SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

ITEM: 15.2
(ID # 18672)
MEETING DATE:
Tuesday, March 29, 2022

FROM : RUHS-MEDICAL CENTER:

SUBJECT: RIVERSIDE UNIVERSITY HEALTH SYSTEM-MEDICAL CENTER: Ratification of Medical Staff Appointments, Reappointments, Clinical Privileges

RECOMMENDED MOTION: That the Board of Supervisors:

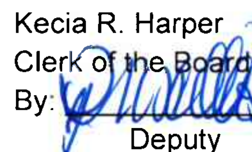
1. Ratify and approve the Medical Staff appointments, reappointments, proctoring, additional privileges, withdraw of privileges, leave of absence, resignations/withdrawals, automatic termination and privileges, approved new and revised privilege forms & Policy and Procedures. as recommended by the Medical Executive Committee.

ACTION:Consent

MINUTES OF THE GOVERNING BOARD

On motion of Supervisor Washington, seconded by Supervisor Jeffries and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes: Jeffries, Spiegel, Washington, Perez and Hewitt
Nays: None
Absent: None
Date: March 29, 2022
xc: RUHS-MC

Kecia R. Harper
Clerk of the Board
By:

Deputy

SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD OF DIRECTORS COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$ 0	$ 0	$ 0	$ 0
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0
SOURCE OF FUNDS: N/A			Budget Adjustment: No	
			For Fiscal Year: 21/22	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

The Medical Executive Committee met on July 8, 2021, August 12, 2021, September 9, 2021, October 19, 2021, November 4, 2021, and December 16, 2021, and recommended to refer the following RUHS-MedicalCenter, Medical Staff recommendations to the Board of Supervisors for review and action:

A. Approval of Medical Staff Appointments and Clinical Privileges, Reappointments, FPPE/Reciprocal* Complete Remain on Provisional, FPPE/Reciprocal* Complete Remain on Provisional, FPPE–Final Proctoring for Additional Privileges, Final FPPE/Reciprocal* Advancement of Staff Status, Final Proctoring, FPPE/Partial Proctoring, FPPE/Reciprocal* Complete Remain on Provisional, FPPE – Final Proctoring for Additional Privileges, Final FPPE/Reciprocal* Advancement of Staff Status, Additional Privilege(s), Withdrawal of Privileges, Change in Staff Category, Voluntary Resignations/Withdraw*, Automatic Termination, Per Bylaws 6.4-9 (Failure to Reapply), Proctoring Extension Request, Automatic Termination, Per Bylaws 3.8-3 (Failure to Complete Proctoring), approved new and revised privilege forms & Policy and Procedures.

*Lists attached for monthly meetings.

B. **New Credentialing Report Format and Revised Peer Reference Form**
The Credentials Committee submitted the new Credentialing Report Format and revised Peer Reference Form for review/approval.

C. **2021-2022 RUHS MC PI Plan**
The Performance Improvement and Patient Safety Committee submitted the updated policy for review/approval.

D. **Peer Review – Updated Department Specific Indicators**
The Professional Practice Evaluation Committee submitted the updated Department Specific PeerReview Indicators for review/approval.

a. Radiology – no additions or changes

b. Family Medicine – no additions or changes

c. Anesthesia – Add reintubations in PACU as department specific indicator

d. Medicine – Add ARC events outside of ICU; significant medication errors identified by MERP

E. Revised Pediatric Anesthesia Privilege Forms

The Anesthesia Department submitted revised privileging criteria for Pediatrics Anesthesia.

F. Revised General Surgery Privilege Forms and Department Rules and Regulations

The Surgery Department submitted revised General Surgery privilege form and Department Rulesand Regulations for review/approval.

G. Revised NP/PA Restraint Privileges

The IDPC/Credentials Committee submitted revised Nurse Practitioner and Physician Assistantrestraint privileges removing reference to chemical restraints, for review/approval.

H. Revised Ophthalmology Privilege Forms

The Ophthalmology Department submitted revised Ophthalmology privilege forms

I. Revised Pediatrics Genetics Privilege Form

The Pediatrics Department submitted revised Pediatrics Genetics privileging criteria for review/approval.

J. Revised Physician Well Being Committee Policy and Monitoring Agreement

The Physician Well Being Committee submitted the revised committee policy and monitoringagreement for review/approval.

K. Revised RUHS-Medical Center Medical Staff Bylaws, Rules and Regulations

The Bylaws Committee submitted the proposed revisions to the Medical Staff Bylaws, Rules andRegulations as approved by Medical Staff voting staff members. Submitted for review/approval.

Impact on Citizens and Businesses

Approval of this request will ensure that the County's healthcare practitioners meet all of the necessary credentialing/privileging requirements and are appropriately qualified to care for and treat the County's patient population

SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD OF DIRECTORS COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

ATTACHMENTS:

ATTACHMENT A:	MEDICAL STAFF ATTESTATION, APPOINTMENT REAPPOINTMENTS AND CLINICAL PRIVILEGES, JULY 8, 2021
ATTACHMENT B:	MEDICAL STAFF ATTESTATION, APPOINTMENT REAPPOINTMENTS AND CLINICAL PRIVILEGES, AUGUST 12, 2021
ATTACHMENT C:	MEDICAL STAFF ATTESTATION, APPOINTMENT REAPPOINTMENTS AND CLINICAL PRIVILEGES, SEPTEMBER 9, 2021
ATTACHMENT D:	MEDICAL STAFF ATTESTATION, APPOINTMENT REAPPOINTMENTS AND CLINICAL PRIVILEGES, OCTOBER 14, 2021
ATTACHMENT E:	MEDICAL STAFF ATTESTATION, APPOINTMENT REAPPOINTMENTS AND CLINICAL PRIVILEGES, NOVEMBER 4, 2021
ATTACHMENT F:	MEDICAL STAFF ATTESTATION, APPOINTMENT REAPPOINTMENTS AND CLINICAL PRIVILEGES, DECEMBER 13, 2021
ATTACHMENT G:	CONFIDENTIAL MEDICAL STAFF COMMITTEE REPORT
ATTACHMENT H:	PEER REFERENCE FORM
ATTACHMENT I:	PERFORMANCE INPROVEMENT AND PATIENT SAFETY PLAN
ATTACHMENT J:	MEDICAL STAFF PEER REVIEW CRITERA
ATTACHMENT K:	ANESTHESIOLOGY CLINICAL PRIVILEGES FORM
ATTACHMENT L:	DEPARTMENT OF SURGERY RULES & REGULATIONS
ATTACHMENT M:	GENERAL SURGEY CLINICAL PRIVILEGS FORM
ATTACHMENT N:	NURSE PRACTITIONER EMERGENCY MEDICINE CLINICAL PRIVILEGES FORM
ATTACHMENT O:	PHYSICIAN ASSISTANT EMERGENCY MEDICINE CLINICAL PRIVILIGES FORM
ATTACHMENT P:	OPTHALMOLOGY CLINICAL PRIVILEGES FORM
ATTACHMENT Q:	PEDIATRIC MEDICAL GENETICS CLINICAL PRIVILEGES FORM
ATTACHMENT R:	MEDICAL STAFF WELL-BEING COMMITTEE POLICY
ATTACHMENT S:	PROPOSED REVISIONS TO MEDICAL STAFF BYLAWS, RULES AND REGULATIONS, SEPTEMBER 9, 2021

SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD OF DIRECTORS COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

Jacqueline Ruiz

Jacqueline Ruiz, Sr. Management Analyst 3/22/2022

Attachment A

DATE: July 8, 2021

To: File

FROM: Medical Staff Executive Committee

SUBJECT: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

A. Approval of Medical Staff Appointments and Clinical Privileges:

#	Name	Department	Status
1.	Ahmad, Kinza T., MD	Ophthalmology	Provisional
	Temporary Privileges Granted 7/01/21		
2.	Borden, Kimberly G., MD	Medicine	Provisional
	Temporary Privileges Granted 7/01/21		
3.	Chinn, Derek B., DO	Medicine	Provisional
	Temporary Privileges Granted 7/01/21		
4.	Collier, Carl, DO	Anesthesiology	Provisional
	Temporary Privileges Granted 7/01/21		
5.	Douglas, Michael, MD	Anesthesiology	Provisional
	Temporary Privileges Granted 7/01/21		
6.	Ho, Derek, MD	Anesthesiology	Provisional
	Temporary Privileges Granted 7/01/21		
7.	McLarty, Justin, MD	Surgery	Provisional
8.	Puri, Latika, MD	Pediatrics	Provisional
9.	Russell, Amy E., MD	Emergency Med	Provisional
	Temporary Privileges Granted 7/01/21		
10.	Solis, Daniel C., MD	Medicine	Provisional
	Temporary Privileges Granted 7/01/21		
11.	Soloniuk, Leonard, MD	Anesthesiology	Provisional
	Temporary Privileges Granted 7/01/21		
12.	Stier, Gary R., MD	Anesthesiology	Provisional
	Temporary Privileges Granted 6/18/21		
13.	Townsend, Dwight A., MD	Radiology	Provisional
14.	Wettstein, Michael E., MD	Anesthesiology	Provisional
15.	Yoro-Bacay, Vincent-Arthur, MD	Anesthesiology	Provisional
	Temporary Privileges Granted 7/01/21		
16.	Yuan, Adam K., DO	Anesthesiology	Provisional
	Temporary Privileges Granted 7/01/21		

B. Approval of Reappointments:

#	Name	Department:	Status:	Reappointment Cycle
1.	Albini, Paul T., MD	Surgery	Active	8/1/2021 – 7/31/2023
2.	Amador, Cory, PA-C	Medicine	AHP	8/1/2021 – 7/31/2023
3.	Ames, Angharad E., MD*	Psychiatry	Moonlighting	8/1/2021 – 7/31/2022
4.	Avesar, Michael, MD	Pediatrics	Active	8/1/2021 – 7/31/2023

No.	Name	Department	Status	Term
5.	Banjeri, Anamika I., MD	Pediatrics	Active	8/1/2021 – 7/31/2023
6.	Chalam, Kakarla V., MD	Ophthalmology	Active	8/1/2021 – 7/31/2023
	Withdraw of Privilege: Phakic Intraocular Lens Implant Surgery			
7.	Christensen, Michael R., MD	Psychiatry	Active	8/1/2021 – 7/31/2023
8.	Clarke, Lenorre R., MD	OB / Gyn	Active	8/1/2021 – 7/31/2023
9.	Davalos, Michael A., PA-C	Emergency Medicine	Active	8/1/2021 – 7/31/2023
10.	Dennis, Tshekedi G., MD	Psychiatry	Active	8/1/2021 – 7/31/2023
11.	Downey, Christina D., MD	Medicine	Active	8/1/2021 – 7/31/2023
12.	Downey, Kelly, MD	Medicine	Active	8/1/2021 – 7/31/2023
13.	Faerber, Wade, DO	Orthopedic Surgery	Active	8/1/2021 – 7/31/2023
14.	Guan, Howard D., MD	Ophthalmology	Active	8/1/2021 – 7/31/2023
	Withdraw of Privilege: Pediatric			
15.	Hojjati, Mehrnaz, MD	Medicine	Active	8/1/2021 – 7/31/2023
16.	Hu, Brian R., MD	Surgery	Active	8/1/2021 – 7/31/2023
17.	Imbertson, Erick J., MD	Medicine	Active	8/1/2021 – 7/31/2023
	Withdraw of Privilege: Telemedicine			
18.	Khandelwal, Keerti M., MD	Medicine	Active	8/1/2021 – 7/31/2023
19.	Kim, Daniel I., MD	Medicine	Active	8/1/2021 – 7/31/2023
	Withdraw of privilege: Ambulatory			
20.	Klein, Walter F., MD	Medicine	Active	8/1/2021 – 7/31/2023
21.	Kraus, Nicole J., DO	Pediatrics	Active	8/1/2021 – 7/31/2023
22.	Krishnan, Rajagopal, MD	Medicine	Active	8/1/2021 – 7/31/2023
23.	Kurz, Troy L., MD	Psychiatry	Provisional	8/1/2021 – 7/31/2023
	Temps granted 7/1/2021:			
	Additional privilege: Psychiatry Core Supervision of AHP			
	Withdrawal of privilege: Resident in Training			
24.	Lee, Richard J., MD	Psychiatry	Active	8/1/2021 – 7/31/2023
25.	Loo, Lawrence K., MD	Medicine	Active	8/1/2021 – 7/31/2023
	Status change from Active to Courtesy due to zero patient volume			8/1/2021 – 7/31/2023
	Withdraw of privilege: Telemedicine			
26.	Majithia, Rishi, MD	Family Medicine	Adjunct	8/1/2021 – 7/31/2023
27.	Massi, Mark, MD	Pediatrics	Active	8/1/2021 – 7/31/2023
28.	Mesisca, Michael, DO	Emergency Medicine	Active	8/1/2021 – 7/31/2023
	Additional Privilege: TEE			
29.	Michelotti, Marcos J., MD	Surgery	Active	8/1/2021 – 7/31/2023
30.	Mittal, Aarti C., DO	Medicine	Active	8/1/2021 – 7/31/2022
	Withdraw of Privilege: Rigid Bronchoscopy			
31.	Naftel, John C., MD	Emergency Medicine	Active	8/1/2021 – 7/31/2023
32.	Nguyen, Diem-Chau, MD	Psychiatry	Provisional	8/1/2021 – 7/31/2023
	Temps granted 7/1/2021:			
	Additional privilege: Psychiatry Core & Supervision of AHP			
	Withdrawal of privilege: Resident in Training			
33.	Ortega, Edgar, MD*	Psychiatry	Moonlighting	8/1/2021 – 7/31/2022
34.	Panton, Christina, MD	OB/GYN	Active	8/1/2021 – 7/31/2023
35.	Parashette, Kalyan, MD	Pediatrics	Active	8/1/2021 – 7/31/2023
36.	Quinonez, Bridgett X., NP	Medicine	AHP	8/1/2021 – 7/31/2023
37.	Rosario, Debbie Ann I., MD	Psychiatry	Active	8/1/2021 – 7/31/2022
38.	Rosenfeld, Jeffrey, MD	Medicine	Active	8/1/2021 – 7/31/2022

39. Simonson, Kevin C., MD	Psychiatry	Provisional	8/1/2021 – 7/31/2023

Temps Requested for 7/1/2021:
Additional privilege: Psychiatry Core & Supervision of AHP
Withdrawal of privilege: Resident in Training

40. Singh, Saloni, MD*	Psychiatry	Moonlighting	8/1/2021 – 7/31/2022
41. Tom, Michelle, MD*	Psychiatry	Moonlighting	8/1/2021 – 7/31/2022
42. Torralba, Karina Marianne, MD	Medicine	Active	8/1/2021 – 7/31/2023
43. Truong, Kevin, MD	Psychiatry	Provisional	8/1/2021 – 7/31/2023

Temps Requested for 7/1/2021:
Additional privilege: Psychiatry Core & Supervision of AHP
Withdrawal of privilege: Resident in Training

44. Tsang, Alexander H., MD*	Psychiatry	Moonlighting	8/1/2021 – 7/31/2022
45. Tsang, Shunling, MD	Family Medicine	Active	8/1/2021 – 7/31/2023

Withdraw of Privilege: OB/GYN

46. Tseng, Philip H., MD	Medicine	Active	8/1/2021 – 7/31/2023
47. Villarreal, Humberto G., MD	Surgery	Active	8/1/2021 – 7/31/2023
48. Vora, Farha M., MD	Pediatrics	Active	8/1/2021 – 7/31/2023

C. FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF STATUS

1. Casassa, IV, Charles M., MD	Neurology	Active
2. Chen, Chien-Shing, MD	Medicine	Active
3. Cravanas, II, Brian A., MD	Medicine	Active
4. Nguyen, Khai T., MD	Psychiatry	Active
5. Nitahara, Michi R., MD	Emergency Medicine	Active
6. Shah, Shivang H., MD	Medicine	Active
7. Waheed, Osmond, DO	Psychiatry	Active

D. FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

1. Chen, Kevin G., MD	Emergency Medicine
2. Rogers, Nathan C., MD	Psychiatry

E. FPPE – FINAL PROCTORING

1. Acevedo, Vivian, PA-C	Emergency Medicine
2. Harris, Kurt, PA-C	Emergency Medicine
3. Mendoza, Tiffany D., PA-C	Emergency Medicine

F. WITHDRAWAL OF PRIVILEGES

1. Cravanas, II, Brian A., MD — Medicine
    - PCU
    - Ambulatory

G. CHANGE IN STAFF CATEGORY **Change to:**

1. Batish, Suraj, MD Pediatrics Provisional
   Temps Requested for 7/1/2021
   (Additional privilege)
   - Pediatric Core
   - Neonatal Core
   - Participate in Teaching Program
   - Supervision of AHP
   - Moderate Sedation

   (Withdrawal of privilege)
   - Resident in Training
2. Dadachanji, Kaivan, DO Pediatrics Provisional
   Temps Requested for 7/1/2021
   (Additional privilege)
   - Pediatric Core
   - Neonatal Core
   - Participate in Teaching Program
   - Moderate Sedation

   (Withdrawal of privilege)
   - Resident in Training
3. Davies, Maryann, MD Pediatrics Provisional
   Temps Requested for 7/1/2021
   (Additional privilege)
   - Pediatric Core
   - Neonatal Core
   - Participate in Teaching Program
   - Supervision of AHP

   (Withdrawal of privilege)
   - Resident in Training
4. Despujos Harfouche, Fairuz C., MD Emergency Med Active

H. AUTOMATIC TERMINATION, PER BYLAWS 3.8-3 (FAILURE TO COMPLETE PROCTORING) **Effective**

1. Acevedo, Vivian, PA Emergency Medicine 7/8/2021

I. AUTOMATIC TERMINATION, PER BYLAWS 6.4-9 (FAILURE TO FILE REAPPOINTMENT FORM) **Effective:**

1. Lee, Christopher, MD Anesthesiology 08/01/2021

J. VOLUNTARY RESIGNATIONS/ WITHDRAWALS*

1. Grover, Douglas S., MD Psychiatry 07/01/2021
2. Kim, Noemi, NP Medicine Withdrawn
3. Lafontant, Jean, MD Public Health 06/13/2019
4. Lester, Casey S., MD Psychiatry 07/01/2021
5. Lin, Jen-Gu, FNP Medicine 07/03/2021
6. Oluoha, Nneka C., MD Medicine 07/03/2021
7. Thorney, Britney S., PA-C Medicine 07/08/2021
8. Vuong, Christopher D., MD Surgery 07/16/2021

DATE: August 12, 2021

To: File

FROM: Medical Staff Executive Committee

SUBJECT: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

A. Approval of Medical Staff Appointments and Clinical Privileges:

	Name	Department	Status
1.	Bonenfant, Jeffrey M., DO	Medicine	Provisional
	Temporary Privileges requested for 8/1/21		
2.	Douglas, Michael, MD	Anesthesiology	Provisional
	Temporary Privileges granted 7/1/21		
3.	Elsensohn, Ashley N., MD	Medicine	Provisional
4.	Green, Morgan, MD	Pediatrics	Provisional
	Temporary Privileges requested for 8/1/21		
5.	Gupta, Nancy, MD	Medicine	Provisional
	Temporary Privileges requested for 8/1/21		
6.	Han, Peter S., MD	Surgery	Provisional
7.	Ho, Derek, MD	Anesthesiology	Provisional
	Temporary Privileges granted 7/1/21		
8.	Kuo, Benjamin, MD	Anesthesiology	Provisional
	Temporary Privileges requested for 8/1/21		
9.	LeClair, Bronson, MD	Anesthesiology	Provisional
	Temporary Privileges requested for 7/26/21		
10.	Leonor, Paul A., MD	Medicine	Provisional
	Temporary Privileges requested for 8/1/21		
11.	Liu, David X. MD	Radiology	Provisional
	Temporary Privileges granted 7/19/21		
12.	Pachon, Andrew G., MD	Emergency Med	Provisional
13.	Quan, Michele V., MD	Medicine	Provisional
14.	Stradleigh, Ryan, DO	Anesthesiology	Provisional
	Temporary Privileges granted on 7/1/21		
15.	Tawfik, Kyrollos Y., MD	Radiology	Provisional
16.	Vitorovic, Danilo, MD	Medicine	Provisional
17.	White, Rachel L., PA-C	Medicine	AHP-Provisional
	Temporary Privileges requested for 8/1/21		
18.	Yoro-Bacay, Vincent-Arthur, MD	Pediatrics	Provisional
	Temporary Privileges granted on 7/1/21		

B. Approval of Reappointments:

	Name	Department:	Status:	Reappointment Cycle
1.	Baye, Zebayel A., MD	Medicine	Active	9/1/2021 – 8/31/2023
	Additional Privilege: Participate in Teaching Program			
2.	Chen, Chien-Shing, MD	Medicine	Active	9/1/2021 – 8/31/2023
3.	Fuller, Jennifer C., MD	Surgery	Active	9/1/2021 – 8/31/2023
4.	Galvan, Vivian D., NP	Medicine	AHP	9/1/2021 – 8/31/2023
5.	Khamsi, Babak, MD	Orthopedic Surgery	Courtesy	9/1/2021 – 8/31/2023
6.	Kim, Christina K., MD	Medicine	Active	9/1/2021 – 8/31/2023
7.	Le, Ngyuen M., MD	Surgery	Active	9/1/2021 – 8/31/2023
8.	Ludi, Hector D., MD	Surgery	Active	9/1/2021 – 8/31/2023
9.	Luu, Tri T., MD	Medicine	Active	9/1/2021 – 8/31/2023
10.	Mc Keever, Rodney, MD	Anesthesiology	Active	9/1/2021 – 8/31/2023
11.	Nesper, Timothy P., MD	Emergency Medicine	Active	9/1/2021 – 8/31/2023
12.	Puvvula, Lakshmi K., MD	Medicine	Active	9/1/2021 – 8/31/2023
13.	Randall, Melanie M., MD	Emergency Medicine	Active	9/1/2021 – 8/31/2023
14.	Robker, Amy L., PA-C	Emergency Medicine	AHP	9/1/2021 – 8/31/2023
15.	Tan, Gordon L., MD	Pediatrics	Active	9/1/2021 – 8/31/2023
16.	Thimmappa, Vikrum A., MD	Surgery	Active	9/1/2021 – 8/31/2023
17.	Tiao, Lily J., NP	Medicine	AHP	9/1/2021 – 8/31/2023
18.	Victor, Priya S., MD	Family Medicine	Active	9/1/2021 – 8/31/2023
19.	Washburn, Destry G., DO	Medicine	Active	9/1/2021 – 8/31/2023
20.	Williams, Shammah O., MD	Medicine	Active	9/1/2021 – 8/31/2023
	Additional Privilege: Exercise Testing			

C. FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF STATUS

	Name	Department	Status
1.	Al Harash, Abdalhamid, MD	Medicine	Active
2.	Baker, Nancy A., MD	Medicine	Active
3.	Duong, Jason N. DO	Neurosurgery	Active
4.	Lee, Vallent, MD	Pediatrics	Active
5.	Martinez, Juan J., MD	Pediatrics	Active
6.	Nguyen, Khanh K., MD	Surgery	Active
7.	Skef, Wasseem, MD	Medicine	Active
8.	Yu, Grace L., MD	Surgery	Active

D. FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

	Name	Department
1.	Agarwal, Vikash, MD	Pediatrics
2.	Gandotra, Gaurav, MD	Psychiatry
3.	Kar, Ashok J., MD	Surgery
4.	Soneji, Maulin S., MD	Pediatrics
5.	Voleti, Sonia, MD	Pediatrics

E. FPPE – FINAL PROCTORING

	Name	Department
1.	Formal, Elliot S., PA-C	Emergency Medicine
2.	Montejano, Arianna, NP	Surgery

F. FPPE – FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

	Name	Department	Privilege
1.	Hashmi, Asra, MD	Surgery	Fluoroscopy
2.	Jahng, Alexander W., MD	Medicine	Ambulatory
3.	Mattison, Katherine M., NP	Medicine	Informed Consent

G. REQUEST FOR ADDTIONAL PRIVILEGES

1. Aung, Heain H., FNP Medicine Medicine-Gastroenterology
   Temporary Privileges requested 8/1/2021

H. WITHDRAWAL OF PRIVILEGES

	Name	Department	Privileges
1.	Al Harash, Abdalhamid, MD	Medicine	• Internal Medicine • PCU • Ambulatory
2.	Formal, Elliot S., PA-C	Medicine	• Central Line/PICC • Lumbar Puncture • Endotracheal Intubation • Arterial Catheterization • Paracentesis
3.	Skef, Wasseem, MD	Medicine	• Internal Medicine
4.	Yu, Grace L., MD	Surgery	• Laser Surgery • Microvascular • Moderate Sedation

I.	**CHANGE IN STAFF CATEGORY**		**Change to:**
1.	Cacho, Bradley, MD	Pediatrics	Active
2.	Yang, Almira J., DO	Medicine	Active

J.	**PROCTORING EXTENSION**		**Extended to:**
1.	Friar, Lauren M., PA-C	Emergency Medicine	08/27/2021
2.	Holguin, Christine, PA-C	Emergency Medicine	11/13/2021
3.	Nesmith, Alysia, PA-C	Emergency Medicine	08/27/2021

K. AUTOMATIC TERMINATION, PER BYLAWS 6.4-9 (FAILURE TO FILE REAPPOINTMENT FORM)

	Name	Department	**Effective:**
1.	Azer, David, DO, MD	Anesthesiology	08/31/2021

I. VOLUNTARY RESIGNATIONS/ WITHDRAWALS*

	Name	Department	Date
1.	Dickinson, Mark T., MD	Surgery	06/18/2021
2.	Hoff, Jason M., MD	Medicine	06/24/2021
3.	Lewis, Terence D., MD	Medicine	06/30/2021
4.	Liang, Jayce, FNP	Medicine	08/02/2021
5.	Le, Mai T., PA-C	Emergency Medicine	06/30/2021
6.	Mason Danielle M., MD	OB/GYN	08/31/2021
7.	Saleh, Ahmad S., DO	Medicine	06/23/2021
8.	Sandy, Jewel L., MD	Ophthalmology	07/31/2021

I hereby:

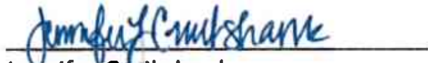
1) Attest that the medical center's Medical Executive Committee July 8, 2021 recommend approval of the appointment, reappointments, proctoring, change of status, withdraw of privileges, automatic terminations, resignation/withdrawals and privilege forms.
2) Approve the listed changes as recommended by the Medical Executive Committee; and
3) Recommend that the Board of Supervisors ratify the listed changes as recommended by the Medical Executive Committee.

Jennifer Cruikshank
Chief Executive Officer – RUHS Medical Center

Created 08.12.2021

I hereby:

1) Attest that the medical center's Medical Executive Committee July 8, 2021 recommend approval of the appointment, reappointments, proctoring, change of status, withdraw of privileges, automatic terminations, resignation/withdrawals and privilege forms.
2) Approve the listed changes as recommended by the Medical Executive Committee; and
3) Recommend that the Board of Supervisors ratify the listed changes as recommended by the Medical Executive Committee.



Jennifer Cruikshank
Chief Executive Officer – RUHS Medical Center

Created 07.08.2021

DATE: September 9, 2021

To: File

FROM: Medical Staff Executive Committee

SUBJECT: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – September 9, 2021 - August 31, 2023

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Bailey, Kevin J., PA-C	AHP Provisional	Physician Assistant	Emergency Medicine	NCCPA
Calvert, Justin, MD	Provisional	Anesthesiology	Anesthesia	Eligible
Chaves, Kristen N., NP	AHP Provisional	Nurse Practitioner	Surgery	ANCC
Chao, Amanda, T., MD	Provisional	Anesthesiology	Anesthesia	Anesthesiology
Edwards, Montessa L., MD	Provisional	Emergency Medicine	Emergency Medicine	Emergency Medicine
Elledge, Nathan R., DO	Provisional	Ophthalmology	Ophthalmology	Eligible
Francois, Nedy, NNP	AHP Provisional	Nurse Practitioner	Pediatrics	NCC
Gonzalez, Reyna T., MD	Provisional	Surgical Critical Care	Surgery	Surgery Surgical Critical Care
Long, Wen, PA-C	AHP Provisional	Physician Assistant	Medicine	NCCPA
Nguyen, Elaine, MD Temporary Privileges Granted 8/28/21	Provisional	Pulmonary Disease/ Critical Care Medicine	Medicine	Internal Medicine Pulmonary Disease
Park, Joseph, DPM	Provisional	Podiatry	Orthopedic Surgery	Foot Surgery Reconstructive Rearfoot/ Ankle Surgery
Phillips, Sommer C., NP	AHP Provisional	Nurse Practitioner	Surgery	ANCC
Smithson, Sarah, DO Temporary Privileges Granted 8/27/2021	Provisional	Maternal Fetal Medicine	OB / Gyn	OB / Gyn
Thiruvengadam, Nikhil R., MD Temporary Privileges Granted 9/1/21	Provisional	Gastroenterology	Medicine	Internal Medicine Gastroenterology
Vora, Halley P., MD	Provisional	Surgical Oncology	Surgery	Surgery
Yalamanchili, Ronica R., MD	Provisional	Otolaryngology	Surgery	Eligible

REAPPOINTMENTS - October 1, 2021 - September 30, 2023

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Ackerman, Barbara C., PhD	Active	Psychology	Family Medicine	N/A
Alani, Anas A., MD	Active	Cardiovascular Disease	Medicine	Internal Medicine Cardiovascular Disease
Baldwin, Dalton D., MD	Active	Urology	Surgery	Urology
Brar, Harbinder, MD	Courtesy	Maternal Fetal Medicine	OB / Gyn	OB / Gyn Clinical Genetics
Church, Christopher A., MD	Active	Head/Neck Surgery & Otolaryngology	Surgery	Otolaryngology
Estes, Adrienne M., DPM	Active	Podiatry	Orthopedic Surgery	Foot Surgery

Riverside University HEALTH SYSTEM

Fargo, Ramiz A., MD	Active	IM/Pulmonary Critical Care Medicine	Medicine	Internal Medicine Pulmonary Disease Critical Care Medicine Sleep Medicine
Hadley, Henry R., MD	Active	Urology	Surgery	Urology
Herford, Henry R., MD	Courtesy	Oral & Maxillofacial Surgery	Surgery	Oral & Maxillofacial Surgery
Ing, Jeffrey J., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Ingui, Christian J., MD	Consulting	Diagnostic Radiology	Radiology	Diagnostic Radiology
Jutzy, Gregory, MD	Active	Pediatric Cardiology	Pediatrics	Pediatrics Pediatric Cardiology
Keyes, Brian O., DO	Active	Anesthesiology	Anesthesia	Anesthesiology
Koenig, Rodney J. PA-C	AHP	Physician Assistant	Emergency Medicine	NCCPA
Lightfoot-Siordia, Catrissa, MD	Active	Anesthesiology	Anesthesia	Anesthesiology
Lopez, Yamil, MD	Active	Pathology	Pathology	Anatomic Pathology & Clinical Pathology Cytopathology
Massrour, Kamiar, MD	Consulting	Diagnostic Radiology	Radiology	Diagnostic Radiology
Munir, Iqbal, MD, PhD	Medicine	IM/Endocrinology	Medicine	Internal Medicine Endocrinology & Metabolism
Patel, Bipin L., MD	Active	Psychiatry	Psychiatry	Psychiatry General Child & Adolescent Psychiatry
Poole, Joshua S., MD* 10/01/2021 – 09/30/2022	Moonlighting	Psychiatry	Psychiatry	Eligible
Qureshi, Sonea I., MD	Active	Pediatric Critical Care	Pediatrics	Pediatric Critical Care
Srikureja, Daniel P., MD	Active	Surgery	Surgery	Surgery
Thompson, Kevin, MD	Active	Pathology	Pathology	Anatomic Pathology & Clinical Pathology
Tran, Jade C., MD	Active	Pediatric Cardiology	Pediatrics	Pediatrics Pediatric Cardiology
Weiner, Alyssa R., PA-C	AHP	Physician Assistant	Emergency Medicine	NCCPA

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Craychee, Judith A., MD	Provisional	Diagnostic Radiology	Radiology	Remain on Provisional
Park, Shaun H., MD	Provisional	Pediatrics	Pediatrics	Remain on Provisional
Shu, Fred P., MD	Provisional	Diagnostic Radiology	Radiology	Remain on Provisional

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Cantas Orsdemir, Sena, MD	Provisional	Pediatric Endocrinology	Pediatrics	Advance to Active
Cohen, Mallory E., MD	Provisional	Pediatrics	Pediatrics	Advance to Active
Ijeaku, Ijeoma O., MD	Provisional	Psychiatry	Psychiatry	Advance to Active
Leong, Beatriz V., MD	Provisional	Vascular Surgery	Surgery	Advance to Active
Olson, Moses, MD	Provisional	Anesthesiology	Anesthesia	Advance to Active
Rhee, Alice, MD	Provisional	Pediatrics	Pediatrics	Advance to Active

Riverside University HEALTH SYSTEM

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Nesmith, Alysia N., PA-C	AHP-Provisional	Physician Assistant	Emergency Medicine	

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES - None

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Nesmith, Alysia N., PA-C	AHP-Provisional	Physician Assistant	Emergency Medicine	Withdrawal of privileges: • Central Line/PICC Placement • Lumbar Puncture • Endotracheal Intubation • Thoracentesis
Salcedo, Regine Vielka T., FNP Temporary Privilege Request for 9/1/21	AHP-Provisional	Nurse Practitioner	Medicine	Additional Privileges: • Department of Medicine, Division of Gastroenterology

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Ads, Ayman M., MD	Provisional	Anesthesiology	Anesthesia	Advance to Active
Batish, Suraj R., MD	Temporary Privileges	Pediatrics	Pediatrics	Advance to Provisional
Chen, Kevin G., MD	Provisional	Emergency Medicine	Emergency Medicine	Advance to Active
Davies, Maryann, DO	Temporary Privileges	Pediatrics	Pediatrics	Advance to Provisional
Duong, Jason N., DO	Provisional	Neurosurgery	Neurosurgery	Advance to Active
Fu-Sheng, Chou, MD	Provisional	Neonatology	Pediatrics	Advance to Active
Hathout, Eba H., MD	Provisional	Pediatric Endocrinology	Pediatrics	Advance to Active
Jeu, Kelly A., MD	Provisional	Pediatrics	Pediatrics	Advance to Active
Lee, Jessica, MD	Provisional	Anesthesiology	Anesthesia	Advance to Active
Lee, Vallent, MD	Provisional	Pediatrics	Pediatrics	Advance to Active
Liu, Yuan F., MD	Provisional	Head/Neck Surgery & Otolaryngology	Surgery	Advance to Active
Lodhi, Shaina, MD	Provisional	Neonatology	Pediatrics	Advance to Active
Martinez, Juan J., MD	Provisional	Pediatric Critical Care	Pediatrics	Advance to Active
Myklak, Kristene C., MD	Provisional	Urology	Surgery	Advance to Active
Nguyen, Christopher V., MD	Provisional	Diagnostic Radiology	Radiology	Advance to Active
Nune, Sunitha L., MD	Provisional	Pediatric Neurology	Pediatrics	Advance to Active
Nwachukwu, Oluwafisayomi, DO	Provisional	Pediatrics	Pediatrics	Advance to Active
Ravel, Ronak, MD	Provisional	Anesthesiology	Anesthesia	Advance to Active
Rogers, Nathan C., MD	Provisional	Psychiatry	Psychiatry	Advance to Active

Riverside University HEALTH SYSTEM

Attachment D

DATE: October 14, 2021

To: File

FROM: Medical Staff Executive Committee

SUBJECT: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – October 14, 2021 – September 30, 2023

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Collier, Carl E., DO	Provisional	Anesthesiology	Anesthesia	Anesthesiology
Guglielmo, Mona, MD	Provisional	Pediatric Critical Care	Pediatrics	Pediatrics Pediatric Critical Care
Guglielmo, Robert, MD	Provisional	Pediatric Critical Care	Pediatrics	Pediatrics
Hassanian, Mohammad, MD	Provisional	Anesthesiology	Anesthesia	Anesthesiology
Khera, Sofia, MD	Provisional	Pediatrics	Pediatrics	Pediatrics Pediatric Hospital Medicine
Kim, Cherine H. MD	Applicant	Otolaryngology	Surgery	Eligible
Nguyen, Daniel, MD	Provisional	Anesthesiology	Anesthesia	Anesthesiology
Nwigwe, Desiree C., NP	AHP-Applicant	Nurse Practitioner	Psychiatry	ANCC
Shin, Benjamin, MD* 10/14/2021 – 09/30/2022	Applicant	Psychiatry	Psychiatry	Eligible
Soloniuk, Leonard J., MD	Provisional	Anesthesiology	Anesthesia	Anesthesiology Internal Medicine
Tran, Min Chau (Joe), MD Temporary Privileges requested for 10/01/21	Temporary Privileges	Anesthesia	Anesthesiology	Anesthesiology Pediatric Anesthesiology
Yuan, Adam K., DO	Provisional	Anesthesiology	Anesthesia	Eligible
Zerr, Ashley, MD	Provisional	Pediatrics	Pediatrics	Pediatrics

