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 Officer, 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 Officer, 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 Officer 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 Bylaws Committee

1.1.1 Composition

The Bylaws Committee shall include at least 5 Active Members, including the Vice Chief of Staff who serves as an Ex-Officio member with vote and the Chief Medical Officer (CMO) who serves Ex Officio without vote.

1.1.2 Duties

1.1.2.1 Conduct an annual review of the Medical Staff Bylaws, as well as the Rules

promulgated by the Medical Staff and its Departments.

1.1.2.2 Receive and evaluate suggestions for modifications of the Medical Staff Bylaws, as well as the Rules promulgated by the Medical Staff and its departments

1.1.2.3 Submit recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices and;

1.1.2.4 Assure that the Medical Staff Bylaws and Rules adequately and accurately describe the Medical Staff structure, including but not limited to:

1.1.2.4.1 mechanism used to review credentials and to delineate individual clinical privileges, establishment and enforcement criteria and standards for Medical Staff membership

1.1.2.4.2 provisions for assessing Medical Staff dues and use of Medical Staff dues as appropriate for the purposes of the Medical Staff, and in a manner that is consistent with the Hospital's nonprofit tax-exempt status

1.1.2.4.3 the organization of the quality improvement and assessment, utilization review and other Medical Staff activities including the procedures for conducting, evaluating, and revising such activities,

1.1.2.4.4 the mechanism for terminating Medical Staff membership,

1.1.2.4.5 the fair hearing and appeal procedures.

1.1.2.4.6 Provisions respecting the Medical Staff's ability to retain and be represented by independent legal counsel at the expense of the medical staff; and

1.1.2.4.7 The Bylaws Committee should review and update the Bylaws and Rules as necessary

1.1.3 Meetings

The Committee will meet as requested by the Bylaws Committee Chair or the Chief of Staff.

1.2 Cancer Committee

1.2.1 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.

1.2.2 Definition and Requirements:

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

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.

1.2.3 Meetings and Reporting

The Committee shall meet as often as necessary, but no less than quarterly. It shall report to the Quality Enhancement Committee.

1.3 Committee on Physician Health

1.3.1 Composition

1.3.1.1 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.

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

1.3.1.3 Whenever possible, members of this committee may not actively participate on other peer review or quality improvement committees while serving on this committee. Members of the committee shall not actively participate on any other peer review or quality improvement committees while serving on this committee.

1.3.2 Duties

1.3.2.1 In accordance with the Rule 13 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:

1.3.2.2 Receive reports related to the health, well-being, or impairment of Medical Staff members.

1.3.2.3 Investigate such reports as it deems appropriate.

1.3.2.4 Consult with individual staff members when requested.

1.3.2.5 Provide advice, counseling or referrals on a voluntary basis, as may seem appropriate.

1.3.2.6 Respond or make recommendations to the referral source and the concerned physician.

1.3.2.7 Develop and recommend individualized monitoring plans.

1.3.2.8 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.

1.3.2.9 Consider general matters related to the health and well-being of the Medical Staff.

1.3.2.10 Educate the Medical Staff and hospital staff about illness and impairment recognition issues specific to practitioners.

1.3.2.11 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.

1.3.2.12 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.

1.3.2.13 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.

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

1.3.3 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.

1.4 Credentials Committee

1.4.1 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. Members shall be appointed for staggered three-year terms, with two members appointed each year. 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.

1.4.2 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.

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

1.5 *Department Executive Committees*

1.5.1 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.

1.5.2 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,

1.5.3 Meetings
Each Department Executive Committee shall meet as often as necessary.

1.6 Department Quality Enhancement Committees

1.6.1 Composition
Departments may have a separate Department Quality Enhancement committee consisting of at least 3 Members of the Department appointed by the Department Chair. The Department Chair may designate the Department as a whole or may designate the Department Executive Committee to act as the Department Quality Enhancement Committee. The Department Chair or designee will serve as the Department Quality Enhancement Committee's Chair.

1.6.2 Duties
For services provided in the Department, each Department Quality Enhancement Committee shall carry out the following functions:

1.6.2.1 Quality Improvement

1.6.2.1.1 Provide leadership and oversight of the measurement, assessment and improvement of the processes that depend primarily upon practitioners and AHPs who have been granted clinical privileges. These include:

1.6.2.1.1.1 Medical assessment and treatment of patients.
1.6.2.1.1.2 Use of medications.
1.6.2.1.1.3 Use of blood and blood components.
1.6.2.1.1.4 Use of operative and other procedures.
1.6.2.1.1.5 Efficacy of clinical practice patterns, and
1.6.2.1.1.6 Significant departures from established patterns of clinical practice.

1.6.2.1.2 Provide leadership and oversight of the measurement, assessment and improvement of other patient care processes, including:

1.6.2.1.2.1 Education of patients and families.
1.6.2.1.2.2 Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient.
1.6.2.1.2.3 Accurate, timely and legible completion of patients' medical records.

1.6.2.1.3 Assure that findings relating to the performance of an individual are considered, when appropriate, for peer review and the granting and renewal of privileges.

1.6.2.1.4 Review and act upon factors affecting the quality, appropriateness and efficiency of patient care provided in the Hospital.

1.6.2.1.5 Coordinate the findings and results of sentinel event evaluations pertinent to the Department; cost quality activities; patient safety review; continuing education activities; reviews of medical record completeness, timeliness, and clinical pertinence; and other staff activities designed to monitor patient care practices.

1.6.2.1.6 Recommend performance improvement priorities, giving priority consideration to process that affect a large percentage of patients, place patients at risk if not performed well, and/or that have been problem-prone.

1.6.2.1.7 Provide oversight of the systematic aggregation and analysis of data to monitor improvements in performance, and assure the Hospital compares its performance over time and with other sources of information.

1.6.2.1.8 Provide oversight of the intensive analysis of undesirable patterns or trends in performance and sentinel events.

1.6.2.1.9 Submit regular reports to the Quality Enhancement Committee on the overall quality, appropriateness and efficiency of medical care provided in the Hospital, and on the Department, Section, and Staff patient care review, resource management and other quality review, evaluation, improvement, and monitoring activities.

1.6.2.1.10 Make recommendations to the committee(s) responsible for continuing medical education for the development of appropriate educational programs.

1.6.2.1.11 At least once a year, evaluate the quality improvement program to assess the effectiveness of the monitoring and evaluation activities and to recommend improvement.

1.6.3 Meetings and Reporting

Each Department Quality Enhancement Committee shall meet as often as necessary, but at least quarterly. The Department Quality Enhancement Committee will report to the Department Executive Committee and to the Quality Enhancement Committee.

