lies with the Clinic's Governing Board. The Board is responsible for the final action to accept, modify or deny the privileges recommended. The president or the secretary of the Board on behalf of the Board signs the Re-credentialing Report.

RE-CREDENTIALING ACTIVITIES AFTER BOARD ACTION

Once the Board has approved a volunteer for privileges or scope of practice, several actions must be completed:

1. A signed copy of the Re-credentialing Report will be placed in the Credentialing File.

2. Applicants are then notified of acceptance/rejection of application.

3. During the period between re-credentialing, the Clinic Credentialing Coordinator should have in place a system to verify renewal of any dated or renewable authorizations. These verifications should be kept in each volunteer's Credentialing File and will apply to re-credentialing:

    a. License/Certification
    b. Board Certification
    c. DPS Registration
    d. DEA Registration
    e. Malpractice Insurance

f. CPR certification
g. Re-credentialing due date

SPECIAL RE-CREDENTIALING CONSIDERATIONS
If a volunteer's scope of practice changes significantly during the credentialed period, re-credentialing should take place at the time of the change, and then again two years after that date.

CONFIDENTIALITY

All credentialing and privileging activities are to be considered confidential.

CREDENTIALING PROGRAM EVALUATION

When necessary the credentialing program will be reviewed to make sure that it is accomplishing its goals. If needed, adjustments will be made to the program. These adjustments and improvements will be reported to the Clinic's Governing Board.

CLINIC NAME	***Volunteer Practitioner Credentialing and Verification***	Policy Approved by Board of Trustees DATE
		Reviewed/Revised/ Approved by Board of Trustees DATE

Purpose of Policy

The purpose of this policy is to establish a credentialing process for the purpose of validating and evaluating the credentials and competencies of licensed and certified staff as a basis for volunteering, continued volunteering, or a change in assignment.

Policy

The Clinic's credentialing program shall apply to all licensed professional, volunteer and paid, and to certified professionals volunteer and paid. Licensed and certified volunteers apply for privileges or scope of services. This process will clarify who is authorized to perform what tasks and services, and assures (to the extent possible) that persons are practicing within the scope of their licensure or certification, training and experience.

Responsibilities

Governing Board

The Clinic's Governing Board is ultimately responsible for the management and quality of Clinic services. The Board must determine that appropriate quality management and credentialing programs are in place to assure the Clinic's eligibility for "deemed status" coverage under the FTCA.

The Governing Board shall delegate authority for performing verification activities to the Executive Director, who shall provide reports at Board meetings (or through other approved means between meetings, such as e-mail or phone) so that the Board may make final decisions concerning the granting or denying of privileges.

Credentialing Committee

The Credentialing Committee shall be comprised of licensed professionals generally under the leadership of the Clinic's Medical Director, unless otherwise designated by the Medical Director and with the approval of the Board. The committee or its designee is responsible for reviewing all credentialing and re-credentialing files and making recommendations to the Governing Board concerning the granting of privileges. In order to make these recommendations the committee may seek additional references or information.

Executive Director

The Clinic's Executive Director is responsible for overseeing that credentialing programs are implemented properly, effectively and fairly. The Executive Director must ensure that the credentialing tasks are conducted privately, and must make sure that the program is implemented in accordance with applicable laws and guidelines. It is the responsibility of the Executive Director to make sure the Clinic and the licensed or certified staff qualifies for FTCA liability coverage.

Credentialing Coordinator

The Volunteer Coordinator of the Clinic shall be the "Clinic's Credentialing Coordinator" and is responsible for completing and overseeing the credentialing processes. In the absence of a Volunteer Coordinator, this duty falls to the Executive Director. This coordinator must have the ability to:

- Maintain the files and information in a confidential manner
- Carry out telephone conversations and conference in private
- Receive unopened mail directly
- Receive confidential facsimile information directly
- Maintain confidentiality

- Establish systems for tracking the mailing and receipt of requests for information including time frames for re-credentialing, and renewing items such as licenses, registrations, etc.
- Make recommendations to the Executive Director and the Credentialing Committee
- Verify the credentials of all licensed and certified volunteers
- Maintain a credentialing file on each licensed or certified volunteer

Procedures

The Clinic will use the following procedures in the credentialing and privileging program.

15. All volunteers who are either licensed or certified must be credentialed at the time they begin their volunteer commitment with the Clinic. At the time the application forms are given to the applicant, he/she is informed that failure to provide full disclosure and/or truthful information on the application is grounds for denial of an application for privileges.

16. At the time the Licensed Individual Practitioner (LIP) begins volunteer service, information as to their credentialing and privileging status will be obtained from the Credentials Verification Organization (CVO). The Clinic then has 120 days in which to gather secondary source verification information.

17. All licensed dental and medical practitioners will complete The Community Clinic's "Licensed Independent Practitioner Standard Credentialing Form". An example of this form is contained in Appendix A. Certified dental and medical volunteers will complete the Clinic's "Certified Volunteers Credentialing Form". An example of this is contained in Appendix A.

18. All applicants will complete an informed consent. The informed consent form authorizes Clinic representatives to request confidential information concerning the applicant and should be attached to each application.

19. Primary Source Verification and Secondary Source Verification
    a. The Community Clinic will use St. Luke's Hospital System and Memorial Hermann Hospital System as the Clinic's (CVO) for primary source verification of LIP'S and Certified Professionals.
    b. The Clinic will however, maintain individual credentialing files on each professional volunteer that will include:

        1. Identification
        2. Current License
        3. DEA Registration
        4. DPS Registration
        5. Immunization and PPD Status
        6. Life Support Training
        7. Current C.V.

20. As soon as an application and the attachments are received, the Clinic Credentialing Coordinator must review the application to be certain that all questions have been answered in full. A signed "consent to release" form must be included with the application to authorize the Clinic to secure information from the CVO. (See attached form)

21. The Clinic Credentialing Coordinator shall prepare and maintain a credentialing file on each volunteer.

22. Credentialing files are to be marked and stored according to their status:
    a. Active
    b. Inactive
    c. Withdrawn Application/Application Denied

23. Upon receipt of the application, the Credentialing Coordinator will contact the applicant for any missing or incomplete information.

