St. Joseph Hospital Medical Staff Rules & Regulations

Rule 1 Committees ... 4
- 1.0 General ... 4
- 1.1 Cancer Committee ... 6
- 1.2 Committee on Physician Health (COPH) ... 7
- 1.3 Credentials Committee ... 8
- 1.4 Department Executive Committees ... 9
- 1.5 Infection Control Committee ... 9
- 1.6 Interdisciplinary Practice Committee ... 10
- 1.7 Continuing Medical Education Committee ... 11
- 1.8 Operating Room Committee ... 12
- 1.9 Pain Management Committee ... 13
- 1.10 Pharmacy and Therapeutics Committee ... 14
- 1.11 Quality & Safety Committee of the Medical Staff ... 15
- 1.12 Section Committees ... 17
- 1.13 Special Procedures Committee ... 18
- 1.14 Staff Officer Committee ... 18
- 1.15 Utilization Management Committee ... 19
- 1.16 Physician Quality Review Board (PQRB) ... 20
- 1.17 Dialysis and Transplant Committee ... 21
- 1.18 Committee on the Aging Medical Practitioner (CAMP) ... 22

Rule 2 Credentials Files ... 23
- 2.1 General ... 23
- 2.2 Contents ... 23
- 2.3 Disclosure to Applicant or Medical Staff Member ... 23
- 2.4 Disclosure to Medical Staff Officers and Medical Staff Committees or Their Designee ... 24
- 2.5 Disclosure to the Hospital Governing Body ... 24

Rule 3 Professional Liability Insurance ... 25
- 3.1 General ... 25
- 3.2 Proof of Insurance ... 25
- 3.3 Reporting Changes ... 26
- 3.4 Failure to Maintain Professional Liability Insurance ... 26
- 3.5 Availability of Information ... 26

Rule 4 Category of Membership ... 27
- 4.1 Categories ... 27
- 4.2 Fees ... 27
- 4.3 Annual Medical Staff Dues ... 28

Rule 5 Procedures for Appointment and Reappointment ... 29
- 5.1 Application Form ... 29
- 5.2 Physical and Mental Capabilities ... 29
- 5.3 Effect of Application ... 30
- 5.4 Verification of Information ... 32
- 5.5 Action on the Application ... 33
- 5.6 Duration of Appointment ... 37
- 5.7 Reappointment Process ... 37
- 5.8 Relinquishment of Privileges ... 43

Rule 6 Delineation of Privileges 44
6.1 General 44
6.2 Conditions for Privileges of Limited License Practitioners 44
6.3 Credentialing Telemedicine Staff 45

Rule 7 Criteria for Privileges in Interventional Radiology (Special Procedures) 47
7.1 The Special Procedures Committee (SPC) 47
7.2 Categories of Privileges in Interventional Radiology: 47
7.3 Considerations to be Used in Granting Interventional Radiology Privileges: 47
7.4 Proctoring Requirements 47
7.5 Specific Procedures and Considerations 48

Rule 8 Proctoring 57
8.1 General 57
8.2 General Competency Terms 57
8.3 Completion of Proctoring 58
8.4 Effect of Failure to Complete Proctoring 58
8.5 Assignment of Proctor 59
8.6 Function and Responsibility of The Proctor 59
8.7 Responsibility of the Proctored Practitioner 60
8.8 Proctoring Duration 60
8.9 Methods of Proctoring 60
8.10 Reciprocal Proctoring 61
8.11 Focused Professional Practice Evaluation 62
8.12 Ongoing Professional Practice Evaluation 62
8.13 Confidentiality of Information 67

Rule 9 Call Panel 68
9.1 Call Panel List 68
9.2 Conduct of Call Panel Members 68
9.3 Diagnoses 69
9.4 Hospital Emergency Call 70
9.5 Failure or Refusal to Respond 70

Rule 10 Temporary Privileges 72
10.1 Circumstances 72
10.2 Application 72
10.3 Investigations of Applicants for Temporary Privileges 72
10.4 Granting Temporary Privileges 73
10.5 Deferral, Denial or Termination 73
10.6 General Conditions 74

Rule 11 Medical Education 75
11.1 Patient Participation 75
11.2 Clinical Affiliation Agreement 75
11.3 Medical Students, Residents and Fellows 75
11.4 Record Keeping 75

Rule 12 Research 77

Rule 13 Impaired Medical Staff Members 78

13.1 Definition of Physician Impairment 78
13.2 Purpose 78
13.3 Philosophy 78
13.4 Assisting Impaired Medical Staff Members 78
13.5 Confidentiality 78
13.6 Reporting and Investigating Procedure 79

Rule 14 Allied Health Practitioners and Advanced Practice Providers 82
14.1 Overview 82
14.2 Categories of AHP/APPs Eligible to Apply for Scope of Practice or Privileges 82
14.3 Prerogatives 83
14.4 General Qualifications 83
14.5 Responsibilities 84
14.6 Clinical Responsibilities 85
14.7 Supervising Practitioner Responsibilities 85
14.8 Processing the Application 86
14.9 Proctoring Period 87
14.10 Exception to Credentialing Process - Contract Allied Health Practitioners 87
14.11 Automatic Suspension and Termination. 88
14.12 Procedural Rights of Allied Health Practitioners 89

Rule 1 Committees

1.0 General

1.0.1 Appointment of Members

Unless otherwise specified, the chair and members of all non-departmental committees shall be appointed by and may be removed by the Chief of Staff or his designee, subject to consultation with and approval by the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee.

1.0.1.1 A Medical Staff committee created in these Rules is composed as stated in the description of the committee in the Bylaws or Rules. Except as otherwise provided in the Bylaws or Rules, committees established to perform Medical Staff functions may include any category of Medical Staff Members; Allied Health Practitioners; representatives from Hospital departments such as Administration, Nursing Services, or Health Information Services; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff Member who serves on a Committee participates with vote unless the statement of Committee composition designates the position as non-voting. Non-Medical Staff members participate without vote except when their voting participation is required by federal or state law, or regulatory compliance or the statement of the Committee composition designates the position as voting.

1.0.1.2 The Chief Executive, or his or her designee, shall appoint any non-Medical Staff Members who serve in non-Ex Officio capacities.

1.0.1.3 The committee chair, after consulting with the Chief of Staff and Chief Executive, may call on outside consultants or special advisors.

1.0.1.4 Each committee chair shall appoint a vice chair to fulfill the duties of the chair in his or her absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and may vote on issues presented to the committee only when necessary to break a tie or affect the outcome of the vote.

1.0.2 Representation on Hospital Committees and Participation in Hospital Deliberations

The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing Medical Staff representation on Hospital committees established to perform such functions.

1.0.3 Ex Officio Members

The Chief of Staff, Chief Executive or their respective designees, and the Chief Medical Officer Chief Medical Officer are Ex Officio members of all standing and special committees of the Medical Staff and shall serve without vote unless provided otherwise in the provision or resolution creating the committee.

1.0.4 Action Through Subcommittees

Any standing committee may use subcommittees to help carry out its duties. The Medical Executive Committee shall be informed when a subcommittee is appointed. The committee chair may appoint individuals in addition to or other than members of the standing committee to the subcommittee after consulting with the Chief of Staff regarding Medical Staff Members.

1.0.5 Terms and Removal of Committee Members

Unless otherwise specified, a committee member shall be appointed for a term of two years, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee. Any committee member who is appointed by the Chief of Staff may be removed by a majority vote of the Medical Executive Committee. The removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official. The Medical Executive Committee must consider whether a committee member should be removed whenever the member has missed three consecutive meetings of the committee.

1.0.6 Vacancies

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

1.0.7 Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified for such meeting in Article 10 of the Bylaws.

1.0.8 Attendance of Nonmembers

Any Medical Staff Member who is in good standing may ask the chair of any committee for permission to attend a portion of that committee's meeting dealing with a matter of importance to that Practitioner. The committee chair shall have the discretion to grant or deny the request and shall grant the request if the Member's attendance will reasonably aid the committee to perform its function. If the request is granted, the invited Member shall abide by all Bylaws and Rules applicable to that committee.

1.0.9 Confidentiality

Inasmuch as effective peer review, quality improvement review and consideration of the qualifications of the Medical Staff members and applicants must be based upon free and candid discussions, any breach of confidentiality or unauthorized disclosure of the discussions or deliberations of Medical Staff Department or Committees is considered inappropriate conduct for the Medical Staff and disruptive to the operations of the Hospital. If the Medical Executive Committee determines that such a breach has occurred, the affected practitioner's committee membership may be automatically terminated and the Medical Executive Committee may undertake such corrective action as it deems appropriate. Non-Medical Staff members must be excused during any committee proceedings dealing with sensitive issues regarding Medical Staff members.

1.0.10 Accountability

All committees shall be accountable to the Medical Executive Committee.

1.1 Cancer Committee

1.1.1 Composition

The Cancer Committee shall be multi-disciplinary. The membership of the Cancer Committee is from the specialties of Medical Oncology, Radiation Oncology, Surgery, Palliative Care or Pain, Diagnostic & Therapeutic Radiology, Pathology, and the Cancer Liaison Physician. Whenever feasible, the committee should include members from Gynecology and Urology. The Committee also includes representatives of Hospital Administration, oncology nursing, social services, Certified Cancer Registrar, quality improvement, and Spiritual Care. Other specialties may be represented such as Pharmacy, Nutrition, hospice or home care, clinical research data manager or nurse, psychiatric or other mental health professional and Rehabilitation.

1.1.2 Definition and Requirements

The Cancer committee is responsible for goal setting, planning, initiating, implementing, evaluating, and improving all cancer-related activities in the facility.

1.1.3 The requirements of the Cancer Committee are to:

a. Develop and evaluate the annual goals and objectives and objectives for the clinical, community outreach, educational, quality improvement, and programmatic endeavors related to cancer.
b. Promote a coordinated, multidisciplinary approach to patient management.
c. Establish cancer conference frequency and format on an annual basis and ensure that educational and consultative cancer conferences cover all major sites. The frequency and format of the conferences should be on category, number of annual analytic accessions, type of cases seen and related issues.
d. Establish the multidisciplinary attendance requirements for cancer conferences of an annual as well as ensure that at least 75 percent of the cases are prospective.
e. Monitor and evaluate the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation on an annual basis.
f. Ensure that an active supportive care plan is in place for patients, families and staff.
g. Promote clinical research.
h. Establish and implement a plan to evaluate the quality of cancer registry data and activity on an annual basis. The plan includes procedures to monitor case findings, accuracy of data collection, abstracting timeliness, follow-up, and data reporting.
i. Analyzes patient outcomes and disseminates the results of the analysis annually.
j. Encourage data usage and regular reporting.
k. Advocate that an annual report is prepared that contains the required information and is published annually.
l. Uphold medical ethical standards.
m. Assure the Hospital is meeting cancer accreditation standards.
n. Request that Administration schedule all Director of Oncology applicants for an interview with the Chairman of Cancer Committee or designee for recommendations.

o. Ensure coordinators are designated for each of the four areas of cancer committee activity; cancer conference, quality control of cancer registry data, quality improvement and community outreach.

1.1.4 Meetings and Reporting

The Committee shall meet as often as necessary, but no less than quarterly. It shall report to the Quality & Safety Committee of the Medical Staff

1.2 Committee on Physician Health (COPH)

1.2.1 Composition

The Committee on Physician Health shall be composed of no fewer than three Active Medical Staff Members, a majority of whom, including the Chair, shall be physicians and one of whom should be a psychiatrist whenever possible and one of whom should be a recovering physician whenever possible.

1.2.1.1 Except for initial appointment, each member shall serve a term of three (3) years, and the terms shall be staggered to achieve continuity.

1.2.1.2 Members of the committee shall not actively participate on any other peer review or quality improvement committees while serving on this committee.

1.2.2 Duties

1.2.2.1 In accordance with the Rule 6.2 review the responses from applicants for appointment and reappointment concerning physical or mental disabilities and recommend what, if any, reasonable accommodations may be indicated in order to assure that the Practitioner will provide care in accordance with the Hospital and Medical Staff's standard of care. These processes should include mechanisms for the following:

a. Receive reports related to the health, well-being, or impairment of Medical Staff members.
b. Investigate such reports as it deems appropriate.
c. Consult with individual staff members when requested.
d. Provide advice, counseling or referrals on a voluntary basis, as may seem appropriate.
e. Respond or make recommendations to the referral source and the concerned physician.
f. Develop and recommend individualized monitoring plans.
g. Compile lists of physicians and programs with special expertise who can monitor a physician's compliance with a plan, for consideration of the Chief of Staff.
h. Consider general matters related to the health and well-being of the Medical Staff.
i. Educate the Medical Staff and hospital staff about illness and impairment recognition issues specific to practitioners.

1.2.2.2 The committee is an advisory body, and its activities are confidential, concerned primarily with the needs of the physician in question. The committee shall not

actively seek out instances of impairment, nor shall it provide treatment or supervision of clinical practice.

1.2.2.3 If the Committee receives information that demonstrates that the health or impairment of a Medical Staff Member may pose a risk of harm to the Hospital's patients (or prospective patients), that information shall be referred to the Chief of Staff, who will determine whether to refer the matter for a corrective action investigation.

1.2.2.4 When a monitoring plan has been developed and a monitor assigned, the monitor will report to the Chief of Staff periodically on the physician's compliance with the plan.

1.2.2.5 The effectiveness of the committee shall be evaluated annually by the Chief of Staff.

1.2.3 Meetings, Reporting and Minutes

The Committee shall meet as often as necessary, but at least quarterly. It shall maintain only such records of its proceedings as it deems advisable, and shall routinely report on its activities to the referring party and as deemed appropriate.

1.3 Credentials Committee

1.3.1 Composition

The Credentials Committee shall be composed of at least six (6) medical staff members of different clinical specialties plus the Chairman who have an interest and expertise in the credentialing process. The Vice Chief of the Medical Staff will serve as the Committee's Chair. The appropriate Department Chair shall serve as a consultant to the Credentials Committee. The Interdisciplinary Practice Committee Chair shall serve as a standing member of the Credentials Committee

1.3.2 Duties

The Credentials Committee will be responsible for all credentialing functions, including:

a. Evaluate or coordinate the evaluation of the qualifications of all applicants for Medical Staff appointment, reappointment, or changes in Staff categories or privileges. It may interview applicants.
b. The Committee shall develop recommendations based on its and the Department and/or Section's evaluations of each applicant, as well as the results of any Medical Staff quality assessment and improvement activities.
c. Initiate, investigate, review and report on matters involving the clinical, ethical or professional performance of any member. The Committee may act on its own initiation or upon the referral of a matter by any Medical Staff Officer, Department or Section chair, or Committee.
d. Report to the Medical Executive Committee on the status of pending applications, including the specific reasons for any inordinate delay in processing of an application or request.

e. Review and evaluate the qualifications of each AHP who is eligible to apply for practice privileges; and, in connection therewith, obtain and consider the recommendations of the appropriate departments.

1.3.3 Meetings

The Credentials Committee shall meet at least quarterly, or more often as needed.

1.4 Department Executive Committees

1.4.1 Composition

Each Department must have a Department Executive Committee consisting of at least 3 Active Staff Members appointed by the Department Chair. The Department Chair may designate the Department as a whole to act as the Department Executive Committee. The Department Chair will serve as the Department Committee's Chair.

1.4.2 Duties

The Department Executive Committees shall assist the Department Chair to carry out the responsibilities assigned to the Department and the Department Chair, including the duty to recommend professional criteria for clinical privileges within the department, review applicants for appointment, reappointment, and clinical privileges,

1.4.3 Meetings

Each Department Executive Committee shall meet as often as necessary.

1.5 Infection Control Committee

1.5.1 Composition

The Infection Control Committee shall be multidisciplinary, including at least 5 members. Voting members and required individuals are:

a. Infection Prevention & Control Medical Director (Physician Chair)
b. Director of Infection Prevention and Control
c. Infection Preventionist (1)
d. Nursing Representative (1)
e. Plant Services Representative (1)

Representatives are invited and may include: Medical Staff, Administration, Quality Improvement, Surgical Services, Women's Services, Employee Health, Emergency Services, Food Services, Microbiology, Pharmacy, Environmental Services, Sterile Processing, Plant Services, Renal Dialysis and Respiratory Services.

1.5.2 Duties

The Infection Prevention & Control Committee shall ensure success of an organization-wide Infection Prevention and Control Program (IPC Program) which requires collaboration with all relevant entities. This collaboration is vital to the successful gathering and interpretation of data, design of interventions, and effective implementation of interventions. Managers within the hospital who have the power to implement plans and make decisions about

interventions related to infection prevention and control participate in the IPC Program. An effective IPC Program that can systematically identify risks and respond appropriately must involve all relevant programs and settings within the hospital. The Committee:

a. Oversees an organization-wide IPC Program. All hospital components and functions are integrated into infection prevention activities.
b. Reviews and approves the Infection Prevention Risk Assessment and the Infection Prevention and Control Program Plan. The Committee defines the epidemiologically important issues, sets specific annual objectives, and modifies the IPC Plan to meet those objectives as needed.
c. Reviews surveillance data for trends in infections, clusters, or any unusual pathogens that exceed threshold.
d. Recommends corrective action(s) and approves proposals and protocols for special infection prevention studies.
e. In conjunction with Pharmacy and Therapeutics, the Committee Reviews antibiotic susceptibility/resistance trends and makes recommendations for judicious use of antibiotics as appropriate.
f. Reviews and issues reports on infection control risk assessments (ICRA) as required for construction/ renovation projects.
g. Through its Chair of Infection Prevention and Control Committee or the Infection Prevention and Control Director, is authorized to institute appropriate control measures or studies, including patient testing, patient isolation or environmental sampling, when there is reasonable concern for the well-being of patients, personnel, volunteers, visitors, and/or the community.
h. The Infection Prevention and Control Medical Director has the ultimate authority to manage the antimicrobial stewardship program on a day-to-day basis.
i. Infection Prevention Policies and department-specific infection related policies will be reviewed and/or revised at least every three (3) years by the Committee, unless otherwise specified, and enforced by the department/unit manager.
j. Keeps abreast of regulatory guidelines and standards related to infection prevention & control.
k. Reviews Employee Health measures which are implemented, and approves policies related to the reduction of risks associated with healthcare workers.
l. Contributes to the Emergency Management / Disaster Planning efforts of the hospital.

1.5.3 Meetings and Reporting

The Infection Control Committee shall meet at least quarterly. It shall report to the Quality & Safety Committee of the Medical Staff.

1.6 Interdisciplinary Practice Committee

1.6.1 Composition

The Interdisciplinary Practice Committee shall have:

1.6.1.1 Chairman – appointed by the Chief of Staff

1.6.1.2 Vice President (VP) of Patient Care Services, who functions as the hospital's Chief Nursing Officer

1.6.1.3 Registered Nurses appointed by the VP of Patient Care Services

1.6.1.4 Other attendees invited as needed by the Committee Chair Members.

1.6.1.5 The number of physician members shall be equal to the number of nurse members.

1.6.1.6 Representatives of the categories of allied health professionals (AHPs) granted privileges in the hospital should serve as consultants on an as-needed basis and shall participate when available, in the committee proceedings when practice privileges of a same specialty are being considered.

1.6.2 Duties

1.6.2.1 Standardized Procedures:

1.6.2.1.1 IPC shall develop and review standardized procedures that apply to nurses or AHPs; identify functions that are appropriate for standardized procedures and initiate such procedures; and review and approved standardized procedures.

1.6.2.1.2 Standardized procedures can be approved only after consultation with the Medical Staff department involved and by affirmative vote of the administrative representatives, a majority of physician members, and a majority of nurse members.

1.6.2.2 Credentialing Allied Health Professionals

1.6.2.2.1 The IPC shall recommend policies and procedures for expanded role privileges for assessing, planning and directing the patients' diagnostic and therapeutic care.

1.6.2.2.2 The IPC shall defer credentialing processing to the appropriate Medical Staff Departments and the Credentials Committee.