1.7 Infection Control Committee

1.7.1 Composition

The Infection Control Committee shall be multidisciplinary, including at least 7 members, with representation from the Departments of Medicine, Surgery, Obstetrics/Gynecology, Pediatrics, and Pathology. It shall also include consultants in microbiology and epidemiology if so requested by the Chairman, and representatives from administration, the nursing department, housekeeping, laundry, dietetic services, engineering and maintenance, pharmacy, central service, and operating suite. The Infection Control Committee Chair, in consultation with the Hospital Epidemiologist, may form subcommittees that represent various hospital service departments. The Infection Control Committee Chair, microbiologist, and epidemiologist shall serve on those sub-committees.

1.7.2 Duties

The Infection Control Committee shall:

a. Develop a hospital-wide infection program and maintain surveillance over the program.

b. Develop a system for reporting, identifying, and analyzing the incidence and cause

of all nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action.

c. Develop and implement as preventive and corrective program designed to minimize infection hazards, including establishing reviewing, and evaluating aseptic, isolation, and sanitation techniques. Such techniques shall be defined in written policies and procedures.

d. Develop written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of the policies and quality of care administered.

e. Develop, evaluate and revise preventive, surveillance, and control policies and procedures relating to all phases of the Hospital's activities, including: operating rooms, delivery rooms, special care units; central service, dietetic service, housekeeping, maintenance, and laundry, sterilization and disinfection procedures by heat, chemicals, or otherwise, isolation procedures, prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment, testing of Hospital personnel for carrier status, disposal of infectious materials, food sanitation, waste management, and other situations as requested.

f. Coordinate action on findings from the Medical Staff's review of the clinical use of antibiotics.

g. Act upon recommendations related to infection control received from the Chief of Staff, the Medical Executive Committee, the Departments, and other Medical Staff and Hospital committees.

1.7.3 Meetings and Reporting

The Infection Control Committee shall meet at least quarterly. It shall report to the Quality Enhancement Committee.

1.8 Institutional Review Board

1.8.1 Composition

1.8.1.1 The Institutional Review Board ("IRB") shall be composed in a manner which meets the requirement of the United States Department of Health and Human Services ("HHS") and the Food and Drug Administration ("FDA") regulations for the protection of human subjects. The IRB shall have at least five members, with varying background to promote complete and adequate review of research activities commonly conducted in the institution. The IRB shall be sufficiently qualified through the experience and expertise of its members, and the diversity of the members' backgrounds, including consideration of the racial and cultural backgrounds of members and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects. In addition to possessing the professional competence necessary to review specific research activities, the IRB shall be able to ascertain the acceptability of proposed research in terms of institutional commitments and regulations, applicable law, and standards of professional conduct and practice. The IRB regularly reviews research that involves a vulnerable category of subjects, including but not limited to subjects covered by specific regulations, the IRB shall include one or more individuals who are primarily concerned with the welfare of these subjects.

1.8.1.2 The IRB may not consist entirely of men or entirely of women, or entirely of members of one profession. It shall include at least one member whose primary concerns are in non-scientific areas (for example: lawyers, ethicists, members of the clergy), and at least one member who is not affiliated with the institution. No member may participate in the IRB's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB. The IRB may, in its discretion, invite individuals with

competence in special areas to assist in the review of complex issues which require expertise beyond or in addition to that available on the IRB. These individuals may not vote with the IRB.

1.8.2 Duties

1.8.2.1 The IRB has adopted and follow written procedures for carrying out the duties imposed by the HHS and FDA regulations, as applicable including procedures for:

1.8.2.1.1 Conducting its initial and continuing review of research and for reporting its findings and actions to the investigator and to the institution.

1.8.2.1.2 Determining which projects require review more often than annually and which projects need verification from sources other than the investigators that no material changes have occurred since previous IRB review.

1.8.2.1.3 Assuring prompt reporting to the IRB of proposed changes in a research activity, and for assuring that changes in approved research, during the period for which IRB approval was already given, may not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subject. Reporting to the IRB shall be at the next appropriate opportunity.

1.8.2.1.4 Assuring prompt reporting to the IRB of unanticipated problems involving risks to subjects or others.

1.8.2.1.5 For research subject to HHS or FDA regulations, assuring prompt reporting of unanticipated problems involving risks to subjects or others by filing reports with the appropriate federal agency.

1.8.2.1.6 Assuring timely reporting to the appropriate institutional officials of (i) any serious or continuing noncompliance by investigators with the requirements and determinations of the IRB; and (ii) any suspension or termination of IRB approval. For research subject to the HHS and FDA regulations, these reports must also be made to HHS and/or to the FDA, as appropriate.

1.8.2.1.7 Except when an expedited review procedure is used, the IRB shall review proposed research at convened meetings at which a majority of the members of the IRB are present, including at least one member whose primary concern is in nonscientific areas. This review must be conducted in accordance with the provisions set forth in Paragraph b. below. In order for the research to be approved it must meet the criteria set forth in federal regulations and it must receive the approval of a majority of those members present at the meeting provided a quorum is present. Research which is approved by the IRB may be subject to further appropriate review by officials of the institution. However, those officials may not approve any research subject to the federal regulations if it has not been approved by the IRB.

1.8.2.2 The Institutional Review Board shall:

1.8.2.2.1 Review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities.

1.8.2.2.2 Require that information given to subjects as part of the informed consent process complies with the provisions of the applicable law or regulations. The IRB may require that information, in addition to that specifically mentioned in the law or regulations, be given to the subjects when, in the IRB's judgment, the information would meaningfully add to the protection of the rights and welfare of subjects.

1.8.2.2.3 Require documentation of informed consent and HIPAA authorization or waive documentation in accordance with the provisions of applicable law or regulations.

1.8.2.2.4 Notify the investigator and the institution in writing of its decision to approve or disapprove a proposed research activity, or of modifications required to secure IRB approval of the research activity. If the IRB decides to disapprove a research activity, it shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing in accordance with the IRB policies.

1.8.2.2.5 Conduct continuing review of research covered by these regulations at intervals appropriate to the degree of risk, but not less than once per year, and have authority to observe or have a third party observe the consent process and the research.

1.8.2.2.6 Have authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects. Any suspension or termination of approval shall include a statement of all the reasons for the IRB's action and shall be reported promptly to the investigator, appropriate institutional officials, and appropriate regulatory authorities.

1.8.2.3 The IRB shall develop criteria defining when research or experimental procedures that are not subject to the federal Protection of Human Subjects regulations of HHS and the FDA must nevertheless be submitted to the IRB for review and then shall provide the review and monitoring for such activities.

1.8.3 Meetings

The IRB shall meet as often as needed, but at least quarterly. It shall report to the Board of Trustees.