24. The Clinic Credentialing Coordinator determines the application is complete when all information requested has been received or accounted for and summarized in the credentialing report.

    a. The Credentialing Report is a summary of the completed credentialing process. The Credentialing Report includes a summary of the findings of the investigation and the recommendation to be made to the Credentialing Committee. (An example of the credentialing the report is available in Appendix A.)
    b. This form is used to document the progress of the application and credentialing through the various stages of review and recommendations. (An example of this form is in Appendix A.)

Communication of Credentialing Findings

11. The Executive Director reviews the recommendations of the Clinic Credentialing Coordinator to determine that they are appropriate to the findings. The Executive Director or his /her designee is responsible for forwarding the necessary information to the Clinic Credentialing Committee for review.

12. The Credentialing Report and the Credentialing File are referred to the Credentialing Committee for review and recommendation. The Credentialing Committee, is responsible for making one of the following recommendations:

    a. To grant or renew status/privileges without changes.
    b. To change (expand or decrease) status/privileges.
    c. To deny or terminate status/privileges.

13. If the Committee anticipates making an adverse recommendation, the applicant must be notified in writing of the proposed adverse recommendation and the stated reasons, and be given an opportunity to provide additional information.

14. The Clinic's Credentialing Committee or its designee, will forward the necessary information to the Clinic's Governing Board. The authority for final action on the recommendation to grant privileges to licensed and certified staff lies with the Clinic's Governing Board. The Board is responsible for the final action to accept, modify or deny the privileges recommended. The president or the secretary of the Board on behalf of the Board signs the Clinic Credentialing Report.

15. Adverse action taken against a physician, dentist, or registered nurse that concerns professional competence or conduct which is based on formal peer review and is in effect for 30 days or longer must be reported to the NPDB and the state medical, dental or nursing licensing board within 30 days of the final action

Credentialing Activities After Board Action

Once the Board has approved a volunteer for privileges or scope of practice, several actions must be completed:

4. A signed copy of the credentialing report will be placed in the credentialing file.
5. Applicants are then notified of acceptance/rejection of application.
6. During the period between credentialing and re-credentialing, the Clinic Credentialing Coordinator should have in place a system to verify renewal of any dated or renewable authorizations. These verifications should be kept in each volunteers credentialing file and will apply to re-credentialing

    a. License/Certification Board Certification
    b. DPS Registration DEA Registration
    c. Malpractice Insurance CPR certification
    d. Re-credentialing due date.

Re-credentialing Procedures

16. Re-credentialing does not require verification of original education, qualifications and references; rather, it includes documentation of additional training and continuing education, along with changes in request for scope of practice privileges, verification of current licensure or certification status, and any peer reviews.

17. Each licensed and certified volunteer must apply every two years for renewal of privileges through re-credentialing. Re-credentialing involves updating the volunteer's file consistent with his or her current role and assignment, additional training, and documented competencies.

18. Each practitioner will update the mal-practice claims information on the Credentialing Application. If other information has changed substantially, practitioners will be required to complete a new form.

19. As soon as a re-credentialing application and attachments are received, the Clinic Credentialing Coordinator must review the application documents to be certain that the volunteer provided all information needed.

    a. The Credentialing Report is a summary of the completed credentialing process. The Credentialing Report includes a summary of the findings of the investigation and the recommendation to be made to the Credentialing Committee. (An example of the credentialing the report is available in Appendix A.)
    b. Clinic Credentialing Check List is used to document the progress of the re-credentialing through the various stages of review and recommendations. (An example of this form is in Appendix A.)

20. Primary Source Verification and Secondary Source Verification

    a. The Community Clinic will use St. Luke's Hospital System and/or Memorial Hermann Hospital System as the Clinic's Credentials Verification Organization (CVO) for re-credentialing LIP'S and Certified Professionals.

    b. The Clinic will however, update the credentialing file with the following:

        1. Identification
        2. Current License
        3. DEA Registration
        4. DPS Registration
        5. Immunization and PPD Status
        6. Life Support Training
        7. Current C.V.

21. Routine and/or special evaluations conducted by the applicant's supervisor should be included in the re-credentialing file. Any special reports concerning the applicant, both positive and negative, also should be included.

22. If adverse information is received from any source, the Clinic Credentialing Coordinator will immediately notify the Executive Director. If necessary the executive director will notify the dental/medical director. The Executive Director should consider the most appropriate manner in which to advise the applicant of the adverse information, and provide an opportunity for the applicant to explain or refute the adverse or questionable findings.

23. If the adverse information warrant an investigation, after the conclusion of this investigation the result/recommendations will be placed in the practitioners credentialing file and the applicant will be notified of the outcome of this investigation.

Communication of Re-credentialing Reports

5. The Executive Director reviews the recommendations of the Clinic Credentialing Coordinator to determine that they are appropriate to the findings. The Executive Director, or his/her designee is responsible for forwarding the necessary information to the Clinic Credentialing Committee for review.

6. The Re-credentialing Report and the Credentialing File are referred to the Credentialing Committee for review and recommendation. The Credentialing Committee, is responsible for making one of the following recommendations:

    a. To renew status/privileges without changes.
    b. To change (expand or decrease) status/privileges.
    c. To deny or terminate status/privileges.

7. If the Committee anticipates making an adverse recommendation, the applicant must be notified in writing of the proposed adverse recommendation and the stated reasons, and be given an opportunity to provide additional information.

8. The Clinic's Credentialing Committee or its designee, will forward the necessary information to the Clinic's Governing Board. The authority for final action on the recommendation to grant privileges to licensed and certified staff lies with the Clinic's Governing Board. The Board is responsible for the final action to accept, modify or deny the privileges recommended. The president or the secretary of the Board on behalf of the Board signs the Re-credentialing Report.