1.6.2.2.3 The IPC shall defer AHP peer review and quality improvement activities to the appropriate Medical Staff Department and the Credentials Committee.

1.6.2.2.4 The IPC shall serve as a liaison between AHPs and the medical staff.

1.6.2.2.5 The IPC shall review all new and revised privilege forms and job descriptions for Allied Health and Advanced Practice Providers and make recommendations to the applicable Departments.

1.6.3 Meetings and Reporting

The IPC shall meet as often as needed, but at least quarterly. The IPC shall report to the Credentials Committee.

1.7 Continuing Medical Education Committee

1.7.1 Composition

The Continuing Medical Education Committee shall include at least 3 medical staff members. The Chair shall serve for at least two years, and committee members shall serve staggered terms in order to assure continuity. In addition to the physician members, the committee

will have non-voting representatives from PI/QA, Pharmacy, Infection Prevention, Nursing and Administration.

1.7.2 Duties

1.7.2.1 The Continuing Medical Education Committee shall be responsible for the hospital's CME accreditation program

1.7.2.2 Plan, implement, coordinate and promote ongoing special clinical and scientific and regulatory activities for the medical staff. This includes:

1.7.2.3 Identify practice gaps and educational needs of the medical staff;

1.7.2.4 Formulate clear statements of desired outcomes for each activity

1.7.2.5 Assessing the effectiveness of outcomes for each program;

1.7.2.6 Choose appropriate teaching methods and knowledgeable faculty for each activity;

1.7.2.7 Maintain official records of the CME Program.

1.7.2.8 Assist in developing processes to assure optimal patient care and contribute to each practitioner's continuing education

1.7.2.9 Establish liaison with the Hospital's quality enhancement program in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education.

1.7.2.10 Advise administration of the financial needs of the continuing medical education program.

1.7.3 Meetings and Reporting

The Continuing Medical Education Committee shall meet at least quarterly. It shall report to the Quality & Safety Committee of the Medical Staff.

1.8 Operating Room Committee

1.8.1 Composition

The Committee shall be multi-disciplinary. The Committee shall include at least 5 Active members of the Medical Staff including, when feasible, members from the specialties of Anesthesia, Surgery, Orthopedics, EENT, and OB/Gyn. The Executive Director of Surgical Services, Manager of PAT's and Surgery Scheduling shall serve as ex-officio members. Membership shall also include appropriate representation of hospital Administration, including the line administrator in charge of OR operations and the Vice President of Patient Care Services, who also serve as ex officio members. Other specialties and disciplines may be represented at the discretion of the Chair.

All regular members of the committee may vote on hospital systems/operations issues; voting on Medical Staff issues shall be limited to regular physician members of the committee. Non-physician members may be excused from the meeting at the discretion of the Chair for consideration of sensitive or confidential matters.

1.8.2 Duties

The duties of the Operating Room Committee are to provide leadership and oversight in all matters affecting clinical performance and operations in the Main Operating Room, Pre-operative Unit, PACU, and Surgery Center. These duties shall include but not be limited to:

1.8.2.1 Promote a coordinated, collaborative multi-disciplinary approach to management of OR operations.

1.8.2.2 Receive and evaluate reports that touch on OR operations.

1.8.2.3 Initiate, investigate, review and report on matters involving clinical, ethical, or professional performance in the OR.

1.8.2.4 Evaluate significant departures from established patterns of clinical practice.

1.8.2.5 Evaluate and assure compliance within the OR to Medical Staff Bylaws and Rules, relevant Departmental Rules, Clinical Policies and Procedures as well as applicable regulatory and statutory requirements.

1.8.3 Meetings and Reporting

The Operating Room Committee shall meet quarterly. The Operating Room Committee shall report to the Medical Executive Committee.

1.9 Pain Management Committee

1.9.1 Composition

The Pain Management Committee is an oversight committee reporting to the Medical Staff Quality & Safety Committee of the Medical Staff Membership in the Pain Committee shall be multi-disciplinary and shall include at least five Active members of the Medical Staff including, when feasible, members from the specialties of Anesthesia and Neurology. It shall also include the Medical Director for Palliative Care Pain, the Chair of the Nursing Pain Resource Special Interest Group, the Palliative Care Nurse Practitioner, Pharmacist, and the VP for Patient Care Services and Nursing Performance Improvement Council Chair. All members shall be voting members.

1.9.2 Duties

The Pain Management Committee shall be responsible for coordination of the performance improvement related to pain management activities in the hospital. In carrying out its duties, the Committee shall:

1.9.2.1 Develop for approval, and oversight of, annual performance improvement goals related to pain management.

1.9.2.2 Review and recommend action on all aggregate quality data related to pain management (including operational compliance, satisfaction, patient safety, and outcomes).

1.9.2.3 Review and approve policy, procedures and resource tools related to pain management, with referrals as appropriate to achieve consensus prior to approval.

1.9.2.4 Receive and evaluate reports as referred from other Medical Staff, Nursing and/or Palliative Care committees on pain issues.

1.9.2.5 Conduct case review for the purpose of overall pain management learning, with key focus to highlight both those cases well managed and those offering opportunity for improvement.

1.9.2.6 Make recommendations for related performance improvement activities

1.9.2.7 Make referrals as appropriate for any potential peer review issue to the PQRB, and/or,

1.9.2.8 Make referrals to other medical staff committees or hospital departments as applicable for discipline or topic-specific performance improvement opportunities, and/or,

1.9.2.9 Establish task forces or focus teams where multi-disciplinary group action is required to correct identified systems issues, and then provide appropriate oversight, and/or,

1.9.2.10 Make recommendations for educational needs of medical and hospital staff related to pain management (in conjunction with Physician Education Committee)

1.9.2.11 Undertake at its discretion any other activity appropriate to the facilitation of performance improvement related to pain management.

1.9.3 Meetings

The Pain Management Committee shall meet at least quarterly, with additional meetings as necessary. The Committee shall report to the Quality & Safety Committee of the Medical Staff and the Pharmacy and Therapeutics Committee.

1.10 Pharmacy and Therapeutics Committee

1.10.1 Composition

The Pharmacy and Therapeutics Committee shall consist of at least 5 Medical Staff members and the Director of Pharmacy. Representatives of Administration and of Nursing shall serve ex officio, without vote.

Recommendations of the P&T Committee are presented to the Medical Staff through the approval of the Quality & Safety Committee of the Medical Staff and to the Medical Executive Committee and Board of Trustees as necessary

1.10.2 Duties

The Pharmacy and Therapeutics Committee shall:

1.10.2.1 Assist in formulating the broad professional policies regarding the evaluation, selection, storage, distribution, use, safety procedures, administration and all other matters relating to medication systems and medications, including those used for diagnostic purposes.

1.10.2.2 Advise the Medical Staff and the Hospital's Pharmaceutical Department on matters pertaining to the choice of available drugs and review all significant untoward drug reactions.

1.10.2.3 Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

1.10.2.4 Develop and review periodically a formulary or drug list for use in the Hospital.

1.10.2.5 Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

1.10.2.6 Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

1.10.2.7 Establish a system for identifying and reporting adverse drug reactions and medication errors.

1.10.2.8 Review reports of adverse drug reactions and medication errors and make recommendations for corrective action.

1.10.2.9 Perform any other duties as are assigned by the Chief of Staff or the Medical Executive Committee.

1.10.3 Meetings and Reporting

The Pharmacy and Therapeutics Committee shall meet at least quarterly. It shall report to the Quality & Safety Committee of the Medical Staff. St. Joseph Hospital Medical Staff gives authority for formulary decision-making to the Regional Pharmacy and Therapeutics Committee, led by representatives of experts in medicine, pharmacy and nursing throughout the region and continuum of care, that ensures patients of PSJH and its affiliates are provided with safe, high-quality and affordable medications throughout the continuum of care.

1.11 Quality & Safety Committee of the Medical Staff

1.11.1 Composition

The Quality & Safety Committee of the Medical Staff shall consist of:

a. Secretary/Treasurer, who will serve as Chair of the committee with principal staff support by the Director of Regulatory and Accreditation.
b. Vice Chief of Staff
c. Chief Medical Officer
d. Vice Chairs of each of the Department
e. Chair, Medical Education Committee
f. Chair, Dialysis & Transplant Committee
g. Chair, Pharmacy and Therapeutics Committee
h. Chair, Dialysis & Transplant Committee
i. Administrative representation to include: Chief Operation Officer, Vice President for Patient Care Services, and the Vice Presidents for Operations. and Pharmacy Director

Additional members may be appointed at the discretion of the Chief of Staff or the Chair of the Quality & Safety Committee of the Medical Staff.

j. The Chairs of the committees addressing each of the key process functions and of the other committees that report to the Quality & Safety Committee of the Medical Staff will be invited to present their scheduled reports as due.
k. Key process functions may be supported by either a designated Committee or by a Chair assigned by the Chief of Staff to oversee the particular process.
l. Hospital support staff for key process or other quality function reports will be invited as guests to support the physician Chair for that applicable agenda item.
m. All committee members may vote on hospital systems/operations issues. Only Committee members who are Medical Staff Members may vote on medical staff issues. Non-Medical Staff members may be excused from the meeting at the discretion of the Chair for consideration of sensitive or confidential matters.

1.11.2 Duties

Quality & Safety Committee of the Medical Staff The Quality and Safety Committee of the Medical Staff (QSCMS) is delegated the responsibility to assist the Medical Executive Committee and the Quality Safety Committee of the Board in overseeing and ensuring the quality of clinical care, patient safety, environment of care and regulatory compliance throughout the organization through the development and submission of performance improvement plans related to operational indicators

The QSCMS shall be responsible for:

1.11.2.1 Development and submission of a recommended performance improvement plan for hospital operations annually.

1.11.2.2 Develop and submit a recommended Patient Safety Program and Plan annually

1.11.2.3 Establish performance team(s), patient safety gap analysis teams, failure mode and effect analysis teams, task forces whenever group action is required to correct identified systems problems, or to address issues proactively, and then provide appropriate oversight.

1.11.2.4 Review and recommend action on all operational quality control data (including operational indicators, ORYX Core Measure indicators, satisfaction data, patient safety data, environment of care safety data, outcomes relevant to systems design, etc.) and make recommendations for related performance improvement activities.

1.11.2.5 Undertake at its discretion any other activity appropriate to the facilitation of performance improvement and patient safety.

1.11.2.6 Reviewing and recommending approval of Annual Evaluations and Plans for the following Infection Prevention, Patient Safety, Quality Management, Risk Management and the Environment of Care Safety. Ethics, Cancer Committee, Pain Management Palliative Care.

1.11.2.7 Monitoring summary reports and overseeing hospital and medical staff quality and patient safety activities related to the following:

a. SJO Quality and Safety Dashboards
b. PI Teams and Workgroups
c. Environment of Care Safety

d. Patient Experience
e. Healthcare Ethics Committee
f. Operational Quality Control
g. Regulatory/Accreditation
h. Blood Use
i. Infection Control
j. Interdisciplinary Practice
k. Root Cause Analysis
l. Clinical Outcomes
m. Clinical Excellence Teams
n. Collaborative Practices
o. Medical Record Review
p. Patient Safety
q. Risk Management
r. Physician Education
s. Policy & Procedure
t. State Deficiencies and Approving Plan of Corrections an further recommendations

1.11.2.8 Review and recommend approval of minutes for the following Medical Staff Committees

a. Pharmacy & Therapeutics
b. Utilization Management
c. Pain Management Palliative Care
d. Dialysis &Transplant
e. Cancer Committee
f. Infection Prevention

1.11.3 Sentinel Event Review

Whenever a sentinel event may have occurred, a team shall be created that includes at least one member of the medical staff and other professionals who have the expertise to perform the root cause analysis and recommend a risk reduction plan. The team shall investigate the possible sentinel event, in accordance with the Hospital's policy. The team shall report its findings to the Quality & Safety Committee of the Medical Staff and as required by the Hospital policy.

Oversee proactive risk assessment, using available information about sentinel events known to occur in similar hospitals.

Operative Procedures and Other Procedures That Could Place Patients At Risk Case Review Duties

Screen operative cases and other procedures that could place patients at risk. Review the operative and other procedures cases according to the indicators for review and review a sample of the cases for the following: selecting appropriate procedures; preparing the patient for the procedure; performing the procedure and monitoring the patient; and providing post-procedure care.

1.12 Section Committees

1.12.1 Composition

At the discretion of the Section Chair, a Section may form a Section Committee consisting of at least 3 Active Staff Members from the Section.

1.12.2 Duties

The Section Committee shall assist the Section Chair to carry out the responsibilities assigned to the Section Chair. The Section Committee shall also fulfill the quality improvement functions assigned to it by the Quality & Safety Committee of the Medical Staff , including review of Members' cases for the purposes of fulfilling the quality improvement, surgical case review, blood usage, infection control, medical records, medication usage, and tissue and death review functions otherwise assigned to the Quality & Safety Committee of the Medical Staff.

1.12.3 Meetings and Reporting

Each Section Committee shall meet as often as necessary. It shall report to the Section Chair.

1.13 Special Procedures Committee

1.13.1 Composition

The Special Procedures Committee shall consist of at least five members, including representatives of the following clinical specialties: interventional radiology, diagnostic radiology, vascular surgery, cardiology, and neurology/neurosurgery. The chairman shall serve a two-year term.

1.13.2 Duties

1.13.2.1 Work collaboratively with diagnostic radiology, cardiology and vascular surgery.

1.13.2.2 Develop and evaluate Medical Staff credentialing and privilege criteria for practitioners performing Interventional Radiology procedures.

1.13.2.3 Promote a multidisciplinary approach to patient management.

1.13.2.4 Establish and monitor appropriate quality and outcomes criteria.

1.13.2.5 Forward recommendations regarding credentialing and granting of privileges to the appropriate department chairs.

1.13.2.6 forward recommendations regarding quality improvement to the Quality & Safety Committee of the Medical Staff.

1.13.3 Meetings and Reporting

The Committee shall meet as necessary.

1.14 Staff Officer Committee

1.14.1 Composition

The Staff Officers Committee shall consist of the Chief of Staff, Vice Chief of Staff, Secretary/Treasurer, the immediate Past Chief of Staff, and two members-at-large.

1.14.2 Duties

The Staff Officers Committee shall:

1.14.2.1 Advise the Chief of Staff on peer review and credentialing matters.

1.14.2.2 Advise and assist the Chief of Staff in carrying out his/her responsibilities.

1.14.3 Meetings and Reporting

The Committee shall meet as needed. Meetings shall be called at the request of the Chief of Staff.

1.15 Utilization Management Committee

1.15.1 Composition

The Utilization Management Committee shall consist of at least two Physician Reviewers, serving with vote. Additionally, the Medical Director of Case Management shall serve as an ex officio member with vote, and may serve as chair. Non-physician staff representation shall include the Executive Director of Case Management, and the Case Management staff as ex officio members without vote.

Other members of the Medical Staff may be asked to review cases on an ad hoc basis with vote when their expertise is required.

1.15.2 Duties

The Utilization Management Committee shall establish and maintain procedures necessary to evaluate the medical necessity, appropriateness, and efficient use of health care services for all patients, regardless of the source of payment and with the highest quality of care.

The Committee will consider the appropriateness of care of individual cases referred by Case Management, as well as aggregate UR data

1.15.3 Procedure

The Committee shall consider the patient's need for the acute level of hospital care in cases determined by Case Management to exceed recognized criteria for appropriate utilization. These cases may include:

a. Inappropriate admissions
b. Excessive length of stay
c. Procedures without adequate clinical justification
d. Any pattern of inappropriate use demonstrated on retrospective review

Cases, which do not meet the criteria for admission or continued stay, will be referred to a Physician Reviewer. The Physician Reviewer shall determine if the care tendered to any patient fails to meet clinical criteria for medical necessity, appropriateness, and efficient use of health care services. Physicians may not participate in the review of any case in which he/she has been or anticipates being professionally involved in the care of the patient.

The Reviewer may determine an admission to be inappropriate, may request discharge or transfer to a lower level of care of any patient determined to no longer require acute care, or

may refer patterns of inappropriate usage to the appropriate clinical department for peer review.

The attending physician shall be promptly notified in writing of any negative finding.

1.15.4 Request for reconsideration

The attending physician may request reconsideration by the Utilization Management Committee of any negative determination. This request must be filed in writing within one calendar day of being notified of the negative determination. The Utilization Management Committee chair will then appoint an ad hoc reviewer with vote of the same specialty as the attending physician.

If, after consideration of the input of the ad hoc reviewer's opinion, the Committee determines that the initial negative determination is sustained, the attending physician shall have no further appeal. A negative determination is not a disciplinary action, and does not generate further appeal rights.

If the reviewer sustains the attending physician, there shall be no further action by the Utilization Management committee unless there is substantial and significant change in the patient's clinical condition.

1.15.5 Non-compliance

In the event an attending physician refuses or fails to discharge or transfer to a lower level of care a patient determined by the Utilization Management committee to no longer require acute hospital care, the Utilization Management chairman, with the concurrence of the Department Chair and the Chief of Staff, may discharge or transfer the patient.

Such refusal by the attending shall be considered an inappropriate use of hospital resources in accordance with Article 2.7.15 of the Bylaws, and shall be the basis for corrective action. Such a finding is a disciplinary action, and does afford the attending physician full appeal rights in accordance with Article 13.3 of the Bylaws.

1.15.6 Meeting and reporting

The committee shall report to the Medical Executive Committee.

The committee shall forward aggregate utilization review data and matters pertaining to quality improvement to the QSCMS at least quarterly

The committee shall meet as often as necessary to consider individual cases in a timely manner.

1.16 Physician Quality Review Board (PQRB)

1.16.1 Composition of Physician Reviewers:

At least ten (10) Active Medical Staff Members appointed by the PQRB Nominating Committee and approved by the MEC.

Initial term length is three (3) years. Following the end of the first term, each member may be eligible for reappointment by the PQRB Nominating Committee with Board approval for a subsequent three (3) year term. An individual may serve two consecutive terms and then

must take a one (1) year hiatus from membership. Following this hiatus, the individual is eligible for reappointment according to the terms above.

The Chair of the PQRB will serve a term of six (6) years without eligibility to be reappointed to the position of Chair.

All appointments/reappointments will be based on a term of three (3) years. A commencement date of January 1st of the current calendar year will be applied to all terms, regardless of actual date of appointment. Terms are based on a calendar year (January 1st - December 31st). If attrition or premature termination of current term occurs leaving insufficient membership, it would be appropriate for the Chief of Staff to make adjustments to the membership term/rotation schedule.

Grounds for removal/replacement of a physician reviewer would include but not be limited to:

a. failure to regularly participate in reviews and meetings,
b. breach in confidentiality, (will keep confidential any records, documents,
c. information or names of anonymous reviewers other than oneself), and
d. a pattern of inadequate performance in reviews.

The PQRB Nominating Committee will recommend to the MEC appropriate reviewers from the Active Medical Staff for appointment to the PQRB committee. The Nominating Committee will consist of four (4) members: Chief of Staff; Surgery Department Chair, Medicine Department Chair and one additional member selected by the PQRB membership. The Nominating Committee is chaired by the Chief of Staff.

All members of the PQRB committee will be voting members, but will not vote on a case presentation that they personally reviewed.

1.16.2 Duties:

a. Screening of trends and outliers based on established criteria.
b. Identify education needed by the Medical Staff.
c. Identify Quality/Utilization/Behavioral issues that affect patient care.
d. Send letters to relevant physicians, hospital departments and sections
e. requesting clarification, as necessary.
f. Make recommendations for quality improvement efforts to Quality Review Committee.
g. Sentinel Event Recommendations Review and finalization.

1.16.3 Meeting: PQRB will meet at least quarterly.

1.17 Dialysis and Transplant Committee

1.17.1 Composition

The Dialysis and Transplant Committee shall be multidisciplinary. The membership shall include members of the Medical Staff from the specialties of nephrology, pediatric nephrology, urology, vascular surgery and interventional radiology. Other physician specialties may be represented as appropriate and as appointed by the Committee Chair. The committee shall also include hospital representatives from Administration, Pharmacy, the Dialysis Programs, Kidney Transplant and Critical Care.