1.9 Information Technology Advisory Committee

1.9.1 Composition

1.9.1.1 The Committee shall be composed of no fewer than 5 Active Medical Staff Members.

1.9.1.2 Ex-officio members with vote shall include the Vice President of Patient Care services and the Chief Financial Officer.
1.9.1.3 Additional members at the chair's discretion

1.9.2 Duties

1.9.2.1 Encourage and facilitate the introduction of Information Systems (IS) to clinical care.
1.9.2.2 Act as a liaison between the Medical Staff and Administration on IS matters
1.9.2.3 Provide clinical input on IS hardware and software selection and implementation.
1.9.2.4 Facilitate input from the SJHS and other SJHS entities on IS issues.
1.9.2.5 Actively solicit input from members of the Medical Staff on IS needs and goals.
1.9.2.6 Monitor the impact of IS on clinical quality and outcomes.
1.9.2.7 Promote electronic communication between physicians and the hospital.

1.9.3 Meetings and Reporting

1.9.3.1 The committee shall meet as often as necessary, but no less than quarterly.
1.9.3.2 The committee shall report to the MEC.

1.10 Interdisciplinary Practice Committee

1.10.1 Composition

The Interdisciplinary Practice Committee shall have an equal number of medical staff members and nursing staff members. It shall include a representative from the nursing administration. In addition, 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.

1.10.2 Duties

1.10.2.1 Standardized Procedures:

1.10.2.1.1 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.
1.10.2.1.2 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.

1.10.2.2 Credentialing Allied Health Professionals

1.10.2.2.1 The IPC shall recommend policies and procedures for expanded role privileges for assessing, planning and directing the patients' diagnostic and therapeutic care.
1.10.2.2.2 The IPC shall defer credentialing processing to the appropriate Medical Staff Departments and the Credentials Committee.
1.10.2.2.3 The IPC shall defer AHP peer review and quality improvement activities to the appropriate Medical Staff Department and the Credentials Committee.
1.10.2.2.4 The IPC shall serve as a liaison between AHPs and the medical staff.

1.10.2.3 Meetings and Reporting

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

1.11 Continuing Medical Education Committee

1.11.1 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.

1.11.2 Duties

The Continuing Medical Education Committee shall:

1.11.2.1 Plan, implement, coordinate and promote ongoing special clinical and scientific programs for the medical staff. This includes:
- 1.11.2.1.1 Identifying the educational needs of the medical staff;
- 1.11.2.1.2 Formulating clear statements of objectives for each program
- 1.11.2.1.3 Assessing the effectiveness of each program;
- 1.11.2.1.4 Choosing appropriate teaching methods and knowledgeable faculty for each program; and
- 1.11.2.1.5 Documenting staff attendance at each program.

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

1.11.2.3 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.

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

1.11.3 Meetings and Reporting

1.11.3.1 The Continuing Medical Education Committee shall meet at least quarterly. It shall report to the Quality Enhancement Committee.

1.12 Operating Room Committee

1.12.1 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, Assistant Director of the Main OR, and Assistant Director of Outpatient Surgery 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.

1.12.2 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, SPU, PACU, and Surgery Center. These duties shall include but not be limited to:

Promote a coordinated, collaborative multi-disciplinary approach to management of OR operations.
Receive and evaluate reports that touch on OR operations.
Initiate, investigate, review and report on matters involving clinical, ethical, or professional performance in the OR.
Evaluate significant departures from established patterns of clinical practice.
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.

1.12.3 Meetings and Reporting

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

1.13 Pain Management Committee

1.13.1 Composition

The Pain Management Committee is an oversight committee reporting to the Medical Staff Quality Enhancement Committee. 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.

1.13.2 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:

Develop for approval, and oversight of, annual performance improvement goals related to pain management.
Review and recommend action on all aggregate quality data related to pain management (including operational compliance, satisfaction, patient safety, and outcomes).
Review and approve policy, procedures and resource tools related to pain management, with referrals as appropriate to achieve consensus prior to approval.
Receive and evaluate reports as referred from other Medical Staff, Nursing and/or Palliative Care committees on pain issues.
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.
Make recommendations for related performance improvement activities

Make referrals as appropriate for any potential peer review issue to the appropriate departmental QEC, and/or,
Make referrals to other medical staff committees or hospital departments as applicable for discipline or topic-specific performance improvement opportunities, and/or,
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,
Make recommendations for educational needs of medical and hospital staff related to pain management (in conjunction with Physician Education Committee)
Undertake at its discretion any other activity appropriate to the facilitation of performance improvement related to pain management.

1.13.3 Meetings

The Pain Management Committee shall meet at least quarterly, with additional meetings as necessary. The Committee shall report to the QEC and the Pharmacy and Therapeutics Committee.

1.14 Pharmacy and Therapeutics Committee

1.14.1 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.

1.14.2 Duties

The Pharmacy and Therapeutics Committee shall:

1.14.2.1 Assist in formulating the broad professional policies regarding the evaluation, selection, storage, distribution, use, safety procedures, administration and all other matters relating to drugs and diagnostic testing materials in the Hospital.
1.14.2.2 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.
1.14.2.3 Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.
1.14.2.4 Develop and review periodically a formulary or drug list for use in the Hospital.
1.14.2.5 Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.
1.14.2.6 Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.
1.14.2.7 Establish a system for identifying and reporting adverse drug reactions and medication errors.
1.14.2.8 Review reports of adverse drug reactions and medication errors and make recommendations for corrective action.
1.14.2.9 Perform any other duties as are assigned by the Chief of Staff or the Medical Executive Committee.

1.14.3 Meetings and Reporting

The Pharmacy and Therapeutics Committee shall meet at least quarterly**.** It shall report to the Quality Enhancement Committee.

1.15 Quality Council

1.15.1 Composition

The Quality Council is a staff oversight committee. It shall include:

- Chief of Staff
- Vice Chief of Staff,
- Medical Staff Quality Enhancement Committee Chair,
- Chief Executive Officer,
- Chief Operations Officer,
- Chief Medical Officer
- VP for Patient Care Services,
- VPs for Operations, VP of Sponsorship, and
- VP for Performance Improvement
- The immediate past-chief of staff, who shall serve as the chair.

The Chief of Staff has the discretion to appoint addition members. All members shall serve with vote.

1.15.2 Duties

The Quality Council shall be responsible for coordinating the performance improvement and patient safety activities in the hospital, with a particular emphasis on systems improvements. In carrying out its duties, the Council shall:

- Develop and submit a recommended Performance Improvement Plan for hospital operations annually.
- Develop and submit a recommended Patient Safety Program and Plan annually.
- Establish System Quality Improvement (SQI) team(s), patient safety gap analysis teams, or task forces whenever group action is required to correct identified systems problems, or to address issues proactively and then provide appropriate oversight.
- Review and recommend action on all operational quality control data (including operational indicators, ORYX and Core Measure indicators, satisfaction data, patient safety data, EOC safety data, outcomes relevant to systems design, etc.) and make recommendations for related performance improvement activities.
- Undertake at its discretion any other activity appropriate to the facilitation of performance improvement and patient safety.

1.15.3 Meetings

The Council shall meet monthly, with a minimum of 9 meetings a year.

