I. PURPOSE:
In times of a local, state or national disaster, it may become necessary to grant temporary privileges to external physicians/allied health practitioners to care for unusually high numbers of ill/injured patients.

II. SCOPE:
This policy applies to physicians, dentists and allied health practitioners, not on the Medical Staff or Allied Health Staff of IU Health North Hospital, presenting themselves as volunteers rendering their services during an emergency or disaster.

III. PROCEDURE:
A Temporary Disaster Privileges (TDP) form (Attachment A) shall be provided by The Incident Commander/Unified Commander or his/her designee, and they shall declare a “state of emergency.” Temporary disaster privileges shall be granted on a case-by-case basis when the emergency response plan is activated and the organization is unable to handle immediate patient care needs.
Temporary Disaster Privileges may be granted by the CEO and/or the CMO or designee.

A. For volunteer practitioners to be assigned disaster responsibilities, the hospital obtains for each volunteer practitioner, at a minimum, a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport) and at least one of the following:
1. A current picture hospital ID card that clearly identifies professional designation
2. A current license, certification or registration
3. Primary source verification of the licensure, certification, or registration (if required by law and regulation to practice a profession)
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organization or group
5. Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster
circumstances (such authority having been granted by a federal, state, or municipal entity)
6. Identification by current hospital or medical staff member(s) who possess(es) personal knowledge regarding the volunteer practitioner’s qualifications

B. Primary source verification of licensure, certification or registration (if required by law and regulation to practice a profession) begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization.

In the extraordinary circumstance that primary source verification cannot be completed in 72 hours, (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following:
1. The reason primary source verification could not be performed in the required time frame
2. No evidence that the practitioner is providing anything less than adequate care, treatment, and services,
3. An attempt to rectify the situation as soon as possible (primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges)

C. The Incident Commander shall contact the CEO, CMO or designee for approval and shall then notify the physician as soon as possible of approval. This communication may be verbal and/or written.

D. The volunteer physician, dentist, or allied health practitioner shall be assigned to a current member of the IU Health North Hospital Medical Staff/Allied Health Staff. The volunteer will act under the supervision of the Medical Staff member.

E. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially sought.

F. A list of patients treated by the volunteer shall be maintained in the practitioner’s file.

G. A file shall be maintained for each physician/allied health practitioner granted temporary disaster privileges in the Medical Staff Office.
H. All disaster privileges shall immediately terminate once the disaster is over and may be terminated at any time during the disaster without any reason or cause. Termination of these privileges shall not be interpreted to entitle the practitioner to the fair hearing rights set forth in Article XIII of the Bylaws.

IV. RESPONSIBILITY

Incident Commander
President and CEO
CMO
Medical Staff Office

V. APPROVAL BODY

Credentials Committee
Medical Staff Executive Committee
President and CEO
Board of Managers

VI. APPROVAL SIGNATURES

James Leland, MD  Date
Chairman, Credentials Committee

Lynda Smirz, MD MBA  Date
Chief Medical Officer and Vice President of Surgical Services

Jonathan R. Goble, MHA, MBA, FACHE  Date
President and Chief Executive Officer

James Cumming, MD  Date
Board Quality Chairman
Disaster Credentialing of Physicians and Allied Health Professionals
Temporary Disaster Privileges Form (TDP)

Practitioner Name: ________________________________________________________
Medical Discipline of Practitioner: ___________________________________________
Professional License/State: _________________________________________________
Contact information for Healthcare facility of majority of activity: __________________
_______________________________________________________________________
_______________________________________________________________________

I agree to abide by the Indiana University Health North Hospital policy regarding Disaster Privileges as stated by copy of this information presented to me.

Practitioners must provide a copy of their licensure (wallet-size) card with this form for electronic or telephone verification, photo identification, name and contact information of health care facility where practitioner has privileges. The NPDB will be queried and AMA/education profiles run on all practitioner participants retroactively if unable to process during disaster event.

Participant’s Signature ___________________________ Date __________
Participant’s Name (Printed) ___________________________ DOB __________
Social Security Number ___________________________
Address for Contact (Home or Office) ___________________________
Office Phone #: ___________________________ Pager/Cell/Home #s: ___________________________
Medical Staff or Medical Staff Services Representative ___________________________ Date __________
Approval by Clinical Section Chair or Specialty Advisor ___________________________ Date __________
Approval by CEO/CMO or designee ___________________________ Date __________

Disaster Privileges