REAPPOINTMENTS - November 1, 2021 – October 31, 2023

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Azizi, Faramarz, MD	Active	Pathology	Pathology	Anatomic Pathology
Bhardwaj, Rahul, MD **Status change from Active to Courtesy**	Active	Cardiovascular Diseases	Medicine	Internal Medicine Cardiovascular Disease Clinical Electrophysiology
Febre, Aprille Dawn F., MD	Active	Neonatal-Perinatal Medicine	Pediatrics	Pediatrics Neonatology
Hamra, William S., MD	Active	Pediatrics	Pediatrics	Pediatrics
Khazaeni, Leila M., MD **Status change from Active to Courtesy**	Active	Ophthalmology	Ophthalmology	Ophthalmology
Ko, Edmund Y., MD	Active	Urology	Surgery	Urology
Lavery, Adrian P., MD	Active	Neonatal-Perinatal Medicine	Pediatrics	Pediatrics Neonatology
Loe, Stephanie A., MD **Additional Privileges:** • TEE • Telemedicine	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine

Riverside University
HEALTH SYSTEM

Lui, Paul D., MD **Additional Privileges:** • Holium • CO2	Active	Urology	Surgery	Urology
Luke, Janiene D., MD	Active	Dermatology	Medicine	Dermatology
Martin, Mark C., MD	Courtesy	Plastic Surgery	Surgery	Plastic Surgery
McCarty, Matthew S., MD **Additional Privilege:** • Telemedicine	Active	Internal Medicine	Medicine	Internal Medicine
McLaughlin, Nathan D., MD **Withdraw Privilege:** • OB/GYN	Active	Family Medicine	Family Medicine	Family Medicine
Moretta, Dafne T., MD	Active	Pulmonary/ Critical Care	Medicine	Internal Medicine Pulmonary Disease Critical Care Medicine
Oesterle, Troy D., PA-C	Allied Health Professional	Physician Assistant	Emergency Medicine	NCCPA
Patel, Yogesh M., MD	Active	Nephrology	Medicine	Nephrology
Rogers, Shana L., NP **Withdraw Privilege:** • Thoracentesis • Paracentesis • Arterial Cannulation • Central Venous Cath • Bedside Ultrasound in Shock	AHP-Provisional	Nurse Practitioner	Surgery	ANCC
Schulz, Alyssa M., PA-C	Allied Health Professional	Physician Assistant	Emergency Medicine	NCCPA
Simental, Alfred A., MD	Courtesy	Head/Neck Surgery & Oto	Surgery	Otolaryngology
Stevens, Wesley T., MD	Active	Pathology	Pathology	
Tabuenca, Arnoldo D., MD	Administrative	Surgery	Surgery	Surgery
Wright, Andrew P., MD	Active	Gastroenterology	Medicine	Internal Medicine Gastroenterology

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Chan, Roxanne, MD	Provisional	Diagnostic Radiology	Radiology	12/10/21
Gupta, Ritesh, MD	Provisional	Ophthalmology	Ophthalmology	12/10/21
Price, Martin C, MD	Provisional	Diagnostic Radiology	Radiology	04/08/22
Witkowsky, Michael E., MD	Provisional	Diagnostic Radiology	Radiology	11/12/21

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Lee, Brian T., MD	Provisional	Hepatology	Medicine	Advance to Active
Oregel, Karlos, MD	Provisional	Hematology/Oncology	Medicine	Advance to Active
Shen, Bailey Y., MD	Provisional	Ophthalmology	Ophthalmology	Advance to Active
Shu, Fred P., MD	Provisional	Diagnostic Radiology	Radiology	Advance to Active
Soe, Yuliana, MS	Provisional	Family Medicine	Family Medicine	Advance to Active

Riverside University HEALTH SYSTEM

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Friar, Lauren M., PA-C	AHP-Provisional	Physician Assistant	Emergency Medicine	
Ha, Tiffany, PA-C	AHP-Provisional	Physician Assistant	Medicine	
Pan, Min S., PA-C	AHP-Provisional	Physician Assistant	Medicine	
Rogers, Shana, NP	AHP-Provisional	Nurse Practitioner	Surgery	

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Block, Lindsey L., NP	AHP	Nurse Practitioner	Medicine	Women's Health Privileges

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Aung, Heain H., FNP	AHP	Nurse Practitioner	Neurosurgery / Medicine	Withdraw: • Neurosurgery
Block, Lindsey L., NP	AHP	Nurse Practitioner	Medicine	Withdraw: • Skin Tag Removal
Friar, Lauren M., PA-C	AHP-Provisional	Physician Assistant	Emergency Medicine	Withdraw: • Central Line/ PICC Placement • Lumbar Puncture • Endotracheal Intubation • Arterial Cannulation • Thoracentesis • Paracentesis
Ha, Tiffany, PA-C	AHP-Provisional	Physician Assistant	Medicine	Withdraw: • Injection of Medication into Trigger Points • I&D of Abscesses • Skin Tag Removal • Punch Biopsy • Central Venous Catheterization • Lumbar Puncture • Thoracentesis
Hanson, Rodolfo J., NP	AHP – Provisional	Nurse Practitioner	Neurosurgery / Anesthesia	Additional: • Perioperative Service/Pain Management • Performing Informed Consent for the Perioperative Services/Pain Management

Lee, Brian T., MD	Provisional	Hepatology	Medicine	Withdraw: • Ambulatory • GI
Ludi, Hector D., MD	Active	Surgery	Surgery	Withdraw: • Hyperbaric Medicine
Oregel, Karlos, MD	Provisional	Hematology/ Oncology	Medicine	Withdraw: • Ambulatory
Pan, Min S., PA-C	AHP-Provisional	Physician Assistant	Medicine	Withdraw: • Injection of Medication into Trigger Points • I&D of Abscesses • Skin Tag Removal • Punch Biopsy • Central Venous Catheterization • Lumbar Puncture • Thoracentesis
Quan, Michele G., MD	Provisional	Pulmonary Critical Care	Medicine	Additional: • Fluoroscopy
Salcedo, Regine Vielka T., FNP	AHP - Provisional	Nurse Practitioner	Neurosurgery / Medicine	Withdraw: Neurosurgery

CHANGE IN STAFF CATEGORY - NONE

AUTOMATIC TERMINATION, PER BYLAWS 3.8-3 (FAILURE TO COMPLETE PROCTORING) - NONE

AUTOMATIC TERMINATION, PER BYLAWS 6.4-9 (FAILURE TO FILE COMPLETE REAPPOINTMENT)

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Sherzai, Ayesha Z., MD	Active	Neurology	Medicine	Failed to complete process, auto termination effective 11/1/21.

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT	EFFECTIVE/REASON
Allard, Jillian D., PA-C	AHP	Physician Assistant	Emergency Medicine	9/21/2021
Benlulu, Maxime D., PA-C	AHP	Physician Assistant	Emergency Medicine	11/1/2021
Chan, Kimberly M., MD	Active	Ophthalmology	Ophthalmology	9/30/2021
Chatham Jr., James R., MD*	Applicant	Diagnostic Radiology	Radiology	Withdraw of Application
Craychee, Judith A., MD	Provisional	Diagnostic Radiology	Radiology	9/1/2021
Fteeh, Gamil, MD	Active	Pediatric Neurology	Pediatrics	9/19/2021
Formal, Elliot S., PA-C	AHP	Physician Assistant	Emergency Medicine	8/30/2021
Mahato, Deependra, DO	Active	Neurosurgery	Neurosurgery	5/31/2020
Myklak, Kristene C., MD	Active	Urology	Surgery	9/14/2021
Patel, Viloki, NP	AHP	Nurse Practitioner	Surgery	9/30/2021
Pederson, Ryan T., FNP*	Applicant	Nurse Practitioner	Emergency Medicine	Withdraw of Application
Pratt, Ronald, PA-C	AHP	Physician Assistant	Family Medicine	9/1/2021
Reddy, Kaunteya, MD	Active	Gastroenterology	Medicine	9/10/2021
Tohm, Donald G., MD	Active	Ophthalmology	Ophthalmology	9/30/2021

Riverside University
HEALTH SYSTEM

Victor, Priya S., MD	Active	Family Medicine	Family Medicine	9/1/2021
Wang, Mike Y., MD	Applicant	Anesthesiology	Anesthesia	Withdrawal of Application
Williams, Ashley M., PA-C	AHP	Physician Assistant	Emergency Medicine	10/14/2021

I hereby:

1) Attest that the medical center's Medical Executive Committee October 14, 2021 recommend approval of the appointment, reappointments, proctoring, change of status, withdraw of privileges, automatic terminations, resignation/withdrawals and privilege forms.
2) Approve the listed changes as recommended by the Medical Executive Committee; and
3) Recommend that the Board of Supervisors ratify the listed changes as recommended by the Medical Executive Committee.

Jennifer Cruikshank
Chief Executive Officer – RUHS Medical Center

Created 10.14.2021

Riverside University HEALTH SYSTEM

Soe, Yulinana, MD	Provisional	Family Medicine	Family Medicine	Advance to Active
Srikureja, Mathathep, DO	Provisional	Anesthesiology	Anesthesia	Advance to Active
Tian, Sisi, MD	Provisional	Head/Neck Surgery & Otolaryngology	Surgery	Advance to Active
Vargas, Linda, MD	Provisional	Ophthalmology	Ophthalmology	Advance to Active

AUTOMATIC TERMINATION, PER BYLAWS 3.8-3 (FAILURE TO COMPLETE PROCTORING) - None

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS

AUTOMATIC TERMINATION, PER BYLAWS 6.4-9 (FAILURE TO FILE COMPLETE REAPPOINTMENT) - None

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT	EFFECTIVE/REASON
Gandhi, Purnima V. MD	Active	Family Medicine	Family Medicine	08/25/2021
Myint, Khaing, MD	Active	Family Medicine	Family Medicine	08/25/2021
Ruff, Azucena, NP	AHP	Nurse Practitioner	Family Medicine	08/25/2021
Tayag, Emilio, MD	Active	Neurosurgery	Neurosurgery	09/30/2021
Zhao, Yan S., MD, PhD	Active	Gastroenterology	Medicine	08/06/2021

I hereby:

1) Attest that the medical center's Medical Executive Committee September 9, 2021 recommend approval of the appointment, reappointments, proctoring, change of status, withdraw of privileges, automatic terminations, resignation/withdrawals and privilege forms.
2) Approve the listed changes as recommended by the Medical Executive Committee; and
3) Recommend that the Board of Supervisors ratify the listed changes as recommended by the Medical Executive Committee.

Jennifer Cruikshank
Chief Executive Officer – RUHS Medical Center

Created 09.09.2021

Attachment E

DATE: November 4, 2021

To: File

FROM: Medical Staff Executive Committee

SUBJECT: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – November 4, 2021 - October 31, 2023

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Burke, Sarah, NP	Allied Health Professional	Nurse Practitioner	Neurosurgery	ANCC
Chandwani, Deepak, MD	Provisional	Emergency Medicine	Emergency Medicine	Emergency Medicine
Garvanovic, Samantha, MD	Provisional	Anesthesiology	Anesthesia	Eligible
Hacobian, David S., PA-C	Allied Health Professional	Physician Assistant	Orthopedic Surgery	NCCPA
Juarez, Benjamin, PA-C	Allied Health Professional	Physician Assistant	Emergency Medicine	NCCPA
Knerr, Grace A., PA-C	Allied Health Professional	Physician Assistant	Emergency Medicine	NCCPA
McCalla, Derek J., MD	Provisional	Pediatrics	Pediatrics	Eligible
Navarro, Jesus, NP	Allied Health Professional	Nurse Practitioner	Medicine	ANCC
Nguyen, Tammy, PA-C	Allied Health Professional	Physician Assistant	Emergency Medicine	NCCPA
O'Leary, Michael P., MD	Provisional	Surgical Oncology	Surgery	Surgery
Rivera Melara, Luis, MD Temporary Privileges Requested 10/25/2021	Provisional	Neonatology	Pediatrics	Pediatrics
Rodriguez, Brian M., PA-C	Allied Health Professional	Physician Assistant	Orthopedic Surgery	NCCPA
Sanner, David, MD	Provisional	Anesthesiology	Anesthesia	Anesthesiology
Tone, Ryan, MD	Provisional	Anesthesiology	Anesthesia	Anesthesiology
Torsak, Collin B. PA-C	Allied Health Professional	Physician Assistant	Emergency Medicine	NCCPA
Truong, Khoa, MD	Provisional	Anesthesiology	Anesthesia	Anesthesiology
Williams, Shaute, NP	Allied Health Professional	Nurse Practitioner	Neurosurgery	ANCC
Zwick, Tamar, PA-C	Allied Health Professional	Physician Assistant	Emergency Medicine	NCCPA

REAPPOINTMENTS - December 1, 2021 – November 30, 2023

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Allen, Scott A., MD	Active	Internal Medicine	Medicine	Internal Medicine
Chan, Nadia, MD	Active	Otolaryngology	Surgery	Otolaryngology
Coimbra, Raul	Active	Surgical Critical Care	Surgery	None
Deisch, Jeremy, MD	Active	Pathology	Pathology	Anatomic Pathology & Clinical Pathology
Finnen, Neil P., MD **Status change from Active to Courtesy due to low patient volume**	Active	Ophthalmology	Ophthalmology	Ophthalmology
Galoustian, Arthur, MD **Status change from Active to Courtesy due to low patient volume**	Active	Nephrology	Medicine	Internal Medicine Nephrology
Green, Harry M., OD	Active	Optometry	Ophthalmology	N/A
Hill, Michael E., MD	Active	Plastic Surgery	Surgery	Plastic SUrgery
Ishak, Salam G., MD	Active	Nephrology	Medicine	Internal Medicine Nephrology

Kerstetter, Justin, MD **Pending:** Mandatory Compliance Occupational Health	Active	Pathology	Pathology	Anatomic Pathology & Clinical Pathology
Kramer, Raymond D., MD	Administrative	Family Medicine	Family Medicine	Family Medicine
Krishna, Priya D., MD **Withdraw Privileges:** • **Laser CO2** • **Laser KTP** • **Laser Nd: Yag**	Active	Otolaryngology	Surgery	Otolaryngology
Langley, Shawna K., MD	Active	Dermatology	Medicine	Dermatology
Li, Wing, OD	Active	Optometry	Ophthalmology	N/A
Mann, Neel K., MD	Active	Gastroenterology	Medicine	Internal Medicine Gastroenterology
Plasencia, Alexis N., MD **Additional Privilege:** • **Fluoroscopy**	Active	Colon/Rectal Surgery	Surgery	Surgery
Vincent, Alix, MD	Consulting	Diagnostic Radiology	Radiology	Diagnostic Radiology Neuroradiology

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Stier, Gary, MD	Provisional	Anesthesiology	Anesthesia	Remain Provisional

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Brereton, Daniel S., DO	Provisional	Orthopedic Surgery	Orthopedic Surgery	Advance to Active Status
Khan, Naila A., DO	Provisional	Internal Medicine	Medicine	Advance to Active Status
Kim, Young-Min, MD	Provisional	Pediatric Neurology	Pediatrics	Advance to Active Status
Stern, Eric S., MD	Provisional	Emergency Medicine	Emergency Medicine	Advance to Active Status

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Bux, Michael Y., PA-C	AHP	Physician Assistant	Orthopedic Surgery	
Holguin, Christine T., PA-C	AHP	Physician Assistant	Emergency Medicine	
Johnson, Amy J., PA-C	AHP	Physician Assistant	Emergency Medicine	
Johnson, Onyinye Y., NP-C	AHP	Nurse Practitioner	Psychiatry	

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Bux, Michael Y., PA-C	AHP	Physician Assistant	Orthopedic Surgery	Withdraw of Privileges: • Administration of General, Spinal, and Epidural Anesthetics • Insertion of Arterial Catheters • Insertion of Central Venous Catheters • Lumbar Puncture
Escoto, Rebecca E., PA-C	AHP	Physician Assistant	Emergency Medicine	Withdraw of Privileges: • Central Line/PICC Placement • Lumbar Puncture • Arterial Cannulation • Thoracentesis
Holguin, Christine T>, PA-C	AHP	Physician Assistant	Emergency Medicine	Withdraw of Privileges: • Lumbar Puncture • Paracentesis
Johnson, Amy J., PA-C	AHP	Physician Assistant	Emergency Medicine	Withdraw of Privileges: • Thoracentesis
Khan, Naila A., DO	Provisional	Internal Medicine	Medicine	Withdraw of Privileges: • Ambulatory • EKG • Moderate Sedation

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				

AUTOMATIC TERMINATION, PER BYLAWS 3.8-3 (FAILURE TO COMPLETE PROCTORING)

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				

AUTOMATIC TERMINATION, PER BYLAWS 6.4-9 (FAILURE TO FILE COMPLETE REAPPOINTMENT)

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Nguyen, Thuy, MD	Adjunct	Family Medicine	Public Health	Failure to reapply on a timely manner (10/19/2019 – 09/30/2021)
Granger, Shannon, DO	Active	Anesthesiology	Anesthesia	Failure to Reapply

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT	EFFECTIVE/REASON
Gregerson, Katherine, DO	Active	Pediatric Critical Care	Pediatrics	09/30/2021
Kang, Michael, MD	Active	Emergency Medicine	Emergency Medicine	11/30/2021
Ninan, David, DO	Active	Anesthesiology	Anesthesia	10/05/2021
Renner, Mayonne D., NP	AHP	Nurse Practitioner	Surgery	11/28/2021
Schell, Catherine, NP	AHP	Nurse Practitioner	Surgery	10/29/2021

I hereby:

1) Attest that the medical center's Medical Executive Committee November 4, 2021 recommend approval of the appointment, reappointments, proctoring, change of status, withdraw of privileges, automatic terminations, resignation/withdrawals and privilege forms.
2) Approve the listed changes as recommended by the Medical Executive Committee; and
3) Recommend that the Board of Supervisors ratify the listed changes as recommended by the Medical Executive Committee.

Jennifer Cruikshank
Chief Executive Officer – RUHS Medical Center

Created 11.4.2021

Riverside University HEALTH SYSTEM

Attachment F

DATE: December 13, 2021

To: File

FROM: Medical Staff Executive Committee

SUBJECT: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – December 13, 2021 - November 30, 2023

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Armon, Carmel, MD	Provisional	Neurology	Medicine	Neurology
Darden, Lisa, NP	Allied Health Professional	Nurse Practitioner	Neurosurgery	ANCC
Farshidpour, Maham, MD	Provisional	Internal Medicine	Medicine	Internal Medicine
Horricks, Justin, MD	Provisional	Anesthesiology	Anesthesia	Anesthesiology Pediatric Anesthesiology
Moinuddin, Mehwish, DO	Provisional	Family Medicine	Family Medicine	Family Medicine Sports Medicine
Orth, Gregory J., MD	Provisional	Diagnostic Radiology	Radiology	Diagnostic Radiology
Schultz, Dina, NP-C	Allied Health Professional	Nurse Practitioner	Neurosurgery	AANP
Sinha, Ashish C., MD	Provisional	Anesthesiology	Anesthesia	Anesthesiology
Tram, Bich N., CRNA	Allied Health Professional	Certified Registered Nurse Anesthetist	Anesthesia	NBCRNA

REAPPOINTMENTS - January 1, 2022 – December 31, 2023

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Bajwa, Moazzum N., MD **Withdraw Privilege:** • OB-Family Medicine	Active	Family Medicine	Family Medicine	Family Medicine
Caba Molina, David, MD	Active	Surgical Oncology	Surgery	Surgery
Caverly, Jeffrey C., MD	Consulting	Diagnostic Radiology	Radiology	Diagnostic Radiology
Cheng, Peter H., DO	Active	Anesthesiology	Anesthesia	Anesthesiology
Chin, Samuel, MD	Active	Psychiatry	Psychiatry	Psychiatry
Chowdhury, Farys R., DO	Active	Anesthesiology	Anesthesia	Anesthesiology
Demisse, Rahel Z., MD	Active	Hematology/Oncology	Medicine	Internal Medicine Hematology Medical Oncology
Duong, Jason N., DO	Active	Neurosurgery	Clinical Neurological Sciences	Neurological Surgery
Firek, Anthony F., MD	Active	Endocrinology	Medicine	Internal Medicine Endocrinology
Haider, Thomas T., MD	Courtesy	Spine Surgery	Orthopedic Surgery	Spine Surgery
James, Joseph P., MD	Active	Psychiatry	Psychiatry	Psychiatry Geriatric Psychiatry
Inman, Jared C., MD Yellow Flag • 1 Dismissed Claim 2020	Active	Head/Neck Surgery & Oto	Surgery	Otolaryngology
Mangasep, Concepcion R., MD	Active	Psychiatry	Psychiatry	Not Certified
Molkara, Afshin M., MD	Active	Surgery	Surgery	Surgery Vascular Surgery
Qureshi, Huma S., MD Yellow Flag • 1 Closed Claim 2020	Consulting	Diagnostic Radiology	Radiology	Diagnostic Radiology
Saukel, George W., MD	Active	Pathology	Pathology	Anatomic Pathology & Clinical Pathology Forensic Pathology
Wacker, Margaret R., MD	Active	Neurosurgery	Clinical Neurological Sciences	Neurological Surgery

Riverside University
HEALTH SYSTEM

Yeung, Stephen W., DO	Active	Neurology	Medicine	09/30/2021

I hereby:

1) Attest that the medical center's Medical Executive Committee electronic vote on December 13, 2021 recommended approval of the appointment, reappointments, proctoring, change of status, withdraw of privileges, automatic terminations, resignation/withdrawals and privilege forms.
2) Approve the listed changes as recommended by the Medical Executive Committee; and
3) Recommend that the Board of Supervisors ratify the listed changes as recommended by the Medical Executive Committee.

Jennifer Cruikshank
Chief Executive Officer – RUHS Medical Center

Confidential Medical Staff Committee Report
Protected by California Evidence Code 1157

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT
MEDICAL EXECUTIVE COMMITTEE **MEC DATE:__________**
BOARD OF GOVERNORS **BOARD DATE: __________**

The processes of appointment and reappointment to the Medical Staff and of granting and renewing or revision of clinical privileges all involve using information about an applicant to decide whether the individual will be authorized to practice within the hospital and, if so, what the individual will be authorized to do within the hospital. Reappraisal for reappointment to the medical staff and renewal/revisions of clinical privileges is based on information concerning the practitioner's professional performance, judgment and clinical skills, as indicated in part by the results of continuing performance assessment and improvement activities. Department recommendations are part of the basis for the recommendations for continued membership on the medical staff and for the delineation of clinical privileges.

Upon recommendation from each of the Department Chairs, followed by recommendation from the Medical Executive Committee, the following items were referred to the Board of Governors for further action or information as noted:

INITIAL APPOINTMENT – August 1, 2021 – July 30, 2023

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Sample: Dr Smith	Provisional *Temp privileges requested for 7/29/21	Pulmonary/Critical Care	**Medicine**	Pulmonary Disease Internal Medicine

REAPPOINTMENTS - August 1, 2021 – July 30, 2023

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Sample: Dr. Smith	Active	Gastroenterology	Medicine	Withdrawal of Biopsy privileges

COMPLETION OF FPPE-PROCTORING/ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Sample: Dr. Smith	Provisional	General Surgery		Remain Provisional
Dr. Doe	Provisional/Active	General Surgery		Advance to Active

AUTOMATIC TERMINATION PER BYLAWS

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS

VOLUNTARY RESIGNATIONS

NAME	STATUS	SPECIALTY	DEPARTMENT	EFFECTIVE/REASON

DRAFT

MEDICAL STAFF SERVICES/ADMINISTRATION

February 16, 2022

«RS_Name»
«RS_Address»
«RS_Address2»
«RS_City», «RS_State» «RS_Zip»

Fax: «RS_Fax»
Email: «RS_Email»

Dear «RS_Name»,

RE: «FormalNameWithDegree»

The above-named practitioner has applied/reapplied to the medical staff of Riverside University Health System. We must obtain a recommendation from peers before action can be taken from his/her clinical department chair, Credentials and Executive Committees, and Governing Board. Your evaluation should be based on your personal knowledge and observation of the practitioner's clinical knowledge and skills.

We thank you in advance for prompt response to this request, **please fax to (951) 486-5911 or email to «UserEmail»** If you should have any questions please feel free to contact the medical staff office at «UserTelephone»

«UserFullName»
Medical Staff Services

This evaluation is based on my personal knowledge and observations concerning the above practitioner's practice of his/her specialty.

I. RELATIONSHIP OF REFERENCE SOURCE TO APPLICANT

A. How long have you known the applicant?	
B. During what time period and in what capacity did you ~~have the opportunity to~~ directly observe the applicant's practice of his/her specialty?	
C. Was your observation done in connection with any official professional title or position? If yes, please indicate title.	☐ No ☐ Yes, Title:
D. Are you now or about to become related to the applicant as family or through a professional partnership or financial association?	☐ No ☐ Yes, Relationship:

II. EVALUATION

This evaluation should be based on demonstrated performance ~~compared to that~~ which is reasonably expected of a practitioner with a similar level of training, experience and background as this applicant. In your response, provide any knowledge you have on these matters, particularly anything that warrants caution in granting the applicant medical staff appointment or a particular clinical privilege.

If any of the following are answered **"Poor,"** please provide details.
If you do not have knowledge to answer a particular question, please indicate **"Unknown."**

	Poor	Fair	Good	Superior	Unknown
A. Patient Care: Provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.					

	Poor	Fair	Good	Superior	Unknown
B. Medical/Clinical Knowledge: Demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of his/her knowledge to patient care and the education of others.					
C. Practiced-Based Learning and Improvement: Use scientific evidence and methods to investigate, evaluate, and improve patient-care practices.					
D. Interpersonal and Communication Skills: Demonstrate interpersonal and communication skills that enable him/her to establish and maintain professional relationships with patients, families, and other members of health-care teams.					
E. Professionalism: Demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity (including race, culture, gender, religion, ethnic background, sexual preference, language, mental capacity, and physical disability), and a responsible attitude toward his/her patients, profession, and society, and participation in medical staff organization activities.					
F. System-Based Practice: Demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.					
G. Medical Records: Legible and timely completion of medical records.					
H. Ability to exercise the privileges requested. (Please refer to the attached privilege delineation form, which the applicant has completed.)					

III. ACTIONS TAKEN AND CONDUCT

If any of the following questions are answered "**Yes,**" please give details on a separate page.

	No	Yes	Unknown
A. During the time noted in Item I., has this applicant ever been subject to any disciplinary action, such as imposition of consultation requirements, suspension or termination?			
B. To your knowledge, has the applicant ever been under investigation by any government or other legal body?			
C. Are you aware of any investigations at the time the applicant left your institution, were any investigations or actions instituted, in process or pending against the applicant?			
D. Do you know of any malpractice actions instituted or in process against the applicant?			

IV. HEALTH STATUS

If any of the following questions are answered "**Yes,**" please give details under comments section below.

	No	Yes	Unknown
A. Has the applicant ever shown signs of any behavior, drug, or alcohol problems that could interfere with providing safe and quality patient care?			
B. Has the applicant ever shown signs of any mental or physical health problems that could interfere with providing safe and quality patient care?			

Comments:

HEALTH STATUS

(THESE QUESTIONS ARE NOW UNDER CATEGORY IV OF THIS QUESTIONNARE)

~~**APPLICANT: «FormalName»**~~

~~1. Has the applicant ever shown signs of any behavior, drug, or alcohol problems that could interfere with providing safe and quality patient care?~~

~~☐ Yes~~
~~☐ No~~

~~Comments: ____________________________~~

~~2. Has the applicant ever shown signs of any mental or physical health problems that could interfere with providing safe and quality patient care?~~

~~☐ Yes~~
~~☐ No~~

~~Comments: ____________________________~~

~~3. If the answer to Questions 1 or 2 is "yes," would these problems impact the applicant's ability to safely and in a quality manner exercise the clinical privileges that (s)he has requested?~~

~~☐ Yes~~
~~☐ No~~

~~Comments: ____________________________~~

~~**REFERENCE PROVIDED BY:**~~

~~**Signature**~~ ~~**Date**~~

~~**Print Name**~~ ~~**Phone Number**~~

IV. RECOMMENDATION

- ❐ Recommend without reservation
- ❐ Recommend with the following reservations: ____

____

____

- ❐ Do not recommend (Please give details on a separate page.)

What is the best time to contact you by phone? ______________________________________

Telephone Number: (________) ____

Reference Provided by: ______________________________ ___________________________

Signature **Date**

Enc: ~~Health Status Form~~
Privilege Form
Consent to Release Information Form

Rev. ~~050109.coden~~
10.06.21

Riverside University Health System- Medical Center
Performance Improvement and Patient Safety Plan
June 2021 - June 2022

I - INTRODUCTION

Riverside University Health System-Medical Center (RUHS-Medical Center) is committed to fostering an environment that encourages performance assessment and improvement of patient care processes and outcomes.

This document serves as the hospital's Performance Improvement and Patient Safety Plan (PIPSP). It outlines the systems-based approach and methodologies used to improve organizational performance and patient safety. Under this plan, Riverside University Health System-Medical Center:

- Provides high quality clinical services and a safe environment by encouraging recognition and prompt reporting of risks to quality and safety so that actions can be initiated to mitigate risks and promote better outcomes.
- RUHS-Medical Center will initiate the journey towards culture of safety by utilizing a systematic approach
- Achieves performance improvement in a systematic manner through multi-disciplinary collaboration and evidence-based practices.
- Ensure that the quality of care is consistently measured, monitored, and continuously improved; Metrics may be selected to identify efficacy, appropriateness, availability, timeliness, effectiveness, continuity, efficiency, safety, and competency.
- Utilizes performance improvement information and aggregate data in formulating and achieving objectives of the strategic plan.

II - PURPOSE AND GOALS

The purpose of the PIPSP is to reinforce the strategic performance goals of the organization and to assure a safe environment for patients, employees, and visitors. This plan describes the goals, organizational structure, and methodology employed to create a safe environment, and guide all components of RUHS-Medical Center—the governing body, medical staff, administration, management, clinical and non-clinical staff and volunteers—toward the achievement of this environment.

The goals of the plan include:

- Encourage leadership in prioritizing, planning, and providing strong direction for the implementation of performance improvement and patient safety standards.
- Integrate medical staff and all disciplines' involvement in performance improvement and patient safety activities.
- Identify and implement evidence-based best practice.
- Act as a central repository for quality information responsible for reporting data to appropriate committees, groups, and individuals.
- Identify high risk processes in order to focus action through, but not limited to, root cause analysis and failure mode and effects analysis.
- Integrate The Joint Commission Core Measures and National Patient Safety Goals in the hospital wide performance improvement process.
- Continuously maintain, revise, and expand hospital wide systems as necessary to be current in compliance with The Joint Commission standards, local and state, and federal regulations governing operation of acute care hospitals and trauma centers.
- To improve cost-effectiveness and decrease variation in care while maintaining and improving quality of services through maximum utilization of current resources and finding innovative ways of service delivery.

III - SCOPE OF SERVICES

The RUHS-Medical Center PIPSP includes inpatient and Emergency Department services. The quality and safety of care is monitored from the time the patient enters the hospital through discharge to provide continuous appraisal on the provision of care throughout the continuum.

IV - ORGANIZATION AND ACCOUNTABILITY

Board of Supervisors

The Board of Supervisors has the ultimate responsibility to establish, review, and maintain an integrated PIPSP through the hospital's leadership.

Medical Staff Organization

The Medical Staff, including the Medical Director of Quality, and Medical Executive Committee (MEC), working collaboratively with the hospital executive leadership and the hospital's patient care services, share the responsibility for planning, designing, measuring, assessing, improving, and evaluating patient safety and effectiveness of all patient care services and outcomes.

MEC carries out several functions including oversight of implementation of policies and procedures related to medication usage, potential and confirmed sentinel events, root cause analyses and implementation of corrective actions.

The Medical Staff Departments are responsible for the safety and quality of care and service delivered by the members of the department as demonstrated by:

- Providing leadership for PI activities in the facilities;
- Establishing scopes of service for their respective hospital Departments;
- Measuring, assessing, and improving performance indicators for Department functions, and performance improvement and patient safety processes;
- Reporting findings, conclusions, recommendations, actions taken and results of actions to appropriate committees;
- Performing Peer Review and Documentation Review;
- Initiating Focused Professional Practice Evaluation when findings identify concerns with an individual practitioner's performance; and
- In collaboration with the Patient Safety Officer, Quality Management, and Risk Management, and under the auspices of MEC, participate in a multidisciplinary root cause analysis of an actual or potential adverse event.

Administration

The Executive Management Team Members are the Chief Executive Officer, the Chief Operating Officer, the Chief Financial Officer, the Chief Medical Officer, the Chief Nursing Officer, the Chief Information Officer, and Chief Clinical Integration Officer.

RUHS Executive Management provides direction and leadership for the performance improvement and patient safety activities by:

- Aligning strategic planning with PI activities;
- Planning, prioritizing and implementing performance improvement activities in collaboration with Medical Staff and the Performance Improvement and Patient Safety Committee (PIPSC);
- Assessing and providing the adequacy and effectiveness of physical and financial resources to support identified and performance improvement priorities;

- Providing adequate time for personnel to be trained and participate in performance improvement activities including participation in significant care reviews;
- Providing appropriate data management processes to support measurement and analysis of performance improvement activities.
- Providing mechanisms to measure and analyze variation in performance improvement activities and support implementation of improvement initiatives in the frontline arena;
- Fostering a culture of safety through proactive reporting and collaboration to address identification and reduction of medical errors;
- Promoting organizational change to improving performance activities by assisting with removal of barriers to improvement; and
- Ensuring that all sentinel events and near misses are identified and reported through incident reports, and that a thorough root cause analysis and action plans for improvement are completed timely.

Hospital Managers/Directors

Hospital managers/directors are responsible for:

- Developing, measuring, analyzing, reporting, and improving performance indicators;
- Ensuring that all necessary and required quality control programs are in place;
- Leading performance improvement and patient safety activities in their areas(s) of responsibility and evaluation of results; and
- Ensuring that their staff has a basic understanding of the organization's approach to performance improvement, performance improvement activities, and their role in performance improvement and patient safety.

Quality Management Department

The Quality Management Department in collaboration with the Medical Director of Quality, provides guidance and assistance to organizational leaders and managers in Performance Improvement activities, and coordinates summary reports of such activities to the Process Improvement and Patient Safety Committee (PIPSC), Professional Practice Evaluation Committee (PPEC), Medical Executive Committee (MEC), and Joint Conference Committee of the Board. Functions of the Quality Management Department include:

- Coordinate and maintain the PIPSP in accordance with the Medical Staff Bylaws, and Rules and Regulations, and the requirements of licensing, accrediting, and regulatory agencies.
- Coordinate with Risk Management root cause analysis of significant cases leading to potential or actual unexpected outcomes.
- Track and analyze common root causes of significant cases reviewed and present them to the medical staff and hospital leaders for action plan.
- Follow-up implementation of action plans for any unanticipated events.
- Act as a consultant and resource to the Administration, Medical Staff, and other hospital departments.
- Assist with the preparation of summary reports for presentation to the PIPSC, PPEC, MEC, and Joint Conference Committee of the Board.
- Coordinate results of Peer Review in accordance with the Professional Practice Evaluation Program.
- Perform data analysis, research benchmarks and external references for best practices and provide recommendations for improvement
- Review incident reports and reports cases with potential litigation to Risk Management, to the Hospital Executive Team, and to the Patient Safety Officer.
- The Quality Department actively participates in Process Improvement projects in collaboration with operations and direct clinical care staff.

Patient Safety Officer

The Patient Safety Officer is appointed by RUHS-Medical Center executive leadership with approval by the PIPSC. Responsibilities of the Patient Safety Officer include the following:

- Facilitates implementation of the RUHS-Medical Center Patient Safety Program.
- Collaborates with members of the Medical Staff, Quality Department, Risk Management, Infection Control, Life Safety, Security Office, Patient Advocacy, and Regulatory Compliance to effectively roll out organization wide quality and safety initiatives, to ensure a safe environment for RUHS-Medical Center patients and staff.
- Promotes compliance with the National Patient Safety Goals, Quality Reporting Measures, and other mandated performance indicators, and report compliance to Executive Administration.

Riverside University
HEALTH SYSTEM

Employees, medical staff members and volunteers

All employees, medical staff, and volunteers are responsible for the following:

- Participate in identifying opportunities for improvement and data collection.
- Participate in multidisciplinary teams and implement actions to sustain improvement.
- Report actual patient safety incidents and conditions that may jeopardize patient safety and quality care.