16.1 Quality Enhancement Committee

1.16.1 Composition

The Quality Enhancement Committee shall consist of:

- Secretary/Treasurer, who will serve as Chair of the committee
- Vice Chief of Staff
- Chief Medical Officer
- Chairs of each of the specialty Quality Enhancement Committees
- Chair, Medical Education Committee
- Chair, Pharmacy and Therapeutics Committee
- Administrative representation to include: Chief Operation Officer, Vice President for Patient Care Services, the Vice Presidents for Operations, and Vice President for Performance Improvement

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

- The Chairs of the committees addressing each of the key process functions (see Section 1.15.2) and of the other committees that report to the Quality Enhancement Committee will be invited to present their scheduled reports as due.
- 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.
- 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.
- 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.

1.16.2 Duties

The Quality Enhancement Committee shall be responsible for review and oversight of the following functions in accordance with the hospital's Performance Improvement Plan:

Review of key process outcome data with summary reports presented and reviewed at least semi-annually including:

- blood usage
- infection control
- medical records
- medication use
- risk management
- surgical, other invasive and noninvasive procedure review
- utilization management.

1.16.3 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 Enhancement Committee 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.

1.16.5 Cancer

Oversee the Cancer Committee's activities.

1.16.6 Infection Control

Oversee the Infection Control Committee's activities.

1.16.7 Medication Administration and Usage Duties

Oversee the Pharmacy and Therapeutics Committee's activities.

1.16.8 Blood and Blood Components Usage Review Duties

1.16.8.1 Via the Medical Staff Liaison responsible for blood and blood component usage, receive reports of monitoring and evaluating the processes related to the use of blood and blood components;

1.16.8.2 Coordinate and critically assess the activities related to the ordering, distributing, handling, dispensing, administering and monitoring of blood and blood component effects on patients;

1.16.8.3 Establish a mechanism for systematically measuring and documenting, on an ongoing basis, the processes related to the use of blood and blood components; and

1.16.8.4 Evaluate each actual or suspected transfusion reaction referred to the committee and make a report of its findings for review by other Medical Staff committees as appropriate.

1.16.9 Medical Records Function

1.16.9.1 Via the Medical Staff Liaison responsible for Medical Records functions , receive reports of an ongoing review of medical records for clinical pertinence and timely completion, with a quarterly report on findings. The review by a multidisciplinary team (including Medical Staff members, nursing, health information management service staff, and other relevant clinical professionals) will focus on information available at the point of care and administration. The Committee will review a sample of records to determine whether they reflect the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient and the condition of the patient at discharge.

1.16.9.2 Review summary reports concerning timely completion of medical records.

1.16.9.3 Approve a standardized medical record format, forms used in the record and electronic data processing and storage Hospitals.

1.16.9.4 Recommend solutions for problems identified during review and monitor effectiveness of these interventions.

1.16.9.5 Review and make recommendations for Medical Staff and Hospital policies and rules relating to medical records completion and enforcement of the policies and rules.

1.16.9.6 Serve as a liaison to Administration and the Health Information staff on matters relating to health information.

1.16.10 Case Management Function

1.16.10.1 Via the Medical Staff Liaison responsible for Case Management functions receive reports on the review of the medical necessity for admissions, extended stays, and services rendered. The Committee shall address over-utilization, underutilization and inefficient scheduling and use of resources. Patterns of care will be followed, and focused review may be undertaken as deemed necessary. Make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety.

1.16.10.2 Oversee the development and implementation of a Resource Management Plan which must be approved by the Medical Executive Committee and Governing Body, and comply with applicable federal and state regulations.

1.16.10.3 Promote continuity of care upon discharge and oversee the accumulation of data by Case Management Services on the availability of health care resources outside the Hospital.

1.16.11 Institutional Review Board Serious Adverse Event Duties

Oversee the IRB Serious Adverse Event (SAE) activities on an annual basis or as needed for SJH SAE patient specific activities

1.16.12 Meetings

The Committee shall meet at least quarterly.

1.17 Section Committees

1.17.1 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.

1.17.2 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 Enhancement Committee, 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 Enhancement Committee.

1.17.3 Meetings and Reporting

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

1.18 Special Procedures Committee

1.18.1 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.

1.18.2 Duties

1.18.2.1 develop and evaluate Medical Staff credentialing criteria for practitioners performing Interventional Radiology procedures.

1.18.2.2 work collaboratively with diagnostic radiology.

1.18.2.3 promote a multidisciplinary approach to patient management.

1.18.2.4 provide for emergency coverage for Interventional Radiology.

1.18.2.5 establish and monitor appropriate quality and outcomes criteria.

1.18.3 Meetings and Reporting

The Committee shall meet at least quarterly.

1.19 Staff Officer Committee

1.19.1 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.

1.19.2 Duties

The Staff Officers Committee shall:

1.18.2.1 Advise the Chief of Staff on peer review and credentialing matters.
1.18.2.2 Advise and assist the Chief of Staff in carrying out his responsibilities.

1.19.3 Meetings and Reporting

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

1.20.1 Utilization Management Committee

1.20.1 Composition

The UR 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.

1.20.2 Duties

The UR 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

1.20.3 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:

- Inappropriate admissions
- Excessive length of stay
- Procedures without adequate clinical justification
- 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.

1.20.4 Request for reconsideration

The attending physician may request reconsideration by the UR Committee of any negative determination. This request must be filed in writing within one calendar day of being notified of the negative determination. The UR 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 UR committee unless there is substantial and significant change in the patient's clinical condition.

1.20.5 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 UR committee to no longer require acute hospital care, the UR 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.

1.20.6 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 QEC at least quarterly

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

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.

2.3 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 Officer, 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 4.4 below) and may review only the following credentials file items:

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

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

c. 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 4.3.2, 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 4.3.2 and 4.3.3, applicants and Members may not

have access to any item or document contained in the credentials file except as approved by the Chief Executive Officer or the Chief of Staff.

e. 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 Officer. 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 Officer, 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.

3.13 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 3

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 appoint-ment 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 Officer, 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
Administrative:	Provides no patient care, but have administrative positions with the Hospital
Honorary/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	ADMINISTRATIVE	HONORARY & RETIRED
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)	No	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	Yes	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	No	No

4.2 Fees

- The application fee for all applicants to the Medical or Allied Health Staff is $650.00
  - Dental Assistants do not pay application fees.
  - The application fee for AHP's other tha PA's and NP's is $250.00

- The expedited application fee is $250 plus the $650 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 Professionals**	**Honorary/ Emeritus**
Pay Dues *	YES $300	YES $400	YES $100	YES $250 *	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 Officer) 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 Officer.

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 Officer, 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 13.2

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 Section13.2, the Chief Executive Officer 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 13.

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 13.2, the Chief Executive Officer 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 13 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 5.7-4.a or 5.7-4.b, 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 Officer 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 Officer. 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 Officer, 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.