Re-credentialing activities after Board action

Once the Board has approved a volunteer for privileges or scope of practice, several actions must be completed:

4. A signed copy of the re-credentialing report will be placed in the credentialing file.

5. Applicants are then notified of acceptance/rejection of application.

6. During the period between re-credentialing, the Clinic Credentialing Coordinator should have in place a system to verify renewal of any dated or renewable authorizations. These verifications should be kept in each volunteers credentialing file and will apply to re-credentialing.

    a. License/Certification
    b. Board Certification
    c. DPS Registration
    d. DEA Registration
    e. Malpractice Insurance

f. CPR certification
g. Re-credentialing due date

Special Re-credentialing Considerations

If a volunteer's scope of practice changes significantly during the credentialed period, re-credentialing should take place at the time of the change, and then again two years after that date.

Confidentiality

All credentialing and privileging activities are to be considered confidential.

Credentialing Program Evaluation

The credentialing program will be periodically reviewed to make sure that it is accomplishing its goals. If needed, adjustments will be made to the program. These adjustments and improvements will be reported to the Clinic's Governing Board.

Attachments

Certification of Ability to Perform Volunteer Role

As part of my volunteer service at CLINIC NAME, I understand that my licensure/credentials are verified prior to the beginning of my service and on an annual basis thereafter. My signature below indicates that I have not involuntarily lost or had reduced my privileges or duties at another health care facility, that I have maintained all relevant licensure, received all relevant and required education, and am in all ways capable of providing medical care as a volunteer at CLINIC NAME. I further understand that should my ability to perform my duties change, I will notify Clinic personnel immediately to either change the scope of or terminate my volunteer service.

_____ _____

Volunteer Signature Date

_____

Volunteer Printed Name

_____ _____

NAME, Executive Director Date

Section III – Credentialing and Privileging Systems

A. The Clinic verifies licensure for all volunteer health care professional annually. RNs are verified in October and physicians are verified in August; these dates coincide with annual re-application deadlines.
B. The Clinic maintains a copy of each volunteer health care professional's current license and/or registration in their Volunteer Personnel file.
C. The Clinic verifies Board eligibility or certification for each volunteer health care professional on the same schedule as licensure verification (please see A. above).
D. The Clinic utilizes Peer Review activities when periodically privileging volunteer health care professionals; peer reviews are conducted annually and precede the verification schedule.
E. The Clinic requires health care volunteers to demonstrate evidence of fitness to perform expected health care duties; evidence consists of _____.
F. The Clinic has a copy, when applicable, of each volunteer health care professional's hospital privileges on file; the copy is maintained in their individual Volunteer Personnel file.
G. The Clinic reviews each volunteer health care professional's history of prior and current malpractice claims: for new volunteers, this review occurs at the time of volunteer orientation/beginning. For current volunteers, the review coincides with annual licensure/eligibility reviews.
H. During the credentialing process of volunteer health care professionals, the NPDB is utilized as a source of information for verifying volunteer professionals' information.

Description of Risk Management Systems: Sample Documents

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Risk Management	

PURPOSE

The CLINIC NAME has a risk management program that is for the express purpose of lowering any Clinic risks and ensuring patient, staff, volunteer and Clinic safety.

OBJECTIVES

1. To provide mechanisms that help ensure the least possible risk in all Clinic systems, including administrative, personnel, and clinical.
2. When needed, to have systems in place that respond to identified risks in an organized and structured manner.
3. To help measure and improve all Clinic systems.

SCOPE

The Clinic's Risk Management Systems cover the following areas of Clinic functioning:

- Volunteer Practitioner Credentialing and Privileging
- Patient Care
- Quality Assurance
- Peer Review

(While Personnel and Volunteer policies and procedures are not designated components of the Risk Management program, these policies and procedures do help to ensure minimum risk to staff, volunteers, patients and to the Clinic.)

RESPONSIBILITIES

Governing Board:

The Clinic's Governing board has ultimate responsibility for all Clinic functions. This includes implementing and maintaining activities that will help ensure quality care while lowering the possibility of any type of risk for patients, staff, volunteers and the Clinic.

Board Committees:

Board Committees are appointed with specific functions and are responsible for making the promotion of risk management part of all committee plans, actions and recommendations.

Executive Director:

On a day-to-day basis, the Clinic's Executive Director is responsible for overseeing any Clinic activities, including those designed to promote risk management. The Executive Director is also responsible for reporting on an ongoing basis all information concerning clinic risk management to the Governing Board.

PROCEDURES

Individual risk management activities shall have outlined operating procedures. These shall be used in conducting any activities regarding risk management activities.

COMMUNICATION OF RISK MANAGMENT ACTIVITIES

All activities (i.e. Quality Assurance) will submit reports to the appropriate committee and/or the Governing Board of the Clinic. These reports shall be in writing and shall include recommendations or action plans for the improvement of Clinic functions.

CONFIDENTILITY

When appropriate risk managements activities will remain confidential.

RISK MANAGEMENT EVALUATION

Individual Risk Management programs have their own outlined evaluation criteria. The Clinic's Governing Board will accept these individual evaluations and determine if any actions/changes need to occur to ensure the best possible overall Risk Management program for the Clinic.

RISK MANAGEMENT TRAINING EDUCATION

Education and training programs are outlined in each Risk Management Program.

CLINIC NAME	***Volunteer Continuing Risk Management Education***	Policy Approved by Board of Trustees DATE
		Reviewed/Revised/ Approved by Board of Trustees DATE

Purpose of Policy

The purpose of this policy is to ensure that the Clinic's volunteer health care professionals annually participate in risk management continuing education activities.

Policy

Volunteer health care professionals shall engage in all continuing education as required to maintain licensure: this includes _____ [risk management topics]. In the event that a topic not need to be reviewed annually for licensure, the Clinic will provide in-house education on current risk management topics.

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Quality Assurance Program	

PURPOSE

The CLINIC NAME's mission is to:

> "provide medical, legal, counseling and dental services to individuals and families, regardless of their ability to pay."

To help meet our mission and to ensure the delivery of high quality services to our patients, The CLINIC NAME has established a Quality Assurance (QA) program to ensure the delivery of high quality services. The Quality Assurance Program also serves to evaluate that Clinic functions, (i.e. administrative, personnel or clinical) are operating at the most effective level possible to ensure the maximum protection of clients, staff, volunteers and the Clinic itself.