The Performance Improvement and Patient Safety Committee

The PIPSC functions as an oversight committee for all performance and patient safety activities in the clinical and service areas (Refer to Medical Staff Bylaws, Committee Functions Manual, for the description of this Committee and its membership). The Committee has the following responsibilities:

- Achieving performance improvement in a systematic manner through multi-disciplinary collaboration.
- Providing an ongoing, proactive approach that supports and encourages a culture of safety and reporting of patient safety events;
- Identification and mitigation of patient safety risks;
- Performing a thorough risk analysis, which includes, but not limited to, root cause analyses and case conferences, on reported patient safety events;
- Developing recommendations and action planning for proactive risk reduction;
- Monitoring, implementation and follow-up of patient safety process action plans;
- Incorporating patient safety principles into the design (and redesign) of existing processes and services, and determining performance improvement priorities within the organization;
- Monitoring regulatory compliance, which includes, but is not limited to, National Patient Safety Goals, Quality Reporting (which includes Core Measures, readmissions) and other mandated indicators
- Ensuring that procedures are in place to prevent the use of any intravenous connection, epidural connection, or enteral feeding connection for any purpose other than its intended purpose. (per SB 158); and

- Implementing and reviewing as needed, its patient safety, medication safety and root cause analysis processes to ensure unified oversight of patient safety events and all improvement efforts to mitigate future events. The purpose of this unified approach is intended to improve the timeliness and effectiveness of quality assurance and improvement activities.

V - PERFORMANCE IMPROVEMENT

RUHS-Medical Center framework for improvement includes the following key methodologies:

Lean: is a management philosophy derived from Toyota Production System. It focuses on eliminate waste and reduce errors within the healthcare industry. Lean principles are customer focused, data driven decision not intuition, respect, results, accountability, and excellence.

A3: a problem-solving approach built around Plan, Do, Study, and Act (PDSA) that provides a structured way of thinking

Performance Measurement and Monitoring

Performance measurement and monitoring is accomplished in a systematic approach. Data will be used to:

- Establish a performance baseline;
- Describe a process performance or ability;
- Describe the dimensions of performance relevant to the functions, processes and outcomes; and
- Identify areas for more focused data collection to sustain improvement.

At a minimum, but not limited to, the organization collects data to monitor its performance on measures as outlined by the Joint Commission Standards, CMS, state regulations and priorities identified by hospital leadership. Measured data is aggregated and referred to the responsible department for analysis and action planning. The analyzed data is reported to the PIPSC, and then reported to the Medical Executive Committee and the Joint Conference Committee of the Governing Board.

Riverside University HEALTH SYSTEM

Performance and Patient Safety Assessment

Data is aggregated and analyzed using appropriate statistical method. Data for key indicators is reported over time, providing an opportunity to observe performance trends over time.

The organization requires an analysis of low performance trends or significant variations in performance or error patterns when the following is identified:

- Performance outcome is consistently below the set thresholds for the measure
- Significant variance in the performance outcomes compared to national, state, or jurisdictional cohort performance benchmark.
- Significant medication errors, "near misses", and hazardous conditions;
- When a sentinel event occurs
- Confirmed significant transfusion reactions
- Major discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses; and
- Significant adverse events or trends associated with moderate or deep sedation and anesthesia use.

When an undesirable pattern, trend, or variation occurs, the adequacy of staffing, including nurse staffing, is included in the analysis of possible causes.

Risk assessment and mitigation of risk to patients is also identified using Failure Mode Effects Analysis (FMEA), which is a performance improvement process that focuses on a high-risk process. An area of focus is identified at least once within an 18-month period. By using FMEA, a proactive risk assessment examines a process in detail, including the sequencing of events. The FMEA assesses the risks, actual and potential, and identifies potential failure points. FMEA approved for 2021-2022: TBD

Assessment of Findings Related to the Performance of an Individual

The design, measurement, assessment, and improvement of patient care include evaluation of the clinical performance of individuals with clinical privileges through their participation in peer review activities and with oversite from the Professional Practice Evaluation Committee (PPEC).

When the results of performance measurement and analysis relate to performance of an individual licensed practitioner, the medical staff determines their use in peer review, ongoing professional practice evaluation of the individual's competence, and a focused professional practice evaluation as appropriate. The medical staff has adopted the PPEC and peer review policy.

Prioritization of Performance Improvement Opportunities

Prioritization of performance improvement initiatives are based on the following:

- Unanticipated adverse occurrences affecting patients;
- Impact on patient safety;
- Volume of patients affected or frequency with which the process occurs;
- Performance measurement and analysis findings;
- Alignment with mission, vision, commitments;
- Response to the needs and expectations of patients, families, and other customers;
- Availability of resources to improve the process;
- Ease with which the process can be improved.

Performance Improvement Priorities for 2021-2022 (see attachment A):

- Transitions of Care
- Improving Experience:
  - Patient satisfaction (HCAHPS and CG-CAHPS)
  - Employee/provider satisfaction
- Implementing and Maintaining a Culture of Safety

Performance improvement is not limited to these priorities. Continuous performance improvement efforts will also include indicators to improve performance of clinical best practices:

- Quality Reporting including Core Measures and Claims-based measures by CMS
- Primary Stroke Center Core Measures
- Sepsis management and mortality
- Pressure injury prevention and management
- Reduction in hospital Patient Safety Indicator (PSI) Events Retained Foreign Objects
- Latrogenic Pneumothorax
- Perioperative PE/DVT

- Unrecognized Abdominopelvic Accidental Puncture/Laceration

- Quality Incentive Program (QIP)
  - Primary Care Access and Preventive Care
  - Behavioral Health Care
  - Care of Acute and Chronic Conditions
  - Care Coordination
  - Experience of Care
  - Improving Health Equity
  - Maternal and Perinatal Health
  - Patient Safety
  - Overuse/Appropriateness

Reduce risk and all-cause harm to patients
- Antibiotic stewardship
- Opioid stewardship
- Collaboration with Medication Safety program
- Infection prevention and control
- Compliance with new and existing National Patient Safety Goals (NPSG)
- Inpatient and OR Glycemic control
- Implementation of Leapfrog safety measures

Improve care efficiencies and expand Lean methodology
- Inpatient unit performance board and daily huddle deployment, Leadership rounding and frontline A3 projects.
- Hospital Throughput Committee
- Nursing Staffing Effectiveness

VI - PATIENT SAFETY

RUHS-Medical Center strives for a culture of safety by implementing plans that reduce, prevent or mitigate harm. As part of the PIPSP, the search for potential patient safety risk is continual. Proactive risk-reduction strategies are based on community standards; evidence-based practice and professional guidelines and reflect the requirements of accreditation and regulatory agencies. Errors or "near misses" will be evaluated objectively and fairly using a structured method and tools to ensure that the focus is on a true safety culture that balances learning

with accountability and by separating blameless errors, used as an opportunity for learning, from blameworthy errors that is used for equitable discipline. Blameworthy errors would include serious failures to act responsibly, thereby creating or increasing risk to patient safety. RUHS-Medical Center has implemented the Executive Leadership Safety Event Oversight Team, a cohesive structure that will oversee the immediate actions related following a significant safety event and monitor remediation. The revised general process for Root Cause Analysis is depicted in more detail on the attachment B.

Identification of patient safety issues

Patient safety issues are identified through multiple sources, including but not limited to incident reports, patient grievances, patient satisfaction survey reports, performance improvement measurement analysis and findings, infection control findings, safety rounds, administrative rounds, regulatory compliance, Patient Safety Hotline, and other external sources of patient safety information. Recognizing that most incidents result from systems and process failures, the organization supports non-punitive reporting and encourage staff to report all errors or “near misses”.

Response to a patient safety incident

Following an incident, staff will take necessary action to protect and support the patient’s clinical condition. For specific incidents, such as transfusion reactions, adverse drug reactions, and serious medication errors, procedures have been established to ensure the appropriate response. The patient’s physician will be contacted to report the incident and for staff to receive direction from the physician in responding to the incident.

Steps will be taken to control a hazardous condition, e.g. removing faulty equipment from service. Any information related to the incident will be preserved.

The incident will be reported as described below.

Incident reporting

An effective incident reporting system and a "Just Culture" for handling/ managing reported incidents are critical to an effective patient safety program.

Riverside University
HEALTH SYSTEM

Incident reports are expected to be completed and submitted online within 2 days of the incident. Appropriate Department Managers and hospital leaders are notified in real time via email that a report has been submitted. The Department Manager(s) investigate within established timeframes and implement strategies to mitigate future similar events. Quality Management reviews all incident reports for completeness, timeliness, and accuracy of harm score assignments. Quality Management tracks, trends, aggregates, analyze, and reports incident frequencies and severities to assist leadership with prioritizing patient safety improvement initiatives. For a description of the incident reporting procedure, see RUHS-Medical Center Incident Reports policy.

Managing serious, potentially serious and sentinel events

A process is in place to immediately report, investigate and conduct in-depth analysis of serious, potentially serious and sentinel events. A Root Cause Analysis is conducted for all sentinel events and reports of adverse events. The outcome of this process is an action plan targeting the root cause of the event. Progress on the implementation of the action plan is communicated to hospital and medical staff leadership, as well as the Board. For a description of this process, see the RUHS-Medical Center Sentinel Events policy.

Communication of unanticipated outcomes

Following a serious or sentinel event, or a patient outcome which varies significantly from that which was anticipated, the patient, and when appropriate the patient's family, will be informed of the incident, as soon as reasonably possible.

The appropriate time and method of informing patients is determined by the healthcare team under the direction of the attending physician, nursing leadership and hospital administration. The team will determine the extent of detail to be provided, inclusion of family members, and the need for referral for additional support and/or resources. Disclosure will include factual data, avoiding speculation or assignment of blame. Continued dialogue with the patient will be coordinated by the attending physician in collaboration with the healthcare team, including hospital administration, to ensure preservation of the provider-patient relationship and patient/family involvement in the continued plan of care.

The team will designate one or two hospital staff members who will be the primary contacts for questions and to facilitate continuity of the patient's emotional and healthcare needs.

Sentinel Event Alerts

Sentinel Event Alerts are received from The Joint Commission and used as a proactive measure to mitigate potential adverse outcomes for patients. An action plan may be instituted to address vulnerable areas in the organization related to the Sentinel Event Alert.

Root Cause Analysis (RCA) and Quality Case Conference

Significant adverse events are reviewed according to the frequency/severity matrix (see attachment 1) for need of an RCA. A root cause analysis requires a comprehensive systematic analysis which seeks to go beyond individual performance issues to determine the gaps in systems that contributed to the adverse event and to identify strong corrective actions. Significant incidents that do not meet RCA criteria may still need a multidisciplinary detailed review which will occur during a Quality Case Conferences are reviewed using the continuous quality improvement approach. At RUHS-Medical Center, a multidisciplinary subcommittee of the PIPSC is put in place to for completion of the root cause analysis and Quality Case Conferences.

The Executive Leadership Safety Event Oversight Team will meet within 24 hours of notification of a significant or sentinel event to initiate immediate actions to contain the risk of immediate recurrence of the event.

Patient safety education

Patient safety is incorporated into the orientation and continuing education of all staff, physicians, and volunteers. This education includes the expectation that patient safety events and risk to patient safety will be reported. Staff competency issues related to patient safety are identified in the performance evaluation process and are addressed on an individual, department or hospital-wide basis. This education includes, but is not limited to:

- General Orientation
- Nursing and New Graduate Nursing Orientation
- GME/Resident Orientation

Riverside University
HEALTH SYSTEM

- Annual Skills Days
- Departmental/unit in-service education
- Newsletters
- Annual Compliance Training

Education is provided by the Quality Department Team, Regulatory Compliance Team, Nursing Education Department, Human Resources, Chairs, Directors and Managers of Departments, and others as warranted.

The safety of health care delivery is enhanced by the involvement of the patient; appropriate to his/her condition, as a partner in the health care process. Patients and families are educated about their responsibility in helping to facilitate the safe delivery of care.

VII - CONFIDENTIALITY

Appropriate safeguards in compliance with HIPPA regulations have been established to restrict access to sensitive and confidential information, including privileged information protected pursuant to California Evidence Code 1157.

VIII - ANNUAL EVALUATION

The PIPSC will conduct an annual appraisal of the organizational performance improvement program.

Riverside University Health System

Medical Staff
Peer Review Criteria

The medical staff of RUHS has identified the following hospital-wide indicators, which will require peer review by all clinical departments/divisions.

Hospital-wide Indicators:

- Significant/unexpected surgical/anesthesia/procedure complications
- Significant/unexpected medical treatment complications
- Unexpected readmissions
- Unexpected ICU admissions
- Unexpected return to the OR
- All mortalities
- Legal cases
- Referrals from medical staff committees, departments, services, i.e., Quality Management, Risk Management, Administration, etc.
- Incident reports and patient complaints related to medical quality of care (screened by QM Department)
- Random inpatient and/or outpatient case reviews by QM Department
- Reportable cases to regulatory and accrediting agencies

In addition to the above, the clinical departments/divisions have identified their department-specific peer review indicators as follows:

Department	Indicators
Anesthesia	Hospital-wide indicators Reintubation in PACU
Emergency Medicine	Hospital-wide indicators
Head, Neck Surgery Otolaryngology	Hospital-wide indicators
Family Medicine	Hospital-wide indicators
Medicine	Hospital-wide indicators Code Blue Outside ICU Significant Medication Errors identified by MERP process
Neurosurgery	Hospital-wide indicators Blood Utilization > 7 Units (RBC and FFP)

Obstetrics & Gynecology	·	Hospital-wide indicators
	·	Neonatal APGAR <7 at 5 minutes
Ophthalmology	·	Hospital-wide indicators
Orthopedic Surgery	·	Hospital-wide indicators
Oral & Maxillofacial Surgery	·	Hospital-wide indicators
Pathology	·	Hospital-wide indicators
	·	Random sampling of benign and malignant cases
	·	Intradepartmental selection of significant cases
	·	Extra-departmental selection of significant cases
	·	Multidisciplinary discussion at Tumor Board
Pediatrics	·	Hospital-wide indicators
	·	Transfers out of facility
	·	Against medical advice discharges
	·	Ward cases requiring appropriate pain management for more than 4 days
Plastic Surgery	·	Hospital-wide indicators
Psychiatry	·	Hospital-wide indicators
	·	All mortalities within 14 days of discharge
Radiology	·	Hospital-wide indicators
	·	Random mammography peer reviews
Surgery	·	Hospital-wide indicators
		Blood Utilization > 7 units
		Nosocomial infection
Urology	·	Hospital-wide indicators

RIVERSIDE UNIVERSITY HEALTH SYSTEM

ANESTHESIOLOGY CLINICAL PRIVILEGES

Name:______________________________________
(Last, First, Initial)

Effective: ______________________________________
(From—To) To be completed by MSO

QUALIFICATIONS FOR CORE PEDIATRIC ANESTHESIOLOGY PRIVILEGES

PEDIATRIC ANESTHESIOLOGY CORE PRIVILEGE

Criteria: To be eligible to apply for core privileges in pediatric anesthesiology the applicant must meet the following criteria:

- Meet the Anesthesiology Core Privilege Criteria

AND

- Successful completion of a Pediatric Anesthesiology Fellowship

OR

- Demonstrated **significant experience** performing anesthesia on pediatric patients as determined by the Chair

OR

- Successful completion of a Pediatric AND Anesthesiology Residency

AND

- Provide evidence of Pediatric Advanced Life Support (PALS) Certification or equivalent pediatric experience as determined by Department Chair.

Reappointment Requirements: To be eligible to renew core privileges in pediatric anesthesiology, the applicant must meet the following criteria:

- Current demonstrated competence and active Pediatric Anesthesia practice with acceptable results in the privileges requested for the past 24 months based on ongoing professional practice evaluation and outcomes.

AND

- Provide evidence of current Pediatric Advanced Life Support (PALS) Certification or equivalent pediatric experience as determined by Department Chair.

Description of Pediatric Anesthesiology Core Privileges

☐ **Requested** **Pediatric Anesthesiology**

- Management of pediatric patients rendered unconscious or insensible to pain and emotional stress utilizing various pediatric sedation, general, local or regional anesthesia,
- Place and use of invasive monitors (including arterial, central venous, and pulmonary artery catheters,) during surgical and certain other medical procedures;
- preoperative, intraoperative and postoperative evaluation and treatment, support of life functions and vital organs under the stress of anesthetic, surgical and other medical procedures,
- medical management and consultation in pain medicine and critical care medicine,
- direct resuscitation in the care of patients with cardiac or respiratory emergencies, including the need for artificial ventilation, pulmonary care,
- supervision of pediatric patients, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.

Attachment L

Department of Surgery

Rules & Regulations

Table of Contents

SECTION CONTENTS **PAGE**

Forward **3**

1. **Name and Scope of Services** **4**
2. **Organization of the Department** **5**
3. **Department Membership and Clinical Privileges** **6**
4. **Allied Health Professionals** **7**
5. **Department Meetings and Education** **8**
6. **Consultation Requirements** **9**
   Departments Routinely Requested Consultations 10
7. **Monitoring and Evaluation** **11**
   Professional Practice Evaluation Program (PPEP) 11
   Peer Review 11
   Verbal Order Signature, Legibility, Supervision Monitoring 12
   Medical Records Completion Monitoring 12
   Attending Presence at Level "A" Trauma Activation Monitoring 12
8. **Patient Care and Other Department Policies** **13**
   Medical Records 13
   Operative Procedures 13
   Patient Transfer – Operating Room to Pediatric Intensive Care 13
   Assessment of Patient to be Admitted 14
   Subsequent Assessment or Reassessment 14
   Laboratory Diagnostic Testing Evaluation 14
   Patients Transferred from Other Hospitals 14
   Surgery Patient Hand-Off Communication 15
   OMFS Hand-Off Communication 15
   Head, Surgery & otolaryngology Hand-Off Communication 16
   Plastic Surgery Hand-Off Communication 17
   Urology Hand-Off Communication 18
9. **Residents and Other Students** **20**
10. **Division – Specific Information** **21**
11. ~~**Exhibits** .... **22**~~
    - ~~Surgery Department & Divisions Clinical Privilege Forms~~
    - ~~AHP Clinical Privilege Form~~

Forward

In accordance with the Medical Staff Bylaws, Article XV, Section 15. 1-2, each department of the medical staff formulates rules and regulations for the conduct of its affairs and for the supervision of house staff. Department rules and regulations must be consistent with the Medical Staff Bylaws, the General Rules and Regulations of the Medical Staff, and Riverside University Health System Medical Center (RUHS MC) policies. In accordance with bylaws section 15.1-2, the departmental rules and regulations will be reviewed and amended periodically. Information included about department functions, etc., is not repeated in this document. However, references to Medical Staff Bylaws are made when appropriate.

This document was reviewed as follows:

______________________________ ____________________

Afshin Molkara, MD — Date
Chair, Surgery Department

______________________________ ____________________

~~Aleca Clark, MD~~ — Date
Chair, Bylaws Committee

______________________________ ____________________

~~Gary Thompson, DO~~ — Date
Chair, Medical Executive Committee

______________________________ ____________________

~~Zareh Sarrafian~~ — Date
Director/CEO, RUHS-MC

______________________________ ____________________

Board Member, Joint Conference Committee — Date

SECTION 1: NAME AND SCOPE OF SERVICES

The **Department of Surgery** is dedicated to quality surgical care for each patient regardless of race or ability to pay. It also conducts a comprehensive surgical education program directed to training of residents in the surgical fields to help prepare them for board certification.

SCOPE OF SERVICES

- General Surgery, including Trauma, Thoracic, Vascular, and Colorectal Surgery
- Endovascular Surgery
- Surgical Critical Care
- Oral Maxillofacial Surgery
- Head and Neck Surgery and Otolaryngology
- Plastic Surgery
- Urology
- Pediatric Surgery

SECTION 2: ORGANIZATION OF THE DEPARTMENT

The Medical Staff Bylaws of RUHS-MC provide details related to the qualifications, selection, term of office, removal, and duties of the department chair (see Article XI, Section 11.3) and the department vice chair (see Article XI, Section 11.4).

The department chair is appointed by RUHS-MC, is contracted by RUHS-MC, reports to the medical director, and works cooperatively with the department vice chair.

The vice chair of the department is elected by a simple majority of the active staff members for a two-year term. Active staff category member of the Department of Surgery, who work fulltime at RUHS-MC, are eligible to be elected as vice chair of the department. The election is held upon notification by the Medical Staff Administration Department ~~Services Office~~. A special election will be called when there is vacancy in the position of vice chair of the department between regular elections. The elected vice chair shall be approved by the Medical Executive Committee.

Medical Staff Bylaws, Rules and Regulations: The Medical Staff Bylaws, Rules and Regulations manual is posted on the RUHS-MC Intranet:
https://rivcoca.sharepoint.com/sites/ruhs/clinicalservices/medstaff/Pages/default.aspx

SECTION 3: DEFPARTMENT MEMBERSHIP AND CLINICAL PRIVILEGES

All attending physician with clinical privileges in one of the surgical specialties, which are part of the Department of Surgery, are considered members of the Department of Surgery.

Clinical privilege delineation forms are developed by the Department of Surgery and its divisions. The criteria for clinical privileges is developed by the department/division and is recommended by the department chair to the Credentials Committee, the Medical Executive Committee, and the Governing Board. The criteria for granting clinical privileges is incorporated into each delineation of privileges form. ~~Refer to the exhibits section of this document for the department's clinical privilege forms.~~

Proctoring is carried out for providers who are newly appointed to the department, as well as for providers who request additional clinical privileges. The purpose of proctoring is to evaluate the provider's proficiency in the exercise of clinical privileges initially granted or subsequently granted (i.e., request for additional privileges). The Medical Staff Bylaws define some requirements related to proctoring as follows:

- Article III, Section 3.8 through 3.8-3
- Article IV, Sections 4.3-4 and 4.3-5

Performance on an appropriate number of cases as established by the department, and reflected on clinical privilege sheets, shall be observed by the Chair of the department, or Chair's designee, during period of proctoring specified in the Department Rules and Regulations, to determine suitability to continue to exercise the clinical privileges granted in the department. The Department goal is to have proctoring requirements completed within six months of appointment when possible, however, proctoring requirements must be completed to be eligible for reappointment.

Per Joint Commission, supplemental proctoring data may be used from another CMS certified organization where the practitioner holds the same privileges. The use of supplemental data may NOT be used in lieu of a process to capture local data. Organizations choosing to use supplemental data (reciprocal) should assess and determine the supplemental's data relevance, timeliness and accuracy. Minimally, 50% of cases proctored by a provider with RUHS active privileges in cases where the providers are low volume or their activity is limited to periodic call coverage, the department chair may determine a different percentage of reciprocal proctoring accepted – it may not be 100% supplemental proctoring. Supplemental proctoring from another facility reqiores using an Active staff member at RUHS as the proctor and completing the RUHS proctoring forms.

Proctors must be active staff members of the Department of Surgery with sufficient expertise to judge the quality of work being performed. All active, qualified members of the Department of Surgery are subject to serve as a proctor. The proctor shall not expect to be compensated for service unless she/he renders a clinical service to the patient. The division chairs, in agreement with the department chair, may also assign the proctors.

~~Varied cases/procedures covering the full scope of privileges are reviewed. Specific proctoring requirements are defined on each clinical privilege form.~~ The Focused Professional Practice Evaluation (AKA Proctoring) Policy has information regarding completion of provisional status, compilation of proctoring reports, reciprocal proctoring, etc. This policy is available in the Medical Staff Administration Department ~~Services Office~~ and is also posted on the RUHS-MC Intranet:

https://rivcoca.sharepoint.com/sites/ruhs/clinicalservices/medstaff/Pages/default.aspx

EXHIBIT:

- Surgery Privilege Delineation Form
- Head, Neck Surgery & Otolaryngology Privilege Delineation Form
- Oral and Maxillofacial Surgery Privilege Delineation Form
- Plastic Surgery Privilege Delineation Form
- Urology Privilege Delineation Form

SECTION 4: ALLIED HEALTH PROFESSIONALS

Allied Health Professional (AHP's) provides patient care services in the Division of Head, Neck Surgery & Otolaryngology. The allied health professionals are credentialed via the Interdisciplinary Practice Committee. Members of the medical staff Head, Neck Surgery & Otolaryngology Division must be privileged to supervise allied health professionals.

EXHIBIT:

- **AHP Privilege Delineation Form**

SECTION 5: DEPARTMENT MEETINGS AND EDUCATION

There are no standing committees in the Department of Surgery. The department functions as a committee of the whole. The department chair as necessary may appoint ad-hoc committees.

Functions of departments of the Medical Staff of Riverside University Health System-Medical Center are defined in the Medical Staff Bylaws, Article X. Section 10.4.

Scheduled meetings of the Department of Surgery are held at least quarterly as scheduled by the department chair. Announcements of scheduled meetings are provided to all members of the department. Agendas and minutes are prepared in conformance with approved medical staff policies and procedures. Policies and procedures related to medical staff meetings are available from the department secretary and the Medical Staff Administration Department Services Office.

Quorum requirements for department meetings are the number of Active staff members present at the meeting as stated in the Medical Staff Bylaws, Article XIII, Section 13.41. Business may be conducted only when a quorum is present. Only matters indicated on the agenda shall be discussed or considered.

Divisions present a report to the department chair on a quarterly basis. This report is subject to review and approval by the Department of Surgery.

EDUCATIONAL ACTIVITIES

The Department of Surgery is committed to the education of medical and physician assistant students, residents from different services, and General Surgery attending physicians.

The department chair is responsible for the coordination of educational events including weekly Grand Rounds/Morbidity and Mortality conference, weekly teaching conference for students and residents, and teaching rounds.

SECTION 6: CONSULTATION REQUIREMENTS

A. Routine or emergency consultation may be indicated in (but not limited to) the following situations:

1. The patient is not a good risk for operation or treatment.
2. The diagnosis is obscure after diagnostic procedures have been completed.
3. There is doubt as to the choice of therapeutic procedure to be utilized.
4. The situation requires the specific skills of other practitioners.
5. When requested by the patient or his/her family.

B. The vice chair or chair of the Surgery Department (or division chair) has the responsibility to determine the need for consultation when questions about a diagnosis, the appropriateness of the procedure, or the complexity of a serious illness are brought to their attention.

Riverside University Health System – Medical Center
ROUTINELY REQUESTED CONSULTATIONS

Reference: The Joint Commission Standard MS.03.01.03 – *"The organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a physician or other licensed independent practitioner is required. Consultation is obtained for the circumstances defined by the organized medical staff."*

Note: Clinical departments are indicating when a consultation should be obtained if a patient is admitted to another service with the following conditions:

1. **MEDICINE** consultation for any patient with acute coronary syndrome or acute renal failure requiring hemodialysis.
2. **CLINICAL NEUROLOGICAL SERVICES** consultation for any patient with subarachnoid hemorrhage.
3. **OB/GYN** or **FAMILY MEDICINE** physician with obstetric privileges consultation whenever a pregnant patient is admitted to another service. **OB/GYN** consultation when the patient's condition may adversely affect the woman's reproductive organs.
4. **ORTHOPAEDICS** consultation for any patient with an open fracture.
5. **OPHTHALMOLOGY** consultation whenever a patient has sudden, unexplained, severe loss of vision or for all premature infants' ≤1500gm birth weight.
6. **PEDIATRICS** consultation for any patient ≤14 years with chronic underlying medical conditions with the exception of family medicine physicians who have pediatric clinical privileges.
7. **PSYCHIATRY** consultation for any patient that is admitted with a legal hold such as WIC 5150, 5585, 5250, 5260, 5300, LPS conservatorship, or whenever a patient is admitted to another service for a suspected suicide attempt.
8. **GENERAL SURGERY** consultation for any patient with an acute bowel obstruction or gastrointestinal bleeding requiring transfusion.

This does not apply and is not exclusive to the following services:

- Emergency Medicine
- Family Medicine
- Neonatal ICU
- Pathology
- Radiology

> This list is not meant to be comprehensive. It is meant to provide guidelines for the appropriate coordination of patient care. As with most guidelines, all possible circumstances cannot be anticipated and attending physicians will have to individualize patient care. Under certain circumstances the need for consultation may be obviated (for example, a DNR patient who only desires comfort care).

APPROVAL:

MEC: 12/09/04 and for this document be included in all departmental rules and regulations.
MEC: Revised 6/08/06; 1/15/09

SECTION 7: MONITORING AND EVALUATION

I. PROFESSIONAL PRACTICE EVALUATION PROGRAM (PPEP)

The *Professional Practice Evaluation Program (PPEP)* describes the hospital-wide process and "mechanism for the members of the medical staff organization to take an active role in activities that measure and assess the ongoing performance of individuals who are granted clinical privileges and to use the results of such assessments to improve care."

The PPEP also contains information of the following:

- Roles and responsibilities of departments, committees and individuals involved in the peer review process
- Review process (OPPE and FPPE)
- Case Review
- Peer review indicators
- Peer review form
- Timeframes
- Reports
- External peer review

The PPEP is available in the Medical Staff Administration Department ~~Services Office~~ and is also electronically posted on the RUHSMC Intranet: https://rivcoca.sharepoint.com/sites/ruhs/clinicalservices/medstaff/Pages/default.aspx

II. PEER REVIEW

The following is applicable to the Department of Surgery, including its divisions:

A. A peer, who is not involved with the case, reviews every morbidity, mortality, return to the operating room, return to the ICU, and return to the hospital within a month. Additional cases may be reviewed as necessary.
B. Divisions other than General Surgery, summarize their peer review in the quarterly report to the Surgery Department chair.
C. General Surgery handles peer review as follows:
    - A list of cases (see #1 above) is presented at M&M conferences where quality of care and opportunities for improvement are discussed.
    - Each case is reviewed once more at a Surgery Department meeting and the peer review code assigned by the peer reviewer is discussed, confirmed, or modified by a majority of votes.
    - The final assessment is documented in the minutes of the department meeting and submitted to the Medical Executive Committee. The peer review form is also forwarded to the Quality Management Department.

I. VERBAL ORDER SIGNATURE, LEGIBILITY, SUPERVISION, ETC., MONITORING

A. Open chart reviews are done daily, in a rolling fashion, checking for documentation, signature of verbal orders, attestations, clarification of diagnosis and medication reconciliation forms. Notation and queries are provided directly to the practitioner via EMR communications and with email reminders for charting deficiencies that may prompt cessation of EMR access or privileges

B. The results of this review are presented to the Surgery Department at a regular meeting and documented in the minutes.

IV. COMPLETION OF MEDICAL RECORDS MONITORING

A. Fulltime members of the Surgery Department will complete charts provided by Medical Records Department at least once a week.
B. Compliance with this policy is monitored at the Surgery Department meeting by reviewing the medical records sign-in sheet.

V. ATTENDING PRESENCE AT MAJOR TRAUMA ACTIVATION MONITORING

The trauma system is overseen by the trauma medical director and coordinator, with a bimonthly PI meeting held to review cases and oversee attending participation. Monthly multidisciplinary meetings are held to assess processes and procedures for interdisciplinary care of the Trauma patient. The attendance of the trauma attendings and liasons is recorded and monitored. Individuals who do not meet or are approaching inadequate percentage of attendance are notified by the Trauma coordinator and administrative assistant.

SECTION 8: PATIENT CARE AND OTHER DEPARTMENT POLICIES

I. MEDICAL RECORDS

- The surgeon will provide in the medical record sufficient information to justify the proposed procedure.
- The medical record of a patient going for surgery should contain the preoperative diagnosis, documentation of pertinent lab, x-ray, path studies, electrocardiogram, etc., as well as evidence that an informed consent was obtained from the patient. In case of a life threatening emergency, this documentation could be completed post operatively.
- A report of all operations performed shall be immediately dictated by the attending or resident physician or a procedure progress note shall be immediately written and dictation done within 24 hours (see Operative Procedure below).
- Progress notes should be written in sufficient detail and frequency so that the patient's condition is clearly noted in the record at all time.
- After discharge, a summary will be dictated within 48 hours.
- Surgeons will review and complete signatures at the Medical Records Department on a weekly basis.

II. OPERATIVE PROCEDURE

- A member of the team will be present in the holding area at least 15 minutes before the start of the case to reassess the patient and confirm that all the required elements are present and complete in the chart.

- Once in the operating room only the surgeon or individual performing the procedure, as part of the procedure team, will initiate the time out and all required elements of the Joint Commission will be completed prior to starting the procedure.
- As part of the time out, x-rays will be reviewed again if they were used in the decision to operate. The need of antibiotic prophylaxis will also be addressed at the time of time out.
- The attending surgeon will be present for the key parts of the procedure.
- A resident surgeon could perform unsupervised only those procedures that have been approved for that particular resident by the Graduate Medical Education Office.
- The operative report shall be dictated immediately after the procedure by the attending or resident physician, or a procedure progress note will be immediately written and dictation completed within 24 hours.
- A medication reconciliation form must be completed for every patient that is admitted to the hospital.
- The boxes for medication reconciliation in the outpatient orders will be completed so that the patient can receive from nursing his/her list of medications.

III. PATIENT TRANSFER – OPERATING ROOM TO PEDIATRIC INTENSIVE CARE UNIT (PICU) and Adult Surgical Intensive Care

- ICU care team notified by the surgical or anesthesia team at the earliest identification of postoperative ICU needs
- The PICU attending must be notified and accept the patient
- The PICU care team will place admission and care orders following termination of the procedure
- Following surgery, a peer to peer communication will take place to formalize orders and care plan

III. PATIENT TRANSFER – OPERATING ROOM TO Adult Surgical Intensive Care Unit (SICU)

- ICU care team notified by the surgical or anesthesia team at the earliest identification of postoperative ICU needs
- The SICU team must be notified to generate admission or transfer orders
- Orders placed will initiate allocation of bed space by the House Supervisor
- Following surgery, a peer to peer communication will take place to formalize orders and care plan
- Need for ventilator should be identified prior to leaving the OR. Respiratory is to be notified for coordination of care and resource allocation.
- The SICU care team will place any additional care orders following termination of the procedure
- Communication pathways are highlighted in the "Process map OR to ICU"

IV. ASSESSMENT OF THE PATIENT TO BE ADMITTED

- The admitting history and physical will include a detailed history and physical examination with thorough assessment of the patient's status at the time of admission.
- The senior surgical resident may admit the patient after consultation with any attending physician of the Surgery Department.
- If a senior surgical resident admits the patient, an attending surgeon will assess the patient the next day.

V. SUBSEQUENT ASSESSMENT OR REASSESSMENT

- All surgical patients should be assessed on a daily basis with a written progress note in the chart indicating re-evaluation of old problems and any existing new problems.
- Reassessment of the patient should be undertaken whenever there is a significant change in the patient's vital signs or physical status. **This assessment should be documented in the EMR**
- Identification of further care will be discussed with the nursing and social service staff and recorded on the progress notes.
- All surgical patients admitted to the Surgical Intensive Care Unit will be followed by the surgical intensivist who will be in charge of supervising the patient's care.
- All surgical patients admitted to the ward will be followed by the surgical attending in charge of the team to which the patient was admitted.
- All PICU patients will have an automatic pediatric consult and will be followed by the pediatric intensivist who will be in charge of supervising the patient's care.
- All trauma patients may be transferred to a different service when there is evidence of a single system injury and only if the patient is stable and off the ventilator (with the exception of neurosurgery patients).
- Transfers between services will be made between attending physicians of the involved services.

VI. LABORATORY DIAGNOSTIC TESTING EVALUATION

- All radiological tests including plain x-rays, invasive radiological procedures, ultrasound, CT scan, MRI scan, as well as any other radiological diagnostic modality, require a specific diagnosis and pertinent history and physical findings adequate for the assessing radiologist.
- All requests for clinical laboratory testing should be accompanied by a diagnosis on the ordering sheet.
- All anatomical pathology specimens must be accompanied by a form in which adequate history and physical diagnostic information is available for pathologist.

VII. PATIENTS TRANSFERRED FROM OTHER HOSPITALS

- Emergency Department (ED) to ED transfers may be accepted directly by the ED physician with consultation from the surgeon prior to acceptance of the transfer.
- The surgeon shall accept all transfers for higher level of care.
- Transfers of patients with acute abdomen (including acute appendicitis), which are not for higher level of care, will be accepted only if there is not a surgeon available to perform the operation at the other hospital.
- Emergency department to emergency department trauma transfers from other Level II trauma centers will be accepted only if the attending surgeon feels that there is no risk for the patient to become unstable on transfer.
- Refusal to accept a transfer could be decided only by the attending physician if she/he believes that there are medical reasons by which the patient could be hurt.

VIII. SURGERY HAND – OFF COMMUNICATIONS PROCESS

In addition to the following procedure below, see the hospital-wide policies on ~~621.1~~ Hand-Off Communication. This policy is posted on the RUHS-MC Intranet:
~~https://rivcoca.sharepoint.com/sites/ruhs/clinicalservices/medstaff/Pages/default.aspx~~

A. Procedure

The Department of Surgery maintains close oversight of its patients and is committed to a hand-off process that meets the highest standards. Patient rounds are conducted in the morning and afternoon. Integrated patient status lists for the five surgical teams are maintained on the secure hospital computer system in the directory P:/Medicine /Surgery/Gen Surgery Lists. These lists and updates are an important component of the communication process among surgeons.