1.17.2 Duties

The Dialysis and Transplant Committee is responsible for evaluating Dialysis and Kidney Transplant related activities affiliated with St. Joseph Hospital. This includes:

a. Promote coordinated, collaborative, multi-disciplinary support to the policies and processes of the Dialysis and Kidney Transplant Programs
b. Review and offer recommendations regarding performance improvement initiatives in the Dialysis and Kidney Transplant Programs
c. Receive and evaluate quality reports related to the Dialysis and Kidney Transplant Programs
d. Provide a link between the hospital's QAPI program and the Dialysis and Transplant QAPI programs by reporting QAPI data to the St. Joseph Hospital Quality and Safety Committee of the Medical Staff.

1.17.3 Meetings and Reporting

The Dialysis and Transplant Committee shall meet quarterly or as often as necessary. It shall report to the Quality and Safety Committee of the Medical Staff.

1.18 Committee on the Aging Medical Practitioner (CAMP)

1.18.1 Composition

The Committee on the Aging Medical Practitioner (CAMP) is a subcommittee of the Committee on Physician Health (COPH). It shall be composed of at least three Active Staff Medical Staff members. If possible, the committee should include one psychiatrist or psychologist, a neurologist, and a surgeon and/or proceduralist. Membership should be representative of the age range of the Medical Staff. Members may serve on both the Committee on Physician Health (COPH) and CAMP.

1.18.2 Duties

The CAMP shall oversee the development and implementation of the Aging Physician Rules and Regulations and policies and procedures. It shall make referrals to the COPH as indicated.

1.18.3 Meetings and Reporting

The CAMP shall meet at least quarterly, or more often as needed. CAMP shall submit quarterly reports to the COPH.

Rule 2 Credentials Files

2.1 General

2.1.1 The credentials files of Medical Staff applicants and Members shall contain all relevant information regarding the Practitioner that is needed to evaluate the professional competency and performance of Medical Staff applicants and Members.

2.1.2 The credentials files shall be retained in strict confidence in the Medical Staff Office or other designated areas.

2.1.3 It is expressly understood that the contents of the credentials file constitute records and proceedings of Medical Staff committees that are responsible for evaluating and improving the quality of care provided in the Hospital.

2.2 Contents

Each credentials file shall include the Practitioner's application forms and all correspondence, and other documents pertaining to the Practitioner and his or her professional qualifications, performance, and Medical Staff activities and responsibilities.

2.2.1 "Evidence that physicians and other practitioners have been granted clinical privileges which require using a medical device shall be considered inclusive of training on attendant alarm systems".

2.3 Disclosure to Applicant or Medical Staff Member

2.3.1 A Medical Staff applicant or Member who wishes to review any portion of his or her credentials file shall submit a written request that specifies the item(s) he or she wishes to see. Requests to review any portion of the credentials file that conform to the restrictions set forth below may generally be granted, but may be denied in unusual circumstances by the Chief of Staff, the Chief Executive, or either's designee.

2.3.2 An applicant or Member may inspect only his or her own credentials file (unless he or she is authorized to review another applicant's or Member's file in accordance with the provisions set forth in Section 3.4 below) and may review only the following credentials file items:

2.3.2.1 Documents or correspondence the applicant or Member personally prepared and submitted, e.g., his or her application or letters.

2.3.2.2 Documents or correspondence addressed and sent directly to the applicant or Member.

2.3.2.3 Public documents, such as copies of the applicant's or Member's license to practice medicine.

2.3.3 Copies of any item contained in the credentials file shall not be made for an applicant or a Member unless:

a. Pursuant to Section 3.3.2, the applicant or Member may inspect the item, and

b. Approval for such copy to be made has been secured from the Chief of Staff, the Vice Chief of Staff, and/or either's designee, and
c. The applicant or Member has reimbursed the Hospital for the costs it incurred in making such copies.
d. Except as provided in Sections 3.3.2 and 3.3.3, applicants and Members may not have access to any item or document contained in the credentials file except as approved by the Chief Executive or the Chief of Staff.

2.3.4 Disclosures shall be made in connection with any hearing, as provided in the Medical Staff Bylaws and Rules.

2.4 Disclosure to Medical Staff Officers and Medical Staff Committees or Their Designee

2.4.1 Credentials files may be disclosed, as appropriate, to Medical Staff officers, Department and Section leaders, the Chief Medical Officer, Medical Staff committees and their Chairs; or to their designees. Disclosure to such persons or entities shall occur whenever necessary to enable them to carry out their responsibilities of evaluating and improving the quality of care rendered in the Hospital. For example, the contents of the credentials files may be disclosed to persons or committees that are responsible for recommending appointment or reappointment to the Medical Staff and what, if any, clinical privileges shall be granted; for investigating any request for corrective action, or recommending what, if any, corrective action should be taken, and for quality improvement and peer review committee activities. If the custodian of records questions any disclosure request, he or she shall confer with the Chief of Staff or the Chief Medical Officer before releasing the file.

2.4.2 Disclosure to Medical Staff Officer and Committees shall occur in the Committee Meeting or Medical Staff Office except in the rare exception authorized by the Chief of Staff or Chief Executive. Copies of all or a portion of Credentials Files shall not be made for Medical Staff Members or Committee members except as directed by the Chief of Staff, Chief Executive, or Committee Chair.

2.5 Disclosure to the Hospital Governing Body

2.5.1 The contents of the credentials files may be disclosed to the Hospital's Governing Body - or any individual Governing Body member - insofar as is necessary to enable the Governing Body to properly fulfill its legal responsibilities and whenever necessary to enable the members to carry out their responsibilities of evaluating and improving the quality of care in the Hospital. The Chief of Staff shall review and authorize such disclosures.

2.5.2 Disclosure should be limited to the member(s) or subcommittee(s) that are responsible for evaluating and analyzing such information.
a. Generally, any portion of a credentials file that is reviewed by Governing Body members should not be included in or maintained as a part of Governing Body records or minutes.
b. Governing Body actions shall refer, as appropriate, in summary fashion and by reference to any credentials file material.
c. All portion of credentials files reviewed by the Governing Body shall be returned to and maintained by the Medical Staff Office or designated area.

Rule 3 Professional Liability Insurance

3.1 General

Each Practitioner granted clinical privileges (including temporary privileges) shall maintain professional liability insurance in an amount not less than $1,000,000 per occurrence, $3,000,000 aggregate and with a carrier on the list approved by the Medical Executive Committee.

The following criteria shall be used to approve carriers:

3.1.1 Admitted Carrier in California:

Admitted carriers are required to participate in the California Insurance Guaranty Association. If an admitted carrier becomes insolvent, the CIGA settles unpaid claims and assesses each insurance company for its fair share. Admitted status should be a reasonable assurance that losses can be covered. Appropriate hospital Departments will verify admitted status with the Office of California Insurance Commission.

3.1.2 Non-Admitted Carrier in California:

If a carrier is not admitted, it should meet both of the following criteria:

3.1.2.1 Best's Rating of B+, B++ -- Very Good; A, A- -- Excellent; or A+, A++ -- Superior; and

3.1.2.2 Financial Size Category - Class VIII or above (surplus plus conditional reserve funds greater than $100,000,000).

The appropriate hospital department will verify the criteria using A.M. Bestline. A carrier meeting both criteria would be considered evidence of ability to cover losses.

3.1.3 Professional Liability Insurance provided through the hospital or health system applicable to patients treated by volunteer or employed healthcare providers in certain limited circumstances, as applicable, is acceptable for compliance with this Rule 4

The insurance shall apply to all patients the Practitioner treats and to all procedures the Practitioner has privileges to perform in the Hospital.

3.2 Proof of Insurance

Proof of insurance coverage must be provided in the form of current certificates of insurance or confirmation provided by the insurer. The proof shall be maintained in each Practitioner's credentials file. Information about insurance coverage must be provided at the time of appointment and reappointment and upon request from any Medical Staff Committee, officer, or Department, or Section leader.

3.2.1 At the time of initial appointment and reappointment, each applicant or Member must provide information on any professional liability claims filed against him or her, any malpractice claims reported to his or her insurance carrier, any letters of intent to sue he or she received, any claims pending, any judgment entered against him or her, and any settlement made where there was a monetary payment. In addition, the applicant or Member must state whether he or she was denied professional liability insurance, had his or

her policy canceled, had limitations placed on his or her scope of practice, or has been notified of any intent to deny, cancel, or limit coverage.

3.3 Reporting Changes

Each Member shall report any reduction, restriction, cancellation, or termination of the required professional liability insurance or change in insurance carrier as soon as reasonably possible to the Credentials Committee and Chief Executive, through a notice sent to the Medical Staff Office.

3.4 Failure to Maintain Professional Liability Insurance

The automatic suspension procedure set forth in the Medical Staff Rules shall be followed in the event a Practitioner fails to maintain insurance in the required amount.

3.5 Availability of Information

Upon receipt of a written request from a Medical Staff Member, the Medical Staff Office may supply information to the Member regarding another Member's insurance coverage.

Rule 4 Category of Membership

4.1 Categories

The following are the categories of Medical Staff membership: Active, Associate, Affiliate, Administrative and Honorary/Emeritus.

Active: Regularly admit/treat/refer/consult

Associate: Occasionally admit/treat patients. Includes new members.

Affiliate: Have limited privileges only to perform history and physical examinations and assist at surgery

Telemedicine: Not privileged to practice on the hospital premises; who practice at a Distant Site; who are granted privileges to provide only Telemedicine Services to patients physically located in the Hospital, a.k.a., the originating site; and who provide those services pursuant to a contract between the Hospital and a Distant Site

Emeritus: Members of the Staff retired from practice at St. Joseph Hospital with 20 years or more of service at St. Joseph Hospital or individuals of outstanding reputation whom the Medical Staff wishes to honor may request a change of staff status to Honorary/Emeritus.

MEDICAL STAFF CATEGORIES

	ACTIVE	ASSOCIATE	AFFILIATE	TELEMEDICINE	EMERITUS
Prerogatives Admits, consults and refers inpatients and out patients	Yes	Yes	H&P or Surgery assist	No	No
Eligible for clinical privileges	Yes	Yes	Yes (limited)	Yes	No
Vote	Yes	No	No	No	No
Hold Office	Yes	No	No	No	No
Serve as Committee Chair	Yes	No	No	No	No
Serve on Committee	Yes	Yes	Yes	No	Yes
Responsibilities Medical Staff Functions	Yes	Yes	Yes	Yes	Yes
Consulting	Yes	Yes	No	No	No
ER Call	Yes	Yes	No	No	No
Attend Meetings (as requested)	Yes	Yes	Yes	Yes	Yes
Pay Application Fee	Yes	Yes	Yes	Yes	No
Pay Dues	Yes	Yes	Yes	Yes	No
Additional Particular Qualifications					
Have patient activity (zero activity results in non-renewal of appointment	Yes - > 50	Yes > 1	Yes >1	Yes >1	No

4.2 Fees

The application fee for all applicants, except Telemedicine applicants credentialed by proxy, to the Medical or Allied Health Staff is $750.00

The application fee for Telemedicine applicants credentialed by proxy is $375.00

Dental Assistants do not pay application fees.

The application fee for AHP's other than PA's and NP's is $250.00

The expedited application fee is $250 plus the $750 fee

The application fee for practitioners applying for temporary privileges only is $300.00.

4.3 Annual Medical Staff Dues

Staff Category	Active	Associate	Affiliate	Allied Health/ Advanced Practice Professionals	Telemedicine	Emeritus
Pay Dues *	YES $350	YES $450	YES $450	YES $300 *	YES $350	NO

*Dental assistants do not pay annual dues.

Rule 5 Procedures for Appointment and Reappointment

5.1 Application Form

5.1.1 Provision and Return of Application

Each Practitioner who expresses formal interest in a recognized and appropriate category of membership and privileges shall be provided an application form for Medical Staff membership. Upon completion by the Practitioner, the form shall be returned to the Medical Staff Office together with the non-refundable application fee as required by the Rules.

5.1.2 Application Form

The application form shall be approved by the Executive Committee and the Governing Body and, once approved, shall be considered part of these Rules. The application shall request information pertinent to the applicant's qualifications and document the applicant's agreement to abide by the Medical Staff and Hospital Bylaws, Rules and policies (including the standards and procedures for evaluating applicants contained therein) and to release all persons and entities from any liability that might arise from their investigating and/or acting on the application.

5.2 Physical and Mental Capabilities

5.2.1 Obtaining Information

5.2.1.1 The application shall request information pertaining to the condition of the applicant's physical and mental health on a separate page of the form, which can be removed from the remaining application and processed separately. Upon receipt of the application, the page addressing physical and mental disabilities shall be removed and referred to the Committee on Physician Health.

5.2.1.2 When the Medical Staff Office verifies information and obtains references, it shall ask for any information concerning physical or mental disabilities to be reported on a confidential form, which can be processed separately from the other information obtained regarding the applicant. This information will be referred to the Committee on Physician Health.

5.2.1.3 The Committee on Physician Health shall be responsible for investigating any Practitioner who has or may have a physical or mental disability that might affect the Practitioner's ability to exercise his or her requested privileges in a manner that meets the Hospital and Medical Staff's quality of care standards. This may include one or all of the following:

5.2.1.3.1 Medical Examination: To ascertain whether the Practitioner has a physical or mental disability that might interfere with his or her ability to provide care which meets the Hospital and Medical Staff's quality of care standards.

5.2.1.3.2 Interview: To ascertain the condition of the Practitioner and to assess if and how reasonable accommodations can be made.

5.2.1.4 Any Practitioner who feels limited or challenged in any way by a qualified mental or physical disability in exercising his or her clinical privileges and in meeting

quality of care standards should make such limitation immediately known to the Committee on Physician Health. Any such disclosure will be treated with the high degree of confidentiality that attaches to the Medical Staff's peer review activities.

5.2.2 Review and Reasonable Accommodations

5.2.2.1 Any Practitioner who discloses or manifests a qualified physical or mental disability will have his or her application processed in the usual manner without reference to the condition.

5.2.2.2 The Committee on Physician Health shall not disclose any information regarding any Practitioner's qualified physical or mental disability until the Credentials Committee (or, in the case of temporary privileges, the Medical Staff representatives who review temporary privilege requests and the Chief Executive) has determined that the Practitioner is otherwise qualified for membership and/or to exercise the privileges requested. Once the determination is made that the Practitioner is otherwise qualified, the Committee on Physician Health may disclose information they have regarding any physical or mental disabilities and the effect of those on the Practitioner's application for membership and privileges to the Chief of Staff. The Committee on Physician Health shall not disclose information regarding a disability to the Medical Executive Committee unless it has determined that the Practitioner cannot perform the essential functions even with a reasonable accommodation. The Committee on Physician Health and any other appropriate committees may meet with the Practitioner to discuss if and how reasonable accommodations can be made.

5.2.2.3 As required by law, the Medical Staff and Hospital will attempt to provide reasonable accommodations to a Practitioner with known physical or mental disabilities, if the Practitioner is otherwise qualified and can perform the essential functions of the Staff appointment and privileges in a manner which meets the Hospital and Medical Staff quality of care standards. If reasonable accommodations are not possible under the standards set forth herein, it may be necessary to withdraw or modify a Practitioner's privileges and the Practitioner shall have the hearing and appellate review rights described in the Bylaws and Rules.

5.3 Effect of Application

5.3.1 By applying for or by accepting appointment or reappointment to the Medical Staff, the applicant:

5.3.1.1 Signifies his or her willingness to appear for interviews in regard to his or her application for appointment.

5.3.1.2 Authorizes Medical Staff and Hospital representatives to consult with other hospitals, persons or entities who have been associated with him or her and/or who may have information bearing on his or her competence, and qualifications

or that is otherwise relevant to the pending review and authorizes such persons to provide all information that is requested orally and in writing.

5.3.1.3 Consents to the inspection and copying, by Hospital representatives, of all records and documents that may be relevant or lead to the discovery of information that is relevant to the pending review, regardless of who possesses these records, and directs individuals who have custody of such records and documents to permit inspection and/or copying.

5.3.1.4 Certifies that he or she will report any subsequent changes in the information submitted on the application form to the Credentials Committee and the Chief Executive.

5.3.1.5 Releases from any and all liability the Medical Staff and the Hospital and their representatives for their acts performed in connection with evaluating the applicant.

5.3.1.6 Releases from any and all liability all individuals and organizations who provide information concerning the applicant, including otherwise privileged or confidential information, to Hospital representatives.

5.3.1.7 Authorizes and consents to Hospital representatives providing other hospitals, professional societies, licensing boards, and other organizations concerned with provider performance and the quality of patient care with relevant information the Hospital may have concerning him or her, and releases the Hospital and Hospital representatives from liability for so doing.

5.3.1.8 Agrees that the Hospital and Medical Staff may share information with a representative or agent from any Affiliated Healthcare Entity, including information obtained from other sources, and releases each person and each entity who received the information and each person and each entity who disclosed the information from any and all liability, including any claims of violations of any federal or state law, including the laws forbidding restraints of trade, that might arise from the sharing of the information and likewise agrees that the Hospital and any and all Affiliated Healthcare Entity may act upon such information.

5.3.1.9 Consents to undergo and to release the results of a medical, psychiatric, or psychological examination by a Practitioner acceptable to the Committee on Physician Health, at the applicant's expense, if deemed necessary by the Committee on Physician Health or Executive Committee.

5.3.1.10 Signifies his or her willingness to abide by all the conditions of membership, as stated on the appointment application form, on the reappointment application form, and in the Bylaws and these Rules.

5.3.1.11 Agrees to abide by the terms of the Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations.

5.3.2 Definitions

5.3.2.1 The term “Hospital Representative” includes the Governing Body, its individual Directors and committee members; the Chief Executive, the Medical Staff, all

Medical Staff, Service, Department, and Section officers and leaders and/or committee members having responsibility for collecting information regarding or evaluating the applicant's credentials; and any authorized representative or agent of any of the foregoing.

5.3.2.2 The term "Affiliated Healthcare Entity" refers to any other health care entity or provider group with whom the Hospital has agreed to affiliate to provide cooperative credentialing, peer review, corrective action, and hearings and appeals.

5.4 Verification of Information

5.4.1 Completion of Application and Verification

5.4.1.1 The applicant shall fill out and deliver an application form to the Medical Staff Office, which shall seek to verify the information submitted. The application will be deemed complete when all necessary verifications have been obtained, including current and past licenses, licensing board disciplinary records, specialty board certification status, National Practitioner Data Bank information, DEA certificate if privileges to prescribe will be sought, record of exclusion from federal programs, verification of all practice from professional school through the present, current and past malpractice liability insurance, and reference letters.

5.4.1.2 The Medical Staff Office shall then transmit the application and all supporting materials to the Chair of each Department and Section in which the applicant seeks privileges and to the Credentials Committee.

5.4.2 Incomplete Application

5.4.2.1 If the Medical Staff Office is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise significantly incomplete, the Medical Staff Office may delay further processing of the application, or may begin processing the application based only on the available information with a decision that further information may be considered upon receipt.

5.4.2.2 If the processing of the application is delayed for more than 150 days and if the missing information is reasonably deemed significant to a fair determination of the applicant's qualifications, the affected Practitioner shall be so informed. He or she shall then be given the opportunity to withdraw his or her application, or to request the continued processing of his or her application. If the applicant does not respond within 30 days, he or she shall be deemed to have voluntarily withdrawn his or her application. If the applicant requests further processing, but then fails to provide or arrange for the provision within 30 days or any other date mutually agreed to when the extension was granted (whichever is later) of the necessary information that the Practitioner could obtain using reasonable diligence, the Practitioner shall be deemed to have voluntarily withdrawn his or her application.

5.4.2.3 Any application deemed incomplete and withdrawn under this Rule may, thereafter, be reconsidered only if all requested information is submitted, and all other information has been updated.