OBJECTIVES

1. To improve quality care and service by establishing a patient focused process of improvement.
2. To measure and improve all clinic aspects including governance, administrative, support and clinical processes that most affect patient outcomes.
3. To provide a mechanism to implement, measure and assess the goals and objectives as defined by the Clinic's Governing Board.
4. When necessary, use Quality Assurance findings to modify policies and procedures to improve patient care.
5. To provide objective data to be used in the evaluation and re-credentialing process for professional volunteers. Likewise, to use findings from peer reviews when evaluating Quality Assurance Programs.

SCOPE

The Quality Assurance process shall encompass all functions of patient care and support services provided within this organization and include any appropriate form of contracted service. Through the support of the Governing Board, administrative and clinical staff and volunteers shall participate in Quality Assurance activities when appropriate. Quality Assurance activities shall be carried out in accordance with all appropriate rules and

regulations.

RESPONSIBILITIES

Governing Board:

The Clinic's Governing Board shall approve for use and implementation the Quality Assurance Program. The Governing Board shall ultimately be responsible for the delivery of quality services. It is also responsible for setting priorities for ongoing measurement, and ensuring that adequate resources and information systems are available to support the program functions.

Quality Committee:

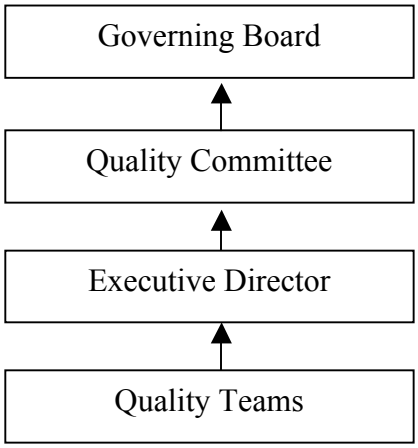
The Governing Board may appoint a "Quality Committee". This "Quality Committee" shall consist of the Dental and/or Medical Director, Executive Director, appropriate program coordinator(s) and any other staff or volunteers deemed necessary. The "Quality Committee" has the responsibility to review all Quality Assurance activities conducted within the Clinic and receives reports from the Executive Director and/or individual "QA Teams".

Executive Director:

The Clinic's Executive Director shall be responsible for the coordination and monitoring of individual Quality Assurance Plans as they are implemented throughout the Clinic. The Executive Director is also responsible for ongoing reporting to the Governing Board regarding QA programs in process.

Quality Teams/Program Coordinator:

When appropriate, "Quality Teams" will be appointed within the different clinic programs with appropriate personnel. (i.e. A medical quality assurance program would have as part of the team, the medical coordinator, staff nurses, and other medical volunteers.)



PROCEDURES

The QA process shall be an organized multidisciplinary approach with a patient focus. Emphasis shall be on processes, system improvements and initiating action when a problem is identified. The following Quality Assurance techniques may be incorporated in the Quality Assurance Process:

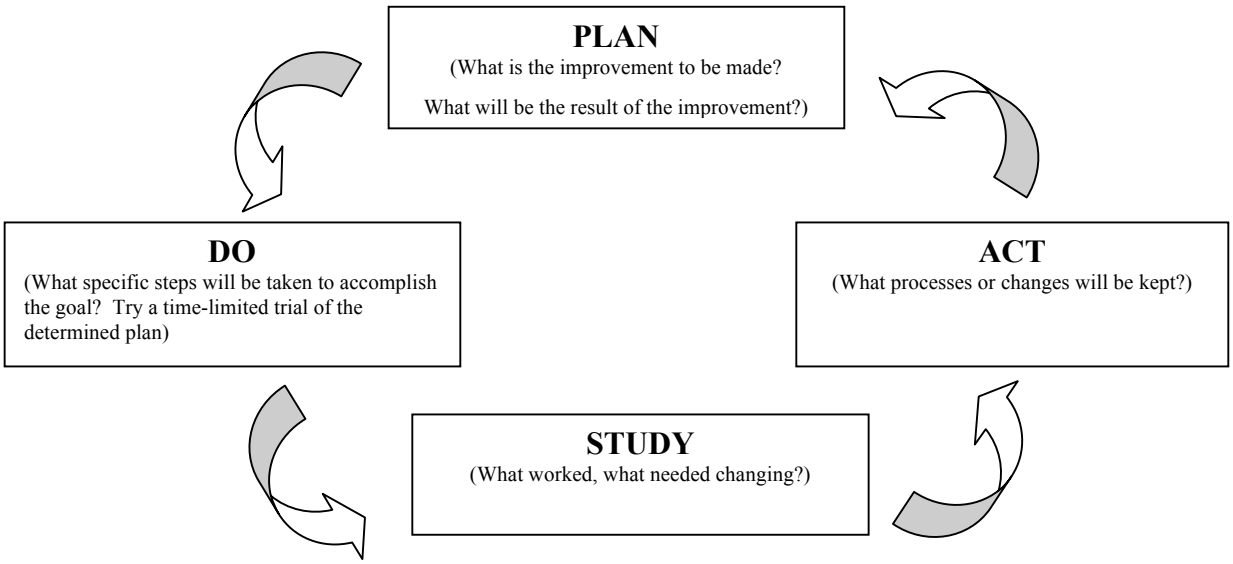
- Identification of Clinic-wide key performance functions/processes
- Prioritizing these functions/processes for ongoing measurement, assessment and improvement
- Development of Quality Assurance indicators
- Collection and communication of data
- Feedback from patients
- Assessment of data collected
- Evaluation of improvement activities

(The peer review process, when an issue, shall be handled through the appropriate Dental/Medical Committee.)

The PDSA Quality Assurance Model shall be used in all Quality Assurance Processes and Plans:

PDSA Quality Assurance Model

1. PLAN: Identify the objective. Predict what will happen. Develop a way to implement.
2. DO: Carry out the plan. Note problems/unexpected results. Gather data for analysis.
3. STUDY: Analyze your findings. Compare to your predictions. Reflect on what you have learned.
4. ACT: Decide what modifications to keep.



COMMUNICATION OF QUALITY ASSURANCE ACTIVITIES

A written report of all Quality Assurance activities shall be prepared by each Program Coordinator or QA Team Leader and presented to the Clinic's Executive Director, to the Quality Committee and the Governing Board. This report shall include documentation of all department specific Quality Assurance activities.