- General Surgery hosts daily "Morning Report" every morning, during which, cases from the last 24 hours and associated imaging and labs are reviewed. The OR daily schedule is also reviewed
- **Attending Surgeon:** Each surgery team does afternoon rounds with their attending surgeon. At the conclusion of rounds, the attending surgeon calls the attending surgeon who will be on call and reports on any problem cases. Dialog occurs and the on-call surgeon references integrated documents on the P: Drive.
- **Senior Resident:** After both morning and afternoon rounds, the senior residents meet face to face at a time protected from patient care and other responsibilities. The patient list is reviewed and potential problems are identified. The arriving surgery resident has opportunity to ask questions.
- **Junior Resident:** The junior surgery residents have responsibility for the portion of work known as cross coverage. During the course of call, medication orders expire, patient's experience pain or constipation, and family may ask questions. The junior residents deal with this plethora of issues.

In the face-to-face encounters that occur in the late afternoon, the surgery residents meet face-to-face to review their patients and potential patient issues. These conversations occur in a quiet setting with focus on communication. Questions and dialog occur in this context. Junior residents taking call also reference summary documentation on the P: Drive and in the medical record. Further, on-call junior surgery residents record each significant encounter on a log sheet which they post in the call room for arriving residents the following morning. That list records how patient identifiers (name and MRN), the caller, the team caring for the patient, the problem and action taken. This log then supplements communication that occurs during morning rounds and leads to prioritization of work on rounds.

IX. ORAL & MAXIFACIAL HAND-OFF COMMUNICATION PROCESS

In addition to the following procedure below, see the hospital-wide policy ~~621.1~~ on Hand-Off Communication. This policy is posted on the RUHS-MC Intranet:
~~https://rivcoca.sharepoint.com/sites/ruhs/clinicalservices/medstaff/Pages/default.aspx~~

A. Purpose

To assure safe patient care, OMFS has developed a call transition event that brings its physicians together face-to-face to hand-off work from the preceding call cycle. The time of the meeting varies slightly, but occurs after morning conference.

B. Procedure

When transferring a patient, either from or to another service, the referring physician will call and discuss with the accepting physician to hand off the patient information. If there are any issues about patient care that would best be served face-to-face, the accepting physician has the option to request a face-to-face hand off.

- **Attending Surgeon:** The OMFS team does rounds with their attending surgeon. At the conclusion of rounds, the attending surgeon call the attending surgeon, who will be on call and reports on any problem cases. Dialog occurs and the on-call surgeon references.
- **Senior Resident:** After rounds, senior residents may call each other at a time protected prom patient care and other responsibilities. The patient list is reviewed. Potential problems are identified. The arriving surgery resident has the opportunity to ask questions. This is generally to take place in the morning.
- **Junior Resident:** Junior surgery residents carry responsibility for the portion of work known as cross coverage. During the course of call, medication orders expire, patients experience pain or constipation, and families ask questions. The junior residents deal with this plethora of issues.

In face-to-face encounters that occur in the late afternoon, the surgery residents meet face-to-face to review their patients and potential patient problems. These conversations occur in a quiet setting with focus on communication. Questions and dialog occur in this context. Junior residents taking call also reference summary documentation on the medical record.

Furthermore, on-call junior OMFS residents will record each significant encounter on a log sheet that they post in the call room for arriving residents the following morning. That list records two patient identifiers (name and MRN), the caller and the team caring for the patient, the problem, and action taken. This log then supplements communication that occurs during morning rounds and leads to prioritizations of work on rounds.

X. HEAD, NECK SURGERY & OTOLARYNGOLOGY HAND-OFF COMMUNICATION PROCESS

In addition to the following procedure, see the hospital-wide policy ~~62.1~~ on Hand-Off Communication. This policy is posted on the RUHS-MC Intranet:
~~https://rivcoca.sharepoint.com/sites/ruhs/clinicalservices/medstaff/Pages/default.aspx~~

A. Procedure

When transferring a patient, either from or to another service, the referring physician will call and discuss with the accepting physician to hand off the patient information. If there are any issues about patient care that would best be served face-to-face, the accepting physician has the option to request a face-to-face hand off.

- **Attending Surgeon:** The otolaryngology team does afternoon rounds with their attending surgeon. At the conclusion of rounds, the attending surgeon calls the attending surgeon, who will be on call and reports on any problem cases. Dialog occurs and the on-call surgeon references.
- **Senior Resident:** After morning rounds and after afternoon rounds, senior residents may call each other at a time protected from patient care and other responsibilities. The patient list is reviewed. Potential problems are identified. The arriving surgery resident has the opportunity to ask questions.
- **Junior Resident:** Junior surgery residents carry responsibility for the portion of work known as cross coverage. During the course of call, medication orders expire, patients experience pain or constipation, and families ask questions. The junior residents deal with this plethora of issues.

In face-to-face encounters that occur in the late afternoon, the surgery residents meet face-to-face to review their patients and potential patient problems. These conversations occur in a quiet setting with focus on communication. Questions and dialog occur in this context. Junior residents taking call also reference summary documentation on the medical record.

Furthermore, on-call junior otolaryngology residents will record each significant encounter on a log sheet that they post in the call room for arriving residents the following morning. That list records two patient identifiers (name and MRN), the caller, the team caring for the patient, the problem, and action taken. This log then supplements communication that occurs during morning rounds and leads to prioritizations of work on rounds.

XI. PLASTIC SURGERY HAND-OFF COMMUNICATION PROCESS

In addition to the following procedure below, see the hospital-wide policy ~~621.1~~ on Hand-Off Communication. This policy is posted on the RUHS-MC Intranet: ~~https://rivcoca.sharepoint.com/sites/ruhs/clinicalservices/medstaff/Pages/default.aspx~~

A. Purpose

To improve patient safety and provide continuity in patient care, the following policy regarding "hand-off" communication between the residents and attending staff of the Plastic Surgery service at Riverside University Health System – Medical Center (RUHS-MC) is adopted. The time of the meeting varies slightly but occurs after morning conference.

B. Procedure

The chief resident in Plastic Surgery assigned to RUHS-MC will be responsible for coordinating requests for consultation and all daily care of patients. She/he will maintain a patient list (updated daily) on the appropriate RUHS-MC network computer drives and make this list available to all Plastic Surgery staff serving RUHS-MC.

Emergency on-call responsibility will extend from 5 p.m. to 7 a.m. on regular work days and for 24 hours continuously from 7 a.m. to 7 a.m. during weekend days and holidays.

The senior resident staff from the Loma Linda University integrated Plastic Surgery Residency Training Program will provide all coverage for emergencies and for calls regarding on-service inpatients 24/7. Resident staff is assigned per the master call schedule distributed monthly from the Department of Plastic Surgery academic offices at Loma Linda University Medical Center.

Resident staff providing emergency call coverage for RUHS-MC will be expected to transmit contemporaneously to the on-call attending physician information about any emergency consultation, emergency surgical procedure, or any admission to the service occurring during their call period.

At the end of each period of on-call responsibility, the outgoing on-call resident will contact the next resident assuming responsibility for emergency call directly by telephone or text page/email. This contact will occur between the hours of 7 a.m. and 9 a.m. The outgoing resident will transmit the following information regarding any admission to the service, emergency procedure, or emergency consultation at RUHS-MC: patient name, medical record number, diagnosis, and disposition of patient. If this contact is by text page or email and not a direct conversation, then acknowledgement or verification that it was received by the oncoming resident is required.

Surgeons in the Department of Plastic Surgery at Loma Linda University rotate the responsibility for daily inpatient work rounds, clinic management, scheduled operative procedures and resident supervision according to a regular weekly schedule. The plastic surgeons of Loma Linda University also provide continuous after-hours emergency call coverage for RUHS-MC. Call responsibility for attending staff is scheduled via the master call schedule distributed monthly from the Loma Linda University Plastic Surgery Department academic offices.

At the of each period of call responsibility, the outgoing attending physician on call will contact the new attending physician assuming responsibility for patient care and pass on information regarding any clinical activity reported to him or her during the call period. This contact will be made between the hours of 7 a.m. and 11 a.m. If a text page or email communication is used, a confirming acknowledgement is required. If there is no procedure, emergency consultation, or admission during the call period, then this "hand-off" communication need not occur.

The **master call schedule** will include contact information for all residents and attending staff. The distribution of this schedule shall include the Department of Surgery at RUHS-MC, the RUHS-MC hospital operator, and critical units within the hospital. It will be the responsibility of the chief resident assigned to RUHS-MC to confirm that the call schedule is available in these important areas.

XII. UROLOGY HAND-OFF COMMUNICATION PROCESS

In addition to the following procedure below, see the hospital-wide policy ~~621.1~~ on Hand-Off Communication. This policy is posted on the RUHS-MC Intranet:
~~https://rivcoca.sharepoint.com/sites/ruhs/clinicalservices/medstaff/Pages/default.aspx~~

A. Purpose

To assure safe patient care, the Urology Service has developed a call transition event that brings its physicians together face-to-face to hand-off work from the preceding call cycle. The time of the meeting varies slightly but occurs after morning conference.

B. Procedure

Urology call coverage is provided on a home call basis by urology residents from Loma Linda University Medical Center. In order to comply with ACGME requirements for adequate rest periods a call schedule has been implemented and hand-off procedure developed in order to ensure both continuity of care and patient safety.

The following guidelines are followed:

1. **Time:** Enough time is allocated to permit an effective hand-off. All other activities are placed on hold during the hand-off procedure. A discussion concerning each patient's present illness, comorbidities and events from the preceding 24 hours, expected patient related issues that may arise (such as pain, blood sugars, etc.), the plan for addressing these issues, and any outstanding items that need to be completed or followed up for each patient.
2. **Active process:** Residents participate in the sign-out procedure, the appropriate questions are asked and information is given using SBAR.
3. **Ill Patients:** Patients whose condition is expected to change or has the potential to change are discussed at length. The expected events and management plan are discussed. Potential needs for changes in level of care as well as the means to accomplish those changes are reviewed.
4. **Senior/Attending Coverage:** Senior residents and attending who are on call are reviewed as well as how to contact each person.
5. **Pending tasks/labs/studies:** Laboratory tests and other studies that are pending and require follow up are reviewed. Tasks (i.e. foley catheter, vaginal packing, central line or jp drain removal) that need to be performed are also reviewed.
6. **Following Day Schedule:** The following day's schedule (i.e. clinic, surgery, surgeries to be performed is reviewed.
7. **Post-Call Update:** Events that had occurred overnight including changes in status, new admissions or surgeries are discussed and hand-off to the next provider of care is performed.

SECTION 9: RESIDENTS AND OTHER STUDENTS

See RUHS-MC Medical Staff Rules and Regulations, #9 for general information about graduate education programs. In addition:

- The best interest of the patient must always be paramount when delegating resident responsibility. In general, each resident functions under the supervision of any attending physician.
- The procedural privileges of each resident will be determined by the chair of surgery or the applicable division chair following the guidelines of the *Procedure Certification Book.* The procedural privileges for each resident specify the procedures that the resident has been certified to perform without the direct presence of the attending physician. This book is reviewed and updated by the chair of surgery and applicable division chair and submitted periodically for approval to the Graduate Medical Education Committee.

Each year, the chair of the Department of Surgery prepares an annual report on resident education. A copy of the report may be obtained by contacting the department chair.

SECTION 10: DIVISION SPECIFIC INFORMATION (If Applicable)

There are division chairs in the Department of Surgery:

- Acute Care Surgery- Trauma, EGS, /Surgical Critical Care
- Vascular Surgery

- Thoracic Surgery
- Oral Maxillofacial Surgery
- Head, Neck Surgery and Otolaryngology
- Plastic Surgery
- Urology
- Pediatric Surgery
- Surgical Oncology

The qualifications, selection, term of office and duties of division chairs are defined in the Medical Staff Bylaws, Article XI Section 11.5.

Revised 8/4/20

RIVERSIDE UNIVERSITY HEALTH SYSTEM

GENERAL SURGERY CLINICAL PRIVILEGES

Name: ____________________ (Last, First, Initial)

☐ Initial Appointment
☐ Reappointment

Effective: ____________________ (From—To) (To be completed by MSO)

Applicant: **CHECK (✓) the "Requested" box for each privilege you are qualified to request and SIGN and DATE this form as indicated.** Applicants may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by RUHS for a proper evaluation of current competence and other qualifications, and for resolving any doubts.

Privileges may only be exercised at the following site(s) and/or setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document.

- RUHS- Medical Center
- RUHS-MSC clinics and OR

QUALIFICATIONS FOR CORE GENERAL SURGERY PRIVILEGES

GENERAL SURGERY CORE PRIVILEGES

CRITERIA: To be eligible to apply for core privileges in general surgery, the initial applicant must meet the membership requirements of Riverside University Health System and the following privileging criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited post-graduate training program in general surgery

AND

- Current board certification or board eligible candidate in the examination process in surgery by the American Board of Surgery and/or Royal College of Surgeons or the American Osteopathic Board of Surgery and/or American College of Osteopathic Surgeons or the Royal College of Physicians and Surgeons of Canada.

REQUIRED PREVIOUS EXPERIENCE: An applicant for initial appointment must be able to demonstrate:

- Performance of at least 100 general surgery procedures, reflective of the privileges requested, during the past 12 months.

OR

- Successful completion of a hospital-affiliated ACGME or AOA accredited residency or special clinical fellowship or research within the past 12 months.

OR

- Proficiency in general surgery to the satisfaction of the department chair and majority of the members of the General Surgery Division.

REAPPOINTMENT REQUIREMENTS: To be eligible to renew core privileges in general surgery, the applicant must meet the following maintenance of privilege criteria:

- Current demonstrated competence and an adequate volume of experience in general surgery procedures with acceptable results in the privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

AND

- Documentation that confirms 50 Category I CME hours during the past two years related to clinical privileges being requested. (CME Attestation)

AND

- Maintenance of board certification and/or board eligibility

AND

- Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

Name:______________________________
(Last, First, Initial)
Effective: ______________________________
(From — To) (To be completed by MSO)

General Surgery Core Privileges

❒ **Requested** **General Surgery Core Privileges –** ❒ **Approved** ❒ **Not Approved**

Admit, evaluate, diagnose, consult, and provide pre-, intra- and post-operative care, and perform surgical procedures, to patients of all ages, except as specifically excluded from practice; to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems, and with upper and lower endoscopy excluding colonoscopy. Management of critically ill patients with underlying surgical conditions in the emergency department, intensive care unit and trauma units to include ventilator management and emergency thoracic and vascular surgery. Includes performance of medical history and physical exam. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.

❒ **Requested** **Outpatients – Ambulatory Care Setting** ❒ **Approved** ❒ **Not Approved**

Privileges to manage and treat outpatients in the ambulatory-care setting at RUHS

CORE PROCEDURES LIST: This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

Please cross out any Core privileges you are not requesting at RUHS facilities.

❒ **Requested** **General Surgery Core Procedures** ❒ **Approved** ❒ **Not Approved**

CORE PROCEDURES

- Abdominoperineal resection
- Amputations, above the knee & below knee, toe, transmetatarsal, digits
- Anoscopy
- Appendectomy
- Biliary tract resection/reconstruction
- Breast: complete mastectomy with or without axillary lymph node dissection, excision of breast lesion, breast biopsy, incision and drainage of abscess, modified radical mastectomy, operation for gynecomastia, partial mastectomy with or without lymph node dissection, radical mastectomy, subcutaneous mastectomy
- Colectomy (abdominal)
- Colon surgery for benign or malignant disease
- Colotomy, colostomy
- Correction of intestinal obstruction
- Drainage of intra abdominal, deep ischiorectal abscess
- Endoscopy (intraoperative)
- Enteric fistulae, management
- Enterostomy (feeding or decompression)
- Esophageal resection and reconstruction
- Esophagogastrectomy
- Excision of fistula in ano/fistulotomy, rectal lesion
- Excision of pilonidal cyst/marsupialization
- Excision of thyroid tumors
- Excision of thyroglossal duct cyst
- Gastric operations for cancer (radical, partial, or total gastrectomy)
- Gastroduodenal surgery

Name:______________________________________
(Last, First, Initial)
Effective: ____________________________________
(From — To) (To be completed by MSO)

Please cross out any Core privileges you are not requesting at RUHS facilities.

☐ Requested **General Surgery Core Procedures Continued:** **☐ Approved** **☐ Not Approved**

CORE PROCEDURES CONTINUED:

- Gastrostomy (feeding or decompression)
- Genitourinary procedures incidental to malignancy or trauma
- Gynecological procedure incidental to abdominal exploration
- Hepatic resection
- Temporary Hemodialysis access procedures
- Hemorrhoidectomy
- Incision and drainage of abscesses and cysts
- Incision and drainage of pelvic abscess
- Incision, excision, resection and enterostomy of small intestine
- Incision/drainage and debridement, perirectal abscess
- Insertion and management of pulmonary artery catheters
- IV access procedures, central venous catheter, and ports
- Laparoscopy, diagnostic, appendectomy, cholecystectomy, lysis of adhesions, mobilization and catheter positioning
- Laparotomy for diagnostic or exploratory purposes or for management of intra-abdominal sepsis or trauma
- Liver biopsy (intra operative), liver resection
- Management of burns
- Management of hemorrhoids (internal and external) including hemorrhoidectomy
- Management of soft-tissue tumors, inflammations and infection
- Operations on gallbladder, biliary tract, bile ducts, hepatic ducts, excluding biliary tract reconstruction
- Pancreatectomy, total or partial
- Pancreatic sphincteroplasty
- Peritoneal venous shunts, shunt procedure for portal hypertension
- Peritoneovenous drainage procedures for relief or ascites
- Proctosigmoidoscopy, rigid with biopsy, with polypectomy/tumor excision
- Radical regional lymph node dissections
- Removal of ganglion (palm or wrist; flexor sheath)
- Repair of perforated viscus (gastric, small intestine, large intestine)
- Scalene node biopsy
- Selective vagotomy
- Sigmoidoscopy, fiberoptic with or without biopsy, with polypectomy
- Skin grafts (partial thickness, simple)
- Small bowel surgery for benign or malignant disease
- Splenectomy (trauma, staging, therapeutic)
- Surgery of the abdominal wall, including management of all forms of hernias, including diaphragmatic hernias, inguinal hernias, and orchiectomy in association with hernia repair
- Thoracentesis
- Thoracoabdominal exploration
- Tracheostomy
- Transhiatal esophagectomy
- Tube thoracotomy

TRAUMA / ACUTE CARE SURGERY CORE PRIVILEGES

CRITERIA: To be eligible for trauma care core privileges, the applicant must have:

- Successful completion of an ACGME-accredited residency in general surgery that included training in trauma and critical care. The approval of these privileges requires a recommendation for appointment by the Medical Director of Trauma Services.

AND

- Current board certification in surgery granted by the American Board of Surgery and/or Royal College of Surgeons or active candidate in the examination process.

AND

- Current ATLS

REQUIRED PREVIOUS EXPERIENCE: Demonstrated current competency and evidence of trauma care within the past 24 months. If the requirement is not met, the surgeon will be required to attend a trauma review course and pass proctoring in trauma before privileges for independent trauma care are granted.

MAINTENANCE OF PRIVILEGE: Demonstrated current competence and evidence of the performance as determined by the Medical Director of Trauma Services.

AND

- Documentation that confirms 16 Category I trauma-related CME hours per year averaged over a 3-year period. Documentation must include the CME topic, date, location, and number of CME hours awarded.

Please cross out any Core privileges you are not requesting at RUHS facilities.

Description of Core Privilege

☐ **Requested** **Adult Trauma Care Core Privileges** ☐ **Approved** ☐ **Not Approved**

Admit, evaluate, diagnose, and manage patients older than 15 years of age, except as specifically excluded from practice, presenting with trauma-related injuries and disorders, including resuscitation, surgical intervention, diagnostic studies, and coordination of operative procedures to be performed by other healthcare professionals, supervise and perform all necessary operative care, manage the trauma patient throughout the stay in the acute-care facility, and coordinate the early institution of rehabilitation and discharge planning.

The provider must have General Surgery Core Privileges

☐ **Requested** **Pediatric Trauma Care Core Privileges** ☐ **Approved** ☐ **Not Approved**

Admit, evaluate, diagnose, and manage pediatric patients 15 years of age and younger, except as specifically excluded from practice, presenting with trauma-related injuries and disorders, including resuscitation, surgical intervention, diagnostic studies, and coordination of operative procedures to be performed by other healthcare professionals, supervise and perform all necessary operative care, manage the trauma patient throughout the stay in the acute-care facility, and coordinate the early institution of rehabilitation and discharge planning.

☐ **Requested** **Trauma/Special Care** ☐ **Approved** ☐ **Not Approved**

Thoracotomy for Trauma

☐ **Requested** **Trauma Endovascular Procedures** ☐ **Approved** ☐ **Not Approved**

Reboa/Aortic Balloon Endovascular Privilege

VASCULAR SURGERY CORE PRIVILEGES

CRITERIA: To be eligible for **vascular surgery** core privileges, the applicant must have:

- Successful completion of an ACGME-accredited or AOA accredited vascular surgery fellowship.

AND

- Current board certification in vascular surgery granted by the American Board of Surgery and/or Royal College of Surgeons or active candidate in the examination process.

AND

- At least 50 vascular surgery procedures reflective of the scope of privileges requested within the past 12 months.

MAINTENANCE OF PRIVILEGE:

- Demonstrated current competence in the performance of 5 vascular surgeries in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Description of Core Privilege

❒ **Requested** **Vascular Surgery Core Privileges** ❒ **Approved** ❒ **Not Approved**

The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills. These core privileges do NOT include privileges for endovascular surgical procedures.

CORE PROCEDURES LIST: This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

Please cross out any Core privileges you are not requesting at RUHS facilities.

❒ **Requested** **Vascular Surgery Core Procedures** ❒ **Approved** ❒ **Not Approved**

CORE PROCEDURES

- Performance of history and physical exam
- Amputations of an upper or lower extremity
- Aneurysm repair, abdominal aorta and peripheral vessels emergent and elective
- Angioplasty
- Bypass grafting all vessels excluding coronary and intracranial vessels
- Central venous access catheters and ports
- Cervical, thoracic or lumbar sympathectomy
- Diagnostic biopsy or other diagnostic procedures on blood vessels
- Embolectomy or thrombectomy for all vessels excluding coronary and intra cranial vessels
- Endarterectomy for all vessels excluding coronary and intra cranial vessels
- Extra cranial carotid and vertebral artery surgery
- Hemodialysis access procedures
- Intraoperative angiography
- Nephrectomy for renovascular hypertension
- Other major open peripheral vascular arterial and venous reconstructions
- Reconstruction, resection, repair of major vessels with anastomosis or replacement (excluding cardiopulmonary, intracranial)
- Sclerotherapy
- Temporal artery biopsy
- Thoracic outlet decompression procedures including rib resection
- Vein ligation and stripping
- Venous reconstruction

Name:______________________________
(Last, First, Initial)
Effective: ______________________________
(From — To) (To be completed by MSO)

ENDOVASCULAR SURGERY CORE PRIVILEGES

CRITERIA: To be eligible for **endovascular surgery** core privileges, the applicant must have:

- Successful completion of an ACGME-accredited or AOA accredited vascular surgery fellowship.

AND

- Current board certification in vascular surgery granted by the American Board of Surgery and/or Royal College of Surgeons or active candidate in the examination process.

REQUIRED PREVIOUS EXPERIENCE:

- Provide documentation of education and experience in the conditions and procedures listed in the attached procedure list: 50 cases for diagnostic endovascular procedures, 25 cases for endovascular intervention, and 5 cases for endovascular graft.

MAINTENANCE OF PRIVILEGE:

- Demonstrated competence with evidence of a total of ~~at least five (5) endovascular intervention and~~ ten (10) endovascular diagnostic cases with at least 5 interventions during the past 24 months .

Description of Core Privilege

❒ **Requested** **Endovascular Surgery Core Privileges** ❒ **Approved** ❒ **Not Approved**
The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

CORE PROCEDURES LIST: This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

Please cross out any Core privileges you are not requesting at RUHS facilities.

❒ **Requested** **EndoVascular Surgery Core Procedures** ❒ **Approved** ❒ **Not Approved**

CORE PROCEDURES

- Balloon angioplasty
- Diagnostic angiography: excluding intra-cerebral and coronary procedures
- Embolization
- Endovascular graft
- Peripheral arterial and venous access
- Remote endarterectomy
- Stenting
- Thrombolysis
- Venous radio frequency ablation
- Vena cava filter insertion

Name:______________________________
(Last, First, Initial)

Effective: ______________________________

(From — To) (To be completed by MSO)

THORACIC SURGERY CORE PRIVILEGES

CRITERIA: To be eligible for **thoracic surgery** core privileges, the applicant must have:

- Successful completion of an ACGME-accredited or AOA accredited thoracic surgery fellowship during the last three years.

OR

- Additional thoracic surgery training that demonstrates proficiency in thoracic surgery to the satisfaction of the department chair and the majority of the members of the General Surgery Division.

AND

- Current board certification in surgery granted by the American Board of Surgery and/or Royal College of Surgeons or active candidate in the examination process.

REQUIRED PREVIOUS EXPERIENCE: Demonstrate current competency and evidence of performance of at least 20 thoracic cases in the past 12 months.

MAINTENANCE OF PRIVILEGE: Applicant must be able to show maintenance of competence with evidence of at least five (5) thoracic cases during the past 12 months.

Description of Core Privilege

❒ **Requested** **Thoracic Surgery Core Privileges** ❒ **Approved** ❒ **Not Approved**

The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

CORE PROCEDURES LIST: This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

Please cross out any Core privileges you are not requesting at RUHS facilities.

❒ **Requested** **Thoracic Surgery Core Procedures** ❒ **Approved** ❒ **Not Approved**

CORE PRIVILEGES

- Performance of history and physical exam
- Bronchoscopy: diagnostic, G.B. management, therapeutic procedures
- Cardiac Surgery: including pericardiocentesis, repair of major thoracic vessel or heart trauma
- Chest wall and pleural space surgery: including rib resection, management of chest wall trauma
- Esophagoscopy: diagnostic, F.B. removal, therapeutic procedures
- Esophageal surgery: including resection, repair or reconstruction. Hiatal hernia and associated esophageal procedures
- Neck and tracheal surgery: including tracheal repair with reconstruction, cervical node and scalene pad biopsy, mediastinoscopy, mediastinotomy and drainage, resection of mediastinal tumor or cyst
- Tracheobronchial tree and lung surgery: including pulmonary resection of any type
- Application of fixation devices to stabilize rib fractures and chest wall.

Name:____
(Last, First, Initial)

Effective: ____

(From — To) (To be completed by MSO)

QUALIFICATIONS FOR SPECIAL NON-CORE PRIVILEGES

- See Specific Criteria below:
- If desired, non-core privileges are requested individually in addition to requesting the core. Each individual requesting non-core privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and maintenance of clinical competence.

PARTICIPATE IN TEACHING PROGRAM

SUPERVISION: Supervision is an intervention provided by a supervising practitioner to a resident physician. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functions of the resident while monitoring the quality of professional services delivered. Supervision is exercised through observation, consultation, directing the learning of the residents, and role modeling.

CRITERIA: To be eligible to participate in the teaching program, the applicant must:

- Be credentialed and privileged at RUHS in accordance with applicable requirements.
- Provide care and supervision only for those clinical activities for which they are privileged.
- Be responsible for and must be personally involved in the care provided to individual patients in the inpatient and outpatient settings and must continue to maintain this personal involvement when residents are involved in the care of these patients.

MAINTENANCE OF PRIVILEGE:

- Enhance the knowledge of the residents and ensure the quality of care delivered to each patient by any resident. This is exercised by observation, consultation, and direction to the resident.
- Assure that medical care for each patient is delivered in an appropriate, timely, and effective manner.
- Participate in the resident's evaluation process according to accrediting and certifying body requirements.
- Direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised.
- Within 24 hours of a patient's admission or transfer (including weekends and holidays), shall personally examine the patient, establish a personal and identifiable relationship with the patient, and record an appropriate history, physical examination, working diagnostic impression(s) and plan for treatment. The attending shall countersign and add an addendum to the resident's note detailing his/her involvement and supervision.
- Ensure that discharge or transfer of the patient from an inpatient team or clinic is appropriate, based on the specific circumstances of the patient's diagnoses and therapeutic regimen.
- Meet with each patient who received consultation by a resident and perform a personal evaluation in a timely manner based on the patient's condition, unless otherwise stated in the graduated levels of responsibility.
- Shall be immediately available to the resident in person or by telephone and able to be present within a reasonable period of time, 30 minutes, if needed.
- Available for supervision during clinic hours and ensure the coordination of care that is provided to the patients.
- Provide an appropriate level of supervision during the performance of procedures. (Determination of this level of supervision is generally left to the discretion of the attending physician within the content of the previously described levels of responsibility assigned to the individual resident involved. This determination is a function of the experience and competence of the resident and the complexity of the specific case.)
- Documentation of resident supervision will be monitored during the course of peer review. Any case reviewed in which it appears that there is inadequate supervision will be forwarded to the Professional Practice Evaluation Committee.

Non-Core Privilege			
☐ **Requested**	**Participate in Teaching Program**	☐ **Approved**	☐ **Not Approved**

SUPERVISE ALLIED HEALTH PROFESSIONALS

SUPERVISION: The supervising employing/alternate supervising physician provides general supervision of the activities and services of the allied health professional. The supervising physician provides supervision and direction on any specific patient. The AHP is not allowed to perform any clinical activity/procedure that is not within the clinical privileges of the supervising physician. The supervising physician must be immediately available by electronic communication or on hospital premises for consultation/direction of the AHP.

CRITERIA: To be eligible to supervise allied health professionals, the applicant must:

- Be credentialed and privileged at RUHS in accordance with applicable requirements.
- Provide care and supervision only for those clinical activities for which they are privileged.
- Be responsible for and must be personally involved in the care provided to individual patients in the inpatient and outpatient settings and must continue to maintain this personal involvement when AHPs are involved in the care of these patients.
- Have a current Practice Agreement on file with Physician Assistants being supervised.

MAINTENANCE OF PRIVILEGE:

- Ensure the quality of care delivered to each patient by any allied health professional. This is exercised by observation, consultation, and direction to the AHP.
- Assure that medical care for each patient is delivered in an appropriate, timely, and effective manner.
- Participate in the AHP's competency assessment process according to accrediting and certifying body requirements.
- Direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the AHP being supervised.
- Assume responsibility for supervision or monitoring of the practice as stated in the appropriate hospital or medical staff policy governing AHPs.
- Be continuously available or provide an alternate to provide consultation when requested and to intervene when necessary.
- Assume total responsibility for the care of any patient when requested by the AHP or in the interest of patient care.
- Co-sign all orders entered by the AHP on the medical record of all patients seen or treated by the AHP in accordance with applicable requirements.

Description of Non-Core Privilege			
☐ **Requested**	**Supervision of Allied Health Professionals**	☐ **Approved**	☐ **Not Approved**

ADVANCED LAPAROSCOPIC SURGERY

CRITERIA: To be eligible for advanced **laparoscopic surgery** non-core privileges, the applicant must meet the following privileging criteria:

- Successful completion of an ACGME or AOA accredited laparoscopic surgery fellowship

OR

- Successful completion of an accredited residency in general surgery that included advanced laparoscopic training in the procedures to perform. AND additional training in advanced laparoscopic surgery to the satisfaction of the Chair of the Surgery Department.

For new advanced laparoscopic procedures, a formal course in the advanced laparoscopic procedure and preceptorship by a surgeon experienced in the procedure.

REQUIRED PREVIOUS EXPERIENCE: Demonstrate current competency and evidence of performance of at least 10 cases in the past 24 months.

MAINTENANCE OF PRIVILEGE: Applicant must be able to show maintenance of competence with evidence of at least 5 cases in the past 12 months.

Description of Non-Core Privilege -

❐ **Requested**	Laparoscopic Adrenalectomy	❐ **Approved**	❐ **Not Approved**
❐ **Requested**	Laparoscopic Splenectomy	❐ **Approved**	❐ **Not Approved**
❐ **Requested**	Laparoscopic Low Anterior Resection	❐ **Approved**	❐ **Not Approved**
❐ **Requested**	Laparoscopic Hernia Repair	❐ **Approved**	❐ **Not Approved**
❐ **Requested**	Laparoscopic Paraesophageal Hernia Repair	❐ **Approved**	❐ **Not Approved**
❐ **Requested**	Laparoscopic Fundoplication (Nissen/Dor/Toupet)	❐ **Approved**	❐ **Not Approved**

ADVANCED COLO-RECTAL SURGERY

CRITERIA: To be eligible for advanced **colo-rectal surgery** non-core privileges, the applicant must meet the following privileging criteria:

- Successful completion of an accredited ACGME or AOA colo-rectal surgery fellowship

OR

- Successful completion of an accredited residency in general surgery that included advanced colo-rectal training in the procedures to perform. AND additional training in advanced colo-rectal surgery to the satisfaction of the Chair of the Surgery Department.

REQUIRED PREVIOUS EXPERIENCE: Demonstrate current competency and evidence of performance of at least 6 cases in the past 24 months.

MAINTENANCE OF PRIVILEGE: Applicant must be able to show maintenance of competence with evidence of at least 6 cases in the past 24 months.

❐ **Requested**	Abdominoperineal Resection (laparoscopic/open)	❐ **Approved**	❐ **Not Approved**
❐ **Requested**	Low Anterior Resection (laparoscopic/open)	❐ **Approved**	❐ **Not Approved**
❐ **Requested**	Laparoscopic/Open Rectopexy for rectal prolapsed	❐ **Approved**	❐ **Not Approved**

Name:________________________________
(Last, First, Initial)
Effective: ________________________________
(From — To) (To be completed by MSO)

MODERATE SEDATION

CRITERIA: To be eligible for moderate sedation non-core privileges, the initial applicant must meet the following privileging criteria:

- Meet the qualification as required in the Privileging Criteria and Delineation for Moderate Sedation ~~and the Patient Care Services Policy~~
- Completion of Moderate Sedation Exam with satisfactory passing grade of 85%. ~~Take and pass a written moderate sedation exam. This can be done online www.rcrmc.org (link not working – will need to double check) click on Education Services for the moderate sedation site, which has the instructions, inservice video, and test.~~
- Current knowledge of airway management as demonstrated by residency/fellowship training, or current ACLS/PALS if not board certified or eligible

AND

- Successful completion of one (1) proctored moderate sedation case under the direct supervision of an RUHS practitioner holding this privilege.

REQUIRED PREVIOUS EXPERIENCE: Knowledge of airway management.

MAINTENANCE OF PRIVILEGE: Demonstrated current competence and evidence of the performance of at least two (2) ~~four (4)~~ moderate sedation cases in the past 24 months based on results of ongoing professional practice evaluation and outcomes or completion and satisfactory passing of Moderate Sedation Exam with passing grade of 85%.

Description of Non-Core Privilege			
☐ **Requested**	**Moderate Sedation** Administration of sedation and analgesia	☐ **Approved**	☐ **Not Approved**

PROCEDURES UNDER FLUOROSCOPY

Criteria: To be eligible for Fluoroscopy non-core privilege, the applicant must successfully complete an ACGME- or AOA-accredited residency training program in general surgery and possess a valid State of California fluoroscopy certificate.
Initial Privilege requirement: Current valid State of California fluoroscopy certificate.
Maintenance of Privilege: Must maintain current valid State of California fluoroscopy certificate.

Description of Privilege			
☐ **Requested**	**Fluoroscopy Use and Supervision**	☐ **Approved**	☐ **Not Approved**

TELEMEDICINE

CRITERIA: To be eligible to apply for core privileges in telemedicine, the applicant must

- Current license in State in which the hospital whose patients are receiving the telemedicine is located;
- Attests to competency in use of telemedicine equipment

MAINTENANCE OF PRIVILEGE:

- Internal review of the practitioner's performance as proof that competency is being maintained as part of an ongoing evaluation (OPPE). The evaluation is to be included in decision to renew privileges.

Description of Privilege			
☐ **Requested**	**Provide services remotely through telemedicine capabilities**	☐ **Approved**	☐ **Not Approved**

Name:______________________________
(Last, First, Initial)
Effective: ______________________________
(From — To) (To be completed by MSO)

SURGICAL ROBOTIC PLATFORM

CRITERIA: To be eligible for Surgical Robotic Platform privileges, the initial applicant must meet the following privilege criteria:

- Completed an ACGME approved residency program in General Surgery.
- Certification by the American Board of Surgery OR must be eligible to sit for that board OR demonstrated equivalent competency in General Surgery.
- Current active privileges to perform the underlying surgical procedure to be performed on the Robotic Surgical Platform or be eligible for privileges.

ROBOTIC PLATFORM TRAINING

In order to apply for robotic privileges, the physician must have completed at least one of the following three training experiences:

1. Teaching Proctor Experience:

   a. Evidence of training by attendance at a hands-on training practicum in the use of the Robotic Surgical Platform of at least eight (8) hours duration with experience in a laboratory setting, which includes a minimum of three (3) hours of personal time on the system during animate or cadaver models on console performing routine maneuvers such as knot tying.

   b. Successful completion of a minimum of five (5) cases is required under the supervision of and with the help of a teaching proctor. A proctor of the same specialty is required for the first two (2) cases but is not required for the remaining three cases.

   c. This teaching proctor may be a physician who is privileged to proctor robotic cases OR an outside physician with temporary privileges to proctor. This teaching proctor will be compensated for his/her services.