5.5 Action on the Application

5.5.1 Department and Section Action

Upon receipt, the Department Chair or Section Chair (if the Department has Sections) shall review the application, supporting documentation, and other relevant information available to him or her. The Department Chair and/or Section Chair may personally interview the applicant. The Section Chair shall forward his or her recommendations to the Department Chair. The Department Chair shall send his or her recommendations to the Credentials Committee. The recommendations shall address Staff appointment, Department and Section affiliations, and clinical privileges.

5.5.2 Credentials Committee Action

The Credentials Committee or a subcommittee thereof shall review the application, supporting documentation, Department Chair and Section Chair recommendations, and other relevant information available to it. The Credentials Committee or a subcommittee thereof may personally interview the applicant. The Credentials Committee shall send the Executive Committee a written report and recommendations as to Staff appointment, Department and Section affiliations, and clinical privileges.

5.5.3 Executive Committee Action

5.5.3.1 Preliminary Recommendation: At its next regular meeting after receiving the Credentials Committee and Department Chair reports and recommendations, the Executive Committee shall consider all relevant information available to it. The Executive Committee shall then formulate a preliminary recommendation. If the preliminary recommendation is favorable, the Executive Committee shall then, at the same meeting, assess the applicant's health status, the report from the Committee on Physician Health (if any and determine whether the applicant is able to perform, with or without reasonable accommodation, the necessary functions of a Member of the Medical Staff.

5.5.3.2 Final Recommendation: Thereafter, a final recommendation shall be formulated, and the Executive Committee shall forward to the Governing Body a written report and recommendations, as follows:

5.5.3.2.1 Favorable Recommendation: Favorable recommendations shall be promptly forwarded to the Governing Body together with the application form and its accompanying information and Credentials Committee and Department Chair and Section Chair reports on Staff appointment, and Department and Section affiliations, clinical privileges to be granted, and any special conditions to be attached to the appointment.

5.5.3.2.2 Adverse Recommendation: When the recommendation is adverse in whole or in part, the Chief of Staff shall immediately inform the Practitioner by Special Notice, and he or she shall be entitled to the hearing and appeal rights provided in the Bylaws Article 13.

5.5.3.2.3 The Governing Body shall be generally informed of, but shall not receive detailed information and shall not take action on, the pending adverse recommendation until the applicant has exhausted or waived his or her procedural rights.

5.5.3.2.4 For the purposes of this section, an “adverse recommendation” by the Executive Committee is as defined in the Medical Staff Bylaws Section 14.2

5.5.3.3 Deferral: The Credentials Committee, Department Chair or Section Chair, and/or Executive Committee may defer its recommendation in order to obtain or clarify information, or in other special circumstances. A deferral must be followed up within 60 days with a recommendation for appointment and privileges, or for rejection for Staff membership.

5.5.4 Governing Body Action

5.5.4.1 On Favorable Executive Committee Recommendation: The Governing Body shall adopt, reject, or modify a favorable recommendation of the Executive Committee, or shall refer the recommendation back to the Executive Committee for further Consideration, stating the reasons for the referral and setting a time limit within which the Executive Committee shall respond. If the Governing Body's action is a ground for a hearing under Bylaws Section 14.2, the Chief Executive shall promptly inform the applicant by Special Notice, and he or she shall be entitled to the hearing and appeal rights provided in Bylaws Article 14.

5.5.4.2 Without Benefit of Executive Committee Recommendation: If the Governing Body does not receive an Executive Committee recommendation within the time specified below, it may, after giving the Executive Committee written notice and a reasonable time to act, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Governing Body. If the recommendation is a ground for a hearing under Bylaws Section 14.2, the Chief Executive shall give the applicant Special Notice of the tentative adverse recommendation and of the applicant's right to request a hearing. The applicant shall be entitled to the hearing and appeal rights provided in the Bylaws Article 14 before any final adverse action is taken.

5.5.4.3 After Procedural Rights: In the case of an adverse Executive Committee recommendation or an adverse Governing Body decision pursuant to Rule 5.5.3 or 5.5.4, the Governing Body shall take final action in the matter only after the applicant has exhausted or has waived his or her Bylaws, Article 13 procedural

rights. Action thus taken shall be the conclusive decision of the Governing Body, except that the Governing Body may defer final determination by referring the matter back for reconsideration. Any such referral shall state the reasons therefore, shall set a reasonable time limit within which reply to the Governing Body shall be made, and may include a directive that additional hearings be conducted to clarify issues which are in doubt. After receiving the new recommendation and any new evidence, the Governing Body shall make a final decision.

5.5.4.4 Conflict Resolution: The Governing Body shall give great weight to the actions and recommendations of the Executive Committee, and in no event shall act in an arbitrary and capricious manner.

5.5.5 Notice of Final Decision

5.5.5.1 The Chief Executive shall give notice of the Governing Body's final decision to the Executive Committee and to the applicant. If the decision is adverse, the notice to the applicant shall be by Special Notice. A decision and notice to appoint shall include:

5.5.5.1.1 The Staff category to which the applicant is appointed;

5.5.5.1.2 The Department and Section, if any, to which the Practitioner is assigned;

5.5.5.1.3 The Privileges the Practitioner may exercise; and

5.5.5.1.4 Any special conditions attached to the appointment.

5.5.6 Guidelines for Time of Processing

All individuals and groups shall act on applications in a timely and good faith manner. Except when additional information must be secured or for other good cause, each application should be processed within the following time guidelines:

REVIEWER	TIME FRAMES FOR REVIEW
Medical Staff Office	35 days after all necessary documentation is received.
Section Chair (if any)	65 days after receiving application from Medical Staff Office.
Department Chair	65 days after receiving application from Medical Staff Office or Section Chair, if there is one.
Credentials Committee	45 days after receiving application from the Department Chair.
Executive Committee	45 days after receiving application from the Credentials Committee
Governing Body	45 days after receiving application from Executive Committee, except when the hearing appeal rights of Article 13 apply.

These time periods are guidelines and are not directives which create any rights for a Practitioner to have an application processed within these precise periods. If action at a particular step in the process is delayed without good cause, the next higher authority may immediately proceed to consider the application upon its own initiative or at the direction of the Chief of Staff or the Chief Executive. If action is not completed within 180 days from the time the first reference was received, an update on the references shall be requested.

5.5.7 Expedited Action

If the Medical Staff Office determines an applicant has no negative information in the file, the file may be referred to the Credentials Committee Chair or his or her designee, who will determine whether the application qualifies for expedited action. If he or she determines the file qualifies for expedited action, the file shall be forwarded to the Chair of each Department and to each Section Chair (if the Department has Sections) in which the applicant seeks membership. If they agree the applicant qualifies for expedited action, the file shall be referred to the Chief Executive, who will decide whether to act on behalf of the Governing Body to grant membership and privileges on an expedited basis.

The expedited action processing will be terminated and routine processing resumed if anyone who reviews the file finds that expedited action is not warranted. If expedited approval is given, the file will nevertheless be submitted to the Credentials Committee, Executive Committee and Governing Body at their regularly scheduled meetings for review. Any of those bodies except the Governing Body may act within 60 days to rescind an expedited approval for privileges and return the application for routine processing. There will be no right to expedited action and no hearing and appeal rights if expedited action is not taken or if approval given under the expedited action process is rescinded.

5.5.8 Expedited Action – In the Absence of Regular Meetings

If the Medical Staff Office determines an applicant has no negative information in the file, at both initial and reappointment, the file may be referred to the Credentials Committee Chair or his or her designee, who will determine whether the application qualifies for expedited action. If he or she determines the file qualifies for expedited action, the file shall be forwarded to the Chair of each Department and to each Section Chair (if the Department has Sections) in which the applicant seeks membership.

If they agree the applicant qualifies for expedited action, the file shall be referred to the Medical Executive Committee for further action. If the Medical Executive Committee meeting for that month has been cancelled the application may be forwarded to the Chief of Staff for expedited approval. The application may then be forwarded to the Board of Trustees for approval, the Chief of Staff and Vice Chief of Staff may approve an expedited action of an applicant for medical staff membership and privileges, as Board of Trustee members, in the absence of a regular meeting of the Medical Affairs Committee of the Board of Trustees, submitting the expedited action to the next regular meeting of the Medical Affairs Committee of the Board of Trustees.

The applicant's expedited approval will be ratified by the approving bodies, the Credentials Committee, the Medical Executive Committee and the Medical Affairs Committee of the Board of Trustees, at their next regular meetings.

The expedited action processing will be terminated and routine processing resumed if anyone who reviews the file finds that expedited action is not warranted. If expedited approval is given, the file will nevertheless be submitted to the Executive Committee and Board of Trustees at their regularly scheduled meetings for review. Any of those bodies, except the Governing Body, may act within 60 days to rescind an expedited approval for privileges and return the application for routine processing.

There will be no right to expedited action and no hearing and appeal rights if expedited action is not taken or if approval given under the expedited action process is rescinded.

5.6 Duration of Appointment

5.6.1 All new Staff Members shall be appointed to the Associate Staff and subjected to a period of formal observation and review.

5.6.2 Reappointments to any Staff category shall be for a maximum period of 24 months.

5.7 Reappointment Process

5.7.1 Schedule for Reappointment

5.7.1.1 At least 180 days prior to the expiration date of each Staff Member's appointment (except temporary privileges), the Medical Staff Office shall provide the Member with a reappointment form. If the reappointment form is not completed and returned to the Medical Staff Office within 60 days after it was initially mailed, a final written notice shall be promptly sent to the applicant advising the Member that the application has not been received. Failure, without good cause, to return the reappointment form and all requested documentation within 15 days after the final warning notice was mailed shall result in an automatic lapse of membership and Privileges, as described in Section 5.7.11.

5.7.1.2 A Member may request a change in Membership category or Privileges when he or she is not scheduled for biennial review and such request will be processed when it is received. The Member shall also be reviewed in accordance with the standard reappointment schedule.

5.7.1.3 Appointments and reappointment shall expire on date and year shown below, and the reappointment processing shall be started on date and year shown below based upon the Department/Specialty to which a member is assigned.

<u>EVEN YEARS</u>:

<u>January</u>
Genetics
Cardiology
APPs within specialties above

<u>February</u>
Nephrology (Adult & Peds)
Infectious Disease
Rheumatology
Physical/Rehab Med
Sleep
Allergy & Immunology
APPs within specialties above

<u>March</u>
Pulmonology
Hematology/oncology
APPs within specialties above

<u>April</u>
Otolaryngology
Dermatology
Pediatrics (Critical Care)
Pediatrics (Gastroenterology)
APPs within specialties above

<u>May</u>
Podiatry
Ophthalmology

<u>June</u>
Orthopedics (A-R)
APPs within specialties above

<u>July</u>
Pediatrics (K-T)
APPs within specialties above

<u>August</u>
Emergency Medicine
Orthopedics (S-Z)

<u>September</u>
Pediatrics (Cardiology)
Pediatrics (Hem/Onc)
Pediatrics (A-C)
APPs within specialties above

<u>October</u>
Pathology
Neonatology/Perinatal

Pediatrics (Neurology)
Pediatrics (Pulmonology)
Pediatrics (U-Z)
AHP/APPs within specialties above

January
Anesthesia
APPs – Emergency Medicine

February
Psychiatry
Psychology
APPs BHS
AHP – RNFA

March
General Surgery
FP (A-G)
APPs within specialties above

April
FP (H-Z)
APPs with specialties above

May
OB/GYN
Female Pelvic Med & Recon
Maternal Fetal
Reproductive Endocrinology
Obstetrics
APPs with specialties above

June
Thoracic Surgery
Urology
Vascular Surgery
Colorectal Surgery
APPs with specialties above

July
Dentistry
Oral/Max Surgery
AHP – Dental Assist/Surgery Tech
Neurosurgery
APPs with specialties above

August
Pediatrics (D-J)
Neurology
Gynecology Oncology
Gynecology

September
Gastroenterology
Endocrinology
Plastic Surgery
APPs with specialties above

October
Internal Medicine (K-Z)
APPs with specialties above

November
Internal Medicine (A-J)
APPs with specialties above

December
None

November
Radiology
Radiation Therapy
Interventional Radiology
Teleradiology
APPs within specialties above

December
None

ODD YEARS

5.7.2 Content of Reappointment Form

5.7.2.1 The reappointment form shall be approved by the Executive Committee and the Governing Body, and once approved shall be considered part of these Rules. The form shall seek information concerning the changes in the applicant's qualifications since his or her last review. Specifically, the form shall request an update of all of the information and certifications requested in the appointment application form, with the exception of that information which cannot change over time, such as information regarding the Member's premedical and medical education, date of birth, and so forth. The form shall also require information as to what privileges are requested, what, if any changes are requested in staff status and/or clinical privileges, including any reduction, deletion, or additional privileges. Requests for additional privileges must be supported by the type and nature of evidence that would be necessary for such privileges to be granted in an initial application.

5.7.2.2 If the Staff Member's level of clinical activity at this Hospital is not sufficient to permit the Staff and Board to evaluate his or her competence to exercise the clinical privileges requested, the Staff Member shall have the burden of providing evidence of clinical performance at his or her principal institution in whatever form as the Staff may require.

5.7.2.3 Members applying for reappointment must complete the information requested on the reappointment form and pay any reappointment application fee.

5.7.3 Verification and Collection of Information

5.7.3.1 The Medical Staff Office shall, in timely fashion, seek to verify the additional information made available on each reappointment application and to collect any other materials or information deemed pertinent by the Executive Committee, the Credentials Committee, or Chair of any Department or Section (if the Department has Sections) to which the Member belongs. The information shall address, without limitation:

5.7.3.1.1 Patterns of care and utilization as demonstrated in the findings of quality improvement, risk management and resource management activities.

5.7.3.1.2 Participation in relevant continuing education activities

5.7.3.1.3 Level/amount of clinical activity (patient care contacts) at the Hospital

5.7.3.1.4 Sanctions imposed or pending, exclusion from federal programs, and other problems.

5.7.3.1.5 Adverse actions pending or taken by any other hospital or health care entity

5.7.3.1.6 Health status including completion of a physical examination or psychiatric evaluation by a physician who is mutually accepted by the affected Practitioner and Staff, when requested by the Credentials Committee or Executive Committee and subject to the standards set forth in Rule 6.2 pertaining to Physical and Mental Capabilities.

5.7.3.1.7 Timely and accurate completion and preparation of medical records.

5.7.3.1.8 Cooperativeness and general demeanor in relationships with other Practitioners, Hospital personnel, and patients.

5.7.3.1.9 Professional liability claim experience, including being named as a party in any professional liability claims and the disposition of any pending claims.

5.7.3.1.10 Compliance with all applicable Medical Staff and Hospital Bylaws, Rules, and policies.

5.7.3.1.11 Any other pertinent information including the Staff Member's activities at other hospitals and his or her medical practice outside the Hospital.

5.7.3.1.12 Information concerning the Member from the state licensing board and the National Practitioner Data Bank.

The Medical Staff Office shall transmit the completed reappointment application form and supporting materials to the Chair of each Department to which the Staff Member belongs, or to the Section Chair (if the Department has Sections) and to the Chair of any other Department or Section in which the member has or requests privileges and to the Credentials Committee.

5.7.4 Department and Section Action

The Department or Section Chair (if there is a relevant Section) shall review the application and all other relevant available information. He or she shall transmit to the Department Chair his or her written recommendations, which are prepared in accordance with Rule 5.7.7. Upon receipt of an application from a Section Chair or the Medical Staff Office (if there is no Section), the Department Chair shall review the application and all other relevant available information. He or she shall transmit

to the Credentials Committee his or her written recommendations, which are prepared in accordance with Rule 5.7.7.

5.7.5 Credentials Committee

The Credentials Committee shall review the application, the Department Chair and any Section Chair's recommendation, and all other relevant available information. The Credentials Committee shall transmit to the Executive Committee written recommendations, which are prepared in accordance with Rule 5.7.7.

5.7.6 Executive Committee Action

5.7.6.1 The Executive Committee shall review the Credentials Committee and Department Chair and any Section Chair's recommendations and all other relevant information available to it and shall forward to the Governing Body its favorable recommendations, which are prepared in accordance with Rule 5.7.7.

5.7.6.2 When the Executive Committee recommends adverse action, as defined in Bylaws Section 14.2, either with respect to reappointment or clinical privileges, the Chief of Staff shall give the applicant Special Notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Bylaws Section 14.4.1. The applicant shall be entitled to the Section 14 hearing and appeal rights. The Governing Body shall be informed of, but not take action on, the pending recommendation until the applicant has exhausted or waived his or her procedural rights.

5.7.6.3 Thereafter the procedures specified for applicants in Rule 5.5.4 (Governing Body Action), Rule 5.5.5 (Notice of Final Decision) and in the Bylaws Section 5.17 (Waiting Period After Adverse Action), shall be followed. The Committee may also defer action; however, any deferral must be followed up within 70 days with a recommendation.

5.7.7 Reappointment Recommendations

Reappointment recommendations shall be written and shall specify whether the applicant's appointment should be renewed; renewed with modified membership category, Department and any Section affiliation, and/or clinical privileges; or terminated. The reason for any adverse recommendation shall be described. The Medical Staff may require additional proctoring of any clinical privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and such proctoring requirements imposed for lack of activity shall not result in any hearing rights.

5.7.8 Basis for Reappointment

Reappointment recommendations (including privilege recommendations) shall be based upon whether the Member has met all of the qualifications and carried out all of the responsibilities set forth in the Medical Staff and Hospital Bylaws, Rules and policies.

5.7.9 Expedited Action on Reappointments

5.7.9.1 If the Medical Staff Office determines an applicant for reappointment appears to meet all standards for reappointment and has no negative information in the file, the file may be referred to the Credentials Committee Chair or his or her designee, who will determine whether the application qualifies for expedited action. If he or she determines the file qualifies for expedited action, the file shall be forwarded to the Chair of each Department and to the Section Chair (if the Department has Sections) in which the Member seeks renewal of his or her membership. If they agree the applicant qualifies for expedited action, the file shall be referred to the Chief Executive, who will decide whether to act on behalf of the Governing Body to grant membership and privileges on an expedited basis. The expedited action processing will be terminated and routine processing resumed if anyone who reviews the file finds that expedited action is not warranted. If expedited approval is given, the file will nevertheless be submitted to the Credentials Committee, Executive Committee and Governing Body at their regularly scheduled meetings for review. Any of those bodies except the Governing Body may act within 60 days to rescind an expedited approval for privileges and return the application for routine processing.

5.7.9.2 There will be no right to expedited action and no hearing and appeal rights if expedited action is not taken or if approval given under the expedited action process is rescinded.

5.7.9.3 Expedited Action on Reappointments – In the Absence of Regular Meetings (Please refer to Rule 6, Section 5.5.6)

5.7.10 Interim Appointment and Reappointment Realignment

If the reappointment application has not been fully processed before the Member's appointment expires, or if a member's reappointment month is realigned, the Staff Member shall maintain his or her current membership status and clinical privileges until the reappointment review is complete only if approved by the Department Chair, Credentials Committee, Executive Committee and Governing Body. This does not prevent corrective action which may affect the Practitioner's membership and/or clinical privileges.

5.7.10.1 If a member's reappointment month is realigned and their most recent application and or reappointment application does not exceed 180 days, the member will not be required to complete a new reappointment application.

5.7.10.2 At a minimum, the following items will be reviewed and/or verified:

a. Patterns of care as demonstrated in the findings of peer review, quality improvement, and risk management activities through OPPE.
b. Sanctions imposed or pending, exclusion from federal programs, and other problems, including verification of OIG, GSA, NPI and DEA.

c. Compliance with all applicable Medical Staff and Hospital Bylaws, Rules, and policies.
d. Information concerning the Member from the state licensing board and the National Practitioner Data Bank.
e. Verification of current Board Certification (if applicable to membership and/or privilege requirements)

5.7.10.3 An interim appointment may not be granted if the delay is due to the Member's failure to return the reappointment application form completed as required.