5.5.6 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 5.9.11.

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.

EVEN YEARS:

January
Genetics
Cardiology

February
Nephrology
Infectious Disease
Rheumatology
Physical/Rehab Med
Sleep
Allergy & Immunology

March
Pulmonology
Hematology/oncology
Oncology
Neurology

April
Otolaryngology
Dermatology

May
Podiatry
Ophthalmology

June
Orthopedics

July
Pediatrics (D-Z)

August
None

September
Pediatrics (Cardiology)
Pediatrics (Critical Care)
Pediatrics (Dental)

September (continued)
Pediatrics (Gastroenterology)
Pediatrics (Hem/Onc)
Pediatrics (A-C)

October
Pediatrics (Neonatology/Perinatal)
Pediatrics (Neurology)
Pediatrics (Pulmonology)
Pediatrics (Surgery)
Pathology

November
Radiology
Radiation Therapy
Nuclear
Interventional Rad

December
None

ODD YEARS

January
Anesthesia
Emergency

February
Psychiatry
Psychology
AHP – Physician Assistant
AHP – RNFA

March
General Surgery
FP (A-D)

April
FP (E-Z)

May
OB/GYN
GYN Oncology
GYN

June
Thoracic Surgery
Urology
Vascular Surgery
Colorectal Surgery

July
Dentistry
Oral/Max Surgery
AHP – Dental Assist
AHP – Oral Surgery Assist
Plastic Surgery
Neurosurgery

August
None

September
Gastroenterology
Endocrinology

October
Internal Medicine (K-Z)

November

Internal Medicine (A-J) **December**
None

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 8.4 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 5.9.7. 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 5.9.7.

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 5.9.7.

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 5.9.7.

5.7.6.2 When the Executive Committee recommends adverse action, as defined in Bylaws Section 13.2, 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 Rule 17. The applicant shall be entitled to the Rule 17 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 5.7-4 (Governing Body Action), Rule 5.7-5 (Notice of Final Decision) and in the Rule 5.11 (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 Officer, 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 5, Section 5.5.8)

5.7.10 Interim Appointment

If the reappointment application has not been fully processed before the Member's appointment expires, the Staff Member shall maintain his or her current membership status and clinical privileges until the reappointment review is complete only if an interim appointment is approved by the Credentials Committee, Executive Committee and Governing Body. This does not prevent corrective action which may affect the Practitioner's membership and/or clinical privileges. 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 and Rule 8.9.11 below applies. 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 ~~45~~ 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 in General

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.

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

7.1 **The Special Procedures Committee (SPC)** will review the training, experience, and demonstrated competence of the applicant, whether radiologist or other specialist. The Committee will interview the applicant if necessary, and make recommendations to the appropriate department for the granting of Class IA and Class I privileges.

7.2 **Categories of privileges in interventional radiology** will be in Class I and Class IA, as follows:

7.2.1 Class I: Full or unlimited privileges to perform specific procedure.
7.2.2 Class IA: Limited privileges, subject to proctoring requirements, to perform specific procedures.

7.3 **The considerations to be used in granting interventional radiology** privileges are:

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 Grants

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 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 .a physician with appropriate fluoroscopic licensure.

7.5.13.4 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.

7.5.14 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 .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

8.1 General

8.1.2 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.

8.1.3 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.

8.1.4 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 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.

8.3 Effect of Failure to Complete Proctoring

8.3.1 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.

8.3.2 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.

8.3.3 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 twenty-four (24) months. A single twelve (12) 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.

8.4 Assignment of Proctor

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

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

8.4.3 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.

8.4.4 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.

8.4.5 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.

8.4.6 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.

8.5 Function and Responsibility of The Proctor

8.5.1 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.

8.5.2 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.

8.5.3 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.

8.5.4 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.

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

8.5.6 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.

8.5.7 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.

8.5.8 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.

8.6 Responsibility of the Proctored Practitioner

8.6.1 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.

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

8.7 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.

8.8 Extension of Proctoring

If at the time of completion of the minimum number of cases required for general or special Privileges, the Department Chair or the Department Committee concludes that the Practitioner should be proctored on additional cases, the Department Chairman shall notify the proctored Practitioner. Proctoring shall be extended for 3 additional cases at a time, for a maximum number of 24 cases. The Department Chairman shall report any failure to complete proctoring satisfactorily to the Executive Committee and corrective action may be initiated in accordance with the procedure set forth in the Medical Staff Bylaws. This provision does not, however, preclude the initiation of corrective action at an earlier time.

8.9 Reciprocal Proctoring

8.9.1 Reciprocal proctoring may be accepted from Children's Hospital of Orange County to meet all proctoring requirements and from other hospitals for up to 50% of the cases to supplement actual observation on the premises.

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

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

8.9.2.2 The Hospital has JCAHO accreditation.

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

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

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 An Emergency Department Call Panel has been established for the purpose of referring emergency patients, who have no private physician, 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 Emergency Room coverage, the Chief of Staff of the Medical Staff has the authority to override that Department's rules and regulations and to make Emergency Room 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 Emergency Department 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. (Refer to Emergency Department Rules and Regulations relative to coverage of unassigned patients).

9.2 Conduct of Call Panel Members

9.2.1 Practitioners on call must respond promptly when requested to see a patient. The response time must be reasonable in view of the patient's clinical circumstances. Each panelist must let the Hospital know how to reach him or her immediately and remain close enough to the Hospital to be able to arrive within a reasonable time.

9.2.2 A panelist who is unable to provide panel coverage during his or her scheduled time (including when he or she is detained due to another medical commitment) 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 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.

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

9.2.4.1 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:

9.2.4.2.1 the receiving facility must consent to the transfer,
9.2.4.2.2 staff and equipment necessary for a safe transfer must be arranged,
9.2.4.2.3 copies of pertinent medical records must be provided, and
9.2.4.2.4 the "Transfer Summary Form" must be completed, and a copy sent with the patient.

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

9.2.6 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.

9.2.7 Panelists will see unassigned patients in Emergency Services 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.

9.2.8 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. (See Article 12.3.1 of Bylaws).

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

9.3.1 Cardiology
- Acute coronary syndrome as primary working diagnosis
- Arrhythmia as primary working diagnosis
- Initial diagnosis of CHF (recurrent CHF can be admitted to the hospitalists)
- Admission requiring device (pacemaker, defibrillator, etc.)
- Ischemia as a primary working diagnosis

9.3.2 ENT
- Peritonsilar 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 faciititis

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 The physician on ER call is responsible for IP consultations and ER coverage for the day they are scheduled. The exceptions are SJHAP patients, which are covered by the SJHAP panel.

9.5 Physicians who fail to respond or refuse to respond to inpatient consultation requests **<u>may</u>** 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 Bylaws, after the Practitioner has satisfied the requirements set forth in these Bylaws.