2. Fellowship or Residency Training Experience:

Previous practical experience via an accredited fellowship or residency program with documented clinical experience in a minimum of thirty (30) robotic-assisted procedures in that program. If less than thirty (30) robotic-assisted procedures done, follow the process in 1 b. above

OR

3. Robotic Privileges at another Hospital:

Previous full robotic surgery privileges at another hospital as documented by providing operative reports and discharge summaries for the last ten (10) ~~twenty (20)~~ consecutive robotic cases performed as the operating surgeon (cases performed as assistant surgeon do not count) for review.

MEDICAL STAFF PROCTORING REQUIREMENTS

Once provisional robotic privileges are granted, the applicant will need to be proctored on at least two (2) additional cases performed without the assistance of the proctor. The proctor will be present during the entire case and will observe the procedure.

This proctoring must be performed by a member of the Medical Staff who has full robotic privileges. In the event there is no such member appointed to the General Surgery specialty, an outside provider from an established vendor or affiliated institution may serve as the proctor at the discretion of the Medical Staff, with approval of the Department Chair. This provider will have met all proctoring standards including the required credentials and clinical knowledge and practice to provide performance oversight. Up to five (5) cases may be required in some circumstances, but after two to five (2–5) cases, full robotic privileges will be either approved, referred for additional training, or denied based on the proctoring reports and the determination of the appropriate service chief.

This proctor is provided without charge to the applicant in the usual manner for medical staff proctoring requirements. Refer to Department Rules and Regulations for the Requirements for a Teaching proctor at RUHS.

MAINTAINING ROBOTIC PRIVILEGES

The surgeon must have performed 20 cases, including eight (8) ~~and 10~~ within the last two (2) years, or they will either not be eligible to reapply for the privilege or they will be referred for additional proctoring.

The surgeon should participate actively in the ongoing performance improvement programs of the medical staff, hospital, and department.

Name:______________________________
(Last, First, Initial)
Effective: ______________________________

(From — To) (To be completed by MSO)

REQUIREMENTS FOR A TEACHING PROCTOR AT RIVERSIDE UNIVERSTIY HEALTH SYSTEMS

At least one of the following three levels of experience:

1. Full robotic privileges at another hospital as documented by providing operative reports and discharge summaries for the last twenty (20) consecutive robotic cases performed as the operative surgeon (cases performed as assistant surgeon do not count) for review. Service Chief to review cases.
2. Current Intuitive Surgical approved proctor.
3. Full robotic privileges granted by Medical Staff.

Description of Non-Core Privilege

❒ **Requested** **Surgical Robotic Platform** ❒ **Approved** ❒ **Not Approved**

THYROID/PARATHYROID CORE

CRITERIA: To be eligible to apply for core privileges in Thyroid/Parathyroid Core, the initial applicant must meet the membership requirements of Riverside University Health System and the following privileging criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited post-graduate training program in general surgery ~~during the last three (3) years~~.

AND

- Current board certification or active candidate in the examination process in surgery by the American Board of Surgery and/or Royal College of Surgeons or the American Osteopathic Board of Surgery and/or American College of Osteopathic Surgeons or the Royal College of Physicians and Surgeons of Canada.

REQUIRED PREVIOUS EXPERIENCE: An applicant for initial appointment must be able to demonstrate:

- Performance of at least 5 thyroid/parathyroid procedures during the past 12 months.

REAPPOINTMENT REQUIREMENTS: To be eligible to renew core privileges in general surgery, the applicant must meet the following maintenance of privilege criteria:

- Current demonstrated competence and an adequate volume of experience in thyroid/parathyroid procedures with acceptable results in the privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Description of Core Privilege

❒ **Requested** **Thyroid/Parathyroid Core** ❒ **Approved** ❒ **Not Approved**

CORE PROCEDURES LIST: This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

Please cross out any Core privileges you are not requesting at RUHS facilities.

❒ **Requested** **Thyroid/Parathyroid Core Procedures** ❒ **Approved** ❒ **Not Approved**

CORE PRIVILEGES

- Parathyroidectomy
- Thyroidectomy
- Neck Dissection
- Fine needle aspiration thyroid

Name:________________________________
(Last, First, Initial)
Effective: ________________________________
(From — To) (To be completed by MSO)

SURGICAL ASSIST ONLY

CRITERIA: To be eligible to apply for surgical assist privileges, the applicant must:

- Applicant must be a Physician licensed in the State of California and in good standing
- Applicant must meet the requirements of Medical Staff
- Applicant must provide evidence of 5 surgical cases within the past 12 months.

MAINTENANCE OF PRIVILEGE:

- Demonstrated current competence and evidence of 5 cases in the past 24 months based on ongoing professional practice evaluation and outcomes

Description of Surgical Assist Only

☐ **Requested** **Surgical Assist Only** ☐ Approved ☐ Not Approved

Name:____________________________________
(Last, First, Initial)
Effective: ____________________________________

(From — To) (To be completed by MSO)

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges which by education, training, current experience, and demonstrated performance that I am qualified to perform and wish to exercise at Riverside University Health System.

I understand that:

a. In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

______________________________ ________________________
Practitioner Signature **Date**

DEPARTMENT CHAIR / DESIGNEE RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation:

- ☐ Recommend all requested privileges.
- ☐ Recommend privileges with conditions/modifications as noted below.
- ☐ Do not recommend the requested privileges as noted below.

Privilege	Condition / Modification / Explanation

______________________________ ________________________
Medical Director of Trauma Services/Designee **Date**
(If applicable)

______________________________ ________________________
Department Chair/Designee Signature **Date**

MEC Approval: 6/12/08
Revised: 4/9/09; 6/10/10; 3/10/11, 1/31/12, 3/26/13, 6/12/14, 8/14/14, 9/11/14, 2/10/15, 8/11/16, 11/10/16, 8/10/17, 2/8/18, 7/12/18, 2/14/19, 8/8/19, 10/10/19

Mechanism that may be used to confirm competency of new applicants and/or privileges or to address potential competency issues referred from Ongoing Professional Practice Evaluation (OPPE).

Department Chair/Designee:

Please indicate below the privileges/procedures and the number of FPPE cases to be done on the above-named practitioner, including the method of FPPE.

Privileges/Procedures to be Proctored	Number of Cases to be Proctored*	Method of FPPE A. Concurrent B. Retrospective C. Reciprocal
General Surgery, Core	5 varied cases	A,B,C, as applicable
Trauma, Core	5 varied cases 2 Trauma Endovascular cases	A,B,C, as applicable
Vascular Surgery, Core	5 varied cases	A,B,C, as applicable
Endovascular Surgery Core	10 total cases with at least 5 Interventional	A,B,C, as applicable
Thoracic Surgery, Core	1 case	A,B,C, as applicable
Advanced Laparoscopic Surgery, Non-Core	5 total cases with at least 1 case in each category	A,B,C, as applicable
Advanced Colo-Rectal Surgery	2 cases	A,B,C, as applicable
Procedures under Fluoroscopy	1 case	A,B,C, as applicable
Surgical Robotic Platform	2 cases	A
Thyroid/Parathyroid Core	3 cases	A,B,C, as applicable
Moderate Sedation	1 case	A,B,C, as applicable

***Indicate N/A** if privilege not requested

RIVERSIDE UNIVERSITY HEALTH SYSTEM
26520 Cactus Avenue, Moreno Valley, CA 92555

NURSE PRACTITIONER (NP)
EMERGENCY MEDICINE CLINICAL PRIVILEGES

Name: ______________________________
(Last, First, Initial)

Effective: ______________________________
(From—To) (To be completed by MSO)

GENERAL RELATIONSHIP TO OTHERS

Nurse Practitioners have authority to direct any hospital personnel in the provision of clinical services to patients to the extent that such direction is necessary in order to carry out the services required by the patient and which the NP is authorized to provide.

PERIODIC COMPETENCE ASSESSMENT

Applicants must also be able to demonstrate they have maintained competence based on unbiased, objective results of care according to the hospital's existing quality assurance mechanisms and by showing evidence that they have met the continued competence requirements established by the state licensing authority, applicable to the functions for which they are seeking to provide at this hospital. In addition, continuing education related to the specialty area of practice is required as mandated by licensure.

NURSE PRACTITIONER (NP) CORE PRIVILEGES — EMERGENCY MEDICINE

(Includes Physician Assistant General Clinical Privileges)

☐ **Requested** Patients of all ages: Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. Privileges include but are not limited to:

- To provide informed consent for administration of blood products and procedures within the scope of their privileges that they will be performing independently. May not obtain informed consent for procedures that others will be performing.
- Abscess incision and drainage, including Bartholin's cyst
- Anoscopy
- Application of splints and plaster molds
- Arterial puncture and cannulation
- Arthrocentesis
- Bladder decompression and catheterization techniques
- Local burn management
- ~~Chemical restraint of agitated patient~~ Management of restraints
- Defibrillation
- Delivery of newborn, emergency
- Dislocation/fracture reduction/immobilization techniques, including splint and cast applications
- Electrocardiography interpretation
- GI decontamination (emesis, lavage, charcoal)
- Hernia reduction
- Immobilization techniques
- Irrigation and management of caustic exposures
- Laryngoscopy, direct, indirect
- Management of epistaxis
- Nail trephine techniques
- Nasal cautery/packing

RIVERSIDE UNIVERSITY HEALTH SYSTEM
26520 Cactus Avenue, Moreno Valley, CA 92555

PHYSICIAN ASSISTANT (PA)
EMERGENCY MEDICINE CLINICAL PRIVILEGES

Name: ______________________________
(Last, First, Initial)

Effective: ______________________________
(From—To) (To be completed by MSO)

PHYSICIAN ASSISTANT CLINICAL PRIVILEGES — EMERGENCY MEDICINE

(Includes Physician Assistant General Clinical Privileges)

☐ **Requested** Patients of all ages: Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. Privileges include but are not limited to:

- Abscess incision and drainage, including Bartholin's cyst
- Anoscopy
- Application of splints and plaster molds
- Arterial puncture and cannulation
- Arthrocentesis
- Bi-valve cast removal
- Local burn management
- ~~Chemical restraint of agitated patient~~ Management of restraints
- Delivery of newborn, emergency
- Dislocation/fracture reduction/immobilization techniques, including splint and cast applications
- G tube replacement
- Hernia reduction
- Immobilization techniques
- Injection of Bursa/Trigger point
- Irrigation and management of caustic exposures
- Laryngoscopy, direct, indirect
- Local and Digital anesthesia
- Management of epistaxis
- Nail trephination techniques
- Ocular tonometry
- Paracentesis
- Preliminary interpretation of imaging studies
- Rectal/vaginal foreign body removal
- Removal of foreign bodies, airway including nose, eye, ear, soft instrumentation/irrigation, skin or subcutaneous tissue
- Removal of IUD
- Repair of lacerations
- Rust ring removal with corneal burr
- Slit lamp used for ocular exam, removal of corneal foreign body

RIVERSIDE UNIVERSITY HEALTH SYSTEM

OPHTHALMOLOGY CLINICAL PRIVILEGES

Name:______________________________________
(Last, First, Initial)
Effective: ______________________________
(From—To) (To be completed by MSO)

☐ Initial Appointment
☐ Reappointment

Applicant: <u>CHECK (✓) the "Requested" box for each privilege you are qualified to request and **SIGN** and **DATE** this form as indicated</u>. Applicants may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by RUHS for a proper evaluation of current competence and other qualifications, and for resolving any doubts.

Privileges may only be exercised at the site(s) and/or setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document.

QUALIFICATIONS FOR CORE OPHTHALMOLOGY PRIVILEGES

OPHTHALMOLOGY CORE PRIVILEGES

<u>Criteria:</u> To be eligible to apply for core privileges in **ophthalmology**, the initial applicant must meet the membership requirements of Riverside University Health System and the following privileging criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited postgraduate training program in ophthalmology.

AND

- Current certification or active participation in the examination process leading to certification in ophthalmology by the American Board of Ophthalmology or the American Osteopathic Board of Ophthalmology and Otolaryngology, Head and Neck Surgery or the Royal College of Physicians and Surgeons of Canada.

<u>Required Previous Experience:</u> An applicant for initial appointment must be able to demonstrate:

- At least 20 ophthalmologic procedures in the privileges requested in the past 12 months.

OR

- Successful completion of a hospital-affiliated accredited residency, special clinical fellowship or research within the past 12 months.

<u>Reappointment Requirements</u>: To be eligible to renew core privileges in ophthalmology, the applicant must meet the following maintenance of privilege criteria:

- Current demonstrated competence and an adequate volume of experience of 20 ophthalmologic procedures with acceptable results in the privileges requested during the past 24 months based on results of ongoing professional practice evaluation and outcomes.

AND

- Meet the Continuing Medical Education (CME) requirement necessary for licensure by the applicable California medical board (the Medical Board of California or the Osteopathic Medical board of California).

AND

- Evidence of current ability to perform privileges requested is required of all applicants for renewal of clinical privileges.

Requested	Ophthalmology Core Privileges	Approved	Deferred
	Admit, evaluate, diagnose, treat, and provide consultation, order diagnostic studies and procedures and perform surgical and non-surgical procedures on patients of all ages, except as specifically excluded from practice, with ocular and visual disorders, the eyelid and orbit affecting the eye, including its related structures and visual pathways. Privileges include performance of medical history and physical exam. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. Provide care to patients in the intensive care setting in conformance with unit policies. Also includes the privilege to manage and treat outpatients in the ambulatory-care setting at RUHS.		

Name:____
(Last, First, Initial)

Effective: _______________________________________

(From—To) (To be completed by MSO)

	Supervision of Allied Health Professionals granted privileges by the medical staff		

CORE PROCEDURE LIST: This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

Requested	Ophthalmology Core Procedures	Approved	Deferred
	Lid surgery, including plastic procedures, chalazion, ptosis, ectropion, repair of laceration, blepharospam repair, tumors, flaps, enucleation, evisceration		
	Nasolacrimal duct surgery		
	Conjuctiva surgery, including diathermay, traumatic repair but excluding keratoplasty, keratotomy and refractive surgery		
	Intra and extracapsular cataract extraction with/without lens implant, or phacoemulsification		
	Corneal surgery, including diathermy, traumatic repair but excluding keratoplasty, keratotomy and refractive surgery		
	Anterior automated vitrectomy, limbal approach		
	Strabismus surgery		
	Neuro-ophthalmology		
	Primary trabeculectomy surgery (glaucoma)		
	Cryotherapy for retinal tears		
	Retinal detachment repair with intraocular gas tamponade		
	Orbit surgery including removal of the globe, exenteration blow outs, rim repairs, tumor removal		
	Refractive surgery		
	Glaucoma surgery with intraoperative/postoperative antimetabolite therapy		
	Glaucoma seton/tube surgery		
	Glaucoma reoperation		
	Retrobulbar or peribulbar injections for medical delivery or chemical denervation for pain control		
	Use of local anesthetics		

SPECIAL NON-CORE PRIVILEGES
QUALIFICATIONS

- See Specific Criteria
- If desired, non-core privileges are requested individually in addition to requesting the core. Each individual requesting non-core privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and maintenance of clinical competence.

NON CORE PRIVILEGES – PRIVILEGING CRITERIA

Criteria: To be eligible for non-core privileges listed below, the applicant must meet the following privileging criteria:

- Successful completion of an ACGME- or AOA- accredited residency program in ophthalmology.

AND

- Successful completion of an approved fellowship or clinical experience with proved acceptable results.

AND

- Current certification or active participation in the examination process leading to certification in ophthalmology by the American board of Ophthalmology or the American Osteopathic Board of Ophthalmology and Otolaryngology, Head and Neck Surgery.

Required Previous Experience:

- Current demonstrated competence and evidence of performance of at least one (1) procedure in the past 12 months.

Maintenance of Privileges:

- Current demonstrated competence and performance of at least one (1) procedure in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

AND

- Meet the Continuing Medical Education (CME) requirement necessary for licensure by the applicable California medical board (the Medical Board of California or the Osteopathic Medical board of California).

AND

- Evidence of current ability to perform privileges requested is required of all applicants for renewal of clinical privileges.

Requested	Oculoplastic/Orbital/Neuro-Ophthalmology Non-Core Procedures	Approved	Deferred
	Requires Successful completion of an approved Oculoplastic/Orbital/Neuro-ophthalmology fellowship or clinical experience with proved acceptable results.		
	Orbit surgery, including removal of the globe and contents of the orbit, exploration by lateral orbitotomy, exenteration, blowouts, rim repairs, tumor removal		

Name:______________________________________
(Last, First, Initial)

Effective: __________________________________
(From—To) (To be completed by MSO)

Requested	Corneal Non-Core Procedures	Approved	Deferred
	Requires Completion of Cornea fellowship or clinical experience with proven acceptable results.		
	Keratoplasty, lamellar or penetrating		
	Epikeratophakia		
	Ring Implants		
	Endofilial transplants		
	DALK (spell out)		

Requested	Surgical Vitreoretinal Non-Core Procedures	Approved	Deferred
	Requires Successful completion of a surgical Vitreoretinal Fellowship or clinical experience with proven acceptable results.		
	Posterior vitrectomy, including management of tractional retinal detachment, proliferative vitreoretinopathy, endolaser, intraocular gas tamponade, and membrane dissection.		
	Retinal detachment repair involving encircling bands, exoplants		

Requested	Pediatric Ophthalmology Non-Core Procedures	Approved	Deferred
	Requires Successful completion of a Pediatric Ophthalmology Fellowship or clinical experience with proven acceptable results.		
	Glaucoma surgery for infantile glaucoma including trabeculotomy and goniotomy		

Name:____________________________
(Last, First, Initial)

Effective: ____________________________

(From—To) (To be completed by MSO)

USE OF LASER

Use limited to approved applications for the specific laser indicated. List and check "yes" in the requested column for each specific type of laser for which privileges are requested. Laser use requires documentation of laser use training.

Requested	Laser Use – Type of Laser	Approved	Deferred
	Laser Peripheral Iridotomy		
	Intravitreal injection of medication		
	Laser Trabeculoplasty		
	Laser Pupilo/Gonioplasty		
	Laser Suture Lysis		
	Laser Cyclophotocoagulation		
	Laser Sclerostomy Lysis		
	Argon Laser Pan-retinal Photocoagulation		
	Argon Laser Macular Photocoagulation		
	YAG Capsulotomy		

PARTICIPATE IN TEACHING PROGRAM

Supervision: Supervision is an intervention provided by a supervising practitioner to a resident physician. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functions of the resident while monitoring the quality of professional services delivered. Supervision is exercised through observation, consultation, directing the learning of the residents, and role modeling.

Criteria: To be eligible to participate in the teaching program, the applicant must:

- Be credentialed and privileged at RUHS in accordance with applicable requirements.
- Provide care and supervision only for those clinical activities for which they are privileged.
- Be responsible for and must be personally involved in the care provided to individual patients in the inpatient and outpatient settings and must continue to maintain this personal involvement when residents are involved in the care of these patients.

Maintenance of Privilege:

- Enhance the knowledge of the residents and ensure the quality of care delivered to each patient by any resident. This is exercised by observation, consultation, and direction to the resident.
- Assure that medical care for each patient is delivered in an appropriate, timely, and effective manner.
- Participate in the resident's evaluation process according to accrediting and certifying body requirements.
- Direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised.
- Within 24 hours of a patient's admission or transfer (including weekends and holidays), shall personally examine the patient, establish a personal and identifiable relationship with the patient, and record an appropriate history, physical examination, working diagnostic impression(s) and plan for treatment. The attending shall countersign and add an addendum to the resident's note detailing his/her involvement and supervision.
- Ensure that discharge or transfer of the patient from an inpatient team or clinic is appropriate, based on the specific circumstances of the patient's diagnoses and therapeutic regimen.
- Meet with each patient who received consultation by a resident and perform a personal evaluation in a timely manner based on the patient's condition, unless otherwise stated in the graduated levels of responsibility.
- Shall be immediately available to the resident in person or by telephone and able to be present within a reasonable period of time, 30 minutes, if needed.
- Available for supervision during clinic hours and ensure the coordination of care that is provided to the patients.
- Provide an appropriate level of supervision during the performance of procedures. (Determination of this level of supervision is generally left to the discretion of the attending physician within the content of the previously described levels of responsibility assigned to the individual resident involved. This determination is a function of the experience and competence of the resident and the complexity of the specific case.)
- Documentation of resident supervision will be monitored during the course of peer review. Any case reviewed in which it appears that there is inadequate supervision will be forwarded to the Professional Practice Evaluation Committee.

Description of Non-Core Privilege

☐ **Requested** ☐ Deferred ☐ **Approved**

Participate in Teaching Program

Name:____________________________________
(Last, First, Initial)
Effective: ____________________________________
(From—To) (To be completed by MSO)

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges which by education, training, current experience, and demonstrated performance that I am qualified to perform and wish to exercise at Riverside University Health System.

I understand that:

a. In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

____________________________________ ____________________________________
Practitioner Signature **Date**

DEPARTMENT CHAIR / DESIGNEE RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation and make the follow recommendation:

- ☐ Recommend all requested privileges.
- ☐ Recommend privileges with conditions/modifications as noted below.
- ☐ Do not recommend the requested privileges as noted below.

Privilege	Condition / Modification / Explanation

____________________________________ ____________________________________
Department Chair/Designee Signature **Date**

MEC Approval: 6/12/08
Rev.: 8/24/09, 5/10/10

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

Mechanism that may be used to confirm competency of new applicants and/or privileges or to address potential competency issues referred from Ongoing Professional Practice Evaluation (OPPE).

Department Chair/Designee:

Indicate below the privileges/procedures and the number of FPPE cases to be done on the above-named practitioner, including the method of FPPE.

Please print legibly.

Privileges/Procedures to be Proctored	Number of Cases to be Proctored	Method of FPPE A. Direct Observation B. Retrospective C. Reciprocal
Ophthalmology Core Procedures	3 varied cases	A / B
Pediatric Ophthalmology Core Procedures	3 varied cases	A / B
Corneal Ring Implants, Non Core	2	A / B
Corneal Transplants (Penetrating Keratoplasty), Non Core	2	A / B
Phakic Intraocular Lens Implant Surgery, (ICL) Non Core	2	A / B
Complex Retina & Vitreous Surgery (Scleral Buckle or Vitrectomy), Non Core	2 varied cases (or 1 of each procedure)	A / B

RIVERSIDE UNIVERSITY HEALTH SYSTEM ~~COUNTY REGIONAL MEDICAL CENTER~~

PEDIATRIC MEDICAL GENETICS CLINICAL PRIVILEGES

Name:____ ☐ Initial Appointment
(Last, First, Initial) ☐ Reappointment

Effective: ____ Page 1
(From—To) (MSO Only)

Applicant: **<u>CHECK (✓) the "Requested" box for each privilege you are qualified to request and SIGN and DATE this form as indicated</u>**. Applicants may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by RUHS ~~RCRMC~~ for a proper evaluation of current competence and other qualifications, and for resolving any doubts.

Privileges may only be exercised at RUHS ~~the site(s) and/or setting(s) that have the~~ with appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document.

QUALIFICATIONS FOR CORE PEDIATRIC GENETICS PRIVILEGES

PEDIATRIC GENETICS CORE PRIVILEGES

<u>Initial Appointment Criteria</u>: To be eligible to apply for core privileges in Pediatric Genetics, the applicant must meet the membership requirements of Riverside University Health System ~~County Regional Medical Center~~ and the following privileging criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited postgraduate training in Medical Genetics ~~Pediatrics and additional postgraduate training in Clinical Genetics.~~

~~**AND**~~

- ~~Completion of an ACGME accredited Clinical Genetics postgraduate training program that includes training in Pediatric Genetics.~~

AND

- Current certification or active participation in the examination process leading to certification i~~n Medical Genetics~~ by the American Board of Medical Genetics in Clinical Genetics.

AND

- Must pursue ~~be in process of~~ paneling or be paneled by California Children's Services (CCS).

<u>Required Previous Experience:</u> An applicant for initial appointment must be able to demonstrate:

- Performance and documentation of inpatient, outpatient, or consultative services for at least 24 Pediatric Genetic cases, reflective of privileges requested, during the past 12 months.

OR

- Demonstrate successful completion of a hospital-affiliated accredited residency or special clinical fellowship in Medical Genetics ~~or research~~ within the past 12 months.

<u>Reappointment Requirements</u>: To be eligible to renew core privileges in Pediatric Genetics, the applicant must meet the following maintenance of privilege criteria:

- Current demonstrated competence and an adequate volume of experience, at least 12 Medical ~~Pediatric~~ Genetic inpatient, outpatient, or consultative services with acceptable results in the privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

AND

- Evidence of current ability to perform privileges requested is required of all applicants for renewal of clinical privileges.

AND

- CME Attestation confirming meets ~~Meet~~ the Continuing Medical Education (CME) requirement necessary for licensure by the applicable California medical board (the Medical Board of California or the Osteopathic Medical Board of California). ~~Submit copies of CME certificates.~~

PEDIATRIC GENETICS CLINICAL PRIVILEGES

Name: ______________________________

Effective: ______________________________
(From – To) (MSO Only)

Description of Core Privilege

☐ **Requested** **Genetics Core Privileges**

Admit, Evaluate, diagnose, treat, consult, and provide inpatient and outpatient care to patients between the ages of birth to 21 years, except as specifically excluded from practice, with genetic or possibly genetically linked diseases or disorders with common or uncommon diseases, congenital malformations, inborn errors of metabolism, hemoglobinopathies, chromosome abnormalities, neural tube defects, or heritable traits which may result in mental or physical disability.

Privileges include assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.

Privileges include but are not limited to:

- Perform medical history and physical examination
- Interact with other healthcare professional in the provision of services for patients with genetically influenced disorders
- Interpret clinical genetic and specialized laboratory testing information
- Provide patient and family counseling
- Screening for inborn errors of metabolism, hemoglobinopathies, chromosome abnormalities, neural tube defects, and other genetically influenced conditions

PEDIATRIC GENETICS CLINICAL PRIVILEGES

Name: ______________________________

Effective: ______________________________
(From – To) (MSO Only)

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges which by education, training, current experience, and demonstrated performance that I am qualified to perform and wish to exercise at Riverside County Regional Medical Center.

I understand that:

a. In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

______________________________ ______________________________

Practitioner Signature **Date**

DEPARTMENT CHAIR / DESIGNEE RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation and make the follow recommendation:

- ☐ Recommend all requested privileges.
- ☐ Recommend privileges with conditions/modifications as noted below.
- ☐ Do not recommend the requested privileges as noted below.

Privilege	Condition / Modification / Explanation

______________________________ ______________________________

Department Chair/Designee Signature **Date**

MEC Approval: 3/11/10
Rev.: 05/13/10

Name: ______________________________

Effective: ______________________________
(From – To) (MSO Only)

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

Mechanism that may be used to confirm competency of new applicants and/or privileges or to address potential competency issues referred from Ongoing Professional Practice Evaluation (OPPE).

Department Chair/Designee:

Indicate below the privileges/procedures and the number of FPPE cases to be done on the above-named practitioner, including the method of FPPE.

Please print legibly.

Privileges/Procedures to be Proctored	Number of Cases to be Proctored*	Method of FPPE A. Concurrent B. Retrospective C. Reciprocal
Pediatric Medical Genetic Core Privileges	Five (5) Varied Cases	

***Indicate N/A if privilege not requested.**

Riverside University Health System Medical Center
MEDICAL STAFF ORGANIZATION

Subject:	Issued: 12/10/20	Page 1 of 4
MEDICAL STAFF WELL BEING COMMITTEE POLICY	Revised: Cred. Cmte MEC 12/10/20 Revised 12/10/20 Effective Date: 6/11/20	Medical Staff
Department Consulted: Medical Staff Administration	Reviewed & Approved by: Medical Executive Committee	

DEFINITIONS

In this policy, the term "Licensed Independent Practitioner" (LIP) refers to independently licensed Medical Staff members and Allied Health Professionals who have privileges to provide care at the Medical Center.

"Resident Physician" refers to an intern, resident, or fellow physician who is undergoing training at an approved Graduate Medical Education (GME) program at the Medical Center and affiliated sites.

An "impairment" is the inability to provide medical care with reasonable skill and safety as a result of a mental disorder, physical illness or condition, and/or substance-related disorders including abuse and dependency of drugs and alcohol. This definition is in accordance with the definition provided by the American Medical Association in 1973 and the Federation of State Medical Boards (FSMB).

"Disruptive Behavior" refers to a style of interaction with others and/or a pattern of behavior that significantly interferes with patient care.

INTRODUCTION

It is the policy of the Riverside University Health System (RUHS) Medical Center to identify and assist with matters of individual health, for LIP and Resident Physicians. When a LIP or Resident Physician is suspected of impairment or disruptive behavior, a confidential process will occur through the Medical Staff Well-Being Committee (MSWBC, formerly known as "Physician Well-Being Committee"), a peer review committee, after either a self- referral or a third-party referral has been made. The MSWBC will undertake an initial intake, determine the need for a more formal evaluation, and, if indicated, assist with an appropriate referral. Recommendations of the MSWBC may be taken into consideration when the Medical Executive Committee considers a privileging decision on an impaired individual, but the activities of this committee are not part of any disciplinary process. All efforts will be made to return the LIP or resident physician to safe practice.

PURPOSE AND OBJECTIVES

The **purpose** of the MSWBC is:

- To facilitate rehabilitation by aiding a LIP or Resident Physician in retaining and/or regaining optimal professional functioning, consistent with the protection of patients.
- To offer assistance to the LIP or Resident Physician by creating an environment and consultation mechanism that is conducive to self-referral and rehabilitation when there is a suspicion of impairment.
- To protect patient welfare through various procedures and safeguards, that may include regular monitoring, and, when indicated, informing the RUHS Medical Center's organized medical leadership of the need for further action.

The **objectives** of the MSWBC are:

- Educating the members of the Medical Center to recognize impairment specific to LIP and Resident Physicians and disruptive behavior as defined above and the role of this MSWBC is addressing both impairment and disruptive behavior.
- Enhancing the safety of RUHS Medical Center patients, medical staff, trainees and non-medical staff employees and volunteers.
- Providing oversight, and assistance for a potentially impaired LIP or Resident Physician by:
    1. Allowing for self-referral and third-party referral to the Medical Staff Well-Being Committee.
    2. Evaluation of the credibility of a complaint, concern, or allegation of impairment.
    3. Maintaining all deliberations and records regarding the LIP or Resident Physician seeking referral or referred for assistance and those providing information to the MSWBC, as confidentially as possible except as limited by applicable law, ethical obligation or when the health and safety of a patient is threatened.
    4. Referring the impaired LIP or Resident Physician to an appropriate professional internal or external resource for evaluation, diagnosis and treatment of the condition or concern under the guidance of the Medical Staff Well-Being Committee. Approving the appropriateness of resources located by the LIP or Resident Physician.
    5. Monitoring the licensed LIP or Resident Physician and the safety of patients until the rehabilitation is complete and periodically thereafter, if required according to an agreement established between the LIP or Resident Physician and the Medical Staff Well-Being Committee.
    6. Evaluating and reporting to the appropriate leadership instances in which a LIP or Resident is reasonably suspected to have provided or be at risk of providing unsafe patient care (according to the current Medical Staff RUHS Bylaws and/or GME Impaired Resident Policy).

PROCEDURE

I. Self-Reporting

A LIP or Resident Physician is encouraged to refer themselves to the Medical Staff Well-Being Committee for assistance. They can either call or e-mail the Chair (or designee) of the Medical Staff Well-Being Committee or the Medical Staff Administration Office (who will then contact the MSWB).

II. Third-Party Referral

If any observer suspects that a LIP or a Resident Physician may be impaired, they can refer in two different ways:

1) Complete an anonymous *Report of Observed Behavior Form* and submit it to either the Medical Staff Administration Office (who will then contact the MSWB) and/or the Chair of the Medical Staff Well-Being Committee.
2) Call or e-mail either the Chair (or designee) of the Medical Staff Well-Being Committee or the Medical Staff Administration Office (who will then contact the MSWB).
3) Whether or not made anonymously, all referrals to the MSWBP will be maintained confidentially including the identity of those making referrals.

If a LIP or Resident Physician's conduct appears to pose an imminent threat to the safety of self and/or others, the House Supervisor shall be informed immediately and assess the situation. If the House Supervisor suspects that there is an imminent threat to the safety of self and/or others, they shall relieve the LIP or Resident Physician of duty immediately, follow procedures as indicated by current RUHS Medical Center policy guidelines (Medical Staff Bylaws and GME policy), and inform the designated medical leadership (Chief Medical Officer, Chief of Medical Staff, Chair of Department, Program Director, and/or Director of GME). For further details regarding the necessary procedures for impaired LIPs, please refer to the RUHS Medical Center's Medical Staff Bylaws. For further details regarding the necessary procedures for impaired Resident Physicians, please refer to the RUHS Graduate Medical Education Policy for Impaired Residents (2019).

III. Post-Referral

A. The Chair of the Medical Staff Well-Being Committee or designee will meet privately with the LIP or Resident Physician who is suspected of impairment, and will make a determination regarding the concern.

B. Upon completion of the preliminary evaluation, the Chair of the Medical Staff Well-Being Committee or designee will make one of the following recommendations:
1) No action required.
2) Formally enroll the LIP and/or the Resident Physician in a monitoring agreement (in accordance with the RUHS Medical Staff Bylaws and/or the RUHS Graduate Medical Education Policy).

3) Recommend further action and/or investigation by the Medical Staff Credentials committee or MEC

Please note that if an imminent threat to the safety of self and/or others is suspected, the MSWBC will refer to the appropriate leadership as indicated in the RUHS Medical Staff Bylaws and/or the RUHS Graduate Medical Education Policy for Impaired Residents (2019).

For further information regarding Corrective Action (if indicated), please refer to Article VIII of the RUHS Medical Center's Medical Staff Bylaws.

IV. Confidentiality of Committee Records

The Medical Staff Well-Being Committee shall keep such records of its proceedings as it deems advisable. Records regarding individual LIP or Resident Physicians shall be kept strictly confidential and maintained independently from the general records of the committee.

V. Billing

Medical costs related to the evaluation of the LIP or Resident Physician, including but not limited to referrals for Assessment and/or Treatment are the responsibility of the LIP or Resident Physician.

References:

- Joint Commission MS 11.01.01
- California Code of Regulations, Title 22 Section 70703(d)
- California Civil Code Section 43

RIVERSIDE UNIVERSITY HEALTH SYSTEM

MEDICAL STAFF WELL-BEING COMMITTEE MONITORING AGREEMENT

It is the policy of the Riverside University Health System (RUHS) Medical Center to identify and assist with matters pertaining to the individual health of Licensed Independent Practitioners (LIP) and Resident Physicians. The RUHS Medical Staff Well-Being Committee (MSWBC) is dedicated to providing a supportive program that is designed to protect patient welfare and facilitate rehabilitation by aiding a LIP or Resident Physician in retaining and/or regaining optimal professional functioning, consistent with the protection of patients. Support is provided through various procedures and safeguards, including regular monitoring. The success of this program is contingent on the Medical Staff member's commitment to following the MSWBC's recommendations.

The following serves to define the terms and conditions of the monitoring agreement between ______________________________ and the RUHS MSWBC.

1. **Treating Provider**: Under the guidance of the MSWBC, The LIP or Resident Physician shall arrange treatment with a provider who has expertise in the evaluation, diagnosis and treatment of __________________ .
2. **Authorization to Release Medical Information**: The LIP or Resident Physician shall complete the attached "Authorization to Release Medical Information". The LIP or Resident Physician acknowledges and agrees that their treating provider may communicate directly with the MSWBC Committee Chair about the LIP's or Resident Physician's treatment and progress.
3. **Self-Prescribing**: The LIP or Resident Physician shall not self-prescribe any medications while under this monitoring agreement.
4. **Toxicology Testing**: The LIP or Resident Physician shall undergo toxicology testing as recommended by the treating provider and/or the MSWBC.
5. **Non-Adherence**: In the case of non-adherence to treatment recommendations and the terms of this monitoring agreement, the treating provider shall inform the MSWBC, who may report it to the designated medical leadership (Chief Medical Officer, Chief of Medical Staff, Chair of Department, Program Director, and/or Director of GME).
6. **Duration of Monitoring Agreement**: LIP or Resident Physician's participation in the monitoring program shall begin on _______ and end on _______, assuming satisfactory progress and absence of relapse. This agreement shall be reviewed periodically by the MSWBC, with the right to make modifications as needed.
7. **Cost of Monitoring**: Medical costs related to the evaluation of the LIP or Resident Physician, including but not limited to referrals for Assessment and/or Treatment, are the responsibility of the LIP or Resident Physician.

8. **Confidentiality**: The Medical Staff Well-Being Committee shall keep such records relating to this Agreement as it deems advisable. Records regarding individual LIP or Resident Physicians shall be kept strictly confidential and maintained independently from the general records of the committee in a locked file that can only be accessed by the Chair or designee.