The team leader, following implementation of the improvement plan, shall submit a further report to the Quality Committee. This report shall include the finalized improvement plan, any revised policies and procedures, retraining schedule, and date for process to be remonitored to ensure stability of the process.

On at least a yearly basis, reports summarizing the Clinic-wide Quality Assurance activities are submitted to the Quality Assurance Committee and subsequently to the Governing Board. This report shall also include information on teams that may be in place and the status of the teams' recommendations.

CONFIDENTIALITY

Quality Assurance activities including peer review, team activities and team reports are protected as confidential.

QUALITY ASSURANCE PROGRAM EVALUATION

The Quality Committee shall conduct an annual review of the QA program to assess its effectiveness. This review shall include; evaluation of the effectiveness of the overall process, improvements realized, and the status of ongoing Quality Assurance activities. Results of this evaluation shall be used to improve the organizational QA process. The results of the evaluation shall be submitted to the Governing Board.

QUALITY ASSURANCE PROGRAM TRAINING

All persons involved in the organization and operation of The CLINIC NAME shall receive an orientation to the Clinic-wide Quality Assurance Program.

CLINIC NAME	***Quality Improvement Plan***	Policy Approved by Board of Trustees DATE
		Reviewed/Revised/ Approved by Board of Trustees DATE

Purpose of Policy

The purpose of this policy is to ensure that the Clinic has a written, current QA plan.

Policy

The Clinic shall maintain and adhere to a written Quality Improvement Plan. The Plan shall be updated at least annually, and approved by the Board of Trustees. The Executive Director is responsible for making sure that the Plan is followed and that results of Plan activities are forwarded to the Board, staff, and others as appropriate.

CLINIC NAME	***Quality Improvement Review***	Policy Approved by Board of Trustees DATE
		Reviewed/Revised/ Approved by Board of Trustees DATE

Purpose of Policy

The purpose of this policy is to ensure that the Clinic has regular, periodic meetings to review and assess Quality Improvement issues.

Policy

Quality Improvement issues are addressed at each Board meeting (every other month) and among Clinic staff as needed. As there are only three full-time Clinic staff, there is no formal QI Committee; rather, the Executive Director maintains primary responsibility for carrying out QI activities and reporting the results as necessary. The Board of Directors is updated regularly on these activities and results.

CLINIC NAME	***Peer Review Findings in QI Plan***	Policy Approved by Board of Trustees DATE
		Reviewed/Revised/ Approved by Board of Trustees DATE

Purpose of Policy

The purpose of this policy is to ensure that the Clinic considers findings from its peer review activities when reviewing and/or revising its Quality Improvement Plan.

Policy

Each year, when the QI Plan is revised, results from the preceding year's Peer Reviews are considered and addressed in the Plan as appropriate.

CLINIC NAME	***Utilization of QI Findings***	Policy Approved by Board of Trustees DATE
		Reviewed/Revised/ Approved by Board of Trustees DATE

Purpose of Policy

The purpose of this policy is to ensure that the Clinic utilizes Quality Improvement findings to modify policies to improve patient care.

Policy

Quality Improvement findings shall be utilized to modify policies to improve patient care as described in the Quality Improvement Plan.

Attachments

Attachment X: Quality Improvement Plan

CLINIC NAME	***Quality Improvement Plan FY2010***

Purpose of Quality Improvement Plan

The CLINIC NAME (the Clinic) exists to provide medical and dental care to residents of Lake, Geauga, and Ashtabula Counties free of charge. The organization places great emphasis on creating and maintaining internal processes that guide the development, evaluation, and improvement of its programs and the services it provides.

The Quality Improvement (QI) Plan addresses the internal operations and functions of the Clinic and should serve as a guide for the continuous evaluation and improvement of those operations. An annual review of the Plan will be conducted to ensure that its contents remain relevant and reflective of current best practices in QI.

Quality Improvement Structure

QI Goals

- Ensure the availability of high-quality and accessible medical and dental services to residents of Lake, Geauga, and Ashtabula counties.
- Integrate continuous QI into the Clinic's practices to promote efficient and effective organizational operation
- Promote QI among staff and volunteers to ensure that clients receive high-quality care regardless of practitioner
- Evaluate and monitor the design and delivery of programs and services to ensure that they are consistent, cost-effective, and responsive to clients' needs
- Oversee the expenditure of funds to ensure fiscal responsibility and accountability

QI Objectives

- Continuous evaluation of the service delivery system to identify opportunities for changing programs in response to client needs, incorporating evidence-based best practices into programming, eliminating barriers to client access to services, and correcting deficiencies in service provision
- Monitor compliance with all state, federal, and/or other applicable rules and regulations by practitioners.
- Annual review of the Clinic's achievement of QI goals/objectives
- Facilitate communication of the Clinic's QI activities to its staff, contract providers, volunteers, consumers, and the public
- Solicit and support input and feedback from community agencies/stakeholders, patients and their families, and the public

Clinic Staff and Volunteers

The Clinic's Executive Director, in conjunction with the Nurse Manager and the Medical Director, is responsible for carrying out the tasks that are central to the successful implementation and monitoring of QI initiatives. The Executive Director is responsible for overseeing QI activities, and reports to the Chair of the Board of Trustees.

QI Committee

The purpose of the QI Committee is to monitor Clinic operations to ensure efficient and effective delivery of service by all Clinic staff and volunteers. Standing members of the Committee include the Executive Director, Medical Director, and Nurse Manager.

The Committee shall regularly discuss and review topics relevant to the successful delivery of services by the Clinic. These topics may include results of peer review activities, surveys and other QI instruments, and any other relevant issues. The QI Committee shall be chaired by the Executive Director and will meet semi-annually and as needed outside of scheduled meetings.

Quality Improvement Activities

Identification, development, and implementation of QI activities

QI projects are identified in a variety of ways: some are ongoing, prescribed activities (e.g., peer review) and others are short-term activities resulting from identification of trends or patterns indicating a need for improvement (e.g., from results of a survey or peer review finding). Other activities may arise out of staff or volunteer concern about a particular issue.