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, 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 To fulfill an important patient care, treatment or service need, or

10.1.2.3 For Practitioners who will serve as locum tenens for a Medical Staff Member for up to 30 days at a time, subject to renewal to a total of 60 days in any consecutive 12 months, but only when there is an important patient care need that mandates an immediate authorization to practice.

10.2 Application

Practitioners seeking temporary privileges must complete an application for staff membership (if temporary privileges are sought during the pendency of an application or to serve as locum tenens) or a temporary privilege application form (for temporary privileges to care for specific patients or for training).

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 Officer (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 Officer 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 Disaster Assignments

11.1 General

11.1.1 There shall be a plan for the care of mass casualties at the time of a major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be developed by a disaster planning committee.

11.1.2 All Practitioners shall be assigned to posts, either in the Hospital, an auxiliary hospital, or a mobile casualty station in the event of a mass disaster. The Practitioner shall be responsible for reporting to his or her assigned station and performing the assigned duties unless the Disaster Assignment Chair changes the assignment.

11.1.3 If patients are evacuated from one section of the Hospital to another, or from the Hospital premises, the Administrator on Call, after conferring with the Medical Staff Chair, Department Chairs, and/or Section Chairs, will arrange for the transfers.

11.2 Emergency Disaster Credentialing

11.2.1 Disaster privileges may only be granted to a licensed independent practitioner (LIP) when the following two criteria have been met:

- 11.2.1.1 The organization's emergency management plan has been formally activated, and;
- 11.2.1.2 The organization is unable to meet immediate patient needs.

11.2.2 Granting of disaster privileges must be authorized by the Chief Executive Officer (or designee), the Chief of Staff (or designee) or the appointed Disaster Medical Director (or authorized designee). Disaster privileges will be granted on a case-by-case basis.

11.2.3 An individual who presents as a volunteer LIP should be directed to the medical staff pool or other area as designated by the emergency management Command Center.

11.2.4 A volunteer LIP must present a valid government issued photo identification issued by a state or federal agency (e.g. driver's license or passport). In addition, the volunteer LIP must provide at least one of the following:

- 11.2.4.1 A current hospital picture identification card that clearly identifies the individual's professional designation
- 11.2.4.2 A current license to practice and a valid picture ID issued by a state, federal or regulatory agency.
- 11.2.4.3 Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization or group(s).
- 11.2.4.4 Identification indicating that the individual has been granted authority to render patient care, treatment, or services in disaster circumstances (such as authority having been granted by a federal, state, or municipal entity).
- 11.2.4.5 Identification by a current member of the organization or medical staff who possesses personal knowledge regarding the individual's ability to act as a LIP during a disaster.

11.2.5 The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the

disaster privileges initially granted.

11.2.6 Primary source is the entity or agency that has the legal authority to issue the credential in question. If the entity or agency has designated another entity or agency to communicate information about the status of a staff member's credential, then the other entity or agency may be considered the primary source.

11.2.7 If the volunteer LIP is <u>not</u> providing care, treatment, or service that required the granting of disaster privileges, then primary source verification is not required.

11.2.8 The Medical Staff Office, or other designee, shall be responsible for securing primary source verification on all volunteer practitioners.

11.2.9 Volunteer LIP's will be identified by a name badge or tag provided by the organization. The badge / tag will list the name and professional designation of the volunteer (e.g. John Smith MD) as well as the notation that the individual is a volunteer. The volunteer LIP will be required to wear the badge / tag on his or her person while performing in that role / capacity.

11.2.10 Volunteer LIP's will be assigned to a member of the medical staff who is a peer in the volunteer's area of practice and experience. The medical staff member will serve as a mentor and resource for the volunteer practitioner. The medical staff member will be responsible for overseeing the professional performance of the volunteer LIP. This may be accomplished by;

- 11.2.10.1 Direct observation
- 11.2.10.2 Clinical review of care documented in the patient's medical record.

11.2.11 Volunteer LIP's will cease providing care, treatment, or service if any one of the following criteria is met:

- 11.2.11.1 Implementation of the emergency management plan ceases.
- 11.2.11.2 The capability of the organization's staff becomes adequate to meet patient care needs.
- 11.2.11.3 A decision is made that the professional practice of the volunteer LIP does not meet professional standards.

11.2.12 Termination of privileges under this provision shall not entitle the practitioner to a hearing under Article XIV of the Bylaws.

Rule 12 Medical Education

12.1 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.

12.2 Medical Students, Residents and Fellows Supervision and Privileges

Medical students, residents and fellows participating in training programs at the Hospital shall be supervised by Medical Staff Members and/or the training program's Medical Director and act in accordance with the Agreement governing their training at the Hospital.

12.3 Record Keeping

12.3.1 General

Residents, fellows, and medical students shall be responsible for completing records pertaining to the clinical services they provide while participating in the residency, fellowship, and medical student training programs at the Hospital.

12.3.2 Countersignatures

The attending and supervising physician shall review and then countersign the following reports prepared by a medical student or resident:

- 12.3.2.1 Admission History and Physical Examination Report
- 12.3.2.2 Consultation Reports
- 12.3.2.3 Pre-operative Reports
- 12.3.2.4 Operative Reports
- 12.3.2.5 Discharge Summaries

12.3.3 Designation in Operative Reports

- 12.3.3.1 Residents who act as an assistant surgeon shall be designated in the operative report as the "assisting resident surgeon" and the primary operating surgeon shall be designated as the "primary operating surgeon" in the operative report.
- 12.3.3.2 Medical Students who observe surgery shall be designated as observers. Medical Students who assist with simple procedures during surgery shall be designated in the operative report as the "assisting medical student" and the primary operating surgeon shall be designated as such.

Rule 13 Research

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

13.2 All research undertaken by Medical Staff Members or others involving Hospital patients must be approved when appropriate, by an Institutional Review Board. All research must be conducted in accordance with the Rules and policies governing research approved by the Institutional Review Board and Executive Committee.

13.3 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.

13.4 Patient care shall be rendered according to approved protocols.

13.5 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 14 Impaired Medical Staff Members

14.1 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.

14.2 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.

14.3 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.

14.4 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.

14.5 Confidentiality

14.5.1 The 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.

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

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

14.6 Reporting and Investigating Procedure

14.6.1 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.

14.6.2 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.

14.6.3 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.

14.6.4 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.

14.6.5 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.

14.6.6 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.

14.6.6.1 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.

14.6.6.2 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.

14.6.6.3 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.

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

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

14.6.6.6 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.

14.6.6.7 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.

14.6.6.8 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.

14.6.6.9 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.

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

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

14.6.6.12 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.

14.6.6.13 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).

14.6.6.14 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.

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

14.6.8 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.

14.6.9 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 15 Allied Health Practitioners

15.1 Overview

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

15.1.2 Practitioners who desire to supervise or direct AHPs who provide dependent services must apply and qualify for Privileges to supervise approved AHPs.