By signing below, I have read and understood the above information and agree to comply with its terms.

____________________________________ Date: ______________

Signature of LIP/Resident Physician

Printed Name: ________________________

By signing below, I have read and understood the above information.

____________________________________ Date: _______________

Signature of Treating Provider

Printed Name: ____________________

By signing below, I have read and approved this Agreement.

____________________________________ Date: _______________

Signature of Committee Chair or Designee

Printed Name: ____________________

RUHS – MEDICAL STAFF
SUMMARY OF PROPOSED REVISIONS
TO MEDICAL STAFF BYLAWS, RULES AND REGULATIONS
MEC: SEPTEMBER 9, 2021

***Bylaw Changes** (In the order they present in the document):*

- "Consulting Physician" definition deleted, because it is not used elsewhere in the Bylaws
- 3.2-3 Reworded
- 3-5 Deleted (*See* "Administrative Staff" Category)
- 3-5 (g) – clarification of H&P requirement
- 3-5 (r) – made consistent with 6.4-9
- 3.11-3 – Deleted (duplicated 15.1-1)
- 4.1 – Deleted "Consulting" category; added Telehealth staff category
- 6.2-1 (k) - deleted
- 6.3-11 – Replaced with language from CMA Model
- 6.4-8 – Changed to match 6.4-1
- 6.4-9 – Changed to match 3.6
- 7.4-1 – clarified as "calendar days"
- 7.5 – "Disaster" added to header to reflect the content
- 8.1-2 – Clarification re: FPPE
- New 8.1-3 – External Peer Review language from CMA model (replacing language in 8.1-4)
- Old 8.1-3 – removing "Initiation" section
- 10.2 – Clarification as to current departments and divisions
- 11.1-3 – Change to nominations process – removing report to MEC
- 12.1 – Addition based on Title 22
- 13.5 – Added provisions for audio and video conferences
- 15.1-1 and 15.7 – Copies of documents stored on Intranet
- 15.2 – Clarified review process for Committees and Functions Manual
- 15.3 and 15.4 – Removed descriptions of manuals
- 15.11 – Notices sent by email

Moved from one place to another:

- 15.6 moved to below "Preamble"
- 6.2 moved to 3.2-1(b)
- 3.7 through 3.93 moved to Article VI

Rules and Regulations – Numerous edits to reflect changes in practices and laws.

MEDICAL STAFF BYLAWS

AND

Rules and Regulations

2021-2022

Revised September 2021

RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER
MEDICAL STAFF BYLAWS, RULES AND REGULATIONS
202117– 2022018

TABLE OF CONTENTS

PREAMBLE 1

DEFINITIONS 1

ARTICLE I. NAME 5

ARTICLE II. PURPOSES 5

ARTICLE III. MEMBERSHIP 5

3.1 NATURE OF MEMBERSHIP 5

3.2 QUALIFICATIONS FOR MEMBERSHIP 5
3.2-1 General Qualifications 5
3.2-2 Particular Qualifications 6
3.2-3 Professional Liability Insurance 6

3.3 EFFECT OF OTHER AFFILIATIONS 7

3.4 NONDISCRIMINATION 7

3.5 MEDICO-ADMINISTRATIVE OFFICERS 7

3.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP 7

3.7 DURATION OF APPOINTMENT 9

3.8 PROCTORING REQUIREMENTS 9
3.8-1 For Initial Appointment 9
3.8-2 For Modification of Membership Status or Privileges 10
3.8-3 Term of Proctoring Period 10
3.8-4 Reciprocal Proctoring 10

3.9 **LEAVE OF ABSENCE** 10
3.9-1 Leave Status 10
3.9-2 Reasons for Granting Leave 11
3.9-3 Termination of Leave 11

3.10 **HARASSMENT PROHIBITED** 11

3.11 **STANDARDS OF CONDUCT** 12
3.11.1 General 12
3.11.2 Conduct Guidelines 12
3.11.3 Adoption Rules 13

3.12 **ORGANIZED HEALTH CARE ARRANGEMENT (OHCA)** 13

ARTICLE IV. CATEGORIES OF MEMBERSHIP 13

4.1 **CATEGORIES** 13

4.2 **ACTIVE STAFF** 13
4.2-1 Qualifications 13
4.2-2 Prerogatives 13
4.2-3 Responsibilities 14

4.3 **PROVISIONAL STAFF** 14
4.3-1 Qualifications 14
4.3-2 Prerogatives 14
4.3-3 Responsibilities 15
4.3-4 Observation of Provisional Staff Member 15
4.3-5 Action at Conclusion of Provisional Staff Status 15

4.4 **COURTESY STAFF** 15
4.4-1 Qualifications 15
4.4-2 Prerogatives 16
4.4-3 Responsibilities 16

4.5 **CONSULTING STAFF** 16
4.5-1 Qualifications 16
4.5-2 Prerogatives 16
4.5-3 Responsibilities 16

4.6 **HONORARY STAFF** 17
4.6-1 Qualifications 17
4.6-2 Prerogatives 17

	4.6-3	Responsibilities	17
4.7	**ADJUNCT STAFF**		17
	4.7-1	Qualifications	17
	4.7-2	Prerogatives	17
	4.7-3	Responsibilities	17
4.8	**PER DIEM RESIDENT/MOONLIGHTING**		18
	4.8-1	Qualifications	18
	4.8-2	Prerogatives	18
4.9	**ADMINISTRATIVE**		18
	4.9-1	Limitation of Prerogatives	19
	4.9-2	Right to Hold Office	19
	4.9-3	Responsibilities	19
	4.9-4	Care of Patients	19
	4.9-5	Telehealth	19
	4.9-6	Category	19
	4.9-7	Qualifications of Telehealth Providers	19
	4.9-8	Prerogatives	20
	4.9-9	Responsibilities	20
	ARTICLE V. ALLIED HEALTH PROFESSIONALS		20
5.1	**QUALIFICATIONS**		20
5.2	**DELINEATION OF CATEGORIES OF AHPs ELIGIBLE TO APPLY FOR PRACTICE PRIVILEGES**		20
5.3	**PROCEDURE FOR GRANTING PRACTICE PRIVILEGES**		21
5.4	**PREROGATIVES**		21
5.5	**RESPONSIBILITIES**		21
5.6	**REAPPLICATION**		21
	ARTICLE VI. PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT (Including Telemedicine Services)		22
6.1	**GENERAL PROCEDURE**		22
6.2	**APPLICATION FOR APPOINTMENT**		22

	6.2-1	Content	22
	6.2-2	Effects of Application	23
	6.2-3	Physical and Mental Capabilities	24
6.3	**PROCESSING THE APPLICATION**		25
	6.3-1	Applicant's Burden	25
	6.3-2	Verification of Information	25
	6.3-3	Department and Credentials Committee Action	26
	6.3-4	Medical Executive Committee Action	26
	6.3-5	Appointment Reports	26
	6.3-6	Basis for Appointment	26
	6.3-7	Effect of Medical Executive Committee Action	27
	6.3-8	Action by the Governing Board	27
	6.3-9	Notice of Final Decision	28
	6.3-10	Reapplication After Adverse Decision Denying Application, Adverse Corrective Action Decision, or Resignation in Lieu of Medical Disciplinary Action	28
	6.3-11	Time Period for Processing	29
	6.3-12	Expedited Review	30
6.4	**REAPPOINTMENTS**		30
	6.4-1	Application for Reappointment; Schedule for Review	30
	6.4-2	Verification of Information	30
	6.4-3	Department Action	31
	6.4-4	Credentials Committee Action	31
	6.4-5	Medical Executive Committee Action	31
	6.4-6	Reappointment Reports	31
	6.4-7	Basis for Reappointment	32
	6.4-8	Failure to File Reappointment Form	32
	6.4-9	Between Routine Reappointment Dates	32
	ARTICLE VII. CLINICAL PRIVILEGES		33
7.1	**EXERCISE OF PRIVILEGES**		33
7.2	**DELINEATION OF PRIVILEGES IN GENERAL**		33
	7.2-1	Requests	33
	7.2-2	Basis for Privileges Determination	33
	7.2-3	Procedure	34
7.3	**SPECIAL CONDITIONS APPLICABLE TO DENTAL AND PODIATRIC PRIVILEGES**		34
7.4	**TEMPORARY PRIVILEGES**		34

7.4-1 Pending Application ... 34
7.4-2 Specific Patient Care ... 34
7.4-3 Conditions ... 35

7.5 EMERGENCY PRIVILEGES ... 35

ARTICLE VIII. CORRECTIVE ACTION ... 35

8.1 ROUTINE CORRECTIVE ACTION ... 35
8.1-1 Focused Professional Practice Review ... 36
8.1-2 Criteria for Initiation ... 36
8.1-3 Initiation ... 36
8.1-4 Investigation ... 36
8.1-5 Medical Executive Committee Action ... 37
8.1-6 Deferral ... 38
8.1-7 Procedural Rights ... 38
8.1-8 Other Action ... 38

8.2 SUMMARY RESTRICTION OR SUSPENSION ... 39
8.2-1 Criteria for Initiation ... 39
8.2-2 Written Notice of Summary Suspension ... 39
8.2-3 Medical Executive Committee Action ... 40
8.2-4 Procedural Rights ... 40
8.2-5 Initiation by the Governing Board ... 41

8.3 AUTOMATIC AND IMMEDIATE SUSPENSION OR LIMITATION ... 41
8.3-1 Licensure ... 41
8.3-2 Controlled Substances ... 41
8.3-3 Failure to Satisfy Special Appearance Requirement ... 42
8.3-4 Medical Records ... 42
8.3-5 Failure to Pay Dues/Assessments ... 42
8.3-6 Executive Committee Deliberation ... 42
8.3-7 Professional Liability Insurance ... 42

ARTICLE IX. HEARINGS AND APPELLATE REVIEWS ... 43

9.1 GENERAL PROVISIONS ... 42
9.1-1 Exhaustion of Remedies ... 42
9.1-2 Application of Article ... 42
9.1-3 Timely Completion of Process ... 42
9.1-4 Final Action ... 43

9.2 GROUNDS FOR HEARING ... 43

9.3	**REQUESTS FOR A HEARING**		43
	9.3-1	Notice of Action or Proposed Action	43
	9.3-2	Request for Hearing	44
	9.3-3	Time and Place for Hearing	44
	9.3-4	Notice of Hearing	44
	9.3-5	Judicial Review Committee	45
	9.3-6	Failure to Appear or Proceed	45
	9.3-7	Postponements and Extensions	45
9.4	**HEARING PROCEDURES**		45
	9.4-1	Prehearing Procedure	45
	9.4-2	Representation	46
	9.4-3	The Hearing Officer	47
	9.4-4	Record of the Hearing	47
	9.4-5	Rights of the Parties	47
	9.4-6	Miscellaneous Rules	47
	9.4-7	Burdens of Representing Evidence and Proof	48
	9.4-8	Adjournment and Conclusion	48
	9.4-9	Basis for Decision	48
	9.4-10	Decision of the Judicial Review Committee	48
9.5	**APPEAL**		49
	9.5-1	Time for Appeal	49
	9.5-2	Grounds for Appeal	49
	9.5-3	Time, Place and Notice	49
	9.5-4	Appeal Board	49
	9.5-5	Appeal Procedure	50
	9.5-6	Decision	50
	9.5-7	Right to One Hearing	50
9.6	**EXCEPTIONS TO HEARING RIGHTS**		51
	9.6-1	Medico-Administrative Officer	51
	9.6-2	Fair Hearing and Appeals for Allied Health Professionals	51
	9.6.3	Automatic Suspension or Limitation of Practice Privileges	52
	9.6.4	Department/Division Formation or Elimination	52
9.7	**NATIONAL PRACTITIONER DATA BANK REPORTING**		52
	9.7-1	Adverse Actions	52
	9.7-2	Dispute Process	52

ARTICLE X. CLINICAL DEPARTMENTS AND DIVISIONS 53

10.1 **ORGANIZATION OF DEPARTMENTS AND DIVISIONS** 53

10.2 **DESIGNATION** 53

10.3 **ASSIGNMENT TO DEPARTMENTS AND DIVISIONS** 53

10.4 **FUNCTIONS OF DEPARTMENTS** 54

10.5 **FUNCTIONS OF DIVISIONS/SUBDIVISIONS** 55

10.6 **MODIFICATIONS IN CLINICAL ORGANIZATION UNIT** 55

ARTICLE XI. OFFICERS 56

11.1 **GENERAL OFFICERS OF THE MEDICAL STAFF** 56
- 11.1-1 Identification 56
- 11.1-2 Qualifications 56
- 11.1-3 Nominations 56
- 11.1-4 Election 56
- 11.1-5 Chief of Medical Staff and Immediate Past Chief of Medical Staff Provisions 56
- 11.1-6 Term of Elected Officers 57
- 11.1-7 Removal of Elected Officers 57
- 11.1-8 Vacancies in Elected Office 57

11.2 **DUTIES OF GENERAL OFFICERS** 57
- 11.2-1 Medical Director 57
- 11.2-2 Chief of Medical Staff 58
- 11.2-3 Chief of Medical Staff-Elect 59
- 11.2-4 Immediate Past Chief of Medical Staff 59
- 11.2-5 Secretary-Treasurer 59

11.3 **DEPARTMENT CHAIR** 60
- 11.3-1 Qualifications 60
- 11.3-2 Selection 60
- 11.3-3 Term of Office 60
- 11.3-4 Duties 60

11.4 **DEPARTMENT VICE CHAIR** 61
- 11.4-1 Qualifications 61
- 11.4-2 Selection 62
- 11.4-3 Term of Office 62
- 11.4-4 Removal 62

	11.4-5	Duties	62
11.5	**DIVISION/SUBDIVISION CHAIR**		63
	11.5-1	Qualifications	63
	11.5-2	Selection	63
	11.5-3	Term of Office	63
	11.5-4	Duties	63
	ARTICLE XII. COMMITTEES		64
12.1	**GENERAL**		64
	12.1-1	Ad Hoc Committees	64
	12.1-2	Terms and Removal of Committee Chairs	64
	12.1-3	Terms and Removal of Committee Members	65
	12.1-4	Vacancies	65
	12.1-5	Conduct and Records of Meetings	65
12.2	**MEDICAL EXECUTIVE COMMITTEE**		65
	12.2-1	Composition	65
	12.2-2	Officers	65
	12.2-3	Duties	65
	12.2-4	Meetings	65
	ARTICLE XIII. MEETINGS		67
13.1	**MEETINGS**		67
	13.1-1	Annual Meeting	67
	13.1-2	Agenda	67
	13.1-3	Special Meetings	68
13.2	**COMMITTEE AND DEPARTMENT MEETINGS**		68
	13.2-1	Regular Meetings	68
	13.2-2	Special Meetings	68
13.3	**NOTICE OF MEETINGS**		68
13.4	**QUORUM**		68
	13.4-1	Department and Committee Meetings	68
	13.4-2	Annual Staff Meeting	69
13.5	**MANNER OF ACTION**		69
13.6	**MINUTES**		69

13.7 ATTENDANCE REQUIREMENT ... 69
13.7-1 Regular Attendance ... 69
13.7-2 Absence from Meetings ... 70
13.7-3 Special Appearance ... 70

13.8 **CONDUCT OF MEETINGS** ... 70

ARTICLE XIV. CONFIDENTIALITY, IMMUNITY AND RELEASES ... 70

14.1 **AUTHORIZATION AND CONDITIONS** ... 70

14.2 CONFIDENTIALITY OF INFORMATION ... 71
14.2-1 General ... 71
14.2-2 Breach of Confidentiality ... 71
14.2-3 Confidentiality Agreement ... 71

14.3 **IMMUNITY FROM LIABILITY** ... 72
14.3-1 For Action Taken ... 72
14.3-2 For Providing Information ... 72

14.4 ACTIVITIES AND INFORMATION COVERED ... 72
14.4-1 Activities ... 72

14.5 **RELEASES** ... 73

ARTICLE XV. GENERAL PROVISIONS ... 73

15.1 BYLAWS, RULES AND REGULATIONS, POLICIES AND GOVERNING BOARD BYLAWS ... 73
15.1-1 Medical Staff Rules and Regulations ... 73
15.1-2 Departmental Rules and Regulations ... 73

15.2 MEDICAL STAFF COMMITTEES AND FUNCTIONS MANUAL ... 73

15.3 **CREDENTIALING POLICIES AND PROCEDURES MANUAL** ... 74

15.4 **MEDICAL STAFF POLICIES AND PROCEDURES MANUAL** ... 74

15.5 **FEES/DUES** ... 74

15.6 ~~CONSTRUCTION OF TERMS AND HEADINGS ... 74~~

15.7 **AUTHORITY TO ACT** ... 75

15.8 **ACCEPTANCE OF PRINCIPLES** 75

15.9 **DIVISION OF FEES** 75

15.10 **MEDICAL STAFF REPRESENTATION BY LEGAL COUNSEL** 75

15.11 **NOTICES** 75

15.12 **SECRET WRITTEN BALLOT** 76

ARTICLE XVI. ADOPTION AND AMENDMENT OF BYLAWS 76

16.1 **ADOPTION AND AMENDMENT** 76

16.2 **TECHNICAL AND EDITORIAL AMENDMENTS** 76

RULES AND REGULATIONS

Number

1.	Assignment of Patients	67
2.	Attending Staff Notes	67
3.	Attending Staff Private Patient Charges	67
4.	Autopsies	67
5.	Clinic Patients	67
6.	Consent Form	68
7.	Consultation Criteria	68
8.	Drugs	68
9.	Graduate Education Programs	68
10.	Medical History and Physical for Inpatient and Outpatient Services	68
11.	Media Release	69
12.	Medical Record	69
13.	Medical Records Property of the Hospital	69
14.	Medical Screening Examination	69
15.	Medical Staff Requirement	69
16.	Notification of Attending Staff	69
17.	Operative Record	69
18.	Orders, STANDING	70
19.	Orders, VERBAL	70
20.	Orders, WRITTEN	70
21.	Patients' Bill of Rights	70
22.	Pregnancy Test	70
23.	Preoperative Procedures	70
24.	Preoperative Record	70
25.	Private Patients	70
26.	Provisional Diagnosis	71
27.	Publications	71
28.	Records Authentication	71
29.	Research Projects	71
30.	Responsibility for Private Patients	71
31.	Restraint and/or Seclusion	71
32.	Retrospective Record Reviews	71
33.	Sterilization	72
34.	Suicide	72
35.	Surgery Schedule	72
36.	Surgical Assistants	72
37.	Symbols and Abbreviations	72
38.	Tissue	72
39.	Physician Reference Manual	72

RIVERSIDE UNIVERSITY
HEALTH SYSTEM – MEDICAL CENTER

MEDICAL STAFF BYLAWS

PREAMBLE

WHEREAS, Riverside University Health System is a public general acute hospital organized under the laws of the State of California; and

WHEREAS, its purpose is to serve as a general acute hospital providing patient care, education, and research; and

WHEREAS, it is recognized that the governing board has the ultimate authority and responsibility for all aspects of the hospital operation, including the professional component and, therefore, the medical staff is accountable to the governing board for the proper discharge of its responsibilities, and all medical staff activities and actions are subject to review and approval by the governing board; and

WHEREAS, it is recognized that the medical staff is delegated responsibility by the governing board for the quality of medical care at the hospital and must accept and discharge this responsibility subject to the governing board's ultimate authority; and

WHEREAS, it is recognized that the cooperative efforts of the medical staff, the hospital administration, and the governing board are necessary to fulfill the foregoing responsibilities of the medical staff and the hospital's obligations to its patients; and

WHEREAS, only duly qualified physicians, dentists, podiatrists, and clinical psychologists are eligible for medical staff membership, privileges and prerogatives; and

WHEREAS, some duly qualified allied health professionals may be eligible to participate as independent practitioners in the provision of certain patient care services in the hospital setting;

THEREFORE, the physicians, dentists, podiatrists, and clinical psychologists practicing at this hospital hereby organize themselves into a medical staff in conformity with these bylaws.

CONSTRUCTION OF TERMS AND HEADINGS

Commented [KM1]: Relocated from 15.6

Words used in these bylaws shall be read as the masculine or feminine gender and as the singular or plural as the context and circumstances require. The captions and headings in these bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these bylaws.

DEFINITIONS

1. ALLIED HEALTH PROFESSIONAL or AHP means a Physician Assistant, Nurse Practitioner, Nurse Certified Midwife or Audiologist who exercises judgment within the areas of professional competence and the limits established by the governing board, the medical staff and the applicable State Practice Acts; who is qualified to render direct or indirect medical, dental, podiatric or clinical psychological care under the supervision or direction of a medical staff member possessing privileges to provide such care in the hospital; and who may be

2. ~~ATTENDING PHYSICIAN* is the medical staff physician responsible for rendering, coordinating and directing care and services provided to a patient while hospitalized. Expertise and training relative to the principal diagnosis precipitating hospitalization generally determines initial pairing of patients to attending physicians.~~

~~A patient may have more than one attending physician over the course of a hospitalization, but should have only one attending physician at a time. One physician must be in charge. Transfer of responsibility from one attending physician to another must be clearly specified in the medical record, whether it will be for weekend or holiday coverage within a department, or whether it be a transfer from one medical service to another.~~

Formatted: Indent: Left: 0"

Commented [KM2]: Term is not used in the Bylaws – only the rules and regs – moved there

3.

~~CONSULTING PHYSICIAN** is a medical staff member who responds to the request of the attending physician (or designee). The consulting physician provides specific consultation or service to a patient at the request of the attending physician (or designee). Consultation is provided within the scope of medical staff privileges and expertise.~~

~~The attending physician defines the clinical question or service, and specifies the level of consultation sought: a one-visit opinion, a specific service or intervention, transfer of care (making the consultant the attending physician), or some other defined arrangement, as mutually agreed. Consultation may be sought for specific or general expertise or skill, going from generalists to subspecialists or the other way around, depending on patient care needs.~~

~~Physician consultants respect the relationship between the patient and the attending physician, promptly and effectively communicating recommendations to the attending physician, and should obtain concurrence of the attending physician for major procedures or involvement of additional consultants. Consultants who need temporary charge of the patient's care should obtain the attending physician's cooperation and assent.~~

~~A complex clinical situation may call for multiple consultations. When the attending physician disagrees with the consultant's recommendations, another consultation may be required. To assure a coordinated effort in the best interest of the patient, the attending physician remains in charge of overall care, communicating with the patient and coordinating care on the basis of information derived from consultations.~~

Commented [KM3]: Term not used in Bylaws or Rules and Regs – suggest delete this discussion

~~* Near synonyms: "Principal physician," "primary physician" (not to be confused with primary care physician), "physician of record." Principal physician generally has connotations of a subspecialist who also provides primary care for a patient. Physician of record is a term with retrospective connotations and of specific context. Who was the physician of record? Who was the physician of record for the liver biopsy? Primary physician comes closest to the definition used here, but has the potential of confusion with the term primary care physician.~~

Commented [KM4]: Probabl artifact from earlier revision attempt. Suggest delete.

~~** As used here, "Consulting Physician" refers to a specific role relative to patient care distinct from the medical staff membership category of "Consulting Staff."~~

4. CHIEF OF MEDICAL STAFF or CHIEF OF STAFF means the chief administrative officer of the medical staff.

5. CLINICAL PRIVILEGES means the permission granted to a medical staff and allied health professionals to render specific diagnostic, therapeutic, medical, dental, podiatric, clinical psychological, or surgical services.

6. COMPLETE APPLICATION means the applicant has filled out the application form in full, answered all questions, signed and dated all forms that require signature and has paid the required fees; items on the application have been verified as specified in the Credentials Policies and Procedures Manual (not verified by documents provided by the applicant); the applicant has provided answers to all questions which have arisen during the application verification process; and the relevant department chair, the Credentials Committee and the Medical Executive Committee have all the information they need to make a decision.

7. EX-OFFICIO MEMBER means an officer or other individual as designated by these bylaws, who maybe a committee member by virtue of elected or appointed position. An ex-officio member may attend meetings with power to vote unless otherwise stated in these bylaws or in the Medical Staff Committee and Functions Manual.

8. GOVERNING BOARD or BOARD means the Riverside County Board of Supervisors.

9. HOSPITAL or RUHS MC means Riverside University Health System University Health System Medical Center.

10. HOSPITAL DIRECTOR or ADMINISTRATOR means the person appointed by the governing board to act on its behalf in the overall management of the hospital, or the ~~h~~Hospital ~~d~~Director's authorized representative.

11. IN GOOD STANDING means a practitioner is currently not under suspension or serving with any limitations of voting or other prerogatives imposed by operation of the bylaws, rules and regulations or policies of the medical staff.

12. INVESTIGATION means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the medical staff, and does not include activities of the Physician Well-Being Committee.

13. MEDICAL DIRECTOR or CHIEF MEDICAL OFFICER means the medical administrative officer -of the hospital.

14. MEDICAL EXECUTIVE COMMITTEE or MEC means the Medical Executive Committee of the medical staff.

15. MEDICAL STAFF or STAFF means the formal organization of all licensed physicians, dentists, podiatrists, and clinical psychologists who are privileged to attend patients at the hospital.

16. MEDICAL STAFF YEAR means the period from July l to June 30.

17. MEDICO ADMINISTRATIVE OFFICER means a practitioner, employed by or otherwise serving
the hospital on a full or part time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities, as used herein, are those responsibilities which require a practitioner to exercise clinical judgment with respect to patient care and it includes the supervision of professional activities of practitioners under the medico-administrative officer's direction.

18. PHYSICIAN means an individual with a M.D. or D.O. degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California (MBC) or the Board of Osteopathic Examiners (BOE), who is licensed by either the MBC or the BOE.

19. PRACTITIONER means physician, dentist, podiatrist, or clinical psychologist or allied health professional who exercises clinical privileges at the hospital.

20. PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a medical staff member, which is exercisable subject to, and in accordance with, the conditions imposed by these bylaws and by other hospital and medical staff rules, regulations, or policies.

ARTICLE I - NAME

The name of this organization is the medical staff of Riverside University Health System ~~University Health System~~ Medical Center.

ARTICLE II - PURPOSES

The purposes of this organization are:

1. The purpose of this medical staff is to organize the activities of physicians and other clinical practitioners who practice at Riverside University Health System University Health System Medical Center in order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the hospital's Governing Board~~ of Directors~~.

2. To initiate and maintain rules and regulations for the medical staff to carry out its responsibilities to be self-governing with respect to the professional work performed in the hospital.

3. To provide means whereby issues concerning the medical staff and the hospital may be discussed by the medical staff with the governing board and the H~~h~~ospital D~~d~~irector.

4. To be responsible, in cooperation with affiliated institutions, to carry out the education and training of the house staff as prescribed by the Council on Medical Education and Hospitals of the American Medical Association.

5. To carry out the education and training of other allied hospital personnel.

ARTICLE III - MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

Medical Staff Membership shall be extended only to professionally competent physicians, dentists, podiatrists or clinical psychologists who continuously meet the qualifications, standards and requirements set forth in these bylaws. Appointment to and membership in the medical staff shall confer on the member only such privileges and prerogatives as have been granted by the governing board in accordance with these bylaws. No practitioner shall admit or provide services to patients at the hospital unless medical staff privileges have been granted in accordance with the procedures set forth in these bylaws and the Credentials Policies and Procedures Manual.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

Practitioners shall be qualified for medical staff membership only if they:

(a) ~~(a)~~ document their current licensure, experience, background, training, demonstrated ability, current professional competence and good judgment so as

to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the hospital, and that they are qualified to exercise clinical privileges at the hospital;

~~(a)~~(b) are board certified in their area of speciality. Provider applicants that are board eligible based on the American Board of Medical Specialties (ABMS) eligibility period, must achieve board certification status before the ABMS eligibility period lapses. If the applicant's specialty board eligible period has expired based on the number of years following completion of residency, then they must achieve board certification prior to applying for medical staff privileges.

Commented [KM5]: Moved up from 6.21 (K) below.

(b) are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions, including the principles of the California Medical Association and the Principles of Ethics of the American Medical Association or the American Dental Association, to work cooperatively with others in the hospital setting so as not to adversely affect patient care or hospital operations, to be willing to participate in and properly discharge medical staff responsibilities, and to be willing to commit to and regularly assist the hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials;

(c) Are located closely enough to the hospital to provide continuous care to their patients or provide alternate coverage; and

(d) document physical and mental status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the medical staff that s/he is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality of care for this community.

3.2-2 PARTICULAR QUALIFICATIONS

(a) Physicians. An applicant for physician membership in the medical staff, except for honorary staff, must hold a M.D. or D.O. degree or their equivalent and a valid, unrevoked and unsuspended certificate to practice medicine issued by the Medical Board of California or the Osteopathic Medical Board of California. For the purpose of this section, "or the equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the Osteopathic Medical Board of California.

(b) Dentists. An applicant for dental membership in the medical staff, except for honorary staff, must hold a D.D.S. or equivalent degree issued by a dental school and a valid, unrevoked and unsuspended certificate to practice dentistry issued by the Dental Board of California ~~Board of Dental Examiners~~.

(c) Podiatrists. An applicant for podiatric membership in the medical staff, except for honorary staff, must hold a D.P.M. degree and a valid, unrevoked, and unsuspended certificate to practice podiatry issued by the Medical Board of California.

(d) Clinical Psychologists. An applicant for clinical psychologist membership, except for the honorary staff, must hold a clinical psychologist degree, have not less than two (2) years clinical experience in a multi-disciplinary facility licensed or operated by this or another state or by the United States to provide healthcare or be listed in

the latest edition of the National Register of Health Service Psychologists, and hold a valid, unrevoked, and unsuspended license to practice clinical psychology issued by the California Board of Psychology.

3.2-3 PROFESSIONAL LIABILITY INSURANCE

A member granted clinical or practice privileges in the hospital shall maintain in force professional liability insurance in a form and ~~not less than the minimum~~ amount satisfactory to the County of Riverside's Risk Management department.~~s, if any, as from time to time may be determined by the governing board, or shall provide other proof of financial responsibility in such manner as the governing board may from time to time establish.~~

Commented [KM6]: question pending to Risk Management

3.3 EFFECT OF OTHER AFFILIATIONS

No practitioner shall be automatically entitled to medical staff membership, or to exercise any particular clinical privilege, merely because the practitioner holds a certain degree, is licensed to practice in California or any other state, is a member of any professional organization, is certified by any clinical board, or had or presently has, staff membership or privileges at this hospital or at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital.

3.4 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, sexual orientation, or on the basis of any other criterion, unrelated to the delivery of quality patient care in the hospital setting, to professional qualifications, the hospital's purposes, needs and capabilities, or community needs.

~~**3.5 MEDICO-ADMINISTRATIVE OFFICERS**~~

~~A practitioner who is engaged in a medico-administrative position must be a medical staff member, achieving this status by the procedure provided in Article VI and VII. The medical staff membership and clinical privileges of any medico-administrative officer shall also be subject to the terms and conditions of the practitioner's contract or agreement with the hospital. The contract or agreement shall govern over these medical staff bylaws as to all matters covered by said contract or agreement, and shall be consistent with these bylaws.~~

3.56 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for honorary, retirees and Administrative members, all other mMembers of the medical staff shall:

(a) Provide patients with care at the generally recognized professional level of quality and efficiency established by the hospital's medical staff.

(b) Retain responsibility within the area of professional competence for the continuous care and supervision of patients at the hospital for whom providing services, or arrange for a suitable alternative physician, who is on the medical staff with equivalent clinical privileges, to assure such care and supervision.

(c) Abide by the medical staff bylaws and rules and regulations and by all other lawful standards, policies, and rules of the hospital and shall conform to current accreditation, federal ~~JC, HIPAA, CMS a~~and state mandated standards.

(d) Comply with all requirements set forth in the medical staff bylaws and rules and regulations, including, but not limited to, those requiring maintenance of professional liability insurance (Section 3.2-3~~15.3~~), payment of medical staff dues (Section 15.5~~4~~), acceptance of principles (Section 15.8~~7~~), and refraining from division of fees (Section 15.9~~8~~).

(e) Discharge such personal, medical staff, department, committee and hospital functions, including, but not limited to, peer review, patient care audit, utilization review, quality assessment, emergency service and back-up functions, for which the member is responsible by virtue of staff category assignment, appointment, election, utilization of allied health professionals or exercise of privileges, prerogatives or other rights in the hospital.

(f) Prepare and complete in a timely fashion the medical and other required records for all patients the staff member admits or in any way provides care to at the hospital.

(g) ~~A c~~Complete and document a medical history and physical examination ~~must be~~ performed within (30) days prior to a patient's admission or within 24 hours after ~~inpatient a~~admission or registration but prior to surgery or a procedure requiring anesthesia services. For a medical history and physical examination that was performed thirty (30) days prior to inpatient admission, an updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination are completed within 30 days before admission or registration then any appropriate screening tests, based on the needs of the patient, shall be accomplished and recorded in the patient's chart within 72 hours prior to the patient's surgery. As in the ASA (American Society of Anesthesiology) Class I and II patients, appropriate screening tests will be considered acceptable if done within seven (7) days prior to the patient's surgery. The ~~updated e~~examination of the patient, including any changes in the patient's condition, must be completed and documented by a doctor of medicine, osteopathy, surgeon, doctor of podiatry medicine or other qualified licensed practitioner, who has been granted privileges at RUHS MC. ~~by the medical staff in accordance with state law and hospital policy~~.

(h) Aid in any educational programs for medical staff members, medical students, ~~interns,~~ resident physicians, resident dentists, nurses, and other personnel when so

assigned. A medical staff member who chooses not to participate in the teaching programs is not subject to denial or limitation of privileges for this reason alone.

(i) ~~Agree to p~~Provide continuous quality care for patients.

(j) Assist the hospital in fulfilling its uncompensated or partially compensated patient care obligations within the areas of the staff member's professional competence and credentials.

(k) Pledge not to receive or pay to another physician or dentist, either directly or indirectly, any part of a fee received for professional services.

(l) Pledge to maintain an ethical practice, including to refrain from illegal inducements for patient referral, and to refrain from failing to disclose to patients when another surgeon will be performing the surgery.

(m) Refrain from any unlawful harassment or discrimination against any person (including any patient, hospital employee, hospital independent contractor, medical staff member, volunteer, visitor, etc.) based upon the person's age, sex, religion, race, creed, color, national origin, or health status as further described in Section 3.10, or ability to pay or source of payment.

(n) Refrain from delegating patient care responsibility, including diagnosis or care of hospitalized or outpatient patients to a practitioner or allied health professional that is not qualified to undertake this responsibility or who is not adequately supervised.

(o) Coordinate individual patient care, treatment, and service with other practitioners and hospital personnel, including, but not limited to, seeking consultation whenever warranted by the patient's condition or when required by the rules or policies and procedures of the medical staff or applicable department.

(p) Recognize the importance of confidentially communicating concerns to appropriate department officers and/or medical staff officers when s/he obtains credible information including that a fellow medical staff member may have engaged in unprofessional or unethical conduct, or may have a health condition which poses a significant risk to the well-being or care of patients, and then cooperate as reasonably necessary toward the appropriate resolution of any such manner.

(q) Participate in the medical staff focused professional practice evaluation and ongoing professional practice evaluation in accordance with the bylaws, rules and policies and procedures of the medical staff.

(r) Immediately notify the Medical Staff Services Office by telephone and furnish in writing within ~~two (2) business~~ ten (10) calendar days upon notification of any action taken regarding the member's license, DEA registration, privileges at other facilities, changes in liability insurance coverage, any report filed with the National Practitioner Data Bank, or any other ~~action~~ change or circumstance that could affect his/her medical staff standing and/or clinical privileges at the hospital.

(s) Adhere to the medical staff organization's Standards of Conduct (as further described in Section (3.11), so as not to adversely affect patient care or hospital operations.

3.7 DURATION OF APPOINTMENT

Commented [KM7]: Next sections moved to Article VI

Initial appointment to the medical staff shall not exceed a period of two (2) years. Reappointment shall be for a period of not more than two (2) years.

3.8 PROCTORING REQUIREMENTS

3.8-1 FOR INITIAL APPOINTMENT

Except as otherwise determined by the Medical Executive Committee, all initial appointees to the medical staff that have been granted clinical privileges and all members granted additional clinical privileges, shall be subject to a period of proctoring. Proctoring can be prospective, concurrent and retrospective review. An initial appointee shall be assigned to a department where the appointee's performance shall be proctored by the chair of the department or the department designee, during the term of proctoring required by that department, as established pursuant to Section 3.8-3, to determine the initial appointee's eligibility for continued medical staff membership in the to which appointed and to exercise the clinical privileges initially granted in that department. Proctoring arrangement shall be the responsibility of the appointee. The exercise of clinical privileges in any other department shall also be subject to prospective, concurrent and retrospective proctoring. The appointee shall remain subject to proctoring until the Credentials Committee has been furnished with.

(a) A report signed by the chair, or designee, of the department to which the appointee is assigned describing the types and number of cases observed, an evaluation of the appointee's performance, and a statement that the appointee appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which appointed. The proctoring will include prospective, concurrent and retrospective chart review.