5.7.10.4 An interim appointment shall not create any right for continued membership.

5.7.11 Failure to File Reappointment Application

Failure to file a complete application for reappointment within 75 days of the initial mailing of the reappointment application shall result in the automatic lapse of a Practitioner's Membership and privileges at the expiration of the Member's current term. Members whose membership automatically lapses will be processed as new applicants should they wish to reapply. In the event membership lapses for the reasons set forth herein, the Member is not entitled to any hearing or review.

5.8 Relinquishment of Privileges

A Staff Member who wishes to relinquish or limit particular privileges shall send written notice to the Chief of Staff and the appropriate Department Chair or Section Chair (if the Department has Sections) identifying the particular privileges to be relinquished or limited. A copy of this notice shall be forwarded to the Medical Staff Office for inclusion in the Member's credentials file.

Rule 6 Delineation of Privileges

6.1 General

6.1.1 Requests

6.1.1.1 Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Privileges desired by the applicant. A request for a modification and or addition of Privileges must be supported by documentation of training and/or experience supportive of the request.

6.1.1.2 Each Department and Section will be responsible for developing criteria for granting Privileges, and including those criteria in the Department Rules or Section Rules and subject to approval by the Credentials Committee, Executive Committee and Governing Body.

6.1.2 Bases for Privileges Determinations

Requests for Privileges shall be evaluated on the basis of the Practitioner's education, training, experience, demonstrated professional competence and judgment, clinical performance, the documented results of patient care and other quality improvement review and monitoring, performance of a sufficient number of procedures each year to develop and maintain the Practitioner's skills and knowledge and compliance with any specific criteria applicable to the Privileges. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a Practitioner exercises privileges.

6.2 Conditions for Privileges of Limited License Practitioners

6.2.1 Admissions

Dentist, psychologist, oral surgeon, and podiatrist Members may admit patients only if a Physician Member assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license Practitioner's lawful scope of practice.

6.2.2 Medical Appraisal – History and Physical Examinations

All patients admitted for care in a Hospital by a dentist, psychologist, oral surgeon, or podiatrist shall receive the same basic medical appraisal as all other patients, including those admitted by a physician. In all cases, a Physician Member shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a Physician Member and a limited license Practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license Practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Department(s) or Section.

The history and physical update will include review, interview and examination of the patient as determined by the physician or qualified licensed individual clinical judgment, based upon his/her assessment of the patient's condition and co-morbidities, if any, in relation to the patient's planned surgery to decide the extent of the update assessment/examination needed as well as the information to be included in the update note in the patient's medical record

6.3 Credentialing Telemedicine Staff

6.3.1 **Reliance on the Credentialing Decision, or Credentialing Information, of a Distant Joint Commission-Accredited Hospital or Ambulatory Care Organization, (a.k.a. "Entity" for purposes of these provisions):** In lieu of the credentialing and privileging processes set forth elsewhere in these Rules, and as authorized by the Medical Staff Bylaws, the medical staff may recommend Telemedicine Staff membership and Telemedicine Privileges for a physician by relying upon the credentialing and privileging decision of a distant Entity, when all of the following requirements are met:

6.3.1.1 The Medical Executive Committee receives credible assurances that:

a. the physician will function under a written contract between St. Joseph Hospital and the distant entity that requires the entity to provide services in a manner that permits St. Joseph Hospital to be in compliance with all Medicare Conditions of Participation;
b. The contract requires the distant site to implement a process that is consistent with the credentialing and privileging requirements in the Medical MEC chapter of The MEC Hospital Accreditation Standards.
c. the contract does not hinder the medical staff from ensuring that the services performed under the contract are provided in a safe and effective manner, in accordance with all requirements of the law and medical staff governing documents;
d. The physician completes an application form as approved by the MEC.

6.3.1.2 The Credentials Committee:

a. reviews the current list of the privileges obtained from the distant hospital that it has granted to the physician, and verifies that the distant hospital has privileged the physician to provide the same services intended to be provided to St. Joseph Hospital's patients;
b. verifies the physician holds a valid California medical license.
c. verifies the physician has malpractice insurance as required by the Hospital;
d. reviews any reports regarding the physician obtained by the Medical Staff Office from the Medical Board of California and the National Practitioner Data Bank, and recommends any additional action as appropriate.

6.3.1.3 At the MEC's discretion for good cause, and in lieu of the process described in section 6.3.A(2), an initial or reappointment application for

Telemedicine Staff may be credentialed under this section by relying on the distant entity's credentialing information rather than the distant entity's credentialing decision, to the degree such information satisfies medical staff requirements for credentialing information, and as long as the Credentials Committee has verified that the distant site physician holds a valid California medical license.

6.3.1.4 In all cases under this subsection A., the Credentials Committee may seek and require any other information regarding the initial or reappointment application it deems appropriate to credential the application.

6.3.2 **Telemedicine Privileges for Physicians Practicing at a Distant Entity that is not accredited by The Joint Commission:** The MEC shall comply with the requirements and procedures under section 6.3.A in recommending Telemedicine Staff membership and privileges for physicians who practice at a distant entity not accredited by The Joint Commission, except the medical staff shall fully privilege and credential such physicians, and shall not rely on the distant entity's credentialing or privileging decision, nor its credentialing information.

6.3.3 **FPPE for Telemedicine Privileges - Periodic Review of Telemedicine Care by Medical Staff:** For any physician granted Telemedicine Privileges under the subsections of section 6.3:

6.3.3.1 The physician must undergo a period of FPPE, as appropriate for Telemedicine Privileges and as defined by each department.

6.3.3.2 The medical staff must promptly send to the distant site entity's medical staff information from internal reviews that the distant site may use to assess the physician's quality of care, treatment, and services, and professional conduct, for use by that entity in its own privileging and performance improvement. This information must include all adverse events that result from the telemedicine services provided by the distant-site physician to St. Joseph Hospital's patients, and all complaints submitted to St. Joseph Hospital and its medical staff about the physician, plus any other information about the physician deemed appropriate by the St. Joseph Hospital Medical Executive Committee or Chief of Staff.

6.3.4 **Medical Staff is Responsible for Quality and Safety of Telemedicine Services:** At all times, the medical staff is responsible for overseeing and enforcing the safety and quality of care and services provided to patients by, and the professional conduct of, Telemedicine Staff members, and shall take all appropriate action in carrying out these responsibilities.

Rule 7 Criteria for Privileges in Interventional Radiology (Special Procedures)

7.1 Special Procedures Committee (SPC)

The Special Procedures Committee will review the training, experience, and demonstrated competence requirements for the Special Procedures Privilege form. The applicant's Section and/or Department Chair will review applicant requests for privileges in accordance with the established privilege criteria and make recommendations regarding approval; however, if requested the Special Procedures Committee can assist with review and recommendations to the appropriate department for the granting of Class IA and Class I privileges.

7.2 Categories of Privileges in Interventional Radiology:

7.2.1 Class I and Class IA, as follows:

7.2.1.1 Class I: Full or unlimited privileges to perform specific procedure.

7.2.1.2 Class IA: Limited privileges, subject to proctoring requirements, to perform specific procedures.

7.3 Considerations to be Used in Granting Interventional Radiology Privileges:

7.3.1 Indication for examination.

7.3.2 Technical performance of the procedure.

7.3.3 Radiographic control of the procedure.

7.3.4 In certain instances, a single individual might be responsible and capable in all of these aspects; whereas in other cases, this may involve multiple disciplines.

7.3.5 It is understood that, when other than a vascular surgeon performs a procedure wherein a potential vascular complication may require such expertise, a vascular surgeon should be available for consultation.

7.3.6 In all cases privileges will be granted to result in optimal performance and patient care.

7.4 Proctoring Requirements

All individuals granted interventional privileges are required to be proctored on a total of seven (7) catheter based interventional cases. Minimum requirements are:

7.4.1	Diagnostic angiography	1
7.4.2	Peripheral interventions	2
7.4.3	Non-CNS, non-cardiac embolizations	2
7.4.4	Abdominal aortic endografts/stents	2

Individuals who elect to not have privileges in a proctored section listed above will be required to be proctored 7 times in the category of privileges for which they request.

The above proctoring requirements do not cover thoracic aortic endografts/stent grafts or neuro-interventional privileges. Those requirements are listed separately in the appropriate section.

7.5 Specific Procedures and Considerations

Once a procedure becomes accepted and commonly used, criteria for its performance should be established by the SPC and documented.

7.5.1 Diagnostic Angiography

7.5.1.1 To be ordered only by physicians knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.1.2 Definition: The percutaneous passage of a catheter into an artery under fluoroscopic guidance with the subsequent injection of contrast material and imaging of the entire vascular distribution in question. For example peripheral angiography of lower extremity vessels must image the vessels from the abdominal aorta to the foot. Conventional cineradiography or video fluoroscopy alone is not sufficient for the routine recording of peripheral angiographic studies.

7.5.1.3 Physician Qualifications

7.5.1.3.1 Body of Knowledge: Physician applicants should have extensive clinical training in the diagnosis and treatment of patients with peripheral vascular disease. The body of knowledge necessary includes anatomy, natural history, and clinical manifestations of peripheral vascular disease.

7.5.1.3.2 Basic Training: At least one of the following must be met by the applicant: American Board of Radiology eligibility or certification, American Board of Internal Medicine eligibility or certification with additional completion of a fellowship in vascular medicine or American Board of Internal Medicine certification with additional eligibility or certification in cardiovascular medicine, or American Board of Surgery eligibility or certification with additional completion of a general vascular surgery residency (fellowship) or other appropriately trained physician specialists at the discretion of the Special Procedures Committee.

7.5.1.4 Specific Procedural Training and Experience

7.5.1.4.1 Qualification by Training: An applicant may qualify by completing a training program that includes a minimum of 50 diagnostic angiograms as the primary operator. These requirements may be met through the completion of a formal residency or fellowship.

7.5.1.4.2 Qualification by Experience: An applicant may qualify by having extensive previous experience in diagnostic angiography with acceptable complication rates. This experience must include at least 50 diagnostic angiograms as the primary operator.

7.5.1.4.3 Qualification by Apprenticeship: Documented performance of 50 diagnostic angiograms as the primary operator. This requirement may be met in part by documentation of previous experience. The preceptor must have Class I privileges in diagnostic angiography. Any physician with Class I diagnostic angiography privileges may act as a preceptor and any physician with Class 1 or IA privileges in vascular surgery, interventional radiology or cardiology may serve as an apprentice.

7.5.1.5 Class 1A physician or other qualified physicians must show documentation of training and/or experience. The Special procedures Committee will determine if the applicant's qualifications meet the requirements.

Once the above qualifications are met the applicant may be recommended to the appropriate department for Class IA privileges. The Committee will determine if the applicant's qualifications meet the requirements. (Temporary privileges will not be granted for peripheral angiographic catheterizations performed in the catheterization laboratory).

7.5.1.6 The applicant must have demonstrated knowledge and competence in the use of radiographic fluoroscopy and possess all required State certificates relating to the same.

7.5.2 Peripheral Interventions

7.5.2.1 To be requested by a physician knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.2.2 Definition: Defined as transluminal angioplasty, stenting, thrombolysis and the placement of Vena Caval Filters.

7.5.2.3 The applicant must have Class I or IA privileges for diagnostic angiography as defined above. To obtain class IA privileges in peripheral interventions, the applicant must have performed at least 60 percutaneous transluminal interventions, including participation in at least ten thrombolysis procedures, (with at least 50% of these 60 procedures being performed as the primary operator) with acceptable results. Documentation of all cases must be provided. The Special Procedures Committee will evaluate the experience and will determine whether or not it qualifies as acceptable. The committee, at its discretion, may require any applicant to complete additional training or

experience. Training in other types of angioplasty, such as coronary angioplasty, will not be credited. Training and experience may be obtained by qualifying through formal training, training by experience or training by apprenticeship as defined above for diagnostic angiography.

7.5.2.4 If the applicant has completed training or experience deemed appropriate by the Special Procedures Committee and has performed the required number of cases with acceptable results during that training or experience, the Special Procedures Committee may recommend that the appropriate department grant the applicant Class IA privileges.

7.5.3 Abdominal Aortic Endografts/Stent Grafts

7.5.3.1 To be ordered by a physician knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.3.2 The requirements for performing abdominal aortic endograft procedures are as follows. The applicant must have performed at least 25 aortic endografts with an acceptable complication rate with at least 50% being performed as the primary operator. OR the applicant must have Class I privileges in peripheral interventions as defined above, must have taken a hands-on course sponsored by the device manufacturer and must perform 10 aortic endograft procedures under the supervision of a qualified (Class I) on staff physician at St. Joseph Hospital. The SPC will review the experience and will make the appropriate recommendation for granting of Class IA privileges to the appropriate department.

7.5.4 Thoracic Aortic Endografts/Stent Grafts

7.5.4.1 To be ordered by a physician knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.4.2 The requirements for performing thoracic aortic endograft procedures are as follows. The applicant must have performed at least 10 thoracic aortic endografts and completed the appropriate training courses specific for the approved device. The submitted experience will be review by the department chair for the granting of Class IA privileges or appropriate recommendations.

7.5.4.3 Proctoring requirements may be met by performing at least 5 thoracic aortic endografts at St. Joseph Hospital under the observation of a qualified (Class I) on staff physician. If there is no qualified physician on staff at St. Joseph Hospital a physician with Class I privileges in thoracic aortic endografts from another institution may be used as the proctor. The Special Procedures Committee will determine the acceptability of the experience. If the experience is acceptable the applicant will be recommended to the appropriate department for Class I privileges.

7.5.5 Carotid Angioplasty and Stenting (CAS)

7.5.5.1 To be ordered by a physician knowledgeable in the diagnosis and management of carotid artery disease.

7.5.5.2 To be granted Class IA privileges, the applicant must have performed at least 30 carotid diagnostic angiograms and have Class I or Class IA privileges in diagnostic angiography and peripheral interventions as defined above. The applicant must have performed at least 10 CAS procedures with acceptable results under the supervision of an on site qualified physician OR must have attended a comprehensive course in carotid stenting consisting of at least 12 hours didactic and hands on course and successfully completed 4 CAS procedures under the supervision of an onsite qualified physician. The Special Procedures Committee will determine the acceptability of the experience. If the experience is acceptable the applicant will be recommended to the appropriate department for Class IA privileges for carotid stenting

7.5.6 Interventional Endovascular Therapy of the Central Nervous System

7.5.6.1 To include selective spinal angiography, intracranial angioplasty, stenting, embolization, infusion therapy and sampling procedures.

7.5.6.2 Ordered by a physician knowledgeable in the diagnosis and management of specific disease or organ involved

7.5.6.3 Performed by and under control of the physician who demonstrates competence. Such competence should include formal training in a recognized training institution of at least six months duration in catheter work, and at least three months of training directly related to neuroradiology to include both cross-sectional imaging and catheter work.

7.5.6.4 Furthermore, the applicant must meet the criteria for brachiocephalic carotid arteriography, brachiocephalic angioplasty, intravascular embolization, non-coronary thrombolysis, and stenting.

7.5.6.5 The applicant is to have at least one year of supervised training in neurointerventional techniques, as well as demonstrated competence in catheter techniques relating to the central nervous system.

7.5.6.6 Review of previous training and experience will be at the discretion of the Special Procedures Committee for the recommendation for Class IA privileges.

7.5.6.7 Recommendations for granting of class I privileges will be made to the appropriate department once the proctored experience is found acceptable by the SPC.

7.5.7 Non-CNS, non-cardiac embolizations

7.5.7.1 To be ordered by a physician knowledgeable in the diagnosis and management of carotid artery disease.

7.5.7.2 Defined as the Percutaneous, transcatheter delivery of various products for the intention of occluding blood vessels

7.5.7.3 To be granted Class IA privileges in non-CNS embolizations, the applicant must have Class I or Class IA privileges in diagnostic angiography the applicant must have performed at least 20 embolizations (with at least 50% of these procedures being performed as the primary operator) with acceptable results. Documentation of all cases must be provided. Qualified physicians in conjunction with an abdominal aortic endograft may perform an iliac embolization if necessary (qualified is defined as having performed 10 embolizations with acceptable results. The Special Procedures Committee will evaluate the experience and will determine whether or not it qualifies as acceptable. The committee, at its discretion, may require any applicant to complete additional training or experience. Training and experience may be obtained by qualifying through formal training, training by experience or training by apprenticeship as defined above for diagnostic angiography. Any physician with Class I embolization privileges may act as a preceptor and any physician with Class IA privileges in vascular surgery, interventional radiology or cardiology may serve as an apprentice.

7.5.8 Percutaneous Gastrostomy Using Radiological Guidance

7.5.8.1 To be ordered by physicians knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.8.2 An applicant for privileges in this procedure must have had appropriate training and experience as reviewed and approved by the Special Procedures Committee. Review and approval of the previous training and experience will be at the discretion of the Special Procedures Committee.

7.5.8.3 Radiographic control by a physician with appropriate fluoroscopic licensure.

7.5.9 Hepatobiliary Tract Manipulation

7.5.9.1 To be ordered by physicians knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.9.2 Radiographic control by a physician with appropriate fluoroscopic licensure.

7.5.10 Non-vascular Interventional Radiology of the Genitourinary Tract

7.5.10.1 To be ordered only by a physician knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.10.2 An applicant for privileges in these procedures must have had one year of formal training in interventional radiology including guide wire and catheter techniques. Included in the training must be at least six months of formal training in abdominal cross-sectional imaging. Such training

must include 25 genitourinary manipulations with the applicant documented as the primary operator. Review and approval of the previous training and experience will be at the discretion of the Special Procedures Committee. All genitourinary tract manipulation using either cross-sectional imaging techniques or percutaneous methods is to be included under this heading.

7.5.10.3 Radiographic control by a physician with appropriate fluoroscopic licensure.

7.5.11 Percutaneous Fluid or Abscess Collection Drainage

7.5.11.1 To be ordered only by a physician knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.11.2 An applicant for privileges in these procedures must have had one year of formal training in interventional radiology including guide wire and catheter techniques. Included in the training must be at least six months of formal training in abdominal cross-sectional imaging. Such training must include 25 drainages with the applicant documented as the primary operator. Review and approval of the previous training and experience will be at the discretion of the Special Procedures Committee. All percutaneous fluid or abscess collection drainage using either cross-sectional imaging techniques or percutaneous methods is to be included under this heading.

7.5.11.3 Radiographic control by a physician with appropriate licensure.

7.5.12 Radiographically Guided Percutaneous Needle Biopsy, Aspiration or Injection Therapy

7.5.12.1 To be ordered only by a physician knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.12.2 An applicant for privileges in this procedure must have had appropriate training and experience including the use of fluoroscopy and required fluoroscopy permits.

7.5.12.3 An applicant for privileges in procedures utilizing cross-sectional imaging must have had a least six months formal training in body cross-sectional imaging or appropriate equivalent training. Review and approval of the previous training and experience will be at the discretion of the Special Procedures Committee. Class IA privileges may be granted by the committee, at their discretion, after review of previous training.

7.5.12.4 Radiographic control by a physician with appropriate fluoroscopic licensure.

7.5.12.5 Applicants must be observed by a Class I physician with privileges in the same procedure for a minimum of six cases. After six cases have been proctored and deemed acceptable, proctoring may be omitted. This decision shall be made after appropriate review by the Special

Procedures Committee. The Class IA applicant will remain provisional Class IA for at least six months. At this time, all cases performed shall be reviewed, and if deemed acceptable by the Special Procedures Committee, advancement to Class I for invasive procedures may be granted by the committee.

7.5.12.6 It is the responsibility of the applicant to find a Class I physician to observe him.

7.5.13 Arthrography

7.5.13.1 To be ordered only by a physician knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.13.2 Performed either by a qualified orthopedist or radiologist.

7.5.13.3 Radiographic control by a physician with appropriate fluoroscopic licensure.

7.5.14 Hysterosalpingogram

7.5.14.1 To be ordered only by a physician knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.14.2 Performed by a qualified gynecologist or radiologist.

7.5.14.3 Radiographic control by a physician with appropriate fluoroscopic licensure.

7.5.14.4 Physician must be observed by a physician with Class I privileges in the same special procedure for a minimum of two months and two cases. Recommendation for advancement to Class I privileges will be made by the Special Procedures Committee.