QI activities are carried out following the Plan-Do-Study-Act model:

- Plan: plan a change or test aimed at improvement
- Do: carry out the change or test, preferably on a small scale
- Study: study the results of the change or test (What did we learn? What went wrong?)
- Act: adopt the change, abandon it, or (if necessary) complete the cycle again

Internal QI activities

Internal Incident Review

An internal incident is defined as any event that threatens:

- the health and/or welfare of Clinic staff, volunteers, or patients
- the normal functioning or planned activities of the Clinic

The purpose of internal incident review is to preserve a safe and normally-functioning work environment at the Clinic. The QI Committee will review internal incidents at each meeting.

Peer Review

Peer review is an essential component of QI at the Clinic. Minimally, medical records are reviewed by practitioners twice per year. The process involved review of records by individuals in the same discipline (e.g., physicians review other physicians' notes, RNs review other RNs' notes, etc.). This is the primary method by which service delivery is evaluated.

Satisfaction Surveys

Internal QI Survey

The Internal QI Survey will solicit feedback from staff and volunteers about the Clinic in the following areas:

- job satisfaction
- communication
- coordination/leadership
- decision-making
- motivation/morale
- group cohesion
- professional growth

The survey is to be administered annually by the Executive Director. Surveys will be administered electronically (utilizing Survey Monkey) and in a way that ensures anonymity so that respondents may feel free to answer honestly.

External QI Survey

The External QI Survey solicits feedback from the community about the Clinic's performance in the following areas:

- services provided
- availability of services
- accessibility of services
- other areas to be determined

At an interval yet to be determined, this survey will be administered electronically and in a way that ensures anonymity so that respondents may feel free to answer honestly.

Suggestion Box

The Clinic will install a suggestion box in order to allow patients (and any others that are so inclined) to suggest ways to improve services at the Clinic. Contents of the boxes are to be collected by the Executive Director, held confidential, and reported in aggregate (except in the instance where further investigation of an individual suggestion is warranted).

Risk Management

Purpose/Objective

Risk management is an essential component of Clinic operations, as it guides policies and procedures in a way that monitors and lowers risk to the safety of patients, staff, volunteers, and the Clinic as a whole. Risk management also provides direction for addressing situations that require revising or creating policies to further reduce risk.

The purpose of continuously monitoring risk is to ensure that the Clinic promotes practices that protect its patients, staff, and volunteers.

Scope of Risk Management Activities

Risk Management policies are in effect relating to topics including:

- Patient Care
- Volunteer Practitioner Credentialing/Privileging
- Staff Training
- Fiscal Practices

This is not an exhaustive list, and policies in each of these areas can be found in the Clinic's policies.

Documentation and Reporting of QI activities

All Quality Improvement-related activities will be documented (e.g., meeting minutes, completed surveys) and will be maintained by the Executive Director, who will shall prepare annual reports summarizing QI activities. Results will be shared with both the Quality Improvement Committee and the Board of Trustees.

Monitoring and Evaluation

QI project evaluation will follow the Plan-Do-Study-Act model (described earlier). QI reports and findings from QI projects will be forwarded to the Board of Trustees through the Executive Director.

Review and Approval

The Board of Trustees shall review and approve the CLINIC NAME Quality Improvement Plan each year.

FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

Notice of Limited Liability of FTCA Deemed Free Clinic Health Care Professionals

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service.

This FTCA medical malpractice coverage applies to deemed free clinic health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)).
The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997 may cover certain free clinic health care professionals providing health care services to patients at this free clinic.

Acknowledged:

_____
(Patient signature)

_____
(Patient name, printed legibly)

_____
Date

Acknowledgment of Receipt of FTCA and Consent to or Declination of Coverage

_____ This is to certify that I have received, read, and had an opportunity to ask questions about the Federal Tort Claims Act Coverage of Free Clinic Volunteer Health Care Professionals (FTCA). I understand that this is the policy by which my work at CLINIC NAME will be covered.

_____ This does not apply to me, as I do not need coverage through CLINIC NAME (evidence of coverage attached).

_____ _____
Volunteer Signature Date

_____
Volunteer Printed Name

_____ _____
NAME, Executive Director Date

CLINIC NAME	***FTCA Explanation***	Policy Approved by Board of Trustees DATE
		Reviewed/Revised/ Approved by Board of Trustees DATE

Purpose of Policy

The purpose of this policy is to ensure that each health care volunteer has a copy of PIN 2004-24 (Revised) and that his/her questions re FTCA medical malpractice coverage have been addressed.

Policy

Volunteers shall be given an overview (written and verbal) of FTCA, including a copy of PIN 2004-24 (Revised) as part of volunteer recruitment and/or orientation. When a volunteer becomes active with the Clinic, an Acknowledgment of FTCA explanation shall be signed and placed in their volunteer file. Volunteers that are currently active have been provided FTCA information and will be provided with PIN 2004-24 before submission of application for FTCA.

CLINIC NAME	***Clinical Supervision and Back-up***	Policy Approved by Board of Trustees DATE
		Reviewed/Revised/ Approved by Board of Trustees DATE

Purpose of Policy

The purpose of this policy is to ensure that the Clinic has policies and procedures in place for the provision of appropriate supervision of and back-up for clinical staff.

Policy

The Director of Nursing (full-time staff position) supervises all nursing and medical assistant staff and volunteers and provides clinical back-up for these positions. In the event that the Director of Nursing is not available, the Nurse Manager is responsible for supervision and back-

up. The Medical Director (volunteer position) supervises all physicians. All physicians are volunteer and staff clinics by themselves; if they are unavailable to conduct a clinic, the clinic is cancelled and all scheduled patients are rescheduled or referred elsewhere if rescheduling is not possible.

Attachments

None.

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Peer Review	

PURPOSE

The CLINIC NAME maintains a peer review program to help ensure that practitioners deliver high quality and appropriate treatment to Clinic patients. A peer review program also helps to ensure the maximum protection of clients, staff, volunteers and the Clinic itself.