(b) A report signed by the chair, or designee, of the other department in which the appointee will exercise clinical privileges, describing the types and number of cases observed, an evaluation of the appointee's performance, and a statement that the appointee has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted.

3.8-2 FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

When recommended by the Credentials and the Medical Executive Committees, and approved by the governing board, medical staff members who are granted additional privileges shall complete a period of proctoring with the procedures outlined in Section 3.8-1 for initial appointees.

3.8-3 TERM OF PROCTORING PERIOD

~~Each department may establish, in its rules and regulations, a term of proctoring and the number of cases, and/or specific number of cases applicable to particular clinical privileges whenever such requirements are appropriate in view of the clinical privileges which are involved. Proctoring will Begin when privileges are initially granted, whether at the time of initial appointment or the granting of temporary privileges. The term of proctoring may be extended not more than six (6) months, for a total proctoring period of not more than twelve (12) months. If an initial appointee fails within that period to complete the minimum number of cases and/or furnish the certificates required in Section 3.8-1, the appointee's medical staff membership or particular clinical privilege, as applicable, shall be automatically terminated. If a medical staff member requesting modification fails within that period to complete the minimum number of cases and/or furnish the certifications required in Section 3.8-1, the change in medical staff category or department assignment or the additional privileges, as applicable, shall be automatically terminated. The Medical Executive Committee chair shall give the initial appointee, or medical staff member so affected, written notice that medical staff membership and/or clinical privileges have been automatically terminated because of failure to satisfactorily complete the proctoring requirements.~~

~~**3.8-4 RECIPROCAL PROCTORING**~~

~~Reciprocal Proctoring is defined as cases proctored at an outside hospital by proctoring physicians who may not have privileges at RUHS. These cases must have occurred within the last 2 years. Submitted cases must align with RUHS department specific proctoring requirements and forms. Minimally 50% of the cases must be proctored by a provider with RUHS active privileges.~~

~~Acceptance of reciprocal proctoring is at the discretion of the department chair. All proctoring forms/summary of cases should be signed by the RUHS department chair.~~

~~**3.9 LEAVE OF ABSENCE**~~

~~**3.9-1 LEAVE STATUS**~~

~~A leave of absence may be considered upon the written request of a medical staff member. A leave of absence may be granted for not more than two (2) years. On no condition will a leave of absence be granted beyond two years. The Credentials Committee will review the request for a leave of absence and the action by Credentials, upon ratification by the Medical Executive Committee, will be transmitted to the hospital director for notation in the practitioner's file. The practitioner must give a date of expected return in order that the leave of absence is kept current. During the period of the leave, the practitioner's clinical privileges, prerogatives, responsibilities shall be suspended.~~

~~**3.9-2 REASONS FOR GRANTING LEAVE**~~

~~The following reasons for granting a leave of absence shall be considered by the Credentials Committee:~~

~~(a) Illness~~
~~(b) Military service~~

~~(c) Temporary medical training or education~~
~~(d) Sabbatical leave~~
~~(e) Outside high achievement of exceptional merit~~
~~(f) Other special conditions as approved by the Credentials Committee~~

~~**3.9.3 TERMINATION OF LEAVE**~~

~~At least thirty (30) days prior to the termination of the leave, or at any earlier time, the medical staff member may request reinstatement of privileges and prerogatives by submitting a written notice to that effect to the hospital director and to the Credentials Committee. If so requested by the Medical Executive Committee or the hospital director, the staff member shall submit a written summary of relevant activities during the leave. The Medical Executive Committee shall recommend whether to approve the member's request for reinstatement of privileges and prerogatives; thereafter, the procedure set forth in Sections 6.3 7 through 6.3 11 shall be followed.~~

~~Failure, without good cause, to request reinstatement or to provide a requested summary of activities shall be deemed to be a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives.~~

3.6~~10~~ HARASSMENT PROHIBITED

Harassment by a medical staff member against any individual (e.g., against another medical staff member, house staff, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation shall not be tolerated.

Sexual harassment is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

All allegations of sexual harassment shall be immediately investigated by the medical staff and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of clinical privileges or membership, if warranted by the facts.

3.117 STANDARDS OF CONDUCT

Members of the medical staff and allied health professionals are expected to adhere to the Medical Staff Standards of Conduct, including but not limited to the following:

3.7-111-1 GENERAL

(a) It is the policy of the medical staff to require that its members fulfill their medical staff obligations in a manner that is within generally accepted bounds of professional interaction and behavior. The medical staff is committed to supporting a culture and environment that values integrity, honesty, and fair dealing with each other, and to promoting a caring environment for patients, practitioners, employees, and visitors.

(b) Rude, combative, obstreperous behavior, as well as willful refusal to communicate or comply with reasonable rules of the medical staff and the hospital may be found to be disruptive behavior. It is specifically recognized that patient care and hospital operations can be adversely affected whenever any of the foregoing occurs with respect to interaction at any level of the hospital, in that all personnel play an important part in the ultimate mission of delivering quality patient care.

(c) In assessing whether particular circumstances in fact are affecting quality patient care or hospital operations, the assessment need not be limited to care of specific patients, or to direct impact on patient health. Rather, it is understood that quality patient care embraces – in addition to medical outcome – matters such as timeliness of services, appropriateness of services, timely and thorough communications with patients, their families, and their insurers (or third party payors) as necessary to effect payment for care, and general patient satisfaction with the services rendered and the individuals involved in rendering those services.

3.7-211-2 CONDUCT GUIDELINES

(a) Upon receiving medical staff membership and/or privileges at the hospital, the member enters common goal with all members of the organization to endeavor to maintain the quality of patient care and appropriate professional conduct.

(b) Members of the medical staff are expected to behave in a professional manner at all times and with all people—patients, professional peers, hospital staff, visitors, and others in and affiliated with the hospital.

(c) Interactions with all persons shall be conducted with courtesy, respect, civility, and dignity. Members of the medical staff shall be cooperative and respectful in their dealings with other persons in and affiliated with the hospital.

(d) Complaints and disagreements shall be aired constructively, in a non-demeaning manner, and through official channels.

(e) Cooperation and adherence to the rules of the hospital and the medical staff is required.

(f) Members of the medical staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral, or behavioral.

~~3.11-3 ADOPTION OF RULES~~

Commented [KM8]: Duplicates 15.1-1

~~The Medical Executive Committee may promulgate rules further illustrating and implementing the purposes of this section, including but not limited to procedures for investigating and addressing incidents of perceived misconduct, and progressive remedial measures, including, when necessary, disciplinary action.~~

3.8~~12~~ ORGANIZED HEALTH CARE ARRANGEMENT

Under the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), the medical staff and the hospital are permitted to operate in an Organized Health Care Arrangement (OHCA). The OHCA is a clinically integrated care setting in which individuals receive health care from more than one provider and the providers hold themselves out to the public as participating in a joint arrangement. The medical staff is in an OHCA with the hospital for care provided at hospital locations. This joint arrangement is disclosed to the patients in the Notice of Privacy Practices given to patients when they access care at any hospital and county affiliated facility. Members of the medical staff shall use patient medical and demographic information only as described in the Notice of Privacy Practices.

ARTICLE IV - CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

The categories of the medical staff shall include the following: active, provisional, courtesy, ~~consulting,~~ honorary, ~~and~~ adjunct, Per Diem Resident/Moonlighting and Administrative.

4.2 ACTIVE STAFF

4.2 1 QUALIFICATIONS

The active staff shall consist of practitioners who:

(a) Meet the qualifications set forth in Section 3.2.

(b) Regularly admit patients to or otherwise regularly provide professional services for patients at the hospital and~~or~~ regularly participate in medical staff functions.

(c) Have satisfactorily completed appointment in the provisional category.

4.2-2 PREROGATIVES

The prerogatives of active medical staff members shall be to:

(a) Exercise such clinical privileges as are granted to them pursuant to Article VII.

(b) Hold office in the medical staff and in the department and committees of which they are a member, and serve on committees, including as the Committee Chair, unless otherwise provided in the medical staff bylaws and/or the Medical Staff Committees and Functions Manual.

(c) Vote for medical staff officers, on bylaws' amendments, and on all matters presented at general and special meetings of the medical staff and of the department and committee of which they are members, unless otherwise provided in the medical staff bylaws and/or the Medical Staff Committees and Functions Manual.

(d) ~~Participate in educational programs and departmental functions at the hospital. Minimum standards of active participation in the teaching program shall be established by the chair or designee, of each department in consultation with the medical director. Active staff members shall participate in educational programs as requested by the medical director.~~

~~(e)~~ Treat and service patients, in both inpatient and outpatient services, as assigned by their department chair and in accordance with privileges granted.

(e) Serve as Chair of Medical Staff Committee(s)

4.2-3 RESPONSIBILITIES

Active staff members shall:

(a) Meet the basic responsibilities set forth in Section 3.6

(b) Actively participate in and regularly assist the hospital in fulfilling its obligations related to patient care within areas of professional competence, including but not limited to emergency service and back-up function, patient care audit, peer review, utilization review, quality evaluation and related monitoring activities required of and by the medical staff in supervising and proctoring initial appointees and AHPs, and in discharging such other functions as may be required from time to time.

(c) Participate in educational programs and departmental functions at the hospital. Minimum standards of active participation in the teaching program shall be established by the chair, or designee, of each department in consultation with the medical director. Active staff members shall participate in teaching programs as requested by the medical director.

4.3 PROVISIONAL STAFF

4.3-1 QUALIFICATIONS

The provisional staff shall consist of practitioners who meet the qualifications for membership set forth in Section 3.2, except that they have not yet satisfactorily completed the proctoring requirements specified in Section 3.8; have been medical staff members for less than one year; and/or have not fulfilled such other requirements as may be set forth in these bylaws, the medical staff and department rules and regulations, or hospital policies.

4.3-2 PREROGATIVES

The prerogatives of provisional staff members shall be to:

(a) Exercise such clinical privileges as are granted to them pursuant to Article VII.

(b) Serve on committees, unless provided otherwise in these bylaws and/or in the Medical Staff Committees and Functions Manual. Provisional members may not hold office in the medical staff or in the department and committee of which they are members, unless otherwise provided in these bylaws.

(c) Vote on all matters presented at committee meetings of which they are members. Provisional members may not vote for medical staff officers, on bylaws' amendments, or on any matters presented at general and special meetings of the medical staff and of the department of which they are members, unless otherwise provided in these bylaws and/or in the Medical Staff Committees and Functions Manual.

4.3-3 RESPONSIBILITIES

Provisional staff members shall be required to discharge the responsibilities which are specified in Section 4.2 3 for active staff members. Failure to fulfill those responsibilities shall be grounds for denial of advancement to active, courtesy, or consulting staff status and termination of provisional staff status.

4.3-4 OBSERVATION OF PROVISIONAL STAFF MEMBER

The provisional staff member shall undergo a period of observation by designated monitors as described in Section 3.8. The purpose of observation shall be to evaluate the member's:

(a) Proficiency in the exercise of clinical privileges initially granted, and

(b) Overall eligibility for continued staff membership and advancement within staff categories.

Observation of a provisional staff member shall follow whatever frequency and format the department deems appropriate in order to adequately evaluate the provisional staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. The results of the observation shall be communicated by the department chair to the Credentials Committee.

4.3-5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

(a) If the provisional staff member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted and otherwise appears qualified for

continued medical staff membership, the member shall be eligible for placement in the active, courtesy or consulting staff as appropriate, upon the recommendation of the Credentials Committee and the Medical Executive Committee.

(b) In all other cases, the appropriate department chair shall advise the Credentials Committee, who shall make its recommendation to the Medical Executive Committee regarding a modification of clinical privileges, a modification of staff category, or termination of medical staff membership.

4.4 COURTESY STAFF

4.4-1 QUALIFICATIONS

The courtesy staff shall consist of practitioners who:

(a) Meet the qualifications set forth in Section 3.2.

(b) Are involved in sufficient patient care activities at the hospital or provide supplemental ongoing professional practice documentation so that the medical staff will be able to evaluate the staff member's current clinical competency on an ongoing basis. Courtesy staff members who provide services for more than twelve (12~~five (5~~) patients during each medical staff year will be given the opportunity to be appointed to the active staff category.

(c) Have satisfactorily completed appointment in the provisional category.

4.4-2 PREROGATIVES

The prerogatives of courtesy staff members shall be to:

(a) Admit or provide professional services for not more than five (5) patients at the hospital during each medical staff year. Members whose activity will exceed this limit must apply and qualify for active or consulting staff status.

(b) Attend meetings of the medical staff and the department of which they are members. Courtesy staff members may not hold office in the medical staff or in the department of which they are members. Courtesy staff members may serve on committees.

(c) Courtesy staff members may not vote on any medical staff matter.

4.4-3 RESPONSIBILITIES

Courtesy staff members shall meet the basic responsibilities set forth in Section 3.6.

~~**4.5 CONSULTING STAFF**~~

~~**4.5-1 QUALIFICATIONS**~~

~~The consulting staff shall consist of practitioners who:~~

(a) Meet the qualifications set forth in Section 3.2, except that this requirement shall not preclude an otherwise qualified out-of-state practitioner from appointment within the limitations of California Business and Professions Code 2060.
(b) Possess clinical expertise and reports to the hospital when so scheduled or when called by a member of the medical staff to render a clinical opinion within their competence.
(c) Have satisfactorily completed appointment in the provisional category.
(d) Are of recognized outstanding professional ability.

4.5-2 PREROGATIVES

The prerogatives of consulting staff members shall be to:

(a) Exercise such clinical privileges as are granted to them pursuant to Article VII, Clinical Privileges, except to an out-of-state practitioner for whom the granting of privileges under Article VII, for the sole purpose of engaging in professional education through lectures, clinics, or demonstrations, shall be subject to the limitations of California Business and Professions Code 2060.
(b) Attend meetings of the medical staff and the department of which they are members. Consulting staff members may not hold office in the medical staff or in the department of which they are members. Consulting staff members may serve on committees.
(c) Teach in the medical education programs as requested by the chair of various departments.
(d) Consulting staff members may not vote on any medical staff matter.

4.5-3 RESPONSIBILITIES

Consulting staff members shall meet the basic responsibilities set forth in Section 3.6.

4.5.6 HONORARY STAFF

4.56-1 QUALIFICATIONS
The honorary staff shall consist of practitioners who do not actively practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health or medical sciences, or their previous long-standing service to the hospital, and who continue to exemplify high standards of professional and ethical conduct.

4.56-2 PREROGATIVES

The prerogatives of honorary staff members shall be to:

Honorary staff members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital. They may, however, attend staff and department

meetings and any staff or hospital educational meetings. Honorary staff members may not vote on any medical staff matter, hold office in the medical staff or in the department of which they are a member, or serve on committees.

4.5~~6~~-3 RESPONSIBILITIES

Honorary staff members shall meet the basic~~s~~ responsibilities specified in Section 3.6, Paragraphs (c), (k), (m), (p), (r), and (s).

4.6~~7~~ ADJUNCT STAFF

4.6~~7~~-1 QUALIFICATIONS

The adjunct staff shall consist of practitioners who do not have clinical privileges.

4.~~7~~6-2 PREROGATIVES

Adjunct staff members may observe the care and treatment of their patients that are cared for at this hospital. Adjunct staff members shall not be assigned to a specific department; therefore, they shall not be expected to attend departmental meetings. They shall not have the right to vote or to serve on committees. Adjunct staff members shall not require proctoring.

4.~~7~~6-3 RESPONSIBILITIES

Adjunct staff members shall meet the basic~~s~~ responsibilities specified in Section 3.6, Paragraphs (c), (k), (m), (p), (r), (s), and including any others which would be relevant to their staff category.

4.7~~8~~ PER DIEM RESIDENT/MOONLIGHTING STAFF

4.7~~8~~-1 QUALIFICATIONS

Per diem/moonlighting resident medical staff membership shall be held by post-doctoral residents who:

(a) have successfully completed at least (2) two out of (3) three years of an accredited residency program approved by the Accreditation Council on Graduate Education -(ACGME)~~) or the American Osteopathic Association (AOA)~~;

(b) who are not eligible for another staff category;

(c) who are either licensed or registered with the appropriate State of California licensing board. All per diem/moonlighting resident medical staff members must have a training license to practice medicine within the State of California ; and

(d) Have approval and acknowledgement of their moonlighting by their Residency Program Director .

4.78-2 PREROGATIVES

(a) Post-doctoral trainees who are enrolled in accredited residency training programs and who meet the above qualifications shall be appointed to the per diem resident medical staff. Members of the per diem resident/moonlighting medical staff are not eligible to hold office within the medical staff, but may participate in the activities of the medical staff through membership on medical staff committees

(b) All medical care provided by per diem resident medical staff is under the supervision of the department chair and/or his designee(s). Care should be in accordance with the provision of a residency program approved by and in conformity with the Accreditation Council on Graduate Medical Education (ACGME) of the American Medical Association, the American Osteopathic Association, or the American Dental Association's Commission on Dental Accreditation.

(c) Appointment to the per diem resident medical staff shall be for (1) one year and may be renewed annually.

(d) Per diem resident medical staff membership may not be considered as the observational period required to be completed by provisional staff.

(c)(e) Per diem resident medical staff membership terminates with termination from the training program. Upon completion of the training program, per diem resident medical staff may apply for regular medical staff membership.

4.89 ADMINISTRATIVE STAFF

The administrative staff shall consist of practitioners who are members of the Medical Staff who have no clinical privileges and who must:

a) Possess expertise in the area that they are working and come to RUHS when scheduled or when called to assist in the Medical Staff administration including, but not limited to, quality improvement, utilization review, and/or patient referral work, or for Medical Staff, Resident, or student educational activities.

b) Agree to refrain from participating in any activities within the Medical Center that require Clinical Privileges.

c) Be recommended for appointment or reappointment to the Administrative Staff by the Chief of the Clinical Service, the Credentials Committee, and by Medical Staff Executive Committee.

Failure to continue to meet any of these qualifications will be adequate grounds to deny reappointment.

4.98.1 LIMITATION OF PREROGATIVES:

The prerogatives of an Administrative Staff member shall be to:

a) Attend meetings of the Medical Staff and the Clinical Service to which s/he has been assigned.

b) Shall document their current licensure, adequate experience, education and training, current professional competency, good judgment, and current physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they'r are professionally and ethically competent to exercise their duties.

4.9 2 RIGHT TO HOLD OFFICE:

A member of the Administrative Staff may not serve as chair or vice chair of a clinical department or hold office in the Medical Staff but may be a voting member or chair on committees they are asked to serve on. By virtue of their position Administrative staff practitioner cannot be a voting member of the Medical Executive Committee.

4.8 -4.9 3 RESPONSIBILITIES:

Each member of the Administrative Staff shall meet the standards in Section 3.2 other than the standards which in the judgment of the Credentials Committee and Medical Staff Executive Committee do not apply because of the absence of clinical activity. If a patient of a member of the Administrative Staff requires care by the Medical Center, the Administrative Staff member relinquishes all responsibility for the patient to a Medical Staff member with the appropriate clinical privileges.

4.8-49 4 CARE OF PATIENTS

If the Administrative Staff member wishes to obtain clinical privileges in the Medical Center, that member must apply for Medical Staff membership Category as described in Section 4.2

4.109 5 **TELEHEALTH STAFF**

Telehealth means the delivery of the health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's healthcare while the patient is at the originating site and the health care provider is at a distant site. Telehealth is not a telephone conversation, email/instant message conversation, or fax; it typically involves the application of videoconferencing or store and forward technology to provide or support healthcare delivery.

4.9 6 CATEGORY

The Medical Staff shall include the following: active, provisional, courtesy, consulting, honorary, adjunct and telehealth provider.

4.10-19 7 **QUALIFICATIONS OF TELEHEALTH PROVIDERS:**

Providers shall consist of practitioners who:

(a) Meet the qualifications set forth in Section 3.2.

(b) only provide diagnostic or treatment services to hospital patients via telehealth technology:

(c) Have satisfactorily completed credentialing by (1) a distant site provider that is either a Medicare certified hospital or a telemedicine provider accredited by the Joint Commission which has a current agreement with the County of Riverside to provide such credentialing and (2) credentialing by the Credentialing committee of this Medical Staff.

4.10-29.8 PREROGATIVES

The prerogatives for Telehealth provider members shall be to: (a) Exercise such clinical privileges as are delineated by the Department Chair and granted to them pursuant to Article VII. (b) Participate in educational programs and departmental functions at the hospital , but without any rights to vote on departmental of medical staff matters. (c) Treat and service patients in accordance with privileges granted.

4.10-39.9 RESPONSIBILITIES

Telehealth provider members shall: (a) Meet the basic responsibilities set forth in section 3.6. (b) Actively participate in quality evaluation and related monitoring activities required of and by the medical staff relating to their delivery of care to hospital patients. Compliance Plan and other regulatory responsibilities.

ARTICLE V - ALLIED HEALTH PROFESSIONALS

5.1 QUALIFICATIONS

Allied Health Professionals (AHPs) holding a license, certificate or such other credentials, if any, as required by California law, which authorize the AHPs to provide certain professional services, are not eligible for medical staff membership. Such AHPs are eligible for practice privileges at this hospital only if they:

(a) hold a license, certificate or other legal credential in a category of AHPs which the Medical Executive Committee has identified as eligible to apply for practice privileges;

(b) document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the hospital, and that they are qualified to exercise practice privileges at the hospital; and

(c) are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the hospital setting; and to be willing to commit to and regularly assist the hospital

in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials.

5.2 DELINEATION OF CATEGORIES OF AHPs ELIGIBLE TO APPLY FOR PRACTICE PRIVILEGES

For each eligible AHP category, the Medical Executive Committee shall identify the mode of practice in the hospital setting and the practice privileges and prerogatives that may be granted to qualified AHPs in that category. The Medical Executive Committee shall also identify the terms and conditions which may be granted and apply to AHPs in each category. The delineation of categories of AHPs eligible to apply for practice privileges and the corresponding practice privileges, prerogatives, terms, and conditions for each such AHP category, when approved by the Medical Executive Committee, shall be set forth by the department in which they serve.

5.3 PROCEDURE FOR GRANTING PRACTICE PRIVILEGES

AHPs must apply and qualify for practice privileges. Applications for initial granting of practice privileges, and biennial renewal thereof, shall be submitted by the Interdisciplinary Practice Committee to the Credentials Committee.

AHPs who do not have licensure or certification in an AHP category identified as eligible for practice privileges in the manner required by Section 5.2 above cannot apply for practice privileges, but may submit a written request to the Interdisciplinary Practice Committee, asking that the Medical Executive Committee consider identifying the appropriate category of AHPs as eligible to apply for practice privileges. AHPs shall be assigned to the clinical department appropriate to their occupational or professional training and, unless otherwise specified in the rules and regulations, shall be subject to terms and conditions paralleling those specified in Article VIII (Corrective Action), as they may be applied to AHPs and appropriately tailored to the particular AHP's profession.

5.4 PREROGATIVES

The prerogatives which may be extended to AHPs shall be defined in the medical staff rules or regulations or hospital policies. Such prerogatives may include:

(a) Provision of specified patient care services under the supervision or direction of a physician member of the medical staff and consistent with the practice privileges granted to the AHP and within the scope of the AHP's licensure or certification.

(b) Service on medical staff, department, and hospital committees.

(c) Attendance at meetings of the department to which assigned, as permitted by the department rules and regulations, and attendance at hospital education programs in their field of practice.

5.5 RESPONSIBILITIES

Allied Health Professionals shall:

(a) Meet those responsibilities required by the medical staff rules and regulations, and if not so specified, meet those responsibilities specified in Section 3.6 (Basic Responsibilities of Medical Staff Membership) and 6.5~~3.8~~ (Proctoring Requirements) as are generally applicable to the more limited practice of AHPs.

(b) Retain appropriate responsibility within their area of professional competence for the care and supervision of patients at the hospital for whom they are providing services.

(c) Participate, as appropriate, in patient care audit and other quality review, evaluation, and monitoring activities required of AHPs, in supervising initial appointees of their same occupation or profession or of a lessor included occupation or profession, and in discharging such other functions as may be required from time to time.

5.6 REAPPLICATION

An allied health professional must reapply every two years for ~~a renewal service authorization~~ practice privileges in accordance with Section 5.3 Procedure for Granting Practice Privileges.

ARTICLE VI - PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT
(Including Telehealth Services)

6.1 GENERAL PROCEDURE

The medical staff through its designated departments, committees, and officers shall consider each completed application for appointment or reappointment to the staff and for clinical privileges and each request for modification of staff membership status or clinical privileges, utilizing the resources of the ~~h~~Hospital D~~d~~irector and its staff to evaluate and validate the contents of the application, before adopting and transmitting its recommendation to the governing board.

The medical staff shall also perform the same function in connection with any individual who has applied only for temporary privileges or who otherwise seeks to exercise privileges or to provide specified medical services in any hospital department or service.

6.2 APPLICATION FOR APPOINTMENT

6.2 1 CONTENT

Commented [KM9]: Standard application now – do we need all this detail?

All applications for appointment to the medical staff shall be in writing, submitted on a form prescribed by the Medical Executive Committee, with all provisions completed (or an explanation why answers are unavailable), and signed by the applicant. The applicant shall

be given a copy of these bylaws, the medical staff rules and regulations, and the hospital bylaws.

The application form shall require detailed information including, but not limited to:

(a) The applicant's professional qualifications and competency, including, but not limited to, professional training and experience, current California licensure, current DEA registration if applicable, and continuing medical education information related to the clinical privileges to be exercised by the applicant.

(b) The names of at least three (3) persons who hold the same professional license, whenever possible, as the applicant, including, whenever possible, at least two (2) staff members who can provide adequate references based on their current knowledge of the applicant's professional qualifications, professional competency, and ethical character. The medical staff may request directed references.

(c) Information as to whether any action, including any investigation, has ever been undertaken, whether it is still pending or completed, which involves denial, revocation, suspension, reduction, limitation, probation, nonrenewal, voluntary or involuntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of the applicant's membership status and/or clinical privileges and/or prerogatives at any other hospital or institution; membership or fellowship in any local, state, regional, national, or international professional organization; license to practice any profession in any jurisdiction; Drug Enforcement Administration or other controlled substances registration; specialty board certification; and/or professional school faculty position or membership.

(c) Information pertaining to the applicant's professional liability insurance coverage, any professional liability claims, complaints, or causes of action that have been lodged against the applicant and the status or outcome of such matters.

(d) Information as to any pending administrative agency or court cases, or administrative agency decisions or court judgments in which the applicant is alleged to have violated, or was found guilty of violating, any criminal law (excluding minor traffic violations) or is alleged to be liable, or was found liable, for any injury caused by the applicant's negligent or willful act or omission in rendering services.

(e) Information as to details of any prior or pending or current exclusion from a federal health care program, government agency or third party payor proceeding or litigation challenging or sanctioning applicant's patient admission, treatment, discharge, charging, collection, or utilization practices, including but not limited to Medicare and Medi Cal fraud and abuse proceedings and convictions.

(g) Information pertaining to the applicant's physical and mental condition, and the applicant agrees to submit any additional documentation if requested.

(h) Certification of the applicant's agreement to terms and conditions set forth in Section 6.2 2 regarding the effects of the application.

(i) An acknowledgment that the applicant has received (or has been given access to) and read the medical staff bylaws and rules and regulations, has received an explanation of the requirements set forth therein and of the appointment process, and that the applicant agrees to be bound by the terms thereof, as they may be amended from time to time, if granted membership or clinical privileges, and to be bound by the terms thereof, without regard to whether or not the applicant is granted membership and/or clinical privileges in all matters relating to consideration of the application.

(j) An acknowledgment of the applicant's responsibility to inform the Medical Staff Services Office of any change in the information provided through the application form during the application period or at any subsequent time.

~~(k) New provider applicants that completed their training prior to 2012 and, are still board eligible based on the American Board of Medical Specialties (ABMS) eligibility period, must achieve board certification status before the ABMS eligibility period lapses. If the provider's specialty board eligible period has expired based on the number of years following completion of residency, then they must achieve board certification prior to applying for medical staff privileges~~

The applicant shall also identify the staff category, clinical department, and clinical privileges for which the applicant wishes to be considered. The applicant shall pay a nonrefundable application fee, payable in advance, in the amount established by the Medical Executive Committee pursuant to Section 15.5~~4~~. The option to waive an applicant's initial processing fee may be considered by the Credentials Committee if requested in writing by the relevant department chair.

6.2 2 EFFECTS OF APPLICATION

By applying for appointment to the medical staff, reappointment, advancement or transfer, the applicant thereby signifies willingness to appear for interviews in regard to the application; authorizes the hospital's medical staff or its designee to consult with members of medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on the applicant's competence, character and ethical qualifications, and authorizes such persons to provide all such information; consents to the hospital's inspection of all records and documents that may be material to an evaluation of professional qualifications, personality, ability to cooperate with others, moral and ethical qualifications for membership, and physical, mental, and professional competence to carry out the clinical privileges the applicant requests and directs individuals who have custody of such records and documents to permit inspection and/or copying; certifies to report in writing any changes in the information submitted on the application form, which may subsequently occur, to the Credentials Committee and the ~~h~~Hospital ~~d~~Director; and releases from any and all liability, all individuals and

organizations providing information to the hospital concerning the applicant and all hospital representatives for their acts performed in connection with evaluating the applicant and his/her credentials; agrees that the hospital and medical staff may share information with a representative or agent from affiliated health care entities and providers, including information obtained from other sources, and release 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 its affiliated health care entities may act upon such information.

6.2-3 PHYSICAL AND MENTAL CAPABILITIES

(a) Obtaining Information:

i. When the Medical Staff Services Office verifies information and obtains references, it shall ask for any information concerning physical or mental disabilities to be reported. This information will also be referred to the department chair.

ii. The medical director, on behalf of the Physician Well-Being Committee, and with the assistance of the Physician Well-Being Committee, 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 the 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:

(1) Medical Examination: To ascertain whether the practitioner has a physical or mental disability that might interfere with the practitioner's ability to provide care which meets the hospital and medical staff's quality of care standards.

(2) Interview: To ascertain the condition of the practitioner and to assess if and how reasonable accommodations can be made.

iii. Practitioners who feel limited or challenged in any way by a qualified mental or physical disability in exercising their clinical privileges and in meeting quality of care standards should make such limitation immediately known to the medical director. Any such disclosure will be treated with the high degree of confidentiality that attaches to the medical staff's peer review activities.

(b) Review and Reasonable Accommodations:

i. Practitioners who disclose or manifest a qualified physical or mental disability will have their application processed in the usual manner without reference to the condition.

ii. The medical director 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 privileges requests and the Hospital Director) 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 medical director and the Physician Well-Being Committee may disclose information they have regarding any physical or mental disabilities and the effect of those on practitioner's application for membership and privileges. The medical director and the Physician Well-Being Committee and any other appropriate committees may meet with the practitioner to discuss if and how reasonable accommodations can be made.

iii. 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 and patient safety 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 below.

6.3 PROCESSING THE APPLICATION

6.3-1 APPLICANT'S BURDEN

In connection with all applications for appointment and reappointment, the applicant shall have the burden of producing accurate and adequate information for a proper evaluation of the applicant's experience, background, training, demonstrated ability, physical and mental health status, and all other qualifications specified in the medical staff bylaws and rules and regulations, and of the applicant's compliance with standards and criteria set forth in the medical staff bylaws and rules and regulations, and for resolving any doubts about these matters. The applicant's failure to sustain this burden shall be grounds for denial of the application. The provision of information containing significant misrepresentations or omissions and/or a failure to sustain the burden of producing adequate information shall also be grounds for denial of the application.

6.3-2 VERIFICATION OF INFORMATION

The applicant shall deliver an application form in full to the Medical Staff Services Office which shall, in a timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. The Medical Staff Services Office shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. An applicant whose

application is not completed within six (6) months after being received by the Medical Staff Services Office shall be automatically removed from consideration for staff membership and/or clinical privileges. Such an applicant's application may, thereafter, be reconsidered only if all information therein which may change over time, including, but not limited to, hospital reports and personal references, has been resubmitted.

6.3-3 DEPARTMENT AND CREDENTIALS COMMITTEE ACTION

Under the direction of the Credentials Committee, the department chair and/or appropriate subject matter experts, as deemed necessary by the Credentials Committee, shall review the application and supporting documentation according to established medical staff criteria regarding clinical privileges, professional conduct and competence, and may conduct a personal interview with the applicant. The department chair subject matter expert shall forward a written evaluation to the Credentials Committee. The department chair subject matter expert may also suggest that the Credentials Committee defer action. The Credentials Committee, or in cases eligible for expedited process the duly appointed designee, shall transmit to the Medical Executive Committee its report and recommendation, prepared in accordance with Section 6.3 6.

6.3-4 MEDICAL EXECUTIVE COMMITTEE (MEC) ACTION

At its next regular meeting, after receipt of the Credentials Committee report and recommendation, the Medical Executive Committee shall consider the Credentials Committee report. The Medical Executive Committee may ask the applicant to appear for an interview and/or request further documentation. The Medical Executive Committee shall then immediately forward to the He hospital dDirector for prompt transmittal to the governing board, its recommendation. The recommendation shall be prepared in accordance with Section 6.3-6. The MEC may also defer action on the application pursuant to Section 6.3-7. (a).

6.3-5 APPOINTMENT REPORTS

The department chair, Credentials Committee, and Medical Executive Committee reports and recommendations shall be transmitted in the form prescribed by the Medical Executive Committee. The report and recommendation shall specify whether medical staff appointment is recommended, and, if so, the membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The reason for the recommendation shall be stated, and supported by reference to the completed application and all other documentation which was considered, all of which shall be transmitted with the report.

6.3-6 BASIS FOR APPOINTMENT

The recommendation concerning an applicant for medical staff membership and clinical privileges shall be based upon whether the applicant meets the qualifications specified in

Section 3.2; can carry out the responsibilities specified in Section 3.6; and meets all of the standards and requirements set forth in all sections of these bylaws and in the medical staff rules and regulations. Specifically, a recommendation shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of the applicant's profession and other hospitals' medical staff bylaws, rules and regulations, and policies, rendition of services to patients, absence or accommodation of any physical or mental impairment which might interfere with the ability to practice medicine with reasonable skill and safety, and provision of accurate and adequate information to allow the medical staff to evaluate the applicant's competency and qualifications.

6.3-7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) Interviews, Further Documentation, Deferral: Action by the MEC to interview the applicant, seek further documentation, or defer the application for further consideration must be followed up within seventy (70) days with a subsequent recommendation for appointment with specified clinical privileges, or for denial of the request for medical staff membership.

(b) Favorable Recommendation: When the MEC's recommendation is favorable to the applicant, the Hospital Director or Chief Operating Officer (COO) shall forward the recommendation to the governing board within 12 months. The Hospital Director or COO is authorized by the Governing Board to make an appointment subject to final action by the Governing Board ratifying the appointment. In the event that the Governing Board does not ratify the Hospital Director's or COO action, that appointment shall be terminated and the Hospital shall notify the applicant and follow the procedure set forth in Section 6.3-8 (a) below.

(c) Adverse Recommendation: When the MEC's recommendation is adverse to the applicant, the chief of medical staff shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3 2; and the applicant shall be entitled to the procedural rights as provided in Article IX. For the purposes of this Section 6.3 8 (c), an "adverse recommendation" by the MEC is as defined in Section 9.2.

6.3-8 ACTION BY THE GOVERNING BOARD

(a) On Favorable Medical Executive Committee Recommendation: The governing board shall, in whole or in part, adopt or reject a Medical Executive Committee recommendation which is favorable to the applicant or refer the recommendation back to the Medical Executive Committee for further interviews, documentation, or consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the recommendation of the governing board is one of those set forth in Section 9.2, the Hospital Director shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner

specified in Section 9.3 2; and the applicant shall be entitled to the procedural rights as provided in Article IX before any final adverse action is taken.

(b) Without Benefit of Medical Executive Committee Recommendation: If the governing board does not receive a Medical Executive Committee recommendation within the time period specified in Section 6.3 12, it may, after notifying the Medical Executive Committee, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the governing board. If the recommendation is one of those set forth in Section 9.2, the Hhospital dDirector shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3 2; and the applicant shall be entitled to the procedural rights as provided in Article IX before any final adverse action is taken.

(c) After Procedural Rights: In the case of an adverse Medical Executive Committee recommendation pursuant to Section 6.3-7 (c) or an adverse governing board recommendation pursuant to Section 6.3-8 (a) or (b), the governing board shall take final action in the matter only after the applicant has exhausted or has waived procedural rights as required in Article IX. Action thus taken shall be the conclusive decision of the governing board, except that the governing board may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons thereof, shall set a time limit within which a subsequent recommendation to the governing board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the governing board shall make a final decision.

6.3-9 NOTICE OF FINAL DECISION

Notice of the final decision shall be given, through the hHospital dDirector, to the Medical Executive Committee, the Credentials Committee, the chair of each department concerned, and the applicant. A decision and notice to appoint shall include:

(a) the staff category to which the applicant is appointed;
(b) the department to which the applicant is assigned;
(c) the clinical privileges the applicant may exercise; and
(d) any special conditions attached to the appointment.
(e) board approval date and expiration date

6.3.10 DURATION OF APPOINTMENT

Initial appointment to the medical staff shall not exceed a period of two (2) years. Reappointment shall be for a period of not more than two (2) years.