7.5.15 Myelography and Intervertebral Discography

7.5.15.1 Ordered only by Board eligible or certified neurologist, neurosurgeon, or orthopedist.

7.5.15.2 Procedures performed by the above named group and/or radiologist

7.5.15.3 Physician must be observed by a physician with Class 1 privileges in the same special procedure for a minimum of two months and two cases. Recommendation for advancement to Class 1 privileges will be made by the Special Procedures Committee.

7.5.16 Lymphangiography

7.5.16.1 To be ordered only by a physician knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.16.2 Performed by a physician with appropriate fluoroscopic licensure

7.5.16.3 Radiographic control by the radiologist.

7.5.16.4 Physicians must be observed by a physician with Class I privileges in the same special procedure for a minimum of two months and two cases. Recommendation for advancement to Class I privileges will be made by the Special Procedures Committee.

7.5.17 Sialography

7.5.17.1 To be ordered only by a physician knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.17.2 Performed by the radiologist

7.5.17.3 Radiographic control by a physician with appropriate fluoroscopic licensure.

7.5.17.4 Physicians must be observed by a physician with Class I privileges in the same special procedure for a minimum of two months and two cases. Recommendation for advancement to Class I privileges will be made by the Special Procedures Committee

7.5.18 Laryngobronchography

7.5.18.1 Ordered by chest surgeons or physicians who are expert in chest disease.

7.5.18.2 Performance of procedures to be done by the above physicians and/or radiologist.

7.5.18.3 Radiographic control by a physician with appropriate fluoroscopic licensure.

7.5.18.4 Physicians must be observed by a physician with Class I privileges in the same special procedure for a minimum of two months and two cases. Recommendation for advancement to Class I privileges will be made by the Special Procedures Committee

7.5.19 Fallopian Tube Recanalization

7.5.19.1 To be ordered only by a physician knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.19.2 Performed by a qualified physician with Class I privileges in hysterosalpingography and demonstrated competence with microcatheter technique. Review and approval of the previous training and experience will be at the discretion of the Special Procedures Committee.

7.5.19.3 Radiographic control by a physician with appropriate fluoroscopic licensure.

7.5.20 Transcatheter Retrieval

7.5.20.1 To be ordered by a physician knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.20.2 Performed by a physician with Class I privileges in diagnostic angiography, as well as documented training and experience using intravascular snares, tip deflectors and similar apparati. Review and approval of the previous training and experience will be at the discretion of the Special Procedures Committee.

7.5.21 Transjugular Intrahepatic Portal Systemic Shunt (TIPS)

7.5.21.1 To be ordered by a physician knowledgeable in the diagnosis and management of the specific disease or organ involved

7.5.21.2 Performed by physicians with Class I privileges in mesenteric venography, diagnostic arteriography, and peripheral interventions. The applicant must have appropriate training and experience as determined by the Special Procedures Committee.

7.5.22 Catheter Directed and Mesenteric Venography

7.5.22.1 Ordered by a physician knowledgeable in the diagnosis and management of the specific disease or organ involved.

7.5.22.2 Performed by and under the control of physicians of demonstrated competence. Such competence to include Class I privileges in diagnostic arteriography. Review of previous training and experience will be at the discretion of the Special Procedures Committee.

7.5.23 New Procedures

7.5.23.1 As new special procedures are developed Class I privileges will be granted based on accepted requirements in place for that procedure at the time. This may include compliance with FDA requirements, attendance at special training courses sponsored by industry or other qualified entities, and/or proctoring by outside qualified physicians. Specific requirements will be developed for each procedure by the Special Procedures Committee in response to applications by interested physicians in appropriate specialties

Rule 8 Proctoring

PURPOSE
To evaluate the performance of practitioners afforded clinical privileges by the Medical Staff and Governing Body.

8.1 General

8.1.1 All Medical Staff Members initially granted Privileges shall be proctored. All Practitioners granted temporary privileges during the pendency of their applications, on a probationary basis, or as locum tenens shall be proctored. Practitioners granted Privileges to care for a specific patient are not required to be proctored, but must comply with any special supervision required by the Department Chairman.

8.1.2 A privilege sheet shall be completed for each Practitioner who is granted Privileges. A copy of the privilege sheet indicating the approved Privileges shall be sent to the Practitioner, Department Chair, and any service in which Privileges were granted (e.g., the Operating Room, ICU, or Radiology). A copy of the privilege sheet shall also be maintained in the Practitioner's credential file. The privilege sheet shall indicate when the Practitioner is required to be proctored.

8.1.3 Except as otherwise determined by the Executive Committee and Governing Body, all initial appointees to the Medical Staff and all Members granted new Privileges shall be subject to a period of proctoring in accordance with standards and procedures set forth in the Rules. In addition, Members may be required to be proctored as a condition of renewal of Privileges (for example, when a Member requests renewal of a Privilege that has been performed so infrequently that it is difficult to assess the Member's current competence in that area). Proctoring may also be implemented whenever the Executive Committee determines that additional information is needed to assess a Practitioner's performance. Proctoring is not viewed as a disciplinary measure, but rather is an information gathering measure. Therefore, it should be imposed only for such period (or number of cases) as is reasonably necessary to enable such assessment. Proctoring does not give rise to the procedural rights described in Article VIII unless the proctoring becomes a restriction of Privileges because procedures cannot be done unless a proctor is present and proctors are not available after reasonable efforts to secure a proctor.

8.2 General Competency Terms

General competencies' form in six areas

8.2.1 Patient Care

Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

8.2.2 Medical / Clinical Knowledge

Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.

8.2.3 Practice Based Learning Environment

Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices

8.2.4 Interpersonal and Communication Skills

Practitioners are expected to demonstrate interpersonal communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of the health care team.

8.2.5 Professionalism

Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society.

8.2.6 Systems Based Practice

Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

8.3 Completion of Proctoring

Shall be deemed successfully completed when the Practitioner completes the required number of proctored cases within the time frame established in the Bylaws and the Rules, and the Practitioner's professional performance in the cases met the standard of care of the Hospital.

During the proctoring, the Practitioners must demonstrate they are qualified to exercise the Privileges that were granted and are carrying out the duties of their Medical Staff category.

8.4 Effect of Failure to Complete Proctoring

8.4.1 Failure to Complete Necessary Volume: Any Member who fails to complete the required number of proctored cases within the time frame established in the Bylaws and Rules shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant Privileges), and he or she shall not be afforded the procedural rights provided in Article VIII. However, the department has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in Article 13.

8.4.2 Failure to Satisfactorily Complete Proctoring: If a Practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during

proctoring, he or she may be terminated (or the relevant Privileges may be revoked), and he or she shall be afforded the procedural rights as provided in Article 13.

8.4.3 The failure to complete proctoring for any specific Privilege shall not, by itself, preclude advancement from provisional staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specified Privileges. The specific Privileges may be voluntarily relinquished or terminated if proctoring is not completed thereafter within twelve (12) months. A single six (6) month extension may be requested. This request must describe the practitioner's case load and the circumstances which will enable him to meet the requirements if an extension is granted.

8.5 Assignment of Proctor

8.5.1 The proctor must have unrestricted privileges to perform the procedures that he or she will proctor.

8.5.2 The proctor may not be an associate of the physician being proctored except as permitted by the Department Rules.

8.5.3 If no Medical Staff Members who have the necessary expertise are available to proctor, special arrangements may be made for proctoring by non-Medical Staff Members (at sites other than the Hospital) and/or by Staff Members who have related Privileges. Special arrangements must be approved by the Executive Committee.

8.5.4 All Active and Associate Staff Members who have completed proctoring must assist in proctoring and a failure to fulfill this responsibility shall be grounds for corrective action, as specified in the Medical Staff Rules.

8.5.5 The Department Chair shall oversee the preparation of a list of Department Members who may serve as proctors. This list will be provided to each Practitioner who is required to complete proctoring. Each proctored Practitioner is responsible for assuring that at least 2 Practitioners proctor his or her cases.

8.5.6 If an assigned proctor is unable to fulfill these responsibilities, he or she shall notify the Department Chair, who shall assign another proctor and revise the list.

8.6 Function and Responsibility of The Proctor

8.6.1 The proctor shall be responsible for evaluating the proctored Practitioner's performance from the time of the patient's admission until discharge and shall evaluate the indications for admission, discharge, diagnostic work-up and therapy management.

8.6.2 If surgery or an invasive procedure is performed, the proctor shall evaluate the indication for the procedure, the technique for the procedure, how it is performed, and the pre-operative, operative, and post-operative care of the patient. He or she

shall utilize the patient's chart, discussions with the Practitioner, and actual observation as the basis for the review. If medical care is provided, the proctor shall review the care of the patient, utilizing the patient's chart, discussions with the Practitioner, and actual observation, as necessary, as the basis for the review. Invasive medical procedures will be proctored by observation unless the case is an emergency or as otherwise specified in the Department Rules.

8.6.3 For each case that is proctored, the proctor shall complete the Proctoring Evaluation Form, and submit it to the Department Committee through the Medical Staff Office.

8.6.4 Proctoring reports shall be completed fully and in a timely manner after the patient's discharge. They shall be submitted no later than 1 week after the patient is discharged.

8.6.5 Unsatisfactory performance during proctoring should be reported immediately by telephone to the Medical Staff Office.

8.6.6 The proctor's primary responsibility is to evaluate the proctored Practitioner's performance. However, if the proctor believes that intervention is warranted in order to avert harm to a patient, he or she may take any action he or she finds reasonably necessary to protect the patient.

8.6.7 If the proctor and the proctored Practitioner disagree on the appropriate treatment of a patient, the dispute shall be referred to the Department Chair or Chief of Staff for resolution.

8.6.8 A proctor may or may not act as the assistant in a surgical procedure. Except when the proctor acts as a surgical assistant, no fee shall be charged by the proctor.

8.7 Responsibility of the Proctored Practitioner

8.7.1 The proctored Practitioner shall be responsible for notifying one of the assigned proctors of each patient whose care is to be evaluated. For surgical or invasive medical procedures that will be observed, the proctored Practitioner shall be responsible for arranging the time of the procedure with the proctor.

8.7.2 The proctored Practitioner shall provide the information that is requested by the assigned proctor regarding the patient and the planned course of treatment.

8.8 Proctoring Duration

Each Practitioner granted Privileges must be proctored on at least 3 cases, or such higher minimum number of cases as may be identified in the Department Rules.

Proctoring duration is for 12 months, with the possibility of an extension for six (6) months.

8.9 Methods of Proctoring

The following guidelines will be used for Medicine Department proctoring:

8.9.1 Direct observation is required for all invasive procedures. Retrospective evaluation of performance will be accepted for all non-invasive procedures.

8.9.2 There shall be a sufficient variety of cases observed depending upon the scope of clinical privileges requested as defined on the clinical privilege form.

8.9.3 The proctor shall complete a proctoring form and submit it to the Medical Staff Office. These forms are available at each nursing station and in the Medical Staff Office. If the proctor's form is not received timely, the Department Chairman will be notified and appropriate action taken.

8.9.4 The proctor's reports shall be maintained in the physician's credential file and should be taken into consideration at the time the new staff member is considered for promotion from the provisional medical staff category.

8.9.5 Proctoring shall involve evaluation of all aspects of the management of any case.

8.9.6 Observation will include concurrent chart review, direct observation in the case of invasive procedures, and monitoring of diagnostic and treatment techniques.

8.9.7 A list of all qualified proctors will be provided to each applicant by the Medical Staff Office.

8.9.8 The name and telephone number of the assigned proctor(s) shall be given to the physician who is being proctored and the name and telephone number of the physician who is being proctored shall be given to the proctor(s). The proctored physician is responsible for calling his proctor each time a patient is admitted. For invasive medical procedures that will be observed, the proctored physician shall be responsible for arranging the time of the procedure with the proctor. The proctored physician shall also provide the proctor with any information regarding the patient requested by the proctor.

8.9.9 The proctor's primary responsibility is to evaluate the proctored physician's performance. However, if the proctor believes that intervention is warranted in order to avert harm to the patient, he may take such action as he believes is reasonably necessary to protect the patient.

8.9.10 If the proctor and a proctored physician disagree on a patient's treatment, the dispute shall be referred to the Department Chairman for resolution.

8.9.11 In accordance with the Medical Staff Bylaws, at the end of the first Provisional/Observation year the physician's proctoring will be assessed to determine if 100% of the requirement has been met.

8.10 Reciprocal Proctoring

8.10.1 Reciprocal proctoring may be accepted from any Southern California Hospital that is fully accredited through CMS authorized regulatory agency (The Joint Commission,

DNV, CIHQ, etc.) Only 50% of the cases may supplement actual observation on the premises.

8.10.2 Reciprocal proctoring is acceptable only if all of the following conditions are met:

8.10.2.1 The proctor is a Member of the Medical Staff at both hospitals, and is eligible to serve as a proctor in both hospitals.

8.10.2.2 The Practitioner has requested the same range and level of privileges at both institutions.

8.10.2.3 Copies of the actual proctoring reports are provided to both hospitals and maintained in confidential files at both hospitals.

8.10.2.4 Reports must not be older than four (4) years.

8.11 Focused Professional Practice Evaluation

Focused professional practice evaluation is a process whereby the privilege specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege at the organization is evaluated. This process may also be used when a question arises regarding a current practitioner’s ability to provide safe, high-quality patient care for which he or she possesses current privileges.

8.12 Ongoing Professional Practice Evaluation

Ongoing professional practice evaluation identifies professional practice trends that may impact the quality and safety of care provided by privileged practitioners. It is intended to identify and resolve potential performance issues as soon as possible, as well as foster a more efficient, evidence-based privilege renewal process.

POLICY

DETERMINATION OF GENERAL COMPETENCIES

Practitioners granted privileges must satisfactorily exhibit the general competencies outlined in this policy at the time of appointment and reappointment respectively. The general competencies of the practitioner can be ascertained in several ways:

1. Peer references that affirmatively attest to the general competencies of the practitioner along with a positive recommendation for appointment or reappointment to the medical staff. Peer recommendations must be obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant’s ability to practice. Recommendations from peers will be obtained and evaluated for all new applicants for privileges. At a minimum, peer recommendations will be obtained upon renewal of privileges if there is insufficient practitioner-specific data available for review.
2. The decision of the Medical Executive Committee (MEC) that the practitioner exhibits the general competencies based on the practitioners relevant education, training, experience and known information about the practitioners performance.
3. Specific information that may arise out of ongoing and/or focused evaluation of a practitioner that affirmatively or adversely speaks to that practitioner’s general competencies.

A practitioner that is unable to satisfactorily exhibit the general competencies outlined in this policy may be subject to the focused evaluation of his or her professional practice.

Focused Professional Practice Evaluation

Initially Requested Privileges

When a practitioner is granted privileges for the first time, he or she shall undergo an initial period of focused evaluation. The scope, method, frequency and duration of this evaluation shall be determined by the Department Chair based on the individual experience, training, and qualifications of the practitioner.

Quality of Care Concern

A focused review of a practitioner's performance will occur when issues are identified that may effect the provision of safe, high-quality medical care. The following criteria will trigger the need for a focused evaluation:

1. There is aggregate, valid, practitioner specific data that demonstrates a significant untoward variation from internal or external benchmarks or performance.
2. There is a problematic pattern or trend identified as a result of the ongoing professional practice evaluation of the practitioner.
3. There is a complaint or quality of care concern raised against the practitioner that is of a serious nature.
4. There is evidence of behavior, health, and/or performance issues that carries an immediate threat to the health and safety of the patient, public, or other members of the health care team.

Evaluation Process

There are two basic processes under which focused evaluation will occur; an expedited process and a standard process:

Expedited Process

An expedited process will be implemented when a quality of care concern arises that carries an immediate threat to the health and safety of the patient, public, or other members of the health care team. The following steps will be taken:

- The Department Chair, Chief of Staff, Chief Executive, or any of their authorized designee, will be contacted immediately and informed of the concern.
- Any of the aforementioned individuals are authorized to instruct the practitioner involved that a focused evaluation is occurring. The practitioner will immediately cease practicing all or certain aspects of his or her privileges as warranted by the scope and breadth of the evaluation until the evaluation process has concluded. If necessary, alternate providers will be identified and assigned to cover the practitioner's care, treatment, and service.
- The Chief of Staff, in collaboration with the Chief Executive and Department Chair, shall determine the construct of the evaluation. The scope, nature, and duration of the evaluation will be only as necessary to determine if in fact an immediate threat to

the health and safety of the patient, public, or other member of the healthcare team is present.

- If such a determination is made, then the practitioner will be informed by the organization and appropriate actions (e.g. summary suspension, termination, revocation or suspension of privileges, membership, etc.) taken consistent with the bylaws and rules and regulations of the medical staff.
- If such a determination is not made, then the aforementioned individuals will make a decision as to whether further action is needed.

Standard Process

A standard process will be implemented for initial requests for privileges and for quality of care concerns that do not indicate an immediate threat to the health and safety of the patient, public, or other members of the healthcare team. The following steps will be taken:

- The Department Chair and/or the MEC will determine the type, amount, frequency, and duration of the focused evaluation period. In making such a determination, the following criteria shall be employed:
  1. The monitoring plan will be specific to the privilege in question.
  2. The practitioner involved will be monitored by a peer
  3. The type of monitoring shall be appropriate for the privileges requested / exercised.
  4. Cases evaluated should be of sufficient number to allow for adequate information. The number of cases will be determined by the Department Chair and/or MEC based on the practitioner's relevant education, training, and experience, as well as the competency need being assessed.
  5. The frequency of monitoring should be appropriate to the privileges requested / exercised. Whenever possible, monitoring should occur early in the evaluation period. Case review and/or monitored performance should occur in the initial number of cases performed by the practitioner, not sporadically over time.
  6. The duration of monitoring shall be only as long as deemed necessary to collect sufficient information about the practitioner's ability to safely and competently perform the privileges in question.
- Information gleaned from the monitoring plan shall be submitted to the Department Chair either throughout or at the end of the evaluation period. The Department Chair shall then review the information and make a recommendation to the MEC to take one or more of the following actions:
  1. That the focused evaluation period be concluded and that one of the following actions occur:
     - No further action is necessary
     - The practitioner involved receives the education and/or training necessary to more competently perform the privilege(s) in question.

- That appropriate mechanisms as outlined in medical staff bylaws, rules, regulations, or other policy be implemented to address suspension, termination, limitation, and/or revocation of the privilege(s) in question.

2. That the focused evaluation period be continued for a determined period of time in order to acquire the information necessary to make an appropriate recommendation to the MEC.
3. The MEC will either accept or reject the recommendation and shall then take such action as deemed necessary in accordance with the bylaws, rules, regulations, and policies of the medical staff.

Circumstances Requiring Evaluation from an External Source

At times, there may be need for an outside evaluation to occur. The following guidelines address the use of outside review. Outside evaluation should be conducted under the following circumstances:

- There is no peer on the Medical Staff.
- There are no peers on the Medical Staff who are not involved in the issues surrounding the evaluation.
- The Department or the MEC determines that an outside evaluation will assist in making a determination on the competency of the practitioner.
- The practitioner being evaluated requests an outside review and in the opinion of the Department Chair or the MEC, there is merit to the request.

Notifying the Practitioner of a Focused Evaluation

The practitioner being evaluated is to be informed of the following:

- The reason(s) for the evaluation and how the evaluation will be conducted
- The practitioner's responsibilities during the evaluation period
- The result(s) of the evaluation
- Actions taken as a result of the evaluation

Use of Evaluation Findings in Appointment / Reappointment

A summary of the evaluation findings will be made available to the Department Chair at the time of the practitioner's reappointment and/or request for privileges. This information shall be considered in making the recommendation for reappointment and/or privileging.

Ongoing Professional Practice Evaluation

Ongoing professional practice evaluation allows the organization to identify professional practice trends that may impact on the quality of care and patient safety. Early identification of problematic performance allows for timely intervention.