15.1.3 Until the AHP has been granted scope of practice and assigned to a Department or Section (if the Department has Sections), an AHP should not be practicing within the Hospital.

15.1.4 Each AHP 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 AHPs and appropriately tailored to the particular AHP.

15.2 Categories of AHPs Eligible to Apply for Practice Privileges

15.2.1 The types of AHPs allowed to practice in the Hospital will be ultimately determined by the Governing Body, based on the comments of the Medical Executive Committee and such other information as may be available to the Governing Body.

15.2.2 The approved categories of AHPs currently eligible to apply are

- 15.2.2.1 Clinical and Non-clinical Research Associate
- 15.2.2.2 Nurse Practitioner
- 15.2.2.3 Optometrists (Outpatient La Amistad only)
- 15.2.2.4 Pathology Assistant
- 15.2.2.5 Physician Assistant
- 15.2.2.6 Private Scrub Personnel:
  - 15.2.2.6.1 Dental Assistants
  - 15.2.2.6.2 Surgical Assistants
- 15.2.2.7 Physician-Employed RNFA

15.2.3 Clinical psychologists who are members of the AHP staff prior to 1993 may continue with AHP status. All other clinical psychologists must apply and qualify for Medical Staff membership.

15.2.4 When an AHP in a category that has not been approved as eligible to apply to practice at the Hospital requests to practice at the Hospital, the IPC may begin to process an application at the same time the request for recognition of the profession is processed; however, no right to practice in the Hospital is thereby created or implied.

15.3 Prerogatives

The prerogatives that may be extended to an AHP include:

15.3.1 Provision of specified patient care services under the supervision or direction of a Medical Staff Member and consistent with the scope of practice approved for the AHP

and within the scope of the AHP's licensure or certification.

15.3.2 Service on the Medical Staff, Department, Section and Hospital committees.

15.3.3 Attendance at the meetings of the Department and Section to which the AHP is assigned, as permitted by the Medical Staff or Department or Section Rules, and attendance at Hospital education programs in the AHP's field of practice.

15.3.4 AHPs are not members of the Medical Staff, and hence are not entitled to vote on Medical Staff or Department or Section matters.

15.3.5 AHPs will be required to pay staff dues on an annual basis.

15.4 Responsibilities

Each AHP shall:

15.4.1 Meet those responsibilities required by the Rules and as specified for Practitioners in the Bylaws or Rules, as modified to reflect the more limited practice of the AHP.

15.4.2 Retain appropriate responsibility within the AHP's area of professional competence for the care and supervision of each patient in the Hospital for whom the AHP is providing services.

15.4.3 Consistent with the scope of practice 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.

15.4.4 Participate directly in the management of patients to the extent authorized by his or her license, certificate, other legal credentials, any applicable Standardized Procedures, and by the scope of practice approved by the Governing Body.

15.4.5 Write orders to the extent established by any applicable Medical Staff, Department or Section policies, rules or Standardized Procedures and consistent with the scope of practice approved for him or her.

15.4.6 Record reports and progress notes on patient charts to the extent determined by the appropriate Department or Section, and in accordance with any applicable Standardized Procedures.

15.4.7 Assure that records are countersigned as follows: (i) the supervising Practitioner, if any, shall countersign all entries except routine progress notes; (ii) unless otherwise specified in the Rules or specific supervision protocols, all chart entries that require countersignatures must be countersigned within 14 days after the entry is made.

15.4.8 Consistent with the scope of practice approved for him or her, perform consultations as requested by a Medical Staff Member.

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

15.4.10 Participate in peer review and quality improvement and in discharging such other functions as may be required from time to time.

15.4.11 Participate as appropriate in quality assurance review, evaluations, and monitoring activities required of AHPs, in supervising initial appointees of his same occupation or profession or of a lesser included occupation or profession, and in discharging such other functions as may be required from time to time.

15.5 Processing the Application:

15.5.1 Applications shall be submitted and processed in a manner parallel to that specified for medical staff applicants in Rule 5, Appointment and Reappointment, including the applications are submitted to the Credentials Committee.

15.5.2 Once the application is determined to be complete, it will be forwarded to the appropriate

Department Chair for consideration. The Department Chair may meet with the applicant and the sponsoring or supervising practitioner (if applicable). The Department Chair shall evaluate the AHP based upon the standards set forth in Rules 5 and 14.4. The Department Chair will also ascertain that appropriate monitoring mechanisms are in place (in the department or through the Quality Enhancement Committee). The Department Chair shall forward his or her recommendations to the Credentials Committee.

15.5.3 Upon receipt of an AHP application from the Credentials Committee shall evaluate the AHP based upon the standards set forth in Rules 5 and 14.4 and upon the department chair recommendations. The Credentials Committee will make a recommendation to the Medical Executive Committee regarding the applicant's qualifications to exercise the requested privileges.

15.5.4 Thereafter, the application shall be processed by the Medical Executive Committee and Governing Body in accordance with the procedures set forth in Rule 5.

15.6 Credentialing Criteria

15.6.1 Basic Requirements

15.6.1.1 The applicant must belong to an AHP category approved for practice in the Hospital by the Governing Body.

15.6.1.2 The applicant must meet the criteria for the scope of practice set forth in the scope of practice forms approved by the Interdisciplinary Practice Committee, Credentials Committee, relevant Department or Section, the Medical Executive Committee and the Governing Body.

15.6.1.3 If required by law, the applicant must hold a current, unrestricted state license or certificate. If the AHP is allowed to prescribe medications, hold a current, unrestricted Drug Enforcement Administration certificate.

15.6.1.4 In addition, Hospital independent contractors shall meet all conditions of their contract with the Hospital.

15.6.1.5 The applicant must document his or her experience, education, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient he or she treats will receive care of the generally recognized professional level of quality and efficiency in the community and as established by the Hospital, and that he or she is qualified to exercise practice within the Hospital.

15.6.1.6 The applicant must maintain in force professional liability insurance or its equivalent covering the scope of practice requested or approved for him or her in the amounts of at least $1,000,000/occurrence and $3,000,000/aggregate.

15.6.1.7 The AHP must maintain professional liability insurance in the amounts of at least $1,000,000 per occurrence/$3,000,000 aggregate per year by a carrier approved by the Medical Staff and Hospital. For dependent practitioners, the certificate must name the practitioner specifically as being covered on that policy. Additionally, the employing physician is responsible for providing evidence that the applicant is covered by workers compensation insurance through his/her employer.

15.6.1.8 The applicant must submit a minimum of 2 references from either licensed physicians or adequately trained Practitioners in the appropriate field and who are familiar with his or her professional work and demonstrated competency.

15.6.1.9 The applicant must be determined, on the basis of documented references, to adhere strictly to the lawful ethics of his or her profession, to work cooperatively

with others in the Hospital setting so as not to adversely affect patient care, to be willing to participate in and properly discharge responsibilities as determined by the Medical Staff.

