

NEVADA CRITICAL ACCESS HOSPITAL (CAH) PROGRAM QUALITY ASSURANCE and CREDENTIALING AGREEMENT

I. PARTIES

This is an agreement between (*Hospital*) and (*QA/Credentialing Entity*) with respect to the periodic review and evaluation of the quality assurance and credentialing activities of (*Hospital*). A condition of participation as a Critical Access Hospital (CAH) is that the hospital has “An agreement with respect to credentialing and quality assurance...with...one other appropriate and qualified entity in the State rural health care plan.” It is recognized that quality assurance is an ongoing, objective and systematic process of monitoring and evaluating that must include identification and correction of problems.

II. TERMS OF AGREEMENT

This agreement is effective upon the granting to (*Hospital*) of status as a Critical Access Hospital, and will remain in effect indefinitely provided that the hospital is a member of (*QA/Credentialing Entity*). This agreement is contingent upon (*Hospital*) meeting any requirements for Critical Access Hospital status, including any renewal of such status. (*QA/Credentialing Entity*) reserves the right to terminate this agreement at any time should (*Hospital*) lose its CAH status for any reason. Furthermore, (*Hospital*) agrees to hold (*QA/Credentialing Entity*) harmless from and against any and all incidents that may affect the determination of continuing CAH status of (*Hospital*) in the performance of this agreement.

III. CONDITIONS OF AGREEMENT

1. As a Critical Access Hospital, (*Hospital*) is required to have “An agreement with respect to credentialing and quality assurance...with...one other appropriate and qualified entity” identified in the State rural health care plan.
2. (*QA/Credentialing Entity*) has been identified by the State Office of Rural Health as such a qualified entity. [*Describe any history you may have with the (QA/Credentialing Entity), for example:*] During the past eleven years, (*QA/Credentialing Entity*) has provided and continues to provide ongoing support and assistance with respect to quality assurance, quality improvement, and credentialing efforts, including, but not limited to, the following products and services:

Development of Model Medical Staff Bylaws - Written in 1990 and revised in 1997, this model is designed to assist Participants with compliance with the Healthcare Quality Improvement Act, and to give appropriate structure to this self-governing body.

Physician Peer Review Network - Assists hospitals with objective physician peer review. Questionable cases can be forwarded through the Chief of Staff to another

hospital outside the geographic region. A report of findings is provided to the referring facility.

Medical Affairs Risk Management Education - Service provided through quarterly Network meetings. Topics have included peer review, handling disruptive physician behavior, and self-governance.

Medical Staff Education – Separate educational service. Topics include documentation, risk management, EMTALA and other regulatory compliance issues.

High Risk Emergency Medicine – A two-day seminar that provides clinical updates on the current standard of practice on high-risk patient diagnosis. Practice parameters are disseminated and incorporation into the Participant’s practice is strongly encouraged. Educational expense reimbursed.

Quality Review Reports – Service provided to all Participants upon request. This form allows hospital management to collect data on quality indicators, high volume and high-risk occurrences.

Monthly Trending Report – Available to all Participants that request this service. Individual Participant data is compiled and compared to all other Participants. Currently, aggregate data is provided in table format. Future trending reports will include control charts and Pareto diagrams.

Quality Improvement Educational Update – Service provided to all Participants every December. A national leader in quality improvement conducts a one-day seminar on data collection and statistical analysis with an emphasis on the improvement cycle and lessons learned.

Quality Improvement and Education Program Development and Review – Service provided on an ongoing basis, upon request. Bimonthly Newsletters on quality and risk management issues are sent to all Participants.

Board Education - Service includes presentations to the board upon request, and a quarterly newsletter that focuses on the governing body(ies)’s role in quality and risk management.

3. At initial granting of Critical Access Hospital status, (*Hospital*) agrees to become a participant in the quality assurance and credentialing activities outlined below.

Quality Assurance

1. Within 90 days of the granting of Critical Access Hospital status to (*Hospital*), (*QA/Credentialing Entity*) will conduct an on-site evaluation of (*Hospital*) quality assurance policies and procedures.

2. Within 30 days of the evaluation, (*QA/Credentialing Entity*) will send a written report to (*Hospital*) outlining the findings of the review and making recommendations for corrections of any deficiencies noted (corrective action plan).
3. Within 90 days of receipt of (*QA/Credentialing Entity*)'s staff report and corrective action plan, (*Hospital*) will demonstrate to the satisfaction of (*QA/Credentialing Entity*)'s staff that the hospital is in substantial compliance with the recommendations of (*QA/Credentialing Entity*).
4. No less than annually thereafter, (*QA/Credentialing Entity*)'s staff will conduct an evaluation of (*Hospital*)'s Quality Assurance activities to insure continued performance and status as a CAH.

Credentialing

1. Within 90 days of the granting of Critical Access Hospital status to (*Hospital*), (*QA/Credentialing Entity*) will conduct an on-site review of (*Hospital*)'s medical staff credentialing process to determine the adequacy and effectiveness of the credentialing program at (*Hospital*). This review will be limited to:
 - A determination that there is a credentialing file maintained for each member of the medical staff;
 - A review of individual files to insure that all required documentation is present; and
 - Written recommendations to (*Hospital*) regarding any observed deficiencies.
2. (*Hospital*) will make available to (*QA/Credentialing Entity*)'s staff any files and supporting documentation necessary to conduct such review.
3. Within 90 days of initial review, (*Hospital*) will provide (*QA/Credentialing Entity*)'s staff with written documentation that any deficiencies identified in initial review have been corrected.
4. No less than annually thereafter, (*QA/Credentialing Entity*) will re-survey (*Hospital*)'s credentialing files to insure that appropriate credentialing files and processes are maintained, according to standard procedures.

IV. NOT COVERED BY THIS AGREEMENT

1. (*QA/Credentialing Entity*) will not play any role in the quality assurance process of (*Hospital*) other than as outlined above.

2. (*QA/Credentialing Entity*) will not participate in any manner in the peer review process of (*Hospital*) nor in recommending changes in clinical practices at (*Hospital*).

3. (*QA/Credentialing Entity*) will not participate in any manner in medical staff and hospital board deliberations in medical staff credentialing.

4. (*QA/Credentialing Entity*) will not consider questions of clinical competence nor suitability for appointment of physicians to the medical staff of (*Hospital*).

5. Decisions regarding appointment or removal from the medical staff, or of levels of privileges extended to any member of the medical staff of (*Hospital*) are solely and exclusively within the purview of the administration, medical staff and governing body of (*Hospital*).

Signed on this _____ day of _____, 2001

Signed: _____

Name
Administrator
Hospital

Signed: _____

Name
Chief Executive Officer
QA/Credentialing Entity