Indicators Used in Ongoing Professional Practice Evaluation

On an annual basis, each department of the medical staff shall determine the quality and patient safety indicators that shall comprise the ongoing professional practice evaluation. These indicators may be occurrence based (i.e. identified each time they occur), or rate based

(i.e. monitored as a percentage of occurrence against a defined population). The indicators chosen by departments may include, but not necessarily be limited to, the following areas:

- Performance of operative and/or invasive procedures and their outcomes
- Patterns of blood and/or pharmaceutical usage
- Requests for tests and procedures
- Length of stay patterns
- Morbidity and mortality data
- Complications of care
- Practitioner use of consultants
- Complaints received from patients, families, or staff and/or unusual occurrences
- Other relevant indicators as determined by the medical staff

Collecting Information

Once the departments have determined the indicators to be measured, the organization will employ those processes necessary to assure that information on practitioners can be collected, aggregated, analyzed, and acted upon. Collection of this information may take the form of the any of the following:

- Periodic chart review
- Direct observation
- Monitoring of diagnostic and treatment techniques
- Use of valid data from health information systems
- Discussions with other individuals involved in the care or each patient including consulting physicians, assistants (at surgery for example), nursing, and administrative personnel.

Reporting of Information

Information on the professional practice of practitioners will be presented to the practitioner's Department Chair and/or other appropriate medical staff committee / forum. Frequency of data collection shall not exceed every 12 months to assure timely identification of issues, patterns, or trends.

Use of Information

The Department Chair shall review and evaluate the information. As a result of the evaluation, the following actions may occur:

- No action is necessary as the review demonstrates satisfactory performance by the practitioner.
- Focused evaluation of the practitioner is warranted to better understand practice issues relative to the indicator(s) measured.

A summary of the ongoing professional practice evaluation will be made available to the Department Chair at the time of the practitioner's reappointment and/or request for

privileges. This information shall be considered in making the recommendation for reappointment and/or privileging.

8.13 Confidentiality of Information

All activities surrounding the professional evaluation of members of the medical staff are considered part of the medical staff's quality assurance program and are therefore considered protected and confidential to the extent permitted by law and regulation.

Rule 9 Call Panel

9.1 Call Panel List

9.1.1 The Hospital operates a 24-hour emergency facility as a service to the community. It is staffed by Emergency physicians with whom the Hospital has a contract to provide continuous coverage.

9.1.2 A Hospital Emergency Call Panel has been established for the purpose of referring emergency patients, who have no assigned physician of the needed specialty to Medical Staff members for treatment beyond that which the Emergency Department physician can provide. This panel is arranged by specialty and physicians serve in rotation in accordance with their Department's rules and regulations.

9.1.3 If a Department is unable or unwilling to provide Hospital Emergency coverage, the Chief of Staff of the Medical Staff has the authority to override that Department's rules and regulations and to make Hospital Emergency coverage mandatory for the Department on a rotational basis until such time as a satisfactory arrangement can be reached.

9.1.4 The following members are exempted from mandatory Hospital Emergency Call Panel:

9.1.4.1 Members who have 20 years or more of service on the Medical Staff.

9.1.4.2 Members who served as Chief of Staff.

9.1.5 When assigned to the Call Panel, members must fulfill the responsibilities of emergency coverage.

9.2 Conduct of Call Panel Members

9.2.1 When the emergent services of on-call physicians are required for a patient, the physician on call should respond to the Physician verbally within 15 minutes and physically within 30 minutes if needed. However, the requesting physician may extend the response time as reasonable in view of the patient's clinical circumstances unless the necessary specialized equipment; facilities or staff are not available in the Hospital. Transfers to another institution for physician convenience are not appropriate and will not be undertaken.

9.2.2 A panelist who is unable to provide panel coverage during his or her scheduled time is responsible for arranging for coverage by a practitioner who meets the criteria for panel eligibility. The panelist shall inform the Hospital of the name of the practitioner who will provide back-up coverage.

9.2.3 If the panelist on call cannot provide a specific service that is part of their specialty, he or she will be responsible for participating in obtaining consultation from a specialist who can provide the service.

9.2.4 When scheduled on call, each practitioner shall accept the care of all patients who are appropriately referred without discrimination on the basis of the patient's race, creed, sex, age, national origin, ethnicity, citizenship, religion, pre-existing medical condition (except to the extent it is pertinent to medical care), physical or mental handicap, insurance status, economic status, or ability to pay.

9.2.5 All transfers shall be carried out in accordance with the Hospital policy on transfers. In summary, it requires:

9.2.5.1 The Emergency Services Physician or a Call Panelist must personally examine the patient prior to transfer, and find that the patient is stable. Patients who are not stable may be transferred only if the physician finds, within reasonable medical probability, that the expected medical benefits of the transfer outweigh the risks posed by the transfer, or the patient, or his or her surrogate decision-maker, requests transfer, after the physician has explained the medical risks and benefits of transfer.

In addition:

9.2.5.1.1 the receiving facility must consent to the transfer,

9.2.5.1.2 staff and equipment necessary for a safe transfer must be arranged,

9.2.5.1.3 copies of pertinent medical records must be provided, and

9.2.5.1.4 the "Transfer Summary Form" must be completed, and a copy sent with the patient.

9.2.6 A patient can be admitted in the name of the Hospital Call Panel practitioner, but only if the requesting Physician so specifies, the panelist must see the patient at that time. The Hospital Emergency Call Panel practitioner must be notified about each admission prior to the patient leaving Emergency Services.

9.2.7 A panelist shall cooperate with and assist the Emergency Services, Emergency Physicians, and all Departments, and Staff who may call a panel member for assistance. The panelist shall act in the best interests of patient care and in accordance with the Hospital's philosophy and rules.

9.2.8 Panelists will see unassigned patients in on a personal physician, private-pay basis. The panelist retains responsibility for billing and collecting his or her fees. The Hospital has no responsibility for this physician/patient relationship and each panelist agrees to release the Hospital from any obligation in this regard.

9.2.9 Unavailability or refusal to respond to call assignments, or arrange appropriate coverage for responsibilities if unable to fulfill the duties, shall be considered conduct reasonably likely to be detrimental to patient safety or delivery of quality patient care within the hospital, and shall be considered for corrective action in accordance with the Medical Staff Bylaws.

9.3 Diagnoses

The following diagnoses shall be admitted to the specialists as listed below:

9.3.1 Cardiology

- STEMI (The Cardiologist will request consultation by the hospitalist or intensivist as needed in cases involving significant co-morbidities)
- Symptomatic bradycardia/heart block requiring a device (pacemaker, defibrillator, etc.) (The Cardiologist will request consultation by the hospitalist or intensivist as needed in cases involving significant co-morbidities)
- Routine Heart Catheterizations

9.3.2 ENT

- Peritonsillar abscess
- Epistaxis as primary working diagnosis

9.3.3 Gastroenterology

- Foreign bodies

9.3.4 GYN

- Vaginal bleeding

9.3.5 Surgery

- Free air in the abdomen
- Small bowel obstruction
- Necrotizing faciitis

9.3.6 Urology

- Bladder outlet obstruction
- Hydronephrosis
- Kidney stone

9.3.7 Intensivist/Hospitalists will be available for consultation if requested on a MD-to-MD basis, but the hospitalists will not be the admitting physician.

9.4 Hospital Emergency Call

The physician on Hospital Emergency call is responsible for inpatient consultations and ER coverage for the day they are scheduled. Hospital Emergency call coverage is from 0700 – 0700.

9.5 Failure or Refusal to Respond

Physicians who fail to respond or refuse to respond to Hospital Emergency call coverage, or inpatient consultation requests may be subject to $1,000 fine 1st time, 2nd $2, 000, 3rd $3,000. Each fine would have to be reviewed by the department chair before implementation of fine, as there may have been circumstances beyond their control. The Department Chair will investigate why the physician failed to show. If it is determined that a fine is warranted, the fine will be levied by the Department Chair. If the physician fails to pay the fine within 14 days, he/she will be suspended. The appeal process will be through the department with a recommendation to the MEC. Reports on offenders should be made through the Medical Staff

office, which will inform the Department Chair. It was also recommended that every occurrence of a violation should be reported to the MEC as information.

Rule 10 Temporary Privileges

10.1 Circumstances

10.1.1 Temporary Privileges may be granted only in those situations provided in these Rules & Regulations, after the Practitioner has satisfied the requirements set forth in these Rules & Regulations.

10.1.2 Temporary privileges may be granted after appropriate application:

10.1.2.1 For 30-day periods, subject to renewal not to exceed 120 days, one time temporary privileges or during the pendency of an application, only when there is an important patient care need that mandates an immediate authorization to practice while the credentials information is verified; or

10.1.2.2 A new applicant, in which the credentialing process is complete, with no issues or concerns that is awaiting the approval of the Medical Executive Committee and Board of Trustees.

10.2 Application

Practitioners seeking temporary privileges must complete an application for staff membership

10.3 Investigations of Applicants for Temporary Privileges

10.3.1 The Medical Staff must determine if there is an important patient care need that mandates an immediate authorization to practice, for a limited time. If there is such a need, the Medical Staff then must investigate the qualifications of any Practitioner who requests temporary privileges and assure that the available information reasonably supports the granting of the temporary privileges. The nature of the investigation may vary, depending upon the privileges that will be exercised.

10.3.2 The depth of the investigation will vary depending upon the independence and responsibility that the Practitioner will assume for patient care. Two levels of scrutiny have been designed for temporary privilege applicants.

10.3.3 Level One: Level One is the minimum investigation that must be completed for each Practitioner who has requested temporary privileges. A Level One investigation is sufficient if the Practitioner will only assist a Medical Staff Member, who will be responsible for all direct patient care. It consists of the following steps:

10.3.3.1 Completion of a Written Request for Temporary Privileges. In the request, the applicant must provide information regarding his or her qualifications and also certify his or her agreement to abide by the Medical Staff Bylaws and the Rules. The temporary privileges request form is not necessary if the applicant has submitted a complete application for Medical Staff appointment.

10.3.3.2 Verification of Licensure. The Practitioner must submit a copy of his or her license. The Medical Staff Office will verify with the California licensing board that the license is valid and that the Practitioner's record is clear.

10.3.3.3 Verification of Professional Liability Insurance. The Practitioner must identify his or her insurer and provide a certificate of coverage. During working hours, the Medical Staff Office will call the insurer to verify coverage.

10.3.3.4 Querying the National Practitioner Data Bank. The Medical Staff Office will submit an inquiry to the National Practitioner Data Bank.

10.3.4 Level Two: A Level Two investigation must be completed for applicants for temporary privileges who will take on responsibilities beyond simply assisting a Medical Staff member. It consists of completing a Level One investigation. In addition, the Medical Staff Office must call the Medical Staff Office of the Hospital where the applicant primarily practices or has recently practiced and/or the Department Chair or Section Chair must call the Department Chair at a Hospital where the applicant primarily practices or has recently practiced, if the applicant does not have a primary hospital. The caller should verify that the Practitioner is in good standing and is competent to exercise the requested privileges. If the person contacted is not personally acquainted with the applicant or has no direct knowledge of his or her qualifications, another Practitioner must be contacted who can provide reliable information regarding the applicant's qualifications.

10.4 Granting Temporary Privileges

10.4.1 Temporary Privileges may be granted by the Chief Executive (or for the care of a specific patient, the Administrator on Call), on the recommendation of the Chief of Staff or the Department Chair or Section Chair where the Privileges will be exercised, or either's designee.

10.4.2 Temporary Privileges shall automatically terminate at the end of the designated period, unless earlier terminated or affirmatively renewed as provided in the Bylaws or the Rules.

10.4.3 A determination to grant temporary Privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.

10.4.4 Members whose membership was automatically terminated for a failure to complete medical records shall not be eligible for temporary privileges except in an emergency, as determined by person asked to grant the temporary privileges.

10.5 Deferral, Denial or Termination

10.5.1 There is no right to temporary Privileges. Accordingly, temporary Privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting Practitioner's or AHP's

qualifications, ability, and judgment to exercise the Privileges requested, and only after the Practitioner or AHP has demonstrated compliance with the Rules.

10.5.2 If the available information is inconsistent or casts any reasonable doubts on the applicant's qualifications, action on the request for temporary Privileges may be deferred until the doubts have been satisfactorily resolved or the request denied.

10.5.3 Temporary privileges must be terminated if information is received later suggesting the Practitioner may not be qualified.

10.5.4 Temporary Privileges may be terminated with or without cause at any time by the Chief of Staff, the responsible Department Chair, Section Chair, or the Chief Executive after conferring with the Chief of Staff or the responsible Department Chair or Section Chair. A person shall be entitled to the procedural rights afforded by the Bylaws and Rules only if a request for temporary Privileges is refused based upon, or if all or any portion of temporary Privileges are terminated or suspended for, a professional disciplinary cause or reason. In all other cases (including a deferral in acting on a request for temporary Privileges), the Practitioner shall not be entitled to any procedural rights based upon any adverse action involving temporary Privileges.

10.5.5 Whenever temporary Privileges are terminated, the appropriate Department Chair or Section Chair or, if the Department and/or Section Chair is absent, the Chief of Staff, shall assign a Member to assume responsibility for the care of the Practitioner's patient(s). The wishes of the patient and affected Practitioner shall be considered in the choice of a replacement Member.

10.6 General Conditions

10.6.1 Practitioners granted temporary Privileges shall be subject to quality improvement review.

10.6.2 All persons requesting or receiving temporary Privileges shall be bound by the Bylaws and Rules.

Rule 11 Medical Education

11.1 Patient Participation

In fulfillment of Medical Education goals, all patients shall be available for teaching purposes unless the patient or a surrogate decision-maker objects or there is specific contraindication and the patient's Attending Practitioner issues a specific order indicating that the patient shall not be involved in any medical education activities.

11.2 Clinical Affiliation Agreement

Any school or program which seeks to place medical students, residents, fellows or other trainees at the hospital must have a current and approved Clinical Affiliation Agreement. The Clinical Affiliation Agreement shall detail the responsibilities of the Hospital, Medical Director and supervising Medical Staff members and will be submitted to the Medical Executive Committee for approval. The Clinical Affiliation Agreement must include a provision for indemnification of the Hospital and Medical Staff and afford a means for removal of any trainee who does not practice at an acceptable standard as determined by the Medical Staff.

11.3 Medical Students, Residents and Fellows

May only work at the hospital if there is a current approved Clinical Affiliation Agreement with an accredited and approved school or program. Residents and fellows participating in training programs at the hospital shall be supervised by Medical Staff members and the training program's Medical Director in accordance with the Clinical Affiliation Agreement governing their training at the hospital.

11.3.1 By agreeing to supervise the trainee, the Medical Staff member assumes responsibility for the conduct and patient care activities of the trainee while at the hospital.

11.3.2 All trainees must remain in good standing with their affiliated medical school or training program at all times.

11.3.3 Supervision by the Medical Staff member will be at the level and frequency required by the program or medical school and as set forth in the Clinical Affiliation Agreement. All trainees will be under the supervision of the designated supervising physician.

11.3.4 The trainee will be provided appropriate hospital department or unit policies and procedures, and as a condition of training at this hospital will agree to abide by the Medical Staff and Hospital Bylaws, Rules, Regulations, Policies and Procedures.

11.3.5 Exception to 12.3.3 are allowed based on approved recommendations from the trainee Program Director and the appropriate Medical Staff department with approval of the Medical Executive Committee and Hospital with a defined clinical supervision plan.

11.4 Record Keeping

11.4.1 General

Residents, fellows, and medical students complete records pertaining to the clinical services they provide while participating in the residency, fellowship, and medical student training programs at the Hospital. It is the supervising physician's responsibility to review and ensure these documents are accurate and timely.

11.4.2 Countersignatures

The attending and supervising physician shall review and then countersign the following reports prepared by a trainee who does not hold an active license to practice medicine in California:

11.4.2.1 Admission History and Physical Examination Report

11.4.2.2 Consultation Reports

11.4.2.3 Pre-operative Reports

11.4.2.4 Operative Reports

11.4.2.5 Discharge Summaries

11.4.3 Designation in Operative Reports

Residents who participate in procedures shall be designated in the operative report as the "resident or fellow surgeon" and the supervising surgeon is the "operating surgeon" in the operative report.

Rule 12 Research

A. Practitioners who desire to conduct research should be encouraged to conduct reasonable and valid research projects.

B. All research undertaken by Medical Staff Members or others involving Hospital patients must obtain facility support and approval and must be approved by an Institutional Review Board. All research must be conducted in accordance with the policies governing research approved by the Institutional Review Board.

C. Researchers may review and have access to confidential patient information for research purposes only if the patient has authorized the disclosure or the Institutional Review Board has approved the research protocol including the disclosure.

D. Patient care shall be rendered according to approved protocols.

E. A Medical Staff Member may use or allow the use of the Hospital's name in published works only with the permission of the Executive Committee. However, Members may identify themselves as Members of the Hospital's Medical Staff within the limits of accepted professional ethics and practices.

Rule 13 Impaired Medical Staff Members

13.1 Definition of Physician Impairment

An impaired physician is one who is unable, or potentially unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skills, behavior problems, or excessive use or abuse of drugs including alcohol.

13.2 Purpose

This rule addresses referral of Medical Staff members who possibly suffer chemical dependence, or mental or physical impairment, and behavior problems for evaluation and initiation of treatment for the purposes of assisting the member and protecting patients and co-workers.

13.3 Philosophy

Chemical dependence (including dependence on mood-altering drugs, such as alcohol, cocaine, opiates, and depressants) is seen as a medical condition that requires treatment. Untreated or relapsing chemical dependence, mental impairment, physical impairment, or behavior problems are incompatible with safe clinical performance in any medical specialty.

13.4 Assisting Impaired Medical Staff Members

All Medical Staff members should share their concerns about chemical dependence, or mental or physical impairment, or behavior problems in themselves or other members, in confidence, with the Committee on Physician Health.

The Committee on Physician Health is dedicated to helping the members identify chemical abuse, and mental and physical impairments, and behavior problems and helping the members to obtain treatment to alleviate the problem. Even though the Committee's mission is to assist Medical Staff members, patient safety must be primary. Thus, if the Committee on Physician Health finds a risk of harm or danger to patients and the practitioner does not willingly enter treatment and/or withdraw from clinical practice, the Committee will suggest to the Chief of Staff to initiate corrective action.

13.5 Confidentiality

13.5.1 Committee on Physician Health shall maintain strict confidentiality. It will release information only with the express agreement of the Member, as needed to carry out Medical Staff duties, or as required by law. Releases to carry out Medical Staff duties shall be limited, insofar as possible, to protecting patients and carrying out Committee on Physician Health activities.

13.5.2 The Committee on Physician Health shall periodically report on its activities to the Credentials and Executive Committees, without identifying individuals.

13.5.3 The Committee on Physician Health shall report directly to the Chief of Staff on the status of particular cases.

13.6 Reporting and Investigating Procedure

13.6.1 The Committee on Physician Health will investigate all reports of impairment to determine whether a problem exists. This protocol applies to Members who have impairments, as well as applicants who have a history of impairment.

13.6.2 The investigation may include evaluation of written reports; interviews of associates, relatives, and others at the Hospital, office or home (when authorized by the doctor); and chart review of records at this or other hospitals for the purpose of identifying impairment rather than assessing quality of care.

13.6.3 If a problem may exist, the Practitioner in question will be invited to meet with the Committee or a minimum of 2 Committee members, to discuss the problem and the findings from the investigation. The interview will be informal.

13.6.4 The Committee may ask the practitioner to be evaluated by a practitioner, including a psychiatrist, other psychotherapist, or substance abuse specialist. The Committee will ask the practitioner to sign a form authorizing disclosure of the results of the evaluation to the Committee. The Committee may pay for the evaluation, although that is discretionary. The practitioner should be given a list of professionals acceptable to the Committee on Physician Health. The report should address the diagnoses, prognosis, and treatment program recommendation, and the practitioner’s ability to continue practice.