15.6.2 Specific Requirements

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

15.6.3 Supervising Practitioner Responsibilities

15.6.3.1 Any supervising Practitioner or group which employs or contracts with the AHP agrees that the AHP 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, and for complying with all relevant laws, including federal and state income tax withholding laws, overtime laws, and workers' compensation insurance coverage laws.

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

15.6.4 Processing the Application

15.6.4.1 Applications shall be submitted and processed in a manner parallel to that specified for Medical Staff applicants in Rule 8 (Appointment and Reappointment), except that the applications shall be submitted to the IPC before the Credentials Committee.

15.6.4.2 Once the application is determined to be complete, it will be forwarded to the Department Chair or Section Chair, who shall evaluate the AHP based upon the standards set forth in Rules 8 and this Rule 14. The Department Chair or Section Chair or his or her designee may meet with the AHP as well as the Sponsoring or Supervising Practitioner (if applicable) to further investigate the AHP's request for privileges. The Department Chair or Section Chair will make a recommendation to the Interdisciplinary Practice Committee regarding the applicant's qualifications to exercise the requested privileges.

15.6.4.3 Upon receipt of an AHP application from the Department Chair or Section Chair, the IPC shall consider the application. The IPC may meet with the applicant and the Sponsoring or Supervising Practitioner (if applicable). The IPC shall evaluate the AHP based upon the standards set forth in rules 8 and 14.5. The IPC will also ascertain that appropriate monitoring mechanisms are in place (in the Department or Section or through the Clinical Performance Improvement Committee). Whenever possible, the IPC shall include practitioners in the same AHP category when conducting its evaluation. The IPC shall forward its recommendations to the Credentials Committee.

15.6.4.4 Thereafter, the application shall be processed by the Credentials Committee, Medical Executive Committee and Governing Body in accordance with the procedures set forth in Rule 8, Sections 8.7.2 through 8.7.7.

15.6.4.5 AHPs may be granted temporary privileges only when there is an important patient care need that mandates an immediate authorization to practice. The review for temporary privileges shall be conducted in accordance with the procedures set forth in Rule 9.3.

15.7 Provisional Status

All AHPs initially shall be appointed to a provisional status not to exceed 24 months. Advancement from the provisional status will be based upon whether the professional's performance is satisfactory, as determined by the Department and Section in which the AHP is assigned, IPC (when its review is necessary for the privileges), the Credentials Committee, the Medical Executive Committee and the Governing Body.

15.8 Duration of Appointment and Reappointment

15.8.1 AHPs shall be given an approved scope of practice for no more than 24 months.
15.8.2 Applications for renewal of the AHP's scope of practice and the supervising Practitioner's approval must be completed by the AHP and supervising Practitioner and submitted for processing in a parallel manner to the reappointment procedures set forth in the Medical Staff Rules.

15.9 Exception to Credentialing Process - Contract Allied Health Practitioners

15.9.1 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 AHPs to work within the Hospital. These AHPs 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 AHPs” and the entity employed or contracting with them shall be referred to as the “Contracting Entity.”
15.9.2 The Contracting Entity is responsible for credentialing the Contract AHPs pursuant to the terms of the contract with the Hospital.
15.9.2.1 Contract AHPs 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.
15.9.2.2 Quality improvement evaluations of the performance of Contract AHPs shall be conducted by the appropriate Hospital department director or Chief Executive Officer, or his or her designee. A report will be made to the Medical Executive Committee on an annual basis unless that Committee requests a report more frequently.
15.9.2.3 Contract AHPs 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 reasonably determined by the Hospital Administration not to meet these conditions.
15.9.2.4 Upon expiration or termination of the contract between the Hospital and the Contracting Entity, the Contract AHP's rights to provide patient care services to Hospital patients will automatically terminate as well. No procedural rights will be afforded to Contract AHPs in the event the contract is terminated.

15.10 Procedural Rights of Allied Health Practitioners

15.10.1 Nothing contained in the Medical Staff Bylaws or Rules shall be interpreted to entitle an AHP to the procedural rights set forth in the Bylaws and Rules. However, an AHP 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 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 shall be informed of the general nature and circumstances giving rise to the action, and the AHP 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.

15.10.2 Automatic Termination -- An AHP's Privileges shall automatically terminate, without review pursuant to Section 18.10.1 or any other Rule, in the event:

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

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

15.10.2.3 The AHP's certification or license expires, is revoked, or is suspended.

15.10.3 Review of Category Decisions

The rights afforded by this section shall not apply to any decision regarding whether a category of AHP shall or shall not be eligible for practice in the Hospital and the scope of practice, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the Governing Body, which has the discretion to decline to review the request or to review it using any procedure the Governing Body deems appropriate.

16. OBSERVATION POLICY

Patient care observers shall not be involved in hands-on patient care. Medical Staff members may submit requests for observers through the Medical Staff Services Department. The request must be submitted prior to any authorized observation or physician shadowing is allowed.

16.1 Definitions:

Observers: This refers to any patient care observer, regardless of whether or not they are enrolled in a medical education program, or have completed their graduate medical education training. This does not include family members of patients or others authorized by the patient to observe that patient's care. Those individuals will be referred to clinical Education for consideration of observation. Observers must be 18 years of age or older. **Observers are not allowed to scrub in the surgical field.**

16.2 Documentation: Any patient care observer must submit:

- Observer confidentiality/responsibility agreement
- Medical history questionnaire, including evidence of tuberculin (TB) skin testing within one year prior to the start date of observation at St. Joseph Hospital. Any positive results will be referred to Infection Control for a recommendation regarding observation status.
- Observation agreement form which includes:
    - name of the observer
    - name of the responsible physician(s),
    - dates the observer will be present at the facility
    - anticipated locations of observation
    - Signatures of the observer and responsible physician that they agree to abide by the policies and procedures of St. Joseph Hospital.
- A driver's license or other government issued identification must be reviewed by Medical Staff Services personnel, other hospital managers, or elected medical staff leaders. A copy of the document will be attached to the application/agreement.

16.3 Orientation: The patient care observer must be oriented to hospital safety procedures. At a minimum, the orientation will include HIPAA confidentiality/security requirements, and safety training.

Once the above has been completed, Medical Staff Services will authorize the Security Department to issue a temporary identification badge. The badge must be worn at all times while in the medical center.

Patients must consent to any observation. This consent will be documented in the medical record by the responsible physician.

Observation periods may not exceed the rotation if the observer is completing a medical rotation. The hospital and/or medical staff leadership reserves the right to terminate the observation rights at any time without cause.

The patient care observer must vacate a patient care area immediately at the direction of any member of the hospital staff, and must agree to release the hospital, its employees and members of the medical staff of any all responsibility in the event that being present at St. Joseph Hospital leads to, physical injury, mental anguish or emotional distress.

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