OBJECTIVES

1. To ensure appropriateness of patient treatment
2. To help ensure Practitioner's continued competence
3. To provide a mechanism for improvement of Practitioner's care
4. To provide objective data to be used in the re-credentialing process for Practitioners
5. To provide information for Quality Assurance Activities

SCOPE

The peer review process will encompass all activities of the Volunteer Practitioner.

RESPONSIBILITIES AND STRUCTURE

Governing Board:

The Clinic's Governing Board wills appointment a Peer Review Committee; in most circumstances this will be comprised of the Clinic's dental/medical committees.

The Governing Board will have the ultimate responsibility for taking action in response to a Peer Review Committee report.

Peer Review Committee:

This Peer Review Committee will be made up of the Dental/Medical Director, other Volunteer Practitioners, Executive Director, the appropriate program coordinator and when necessary outside consultation.

The Peer Review Committee is responsible for conducting all peer review activities, and making any recommendations regarding necessary action based upon peer findings.

Executive Director:

The Clinic's Executive Director shall sit in on each peer review activity and ensure that these activities are carried out on a regular basis. The Executive Director in conjunction with the Peer Review Committee is responsible for ongoing reporting of Peer Review activities to the Clinic's Governing Board.

All employees and volunteers have the responsibility to report any activities that they feel may need to be part of a Peer Review program.

PROCEDURES

Peer review may include but is not limited to the following:

- Periodic review of patient charts to review a Practitioner's actions
- Direct observation of Practitioners by the Program Coordinator
- Direct observation of the Practitioner by the Dental/Medical Director
- Interview by the Dental/Medical Director
- Obtaining references from outside sources familiar with the Practitioner's work

COMMUNICATION OF PEER REVIEW ACTIVITIES

Peer review activities will be reported by the Peer Review Committee to the Clinic's Governing Board.

The Governing Board will make the final decision regarding Peer Review recommendations with instructions communicated to the Clinic's Peer Review Committee.

The Peer Review Committee will keep the Governing Board apprised of any current Peer Review activities as well as follow-up needed from prior Peer Review Activities.

If any restrictive action is to be taken, the head of the Peer Review Committee will submit in writing to the Practitioner in question, the committee's recommendations including any improvement plans or dismissal, if appropriate.

In the event of a Peer Review Committee, if events are discovered that merit reporting to the Practitioner's Board of Licensing, this shall be done the Clinic's Dental/Medical Director.

The Peer Review Committee, following implementation of committee action plans in regard to practitioner improvement, shall submit a further report to the Governing Board.

CONFIDENTIALITY

Peer Review Activities are considered confidential and are not to be shared outside the scope of what has been discussed above**.**

PEER REVIEW EVALUATION

Periodically, the Peer Review Committee will review the Peer Review Program to make sure that it is effective, efficient and meets Clinic needs. Findings of this review shall be submitted to the Clinic's Quality Assurance Committee and to the Clinic's Governing Board.

PEER REVIEW PROGRAM TRAINING

All persons involved in Peer Review will be trained and educated as to the purpose, techniques and responsibilities involved.

Approved by: _____

NAME
Medical Director

Date: _____

Patient Care

PURPOSE

The Clinic maintains policies and guidelines on patient care to help ensure the highest quality care delivered.

OBJECTIVES

1. To help ensure the delivery of quality care to Clinic patients from triage to treatment.
2. To have systems in place that document, track and keep confidential patient information.
3. To ensure that practitioners are following generally acceptable practice protocols.

SCOPE:

Patient Care Policies cover the following areas

- Staffing and Supervision
- Documentation and Tracking
- Triage
- Treatment Protocols

RESPONSIBILITIES

Governing Board:

The Clinic's Governing Board has the ultimate responsibility for ensuring quality patient care. The Governing Board will receive reports from various committees, the Executive Director and appropriate program coordinators to keep apprised of clinic functions and systems. When necessary the Governing Board will implement policy or system changes all in the best interest of the patient and of the Clinic.

Board Committees:

Board Committees are appointed with specific functions to oversee and evaluate the delivery of patient care. These committees are also charged with formulating recommendations to be given to the full board for approval and/or action.

Executive Director:

The Clinic's Executive Director has the day-to-day responsibility to oversee the delivery of patient care. It is also his/her responsibility to ensure that all systems, policies, functions are carried out in the appropriate manner to ensure the delivery of high quality care.

PROCEDURES

The following procedures will be used to address the scope of patient care:

Staffing and Supervision:

The CLINIC NAME is staffed by both paid employees and professional and support volunteers. (The conduct of the paid staff, job expectations and supervision arrangements. are outlined in the Clinic's Personnel Policies as well as individual job descriptions. The below policies primarily pertain to volunteer professionals.)

The CLINIC NAME has systems in place that help ensure the best possible patient care including supervision and back-up of Clinical Staff. This system consists of the following provisions:

- Each Practitioner is licensed in the State of California and is under the direction of the Dental/Medical Director.
- Each Practitioner has completed the Clinic's Credentialing and Privileging Process, and the Dental/Medical Director, the Credentialing Committee and the Governing Board approve the application.
- All new health care personnel attend orientation with the Volunteer Coordinator who orients them to the policies of the Clinic as outlined in the Volunteer Training, Policy and Procedure Manual.
- Volunteer policies encompass general rules regarding the Clinic. Specific guidelines regarding the area of volunteering will be the responsibility of the coordinator or supervisor for that area.
- The Volunteer Coordinator is responsible for securing the necessary personnel for each scheduled clinic.

Documentation and Tracking:

- The CLINIC NAME maintains a record of care on each patient receiving care at the Clinic. Further, each patient's information is entered into a secure database which also stores this information.
- Patient charts are periodically reviewed to help ensure the delivery of quality services.

- Patients who miss appointments will have their charts marked in red with the letters DNKA (did not keep appointment).
- Patients who are scheduled for referrals, x-rays or laboratory tests will have a tracking slip and a copy of the order or referral attached to the front of the chart.
    - Charts of patients who are scheduled for further testing or referrals will be maintained in a separate filing area until the results have been received.
    - The Administrative Assistant or other designated staff person, will be responsible for checking for completion of these exams and providing the results to the Practitioner for review and recommendations.
- No patients are admitted to the hospital directly from the Clinic. Patients of the Clinic who are admitted to the hospital via the emergency room will be rescheduled for follow-up at the Clinic.