13.6.5 Practitioners who have chemical dependency abuse will be referred to the Medical Board of California Diversion Program, and/or a treatment program of the practitioner’s choice approved by the Committee on Physician Health. Practitioners who have other types of impairment will be referred for treatment approved by the Committee on Physician Health.

13.6.6 The Committee on Physician Health will draw up a contract between it and the practitioner, delineating the Committee’s expectations for treatment and monitoring. The contract, as a minimum, will require the member to agree to the following conditions, depending upon the nature of the impairment.

13.6.6.1 To provide documentation from an evaluating or treating professional that initial treatment is being provided and when the member may safely continue practice or return to practice.

13.6.6.2 To abstain from using any medications or drugs or alcohol, except as approved by the treatment program and the Committee on Physician Health. If such is prescribed by another physician, the subject physician shall report immediately to the Committee on Physician Health: the substance, amount, and purpose of the prescription; and provide the name and telephone number of the prescribing physician, and permission for him to confer with the Committee on Physician Health.

13.6.6.3 To participate in an ongoing treatment program approved by the Committee on Physician Health. Any specific terms, such as continuing

psychiatric counseling, securing medical treatment or attending physician recovery groups two nights a week and Alcoholics Anonymous or Narcotics Anonymous two nights a week, should be stated.

13.6.6.4 To agree to any random testing of bodily fluids, by the treatment program or as directed by Committee on Physician Health.

13.6.6.5 To meet regularly, and at least quarterly, with a monitor appointed by the Committee on Physician Health.

13.6.6.6 To allow free and open communication between the treating professionals, the recovery support network, those persons responsible for verifying compliance with the re-entry agreement, and the Committee on Physician Health.

13.6.6.7 To request a medical leave of absence in the event the Committee on Physician Health finds that the impairment or failure to comply with the re-entry agreement presents a risk to patients.

13.6.6.8 To sign whatever forms are needed to authorize release of information from the treatment programs to the Committee on Physician Health, and request that reports shall be made regularly, at defined time intervals, such as quarterly.

13.6.6.9 To acknowledge that any failure to comply with the conditions will result in immediate referral to the Chief of Staff, with suggestions for corrective action.

13.6.6.10 To provide for post treatment monitoring of a sufficient duration (up to five years).

13.6.6.11 To participate in a regular review of the agreement, and to modify it as necessary to achieve the goals of continued recovery.

13.6.6.12 To notify the Committee on Physician Health at any time he is applying for membership at another hospital, and to authorize disclosure of impairment and monitoring status to the equivalent committee of the hospital to which application is being made.

13.6.6.13 When the treating program or the Committee on Physician Health concludes that the member cannot practice safely, the member shall request a leave of absence. Discontinuance of the leave shall be contingent upon the member satisfying the Committee on Physician Health he or she can return safely to practice (if the member still chooses to comply voluntarily with the Physician Health Program).

13.6.6.14 When indicated based upon the severity and duration of the mental or physical impairment, the Member may be required to (1) pass an oral or written test administered by an appointed panel of Department Members and/or (2) be proctored on at least 20 cases and for at least 3 months, and have reports of satisfactory performance on the cases.

13.6.7 The investigation may be closed at any time it appears there is no problem.

13.6.8 If the Practitioner refuses to cooperate at any stage, the matter will be referred to the Chief of Staff, together with a statement that the Practitioner is not participating in a Physician Support Program and the Committee has reason to suspect that the Member may be impaired as a result of a physical or mental impairment. The Chief of Staff will refer the matter to the Executive Committee, which may initiate its own corrective action investigation. Insofar as is feasible, the Executive Committee shall not ask the Committee on Physician Health to share the confidential information that was gathered during an investigation or while a Member was fulfilling his or her Agreement with the Committee on Physician Health. The Committee on Physician Health should be asked only to indicate what action may be necessary to protect patients. Whenever possible, evidence should be developed independently in order to preserve the integrity of the Committee on Physician Health's promises of confidentiality.

13.6.9 After successful completion of the treatment program for a minimum period, the Committee on Physician Health shall close the active case. It will open a monitoring case for a defined period of time, such as 3 years, and review the Practitioner's status every 6 months.

Rule 14 Allied Health Practitioners and Advanced Practice Providers

DEFINITIONS

ALLIED HEALTH PRACTITIONER OR AHP means an individual who is a nonemployee brought into the hospital by a licensed independent practitioner to provide care, treatment, or services, and who have the same qualifications and competencies required of employed individuals performing the same or similar services at the hospital. Categories of AHPs permitted to work under this definition are set forth in the Rules. For the purposes of these bylaws, AHPs do not include nurse practitioners and physician assistants. AHPs are not eligible for Medical Staff membership. AHPs may apply for a scope of practice.

ADVANCED PRACTICE PROVIDER OR APP means an individual who exercises independent judgment within the areas of his professional competence and the limits established by the Governing Body, the Medical Staff and the applicable State Practice Act; who is qualified to render direct or indirect medical, dental, or podiatric care under the supervision or direction of a Medical Staff member possessing privileges to provide such care in the Hospital; and who may be eligible to exercise scope of practice and prerogatives in conformity with the rules adopted by the Governing Body, these Bylaws, and the Medical Staff Rules. Categories of APPs that can qualify for practice prerogatives under this definition are Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives. APPs are not eligible for medical staff membership. APPs may apply for privileges.

14.1 Overview

14.1.1 AHP/APPs may exercise only the scope of practice or privileges specifically granted them by the Governing Body. The scope of practice or privileges for which each AHP/APP may apply and any special limitations or conditions on the exercise of such scope of practice or privileges shall be based on recommendations of the Department/Section Chair, Interdisciplinary Practice Committee, Credentials Committee, and Medical Executive Committee and subject to the approval of the Governing Body.

14.1.2 Each AHP/APP shall be assigned to the Department or Section (if any) appropriate to his or her occupational or professional training and, unless otherwise specified in the Bylaws or Rules, shall be subject to terms and conditions paralleling those specified for Practitioners as they may logically be applied to AHP/APPs and appropriately tailored to the particular AHP/APP.

14.2 Categories of AHP/APPs Eligible to Apply for Scope of Practice or Privileges

14.2.1 The types of AHP/APPs allowed to practice in the Hospital will be ultimately determined by the Governing Body, based on the recommendation of the Medical Executive Committee and such other information as may be available to the Governing Body.

14.2.2 The approved categories of AHPs currently eligible to apply are:

- Clinical Research Coordinator
- Pathology Assistant

- Dental Assistant
- Registered Nurse First Assistant (RNFA)

14.2.3 The approved categories of APPs currently eligible to apply are:

- Certified Nurse Midwife
- Nurse Practitioner
- Physician Assistant

14.3 Prerogatives

The prerogatives that may be extended to an AHP/APP include:

14.3.1 Provide specified patient care services under the supervision or direction of a Medical Staff Member and consistent with the scope of AHP/APP's practice/privileges approved for the AHP/APP and within the scope of the AHP/APP's licensure or certification.

14.3.2 Serve on the Medical Staff Department, Section and Hospital committees as defined in the Medical Staff Rules & Regulations.

14.3.3 Attend meetings of the Department and Section to which the AHP/APP is assigned, as permitted by the Medical Staff or Department or Section Rules, and attend Hospital education programs in the AHP/APP's field of practice.

14.3.4 AHP/APPs are not members of the Medical Staff, and hence are not entitled to vote on Medical Staff or Department or Section matters.

14.4 General Qualifications

Each AHP/APP shall:

14.4.1 Belong to an AHP/APP category approved for practice in the Hospital by the Governing Body.

14.4.2 Have a designated primary physician supervisor/sponsor who is a member of the medical staff in good standing and who is not restricted by their applicable licensing board from supervising the relevant AHP/APP.

14.4.3 Meet the criteria for the scope of practice/privileges approved by the Governing Body.

14.4.4 Hold a current California state license or certificate, as appropriate. If the APP is allowed to prescribe medications, must hold a current, unrestricted Drug Enforcement Administration certificate.

14.4.5 Document the background, training, experience, judgment, ability, and physical and mental health necessary to demonstrate with sufficient adequacy that he/she is able to provide professional services as requested and authorized in accordance with generally recognized professional standards of quality and efficiency.

14.4.6 Possess professional liability insurance or its equivalent covering the privileges/scope of practice requested in the amounts of at least $1,000,000/occurrence and $3,000,000/aggregate per year by a carrier approved by the Medical Staff and Hospital. For APPs, the certificate must individually name the practitioner as being covered on that policy.

14.4.7 Not be excluded from participation in any federally funded health care program, including Medicare or Medi-Cal.

14.4.8 In addition to meeting the general requirements outlined above, applicants must meet any specific requirements established for his or her category of AHP/APP as set forth in the applicable privileges/scope of practice.

14.5 Responsibilities

Each AHP/APP shall:

14.5.1 Meet those responsibilities required by the Rules and as specified for Practitioners in the Bylaws or Rules, as modified to reflect the practice of the AHP/APP.

14.5.2 Be required to attend both the CREW training and complete orientation.

14.5.3 Adhere to generally recognized standards of professional ethics.

14.5.4 Be required to pay an application fee, as well as staff dues on an annual basis as outlined in the Medical Staff Rules & Regulations.

14.5.5 Agree to submit to such physical and/or mental examinations or provide verification of health status as may be required to verify the AHP'S/APP's ability to fully meet his/her responsibilities and/or to perform the requested privileges/scope of practice

14.5.6 Report to the Medical Staff Office immediately upon any action taken affecting licensure, certification, registration, or DEA registration, including, but not limited to, accusations, probation, restriction, suspension, termination, and voluntary or involuntary relinquishment of same.

14.5.7 Report to the Medical Staff Office immediately on any malpractice claims filed against them, notices of intent, judgments being entered, settlements been agreed to, or if their professional liability is terminated, not renewed, restricted, modified, or denied.

14.5.8 Participate as appropriate in peer review, performance improvement, and other monitoring activities as required.

14.5.9 Agree to comply with all policies and procedures, Medical Staff Rules & Regulations, Bylaws, Joint Commission, Title 22, and other state and federal regulations as applicable.

14.5.10 Be capable of working cooperatively with others in furtherance of high quality patient care and efficient Hospital operations

14.5.11 Agree to identify self to patient and public by wearing an approved Hospital identification badge.

14.5.12 Agree to utilize the Hospital's resources appropriately.

14.5.13 Participate directly in the management of patients to the extent authorized by his or her license, certification, other legal credentials, any applicable Standardized Procedures, and by the scope of practice/privileges approved by the Governing Body for the individual AHP/APP.

14.5.14 Comply with all Medical Staff and Hospital Bylaws, Rules and Policies.

14.5.15 Participate as appropriate in peer review, performance improvement, and other monitoring activities required of AHP/APPs.

14.6 Clinical Responsibilities

14.6.1 Consistent with the scope of practice/privileges approved for him or her, exercise independent judgment within his or her areas of competence, provided that a Medical Staff Member who has appropriate privileges shall retain the ultimate responsibility for each patient's care

14.6.2 An APP on a primary or consulting service is meant as a physician extender, not a physician replacement. Therefore, the supervising physician of the APP or the covering physician of record shall visit the bedside at regular intervals appropriate for that service. A suggested weekday interval for doctors to see the patient on services that see the patient daily is every 48 hours.

14.6.3 Consistent with the scope of practice approved for him or her, perform consultations as requested by a Medical Staff Member. At the discretion of the receiving Consultant, an APP may make the call for consultation; however, consults are always the ultimate responsibility of the supervising physician of the APP or the covering physician of record for the day.

14.7 Supervising Practitioner Responsibilities

14.7.1 The primary physician supervisor/sponsor must agree to participate as requested in the evaluation of competency during initial focused professional practice evaluation, at the time of reappointment, and, as applicable, at intervals between reappointment as necessary.

14.7.2 Be physically present or immediately available to provide guidance when the AHP/APP performs any task or function, except in unexpected life-threatening emergencies.

14.7.3 Be physically available within the Hospital until the patient is stable in the recovery room following a surgical procedure.

14.7.4 Maintain ultimate responsibility for directing the course of the patient's medical

treatment.

14.7.5 Assure that the AHP/APP provides services in accordance with accepted medical standards and does not exceed the privileges/scope of practice granted by the Hospital.

14.7.6 Unless otherwise specified in the Rules or specific supervision protocols, all chart entries will be countersigned for the first 90 days. Thereafter, only admitting orders will be countersigned.

14.7.7 Provide active and continuous overview of the AHP's/APP's activities in the Hospital.

14.7.8 Abide by all bylaws, policies, rules & regulations governing the use of AHPs/APPs in the Hospital, including refraining from requesting that the AHP/APP provide services beyond, or that might reasonably be construed as being beyond, the AHP's/APP's privileges/scope of practice in the Hospital.

14.7.9 Any supervising Practitioner or group which employs or contracts with the AHP/APP agrees that the AHP/APP is solely his, her or its employee or agent and not the Hospital's employee or agent. The supervising Practitioner or group has full and sole responsibility for paying the AHP/APP, and for complying with all relevant laws, including federal and state income tax withholding laws, overtime laws, and workers' compensation insurance coverage laws.

14.7.10 A supervising Practitioner or group which employs or contracts with the AHP/APP agrees to indemnify the Hospital against any expense, loss, or adverse judgment it may incur as a result of allowing an AHP/APP to practice in the Hospital or as a result of denying or terminating the AHP/APP's privileges/scope of practice.

14.7.11 Immediately notify the Medical Staff Office in the event of any of the following occur:

14.7.11.1 The scope or nature of the professional arrangement with the AHP/APP changes

14.7.11.2 Notification is given of investigation of the AHP/APP or his/her supervision of the AHP/APP by the Medical Board of California, or any other applicable board.

14.7.11.3 His/her professional liability insurance is changed insofar as coverage of the acts of the AHP/APP is concerned.

14.8 Processing the Application

14.8.1 Applications shall be submitted and processed in a manner parallel to that specified for medical staff applicants in Medical Staff Rules & Regulations, Procedures for Appointment and Reappointment. The Department Chair's recommendation shall be forwarded to the Interdisciplinary Practice Chair and the Chief Nursing Officer (for nursing disciplines), and their recommendations shall be forwarded to the Credentials Committee.

14.8.2 AHPs may be granted temporary privileges in accordance with the Bylaws, Rules and Regulations and as requested by the supervising physician(s).

14.9 Proctoring Period

14.9.1 The performance of all AHPs/APPs will be evaluated as part of the medical staff's routine performance improvement processes. Therefore, the AHP's/APP's performance will be evaluated as applicable and consistent with the medical staff policies and procedures regarding focused professional practice evaluation and ongoing professional practice evaluation.

14.9.2 Any concerns regarding the quality or appropriateness of care provided by an AHP/APP identified during such review processes or any concerns regarding the supervision of an AHP/APP by a physician shall be referred to an appropriate medical staff section, department, and/or review committee.

14.9.3 Proctoring/skills validation shall be required for all applicants and for individuals requesting additional privileges. The AHP/APP will be subject to a period of initial observation for a minimum of 90 days, as well as any other defined proctoring requirements

14.9.3.1 Proctoring shall be required for all APPs who have been granted privileges. Additionally, after 90 days, the following will be obtained and reviewed for initial observation:

- At least two peer evaluations, unless otherwise approved by the applicable section and/or department chair
- At least two physician supervisor reviews, unless otherwise approved by the applicable section and/or department chair
- Review of quality reports
- Verification of licensure status

14.9.3.2 Initial observation shall be required for all AHPs who have been authorized to provide services as outlined under a scope of practice. After 90 days, a skills validation will be obtained to include at least two physician supervisor reviews (if possible), and verification of licensure or certifications status (if applicable).

14.9.4 This information will be reviewed by the chairs of the appropriate section and department as applicable, who will conduct an evaluation of the qualifications and performance of each AHP/APP and may recommend to the Credentials Committee that privileges be continued, extended, limited, or revoked.

14.9.5 AHPs/APPs will be reviewed annually, in a manner parallel to that detailed above for initial observation.

14.9.6 Should the supervising physician not respond to requests for initial observation and/or annual review in a timely manner, the AHP/APP may be suspended until such time as the evaluation is completed. Should the AHP/APP remain on suspension for 90 days, it will be deemed as a voluntary resignation.

14.10 Exception to Credentialing Process - Contract Allied Health Practitioners

14.10.1 On occasion, the Hospital may determine, with the approval of the Medical Executive Committee that the interests of patient care are best served by entering into a contract with an entity, which provides AHP/APPs to work within the Hospital. These AHP/APPs are neither employees nor independent contractors of the Hospital, nor are they independent Practitioners working in their own private practice. Rather, they are employees or independent contractors of an entity that has agreed to provide certain health services to the Hospital's patients. For purposes of these Rules, these persons shall be referred to as "Contract AHP/APPs" and the entity employed or contracting with them shall be referred to as the "Contracting Entity."

14.10.2 The Contracting Entity is responsible for credentialing the Contract AHP/APPs pursuant to the terms of the contract with the Hospital.

14.10.2.1 Contract AHP/APPs shall be limited in their scope of practice to those activities described in the contract or in the job description provided by the Contracting Entity.

14.10.2.2 Quality improvement evaluations of the performance of Contract AHP/APPs shall be conducted by the appropriate Hospital department director or Chief Executive, or his or her designee

14.10.2.3 Contract AHP/APPs are expected to be competent and cooperative in the Hospital setting. The Contracting Entity shall immediately remove or reassign out of the Hospital any Contract AHP/APP reasonably determined by the Hospital Administration not to meet these conditions.

14.10.2.4 Upon expiration or termination of the contract between the Hospital and the Contracting Entity, the Contract AHP/APP's rights to provide patient care services to Hospital patients will automatically terminate as well. No procedural rights will be afforded to Contract AHP/APPs in the event the contract is terminated.

14.11 Automatic Suspension and Termination.

14.11.1 Automatic Suspension – An AHP/APP's privileges/scope of practice shall automatically be suspended in the event that:

14.11.1.1 The Medical Staff membership of the supervising Practitioner is terminated, whether such termination is voluntary or involuntary, and the AHP/APP does not have another supervising Practitioner who has been approved to supervise the AHP/APP;

14.11.1.2 The supervising Practitioner no longer agrees to act as the supervising Practitioner for any reason, or the relationship between the AHP/APP and the supervising Practitioner is otherwise terminated, regardless of the reason therefore and the AHP/APP does not have another supervising Practitioner who has been approved to supervise the AHP/APP;

14.11.1.3 The supervising Practitioner has been restricted by his/her licensing board from supervising the relevant AHP/APP and the AHP/APP does not have another

supervising Practitioner who has been approved to supervise the AHP/APP;

14.11.1.4 The AHP/APP's certification or license expires.

14.11.2 If a practitioner remains suspended under an automatic suspension provision for more than 90 days, his or her Allied Health status shall be automatically terminated without review

14.11.3 Automatic Termination - an AHP/APP's staff status/privileges/scope of practice shall automatically be terminated without review in the event that the AHP/APP's certification or license is suspended or revoked.

14.11.4 On any action that affects the termination of privileges and/or status of the AHP/APP, an email and certified letter shall be sent to the AHP/APP. On any change in supervising physician, the AHP/APP must notify the Medical Staff Office in writing.

14.12 Procedural Rights of Allied Health Practitioners

Nothing contained in the Medical Staff Bylaws or Rules shall be interpreted to entitle an AHP/APP to the procedural rights set forth in the Bylaws and Rules. However, an AHP/APP shall have the right to challenge any action that would constitute grounds for a hearing under the Bylaws or Rules by filing a written grievance with the Medical Executive Committee within 15 days of such action. Upon receipt of such a grievance, the Medical Executive Committee or its designee shall conduct an investigation that shall afford the AHP/APP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a "hearing" as that term is used in the Bylaws and Rules and shall not be conducted according to the procedural rules applicable to such hearings. Before the interview, the AHP/APP shall be informed of the general nature and circumstances giving rise to the action, and the AHP/APP may present information relevant thereto at the interview. A record of the interview shall be made. The Medical Executive Committee or its designee shall make a decision based on the interview and all other information available to it. This decision shall be communicated in writing to the AHP/APP.