Triage:

- The CLINIC NAME is not equipped to handle emergency dental/medical care; therefore, any patient walking in with acute or life threatening symptoms will be referred to a local emergency department.
- Patients with an appointment will be assessed by a dental assistant or nurse prior to being seen by the Practitioner on duty. Any urgent findings will be relayed to the Practitioner as soon as possible.
- Since all patients are seen by appointment, walk-in patients will be instructed how to make appointments, will be worked-in depending on the situation, or will be referred to other facilities.
- Each Volunteer or Staff person answering the telephone or speaking to a patient who has walked into the Clinic will take all the necessary patient information and relay that information to the Dental/Medical Coordinator. The Dental/Medical Coordinator will talk with the Practitioner on duty and instruct the patient accordingly. Documentation of the phone call and any prescribed intervention will be made in the patient's chart.

Treatment:

Patient treatment is done by licensed volunteers or paid professionals. The CLINIC NAME has protocols that define appropriate treatment and diagnostic procedures for selected conditions. These treatment protocols are obtained from the National Guideline Clearinghouse™ (NGC), a public resource for evidence-based clinical practice guidelines. (NGC is an initiative of the Agency for Healthcare Research and the U.S. Department of Health and Human Services.) Copies of these treatment protocols for the most commonly diagnosed diseases at the Clinic are kept in the Clinic and are made available to all practitioners.

When, due to limited resources of the Clinic, treatment deemed necessary by a Practitioner is not available at the Clinic, patients are referred to other resources to seek the needed care.

CLINIC NAME	***Triage***	Policy Approved by Board of Trustees DATE
		Reviewed/Revised/ Approved by Board of Trustees DATE

Purpose of Policy

The purpose of this policy is to ensure that the Clinic has policies and procedures that address triage, walk-in patients and telephone triage.

Policy

Each patient that presents to or calls the clinic is triaged. Scheduled patients are triaged by the nurse and then seen by the physician they are scheduled to see. Walk-in patients are informed that the Clinic does not see walk-in patients as a rule, but are triaged for medical severity and, if warranted, are seen immediately by an available nurse and/or physician. In the absence of a medical professional, patients who present with symptoms they believe warrant immediate medical care are instructed to proceed to the Emergency Room. Where needed, the Clinic will facilitate this process by calling an ambulance for the patient. Telephone contacts are treated in the same manner: if the patient needs to be seen emergently, they will be given the next available appointment. In the event that there are no same-day appointments and the patient feels that he cannot wait until the next available appointment, he will be advised to proceed to the nearest Emergency Room.

CLINIC NAME	***Diagnostic and Treatment Procedures***	Policy Approved by Board of Trustees DATE
		Reviewed/Revised/ Approved by Board of Trustees DATE

Purpose of Policy

The purpose of this policy is to ensure that the Clinic has protocols that define appropriate treatment and diagnostic procedures for selected medical conditions based on current standards of care.

Policy

All clients are seen by practitioners who provide care within the guidelines of the appropriate regulatory body.

ADD ADDITIONAL INFO FROM EXISTING POLICY

Attachments

None.

CLINIC NAME	***Patient Follow-up***	Policy Approved by Board of Trustees DATE
		Reviewed/Revised/ Approved by Board of Trustees DATE

Purpose of Policy

The purpose of this policy is to ensure that the Clinic has a tracking system for patients who miss appointments or require follow-up for referrals, hospitalizations, x-rays, or lab results.

Policy

Missing appointments

When patients are unable to keep appointments, they are asked to call the Clinic to reschedule. In the event that a patient misses two appointments in a row, without calling to reschedule, s/he is sent a letter notifying them that their case is being closed. They will be notified that they are welcome to return to the Clinic should they continue to need our services. We will not maintain open records for patients that do not keep appointments.

Follow-up: appointments

Follow-up appointments are scheduled for patients following appointments they have at the Clinic. Reminder calls are made one or two days before the appointment in order to decrease the likelihood of patients no-showing for appointments.

Follow-up: results

When the Clinic receives lab or x-ray results that are abnormal, the treating physician contacts the patient (if necessary, Clinic staff notify the physician of the result, and the physician contacts the patient). Chronic care patients are seen on a regular basis and provided with lab work or other tests as appropriate to their long-term care.

Attachments

None.

CLINIC NAME	***Medical Records***	Policy Approved by Board of Trustees DATE
		Reviewed/Revised/ Approved by Board of Trustees DATE

Purpose of Policy

The purpose of this policy is to ensure that the Clinic maintains a Medical Record for everyone receiving care from the organization.

Policy

Medical records are opened for each client upon their first visit to the Clinic. Opening paperwork includes demographic information, reporting of income (to verify inability to pay for services elsewhere), Notice of Privacy Practices, and all other appropriate and relevant documentation. Files are updated by the addition of progress notes at each subsequent visit. Each practitioner that sees the patient documents the visit (including what took place and recommendations/instructions). In the event that a client fails to show for a visit (without canceling or rescheduling), that is noted in the chart on the date that the no-show takes place. Records are never destroyed or disposed of, and are all maintained at the Clinic.

Attachments

Attachments X – XXX: Intake Paperwork

CLINIC NAME	***Record Review***	Policy Approved by Board of Trustees DATE
		Reviewed/Revised/ Approved by Board of Trustees DATE

Purpose of Policy

The purpose of this policy is to ensure that the Clinic periodically reviews patients' medical records to determine quality, completeness and legibility.

Policy

At least once per quarter [is this right, or is it once per year?], the Clinic conducts peer review to ensure quality of medical record-keeping. Records are reviewed within discipline (i.e., physicians review other physicians' records, nurses review other nurses' records, etc.) and are reviewed according to a set list of questions/criteria. Any issues that need to be addressed as a result of the review are brought to the record-writer's attention either by the reviewer or a staff person, who will also monitor follow-up to ensure that the problem is corrected and does not persist.

Attachments

Attachment X: Peer Review Form