6.3-110 -REAPPLICATION AFTER ADVERSE DECISION DENYING APPLICATION,

ADVERSE CORRECTIVE ACTION DECISION, OR RESIGNATION IN LIEU OF MEDICAL DISCIPLINARY ACTION

An applicant who has received a final adverse decision regarding membership, adverse corrective action decision or resigned in lieu of medical disciplinary action shall not be eligible to reapply to the medical staff for a period of thirty-six (36) months. Any such reapplication shall be processed as an initial application and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action or medical disciplinary action no longer exists.

~~(a) An applicant who:~~

~~(1) has received a final adverse decision regarding appointment or~~

~~(2) withdrew the application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or governing board;~~

~~(b) A former medical staff member who has:~~

~~(1) received a final adverse decision resulting in termination of medical staff membership and clinical privileges or~~

~~(2) resigned from the medical staff following the issuance of a medical staff or governing board recommendation adverse to the member's medical staff membership or clinical privileges; or~~

~~(c) A medical staff member who has received a final adverse decision resulting in:~~

~~(1) termination or restriction of the staff member's clinical privileges or~~

~~(2) denial of the staff member's request for additional clinical privileges~~

~~shall not be eligible to reapply for medical staff membership and/or clinical privileges affected by the previous action for a period of at least thirty-six (36) months from the date the adverse decision became final, the date the application or request was withdrawn, or the date the former medical staff member's resignation became effective, whichever is applicable.~~

~~For the purpose of this section, a decision shall be considered to be "adverse", for medical disciplinary action reasons, only if it is based on the type of occurrences which might give rise to corrective action and not if it is based upon reasons that do not directly pertain to medical or ethical conduct. Actions which are not considered adverse, for the purpose of this section, include actions based on a failure to maintain a practice in the area, which can be cured by a move, or to pay dues, which can be cured by paying dues, or to maintain professional liability insurance, which can be cured by securing such instance. Further, for the purpose of this section, an adverse decision shall be considered final at the time of completion of:~~

~~(a) all hearing, appellate review, and other quasi judicial proceedings conducted by the hospital bearing on the decision; and~~

~~(b) all judicial proceedings bearing upon the decision which are filed and served within thirty six (36) months after the completion of the hospital proceedings described in (1) above.~~

~~After the thirty- six (36) month period, the former applicant, former medical staff member, or medical staff member may submit an application for medical staff membership and/or clinical privileges, which shall be processed as an initial application. The former applicant, former medical staff member, or medical staff member shall also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists and/or of reasonable rehabilitation in those areas which formed the basis for the previous adverse recommendation or action, whichever is applicable. In addition, such an application shall not be processed unless the applicant or member submits satisfactory evidence to the MEC that the individual has complied with all of the specific requirements any such adverse decision may have included, such as completion of training or proctoring conditions. The Medical Executive Committee decision as to whether satisfactory evidence has been submitted shall be final subject only to further review by the governing board within forty five (45) days after the Medical Executive Committee decision was rendered.~~

6.3-~~1~~12 TIME PERIOD FOR PROCESSING

Applications shall be considered in a timely and good faith manner by all individuals and groups required by these bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in Section 6.3--11 and 6.3-12. The Medical Staff Services Office shall transmit an application to the department chair or designee and Credentials Committee within fifteen (15) days after all information collection and verification tasks are completed and all relevant materials have been received. The relevant department chair or designee shall act on an application within fifteen (15) days after receiving it from the Medical Staff Services Office. The Credentials Committee or designee shall then make its recommendation within thirty (30) days after the department chair has acted. The Medical Executive Committee shall review the application and make its recommendation to the governing board within thirty (30) days after receiving the Credentials Committee report. The governing board shall then take final action on the application within thirty (30) days. The time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the applicant to have the application processed within those periods.

In the event that relevant materials are not received within sixty (60) days after the application is received, the applicant shall be notified, and the application shall remain pending until either the materials are received by the Medical Staff Services Office or the expiration of six (6) months from the date the application was received. Applications that are not completed within six (6) months after receipt shall automatically be removed from consideration as specified in Section 6.3--2.

6.3-13~~2~~ EXPEDITED REVIEW

The Medical Staff Services Office will process the application according to written policies and procedures as defined in the Credentials Policies and Procedures Manual. If the Medical Staff Services Administrative Supervisor determines an applicant has no negative information in the file, as defined in the Expedited Credentialing Evaluation Process Policy and Procedure, the file will be referred to the relevant department chair or designee, who will determine whether the applicant qualifies for expedited action and s/he will, also, make a recommendation for membership and privileges. If they agree the applicant qualifies for expedited action, the file shall be referred to the Credentials Committee Chair or the duly appointed designee for review and recommendation to the Medical Executive Committee. The Medical Executive Committee will act upon the recommendation at its next scheduled meeting and will then forward its recommendation to the Governing Board for final action.

6.4 REAPPOINTMENTS

6.4 1 APPLICATION FOR REAPPOINTMENT; SCHEDULE FOR REVIEW

At least 180 days prior to the expiration of a member's current staff appointment, the Medical Staff Services Office shall mail a reappointment application to the staff member. The schedule for review shall be established in the Credentials Policies and Procedures.

A member's request for a change in membership category or in privileges may be processed in a year in which the member is not scheduled for biennial review; however, such member's appointment shall also be reviewed in accordance with the schedule set forth in the medical staff rules.

At least sixty (60) days prior to the expiration date of staff appointment, the medical staff member shall submit to the Medical Staff Services Office a completed reappointment application form. The reappointment application shall be in writing, on a form prescribed by the medical staff, and it shall require detailed information concerning changes in the applicant's qualifications since the last review. Specifically, the reappointment application form shall request all of the information and certifications requested in the appointment application form, as described in Section 6.2, including department chair recommendations, except for 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 whether the applicant requests any change in staff status and/or clinical privileges, including any reduction, deletion, or additional privileges. Request for additional privileges must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application for same.

6.4 2 VERIFICATION OF INFORMATION

The Medical Staff Services Office shall, in a timely fashion, seek to collect or verify the additional information made available on the reappointment application form and to

collect any other material or information deemed pertinent. The Medical Staff Services Office shall transmit the reappointment application form and supporting material to the chair, or designee, of each department in which the staff member has or requests privileges and to the Credentials Committee.

6.4-3 DEPARTMENT ACTION

The department chair or designee shall review the application, the staff member's file, and shall transmit to the Credentials Committee a written report and recommendation, which are prepared in accordance with Section 6.4 6. The chair or designee's report shall include review of peer review performance and quality assessment activities.

6.4-4 CREDENTIALS COMMITTEE ACTION

Following receipt of the department chair or designee's report concerning the application for reappointment, the Credentials Committee or in cases eligible for expedited process, the duly appointed designee, shall review the application, the department chair or designee's report, and all other pertinent information available on the member who is being considered for reappointment and shall transmit to the Medical Executive Committee its report and recommendation, which are prepared in accordance with Section 6.4 6.

6.4-5 MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive Committee shall review the department chair or designee and Credentials Committee's reports as well as all other relevant information available to it and shall forward immediately to the governing board, through the hHospital Ddirector, its favorable reports and recommendations, which are prepared in accordance with Section 6.4 6.

When the Medical Executive Committee recommends adverse action, as defined in Section 9.2, either in respect to reappointment or clinical privileges, the chief of medical staff shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3 2; and the applicant shall be entitled to the procedural rights as provided in Article IX. The governing board shall be informed of, but not take action on, the pending recommendation until the applicant has exhausted or waived procedural rights.

Thereafter, the procedures specified in Sections 6.3 9 (Action by the Governing Board), 6.3 10 (Notice of Final Decision) and 6.3 11 (Reapplication After Adverse Decision Denying Application, Adverse Corrective Action Decision, or Resignation in Lieu of Medical Disciplinary Action) shall be followed. The committee may also defer action; however, any such deferral must be followed up within seventy (70) days with a subsequent recommendation.

6.4-6 REAPPOINTMENT REPORTS

The department chair, Credentials Committee, and Medical Executive Committee reports and recommendations shall be written and submitted in the form prescribed by the Medical Executive Committee. The report and recommendation shall specify whether the applicant's appointment should be renewed, renewed with modified membership category, department affiliation, and/or clinical privileges, or terminated. Where nonrenewal, denial of requested privileges, a reduction in status, or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

6.4-7 BASIS FOR REAPPOINTMENT

The recommendation concerning the reappointment of a medical staff member and the clinical privileges to be granted upon reappointment shall be based upon whether such member has met the qualifications specified in Section 3.2, carried out the responsibilities specified in Section 3.6, and met all of the standards and requirements set forth in all sections of these bylaws and in the medical staff rules and regulations. Specifically, recommendations shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of the practitioner's profession, with the medical staff bylaws and rules and regulations and hospital policies, rendition of services to patients, any physical or mental impairment which might interfere with the ability to practice medicine with reasonable skill and safety, and the provision of accurate and adequate information to allow the medical staff to evaluate the practitioner's competency and qualifications.

6.4-8 FAILURE TO FILE REAPPOINTMENT FORM

A member shall be deemed to have voluntarily resigned his/her medical staff membership and clinical privileges if the member fails to file a complete application for reappointment at least sixty (60) days ~~seventy (75) days~~ prior to the expiration date of medical staff membership and clinical privileges. If a practitioner subsequently wishes to apply for membership and clinical privileges at Riverside University Health System Medical Center, she/he shall be required to apply for membership and clinical privileges as a new applicant.

Commented [KM10]: Changed to match 6.4-1 (60 days)

6.4-9 CHANGES BETWEEN ROUTINE REAPPOINTMENT DATES

Commented [KM11]: Changed to match 3.6 "Basic Responsibilities" provision

Whenever a member of the medical staff is first made aware of any interim changes from the information provided during a previous appointment or reappointment (as listed below), s/he must immediately notify the Medical Staff Services Office by telephone and shall furnish the information in writing within ten (10) calendar ~~two business~~ days to the Medical Staff Services Office. If the Medical Staff Services Office is closed when the member first calls to report the change(s), the immediate notification by telephone will be made to the medical director or the administrator on call prior to doing any clinical work. "Immediately" is defined as "occurring or accomplished without loss or interval of time."

- notification of any action taken regarding the member's license,
- DEA registration,
- privileges at other facilities,
- changes in liability insurance coverage,
- any report filed with the National Practitioner Data Bank,
- or any other change or circumstance that could affect his/her medical staff standing and/or clinical privileges at the hospital.

~~(a) The unstayed suspension, revocation, or non-renewal of license to practice medicine in California;~~

~~(b) Any suspension, revocation, or non-renewal of DEA or other controlled substance registration;~~

~~(c) Any cancellation or non-renewal of professional liability insurance coverage;~~

~~(d) Any change in health status that would pose a direct threat to the safety of patients;~~

~~(e) Receipt of written notice of any adverse action by the Medical Board of California (or appropriate licensing authority) taken or pending, including, but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation, or limitations, affecting the license to practice medicine;~~

~~(f) Any adverse action by any healthcare organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank;~~

~~(g) The denial, revocation, suspension, reduction, limitation, non-renewal or voluntary relinquishment by resignation of medical staff membership and/or clinical privileges at any healthcare organization;~~

~~(h) Any material reduction in professional liability insurance coverage;~~

~~(i) Receipt of written notice of any legal action, including without limitation any filed and served malpractice suit or arbitration action;~~

~~(j) Conviction of any crime (excluding minor traffic violations);~~

~~(k) Receipt of written notice of any adverse action under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.~~

6.5 PROCTORING REQUIREMENTS

6.5-1 FOR INITIAL APPOINTMENT

Except as otherwise determined by the Medical Executive Committee, all initial appointees to the medical staff that have been granted clinical privileges and all members granted additional clinical privileges, shall be subject to a period of proctoring. Proctoring can be prospective, concurrent and retrospective review. An initial appointee shall be assigned to a department where the appointee's performance shall be proctored by the chair of the department or the department designee, during the term of proctoring required by that department, as established pursuant to Section 3.8-3, to determine the initial appointee's eligibility for continued medical staff membership in the category to which appointed and to exercise the clinical privileges initially granted in that department. Proctoring arrangement shall be the responsibility of the appointee. The exercise of clinical privileges in any other department shall also be subject to prospective, concurrent and retrospective proctoring. The appointee shall remain subject to proctoring until the Credentials Committee has been furnished with.:

(a) A report signed by the chair, or designee, of the department to which the appointee is assigned describing the types and number of cases observed, an evaluation of the appointee's performance, and a statement that the appointee appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which appointed. The proctoring will include prospective, concurrent and retrospective chart review.

(b) A report signed by the chair, or designee, of the other department in which the appointee will exercise clinical privileges, describing the types and number of cases observed, an evaluation of the appointee's performance, and a statement that the appointee has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted.

6.5- 2 FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

When recommended by the Credentials and the Medical Executive Committees, and approved by the governing board, medical staff members who are granted additional privileges shall complete a period of proctoring with the procedures outlined in Section for initial appointees.

6.5- 3 TERM OF PROCTORING PERIOD

Each department may establish, in its rules and regulations, a term of proctoring and the number of cases, and/or specific number of cases applicable to particular clinical privileges whenever such requirements are appropriate in view of the clinical privileges which are involved. Proctoring will begin when privileges are initially granted, whether at the time

of initial appointment or the granting of temporary privileges. The term of proctoring may be extended not more than twelve (12)~~six (6)~~ months, for a total proctoring period of not more than-twenty-four (24) ~~twelve (12)~~ months. If an initial appointee fails within that period to complete the minimum number of cases ~~and/or furnish the certificates required in Section 3.8-1,~~ the appointee's medical staff membership or particular clinical privilege, as applicable, shall be automatically terminated. If a medical staff member requesting modification fails within that period to complete the minimum number of cases ~~and/or furnish the certifications required in Section 3.8-1,~~ the change in medical staff category or department assignment or the additional privileges, as applicable, shall be automatically terminated. The Medical Executive Committee Cchair shall give the initial appointee, or medical staff member so affected, written notice that medical staff membership and/or clinical privileges have been automatically terminated because of failure to satisfactorily complete the proctoring requirements.

Commented [KM12]: There is no such certificate requirement in prior paragraph 3.8-1

6.5-4 RECIPROCAL PROCTORING

Reciprocal Proctoring is defined as cases proctored at an outside hospital by proctoring physicians who may not have privileges at RUHS. These cases must have occurred within the last 2 years. Submitted cases must align with RUHS department specific proctoring requirements and forms. Minimally 50% of the cases must be proctored by a provider with RUHS active privileges.

Acceptance of reciprocal proctoring is at the discretion of the department chair. All proctoring forms/summary of cases should be signed by the RUHS department chair.

6.6 LEAVE OF ABSENCE

6.6-1 LEAVE STATUS

A leave of absence may be considered upon the written request of a medical staff member. A leave of absence may be granted for not more than two (2) years. On no condition will a leave of absence be granted beyond two years. The Credentials Committee will review the request for a leave of absence and the action by Credentials, upon ratification by the Medical Executive Committee, will be transmitted to the Hospital Director for notation in the practitioner's file. The practitioner must give a date of expected return in order that the leave of absence is kept current. During the period of the leave, the practitioner's clinical privileges, prerogatives, responsibilities shall be suspended.

6.6-2 REASONS FOR GRANTING LEAVE

The following reasons for granting a leave of absence shall be considered by the Credentials Committee:

(a) Illness
(b) Military service
(c) Temporary medical training or education

(d) Sabbatical leave
(e) Outside high achievement of exceptional merit
(f) Other special conditions as approved by the Credentials Committee

6.6-3 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave, or at any earlier time, the medical staff member may request reinstatement of privileges and prerogatives by submitting a written notice to that effect to the Hospital Director and to the Credentials Committee. If so requested by the Medical Executive Committee or the Hospital Director, the staff member shall submit a written summary of relevant activities during the leave. The Medical Executive Committee shall recommend whether to approve the member's request for reinstatement of privileges and prerogatives; thereafter, the procedure set forth in Sections 6.3 7 through 6.3 11 shall be followed.

Failure, without good cause, to request reinstatement or to provide a requested summary of activities shall be deemed to be a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives.

ARTICLE VII - CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

A practitioner providing direct clinical services at this hospital, in connection with such practice and except as otherwise provided in Section 7.5 (Emergency Privileges) shall treat and service patients as assigned by the department chair and shall be entitled to exercise only those clinical privileges specifically approved by the medical staff and granted to the member by the governing board. Said privileges must be within the scope of any license, certificate, or other legal credential authorizing the member to practice in this state and consistent with any restrictions thereon.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2-1 REQUESTS

The application for appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. Request from an applicant for privileges, or from a member for modification of privileges, must be supported by documentation of the requisite training, experience, qualifications and competency to exercise such privileges.

7.2-2 BASIS FOR PRIVILEGES DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, and demonstrated ability and judgment. The elements to be considered in making determination regarding privileges, whether in connection with periodic reappointment or otherwise, shall include education, training, observed clinical performance and judgment, performance of a sufficient number of procedures each year to develop and maintain the practitioner's skills and knowledge, and the documented results of the patient care audit and other quality review, evaluation, and monitoring activities required by these, and the hospital ~~corporate~~ bylaws to be conducted at the hospital. Privileges determination shall also take into account pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.

7.2-3 PROCEDURE

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article VI.

7.3 SPECIAL CONDITIONS APPLICABLE TO DENTAL AND PODIATRIC PRIVILEGES

Surgical procedures performed by a dentist shall be under the overall supervision of the chair of the department of surgery or designee. Surgical procedures performed by a podiatrist shall be under the overall supervision of the chair of the department of orthopedic surgery or designee. All dental and podiatric patients shall be co admitted by a physician medical staff member and shall receive the same basic medical appraisal as patients admitted to other surgical services.

The co admitting physician medical staff member shall be responsible for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient. A request for clinical privileges from a dentist or podiatrist shall be processed in the manner specified in Section 7.2

7.4 TEMPORARY PRIVILEGES

7.4-1 PENDING APPLICATION

Temporary clinical privileges may be granted to a physician, dentist, podiatrist, clinical psychologist, or an allied health professional under strictly defined and enforced circumstances. Temporary privileges may be granted up to 120 calendar days when a complete ~~and clean~~ application for membership or clinical privileges is pending review and recommendation by the Medical Executive Committee and Governing Body.

7.4-2 SPECIFIC PATIENT CARE

Temporary clinical privileges may be granted on a case-by-case basis when an important patient care issue exists that mandates an immediate authorization to practice, for a

limited period of time, to a physician, dentist, podiatrist, clinical psychologist, or an allied health professional to fulfill an important patient care, treatment, and service need provided that the procedure described in the medical staff organization's Temporary Privileges Policy and Procedure and~~,~~ in the Credentials Policies and Procedures Manual, are followed.

7.4-3 CONDITIONS

(a) If granted temporary privileges, the applicant shall act under the supervision of the department chair to which the applicant has been assigned, and shall ensure the chair, or the chair's designee, is kept closely informed of his/her activities within the hospital.

(b) Temporary privileges shall automatically terminate at the end of the designated period, unless terminated earlier by the Medical Executive Committee upon recommendation of the department, the Credentials Committee, or the medical director. As necessary, the appropriate department chair or in the chair's absence, the chief of medical staff, shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.

(c) Temporary privileges may at any time be terminated with or without cause by the chief of medical staff, the chair of the department, or the H~~h~~ospital D~~d~~irector after conferring with either of the foregoing. The practitioner shall be entitled to the procedural rights afforded in Article IX of these bylaws only if temporary privileges are terminated or suspended for a medical disciplinary cause or reason. In all other cases, the individual shall not be entitled to any procedural rights based upon an adverse action involving temporary privileges. All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the medical staff.

(d) There is no right to temporary privileges. Temporary privileges shall not be granted if the available information is incomplete, inconsistent or casts any reasonable doubt on the applicant's qualifications. Action on a request for temporary privileges shall be deferred until doubts have been satisfactorily resolved. A decision to defer shall not be deemed a denial of a request for temporary privileges. Such deferral shall not give rise to the rights set forth in Section IX.

7.5 EMERGENCY AND DISASTER PRIVILEGES

In the case of an emergency, any member of the medical staff, to the degree permitted by his/ her California license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency

care and assistance by members of the medical staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the chair with respect to further care of the patient at the hospital.

In the event of emergency disaster privileging, refer to the Emergency Privileging during Disaster Policy in the Credentials Policy/Procedure Manual. The procedures as described in the policy will be implemented.

ARTICLE VIII - CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1-1 FOCUSED PROFESSIONAL PRACTICE REVIEW

The Medical Executive Committee shall define, on a continuous basis, the circumstances warranting further intensive review of a member or other practitioner's services provided under privileges held and establish the parameters for participation of the subject under review in the focused review process. When circumstances warrant, the Medical Executive Committee shall refer the matter to the Professional Practice Evaluation Committee (PPEC) who shall conduct the review in accordance with the "PROFESSIONAL PRACTICE EVALUATION PROGRAM" policy. A focused professional review triggered by an adverse event will result in recommendations for changes to improve the member's performance; recommendations for system, protocol or policy changes; a request for investigation or corrective action or other action.

8.1-2 CRITERIA FOR INITIATION

Whenever a practitioner with clinical privileges shall engage in, make, or exhibit acts, statements, demeanor, or professional conduct, either within or outside of the hospital, and the same is, or is reasonably likely to be detrimental to patient safety or to the delivery of quality patient care at the hospital, to be disruptive to hospital operations, or improper use of hospital resources, or act contrary to the bylaws, or to constitute fraud or abuse; or the same results in the imposition of sanctions by any governmental authority; an investigation or corrective action against such person may be requested by any medical staff officer, by the medical director, or by the chair or vice chair of any department in which the practitioner is a member to exercise clinical privileges. The Professional Practice Evaluation Committee (PPEC) or Department Chairs may initiate Focused Professional Practice ~~Review~~ Evaluation (FPPE). ~~If the FPPE initiated by the Department Chair results in any corrective action, it must be approved by the Medical Executive Committee. The chair of any standing medical staff committee, the governing board, or the Hhospital dDirector may also request an investigation or corrective action.~~ The FPPE Policy describes the process and procedures to be followed.

8.1-3 EXTERNAL PEER REVIEW

Formatted: Indent: Left: 0.5"

Commented [KM13]: Text from CMA Model Bylaws 6-2-5

External peer review may be used to inform medical staff peer review as delineated under these bylaws. The Credentials Committee or the Medical Executive Committee, upon request from a Department or upon its own motion, in evaluating or investigating an applicant, privileges holder, or member, shall obtain external peer review in the following circumstances:

(a) Committee or department review(s) that could affect an individual's membership or privileges do not provide a sufficiently clear basis for action;
(b) No current Medical Staff member can provide the necessary expertise in the clinical procedure or area under review;
(c) to promote impartial peer review;
(d) Upon the request of the practitioner.

8.1-3 INITIATION

Proposed corrective action, including a request for an investigation, must be initiated by the Medical Executive Committee on its own initiative or by a written request which is submitted to the Medical Executive Committee that identifies the specific activities or conduct which are alleged to constitute the grounds for proposing an investigation or specific corrective action. The chief of medical staff or medical director shall promptly notify the hHospital dDirector of all proposals for corrective action so initiated and shall continue to keep the Hhospital Ddirector fully informed of all actions taken in conjunction therewith.

8.1-4 INVESTIGATION

Upon receipt, the Medical Executive Committee may act on the proposal or direct that an investigation be undertaken. The Medical Executive Committee may conduct that investigation itself or may assign this task to an appropriately charged officer or to a standing or ad hoc medical staff committee. No such investigation process shall be deemed to be a "hearing" as that term is used in Article IX.

If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall forward a written report of the investigation to the Medical Executive Committee as soon as is practicable after the assignment to investigate has been made. The Medical Executive Committee may at any time within its discretion, and shall at the request of the governing board, terminate the investigative process and proceed with action as provided in Section 8.1- 5 below.

An external peer review consultant may be considered when:

(a) Litigation seems likely.

(b) The hospital is faced with ambiguous or conflicting recommendations from medical staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by

~~the Medical Executive Committee or the governing board to retain an objective external review.~~

~~(c) There is no one on the medical staff with expertise in the subject under review, or when the only physicians on the medical staff with appropriate expertise are direct competitors or partners of the physician under review.~~

~~(d) In addition, the Medical Executive Committee or Governing Body may require external peer review in any circumstances deemed appropriate by either of these bodies.~~

8.1-5 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as is practicable after the conclusion of the investigative process, if any, but in any event within sixty (60) days after the initiation of proposed corrective action, unless deferred pursuant to Section 8.1-6, the Medical Executive Committee shall act thereon. Such action may include, without limitation, the following actions or recommendations:

(a) Determine no corrective action to be taken, and if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file.

(b) Refer the member to the Physician Well-Being Committee for evaluation and follow-up as appropriate.

(c) -Issue letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude clinical department chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file.

(d) Recommend the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring.

(e) Recommend reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care.

(f) Recommend suspension, revocation or probation of medical staff membership.

(g) Take other actions deemed appropriate under the circumstances.

Nothing set forth herein shall inhibit the Medical Executive Committee from implementing summary suspension at any time, in the exercise of its discretion pursuant to Section 8.2. (Summary Restriction or Suspension)

8.1-6 DEFERRAL

If additional time is needed to complete the investigative process, the Medical Executive Committee may defer action on the request, and it shall so notify the affected practitioner. A subsequent recommendation for any one or more of the actions provided in Section 8.1 5, Paragraphs (a) through (g) above must be made within the time specified by the Medical Executive Committee, and if no such time is specified, then within thirty (30) days of the deferral.

8.1-7 PROCEDURAL RIGHTS

Any recommendation by the Medical Executive Committee pursuant to Section 8.1--5 which constitutes grounds for a hearing as set forth in Section 9.2 shall entitle the practitioner to the procedural rights as provided in Article IX. In such cases, the chief of medical staff shall give the practitioner written notice of the adverse recommendation and of the right to request a hearing in the manner specified in Section 9.3 2.

8.1-8 OTHER ACTION

(a) If the Medical Executive Committee's recommended action is to recommend no corrective action, such recommendation, together with such supporting documentation as may be required by the Ggoverning Bboard, shall be transmitted thereto. Thereafter, the procedure to be followed shall be the same as that provided for applicants in Sections 6.3--9 (Action by the Governing Board) and 6.3--10 (Notice of Final Decision), as applicable.

(b) If the Medical Executive Committee's recommended action is an admonition, reprimand, or warning to a practitioner, it shall, at the practitioner's request, grant the applicant an interview. Following the interview, if one is requested, if the Medical Executive Committee's final recommendation to the Hhospital dDirector is an admonition, reprimand, or warning this shall conclude the matter when approved by the governing board without substantial modification, and notice of the final decision shall be given to the Ggoverning bBoard, hHospital DDirector, Medical Executive Committee, the chair and vice chair of each department concerned, and the practitioner.

(c) If any proposed corrective action by the Ggoverning Bboard will substantially modify the Medical Executive Committee's recommendation, the governing board may submit the matter to the Joint Conference Committee for review and recommendation before making its decision final. Any recommendation of the governing board which constitutes grounds for a hearing, as set forth in Section 9.2, shall entitle the practitioner to the procedural rights as provided in Article IX. In such cases, the governing board shall give the practitioner written notice of the tentative adverse

recommendation and of the right to request a hearing in the manner specified in Section 9.3 2.

(d) Should the Ggoverning bBoard determine that the Medical Executive Committee's failure to investigate, or initiate disciplinary action, is contrary to the weight of the evidence, the Ggoverning Bboard may direct the Medical Executive Committee to initiate an investigation or a disciplinary action, but only after consultation with the Medical Executive Committee. In the event the Medical Executive Committee fails to take action in response to a direction from the Ggoverning Bboard, the Ggoverning bBoard, after notifying the Medical Executive Committee in writing, may take action on its own initiative. If such action is favorable to the practitioner, or constitutes an admonition, reprimand or warning to the practitioner, it shall become effective as the final decision of the Ggoverning Bboard. If such action is one of those set forth in Section 9.2, the Ggoverning Bboard shall give the practitioner written notice of the adverse recommendation and of the right to request a hearing in the manner specified in Section 9.3 2 and the rights shall be as provided in Article IX.

Formatted: Left, Indent: Left: 0.25"

8.2 SUMMARY RESTRICTION OR SUSPENSION

8.2-1 CRITERIA FOR INITIATION

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person, the medical director, the Medical Executive Committee, or the chair of department or designee in which the member holds privileges may summarily restrict or suspend the medical staff membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Ggoverning Bboard, the Medical Executive Committee and the Hhospital Ddirector. In addition, the affected medical staff member shall be provided with a written notice of the action which notice fully complies with the requirement of Section 8.2-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chair or by the medical director, considering where feasible, the wishes of the patient in the choice of a substitute member.

8.2-2 WRITTEN NOTICE OF SUMMARY SUSPENSION

Within one (1) working day of imposition of a summary suspension, the affected medical staff member shall be provided with written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the practitioner's privileges summarily could

reasonably result in an imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 9.3-1 (which applies in all cases where the MEC does not immediately terminate the summary suspension). The notice under Section 9.3-1 may supplement the initial notice provided under this section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

8.2-3 MEDICAL EXECUTIVE COMMITTEE ACTION

Within one (1) week after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee (or a subcommittee appointed by the chief of medical staff) shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article IX, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within two (2) working days of the meeting.

8.2-4 PROCEDURAL RIGHTS

Unless the Medical Executive Committee terminates the summary restriction or suspension, within 14 days the member shall be entitled to the procedural rights afforded by Article IX. In addition, the affected practitioner shall have the following rights:

(a) Any affected practitioner shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether or not the facts stated in the notice present a reasonable possibility of "imminent danger" to an individual. Initially, the practitioner may present this challenge to the Medical Executive Committee at the meeting held within one (1) week of imposition of the suspension. If the MEC's decision is to continue the summary suspension, beyond 14 days, then any practitioner who has properly requested a hearing under the medical staff bylaws may request that the hearing be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters, including the propriety of summary suspension.

(b) At the conclusion of the procedural portion of the hearing, the hearing officer (or hearing panel) shall issue a written opinion on the issues raised, including whether or not the facts stated in the written notice to the affected practitioner adequately support a determination that failure to summarily restrict or suspend could reasonably result in "imminent danger" to an individual. Such written opinion shall be transmitted to both the affected practitioner and the Medical Executive Committee within one (1) week of the date of the procedural hearing.

(c) If the hearing officer's (or hearing panel's) determination is that the facts stated in the notice required by Section 8.2-2 do not support a reasonable determination that failure to summarily restrict or suspend the practitioner's privileges could result in imminent danger, the summary suspension shall be immediately stayed pending the outcome of the hearing and any appeal.

(d) If the hearing officer (or hearing panel) determines that the facts stated in the notice required by Section 8.2-2 support a reasonable determination that summary suspension was necessary to avoid imminent danger to an individual, the summary suspension shall remain in effect pending conclusion of the hearing and any appellate review.

8.2-5 INITIATION BY THE GOVERNING BOARD

If the medical director, members of the Medical Executive Committee and the chair of the department (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the governing board (or designee) may immediately suspend a member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any patient, prospective patient, or other person, provided that the governing board (or designee) made reasonable attempts to contact the medical director, members of the Medical Executive Committee and the chair of the department (or designee) before the suspension. Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two (2) working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provision under Section 8.2 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

8.3 AUTOMATIC AND IMMEDIATE SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership may be immediately suspended or limited as described, and all patient care activity shall immediately cease, if requested, shall be limited to the question of whether the grounds for automatic suspension or limitation as set forth below have occurred.

8.3-1 LICENSURE

(a) **Revocation and Suspension**: Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, medical staff

membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

(b) **Restriction:** Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges that the member has been granted at the hospital, which are within the scope of said limitation or restriction, shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(c) **Probation:** Whenever a member is placed on probation by the applicable licensing or certifying authority, the member's membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation, as of the date such action becomes effective and throughout its term.

8.3-2 CONTROLLED SUBSTANCES

(a) **Revocation, Limitation, Suspension:** Whenever a member's Drug Enforcement Administration (DEA) certificate is revoked, limited or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(b) **Probation:** Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

8.3-3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

Failure of a member without good cause to appear and satisfy the requirements of Section 13.7-3 shall be a basis for corrective action.

8.3-4 MEDICAL RECORDS

Members of the medical staff are required to complete medical records within such reasonable time as may be prescribed in the Medical Staff Rules and Regulations. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the Medical Director, or designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related privileges" means scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services at the hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the Medical Director or designee.

8.3-5 FAILURE TO PAY DUES/ASSESSMENTS

Failure without good cause, as determined by the Medical Executive Committee, to pay fees, dues or assessments as required under Section 15.4 shall be grounds for automatic suspension of a member's clinical privileges, and if within thirty (30) days after written warning of delinquency the member does not pay the required dues or assessments, the member's membership shall be automatically terminated.

8.3-6 EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in Section 8.3-1 (b) or (c), Section 8.3-2, 8.3-3, or 8.3-4, the Medical Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Section 9.3-1.

8.3-7 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance, if any is required, shall be grounds for automatic suspension of a member's clinical privileges, and if within thirty (30) days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.

Formatted: Centered, Widow/Orphan control, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers, Tab stops: Not at 0.7" + 6.4"

ARTICLE IX – FAIR HEARINGS

9.1 GENERAL PROVISIONS

Review Philosophy

The intent in adopting these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners (as defined below), and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures which do not create burdens that will discourage the Medical Staff and Governing Body from carrying out peer review.

Accordingly, the intent of the Medical Staff and Governing Body is to create a hearing process which provides for the least burdensome level of formality in the process and yet still provides a fair hearing and to interpret these Bylaws in that light. Technical, insignificant or nonprejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

The Medical Staff, the Governing Body, and their officers, committees and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

9.1-1 EXHAUSTION OF REMEDIES

If adverse action described in Section 9.2 (Grounds for Hearing) is taken or recommended, the applicant or member must exhaust the procedures under this Article before resorting to legal action.

9.1-2 APPLICATION OF ARTICLE

For the purposes of this Article, the term "member" may include "applicant," as it may be applicable under the circumstances, unless otherwise stated.

9.1-3 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within a reasonable time.

9.1-4 FINAL ACTION

Recommended adverse actions described in Section 9.2 shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived.

9.2 GROUNDS FOR HEARING

Except as otherwise specified in these bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing:

(a) denial of initial or reappointment applications for medical staff membership;
(b) denial of requested advancement in staff membership status, or category;
(c)
(d) involuntary change in medical staff category or membership status;
(e) suspension of medical staff membership;
(f) revocation of medical staff membership;
(g) denial of requested clinical privileges;
(h) involuntary restriction of clinical privileges;
(i) suspension of all clinical privileges;
(j) termination of all clinical privileges;
(k) involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status and Section 3.8) that cannot be completed prior to the time frame required for reporting the restriction to the Medical Board of California; or
(l) any other action which requires a report to be made to the Medical Board of California under the provision of Section 805 of the California Business and Professions Code.

9.3 REQUESTS FOR FAIR HEARING

9.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 9.2, said person or body shall give the member prompt written notice of:

(a) the recommendation or final proposed action and that such action, if adopted, shall be reported to the Medical Board of California pursuant to Section 805 of the California Business and Professions Code and to the National Practitioner Data Bank, , if required;
(b) the reasons for the proposed action including the acts or omissions with which the member is charged;
(c) the right to request a hearing pursuant to Section 9.3-2, and that such hearing must be requested within thirty (30) days; and
(d) that that the hearing will be conducted pursuant to these medical staff bylaws.
(e) the member's right to be represented by legal counsel at the hearing proceedings;

(f) that the Medical Staff will be represented by legal counsel at the hearing proceedings.

9.3-2 REQUEST FOR FAIR HEARING

The member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Medical Executive Committee with a copy to the Governing Board. The request shall include the identity of any legal counsel that will represent the member at the hearing proceedings. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendations or actions involved and, thereupon, said recommendations or actions shall be forwarded to the Governing Board.

9.3-3 TIME AND PLACE FOR FAIR HEARING

Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing and give notice to the member of the time, place, and date of the hearing. ;

9.3-4 NOTICE OF HEARING CONTENTS

Together with the notice stating the place, time and date of the hearing unless waived by a member under summary suspension, the Medical Executive Committee shall provide a list of the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee. The content of this list is subject to update pursuant to Section 9.4-1.

9.3-5—

~~9.3-5~~ FAIR HEARING ARBITRATOR

When a hearing is requested, the Medical Executive Committee shall recommend a qualified Arbitrator to the governing board for appointment. The identity of the proposed arbitrator shall be disclosed the member along with a stated time within which the member may raise objections, if any, in writing as to the qualifications and independence of the arbitrator to the Medical Executive Committee. The governing board shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objections within five (5) days.

The arbitrator shall be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the hospital, the medical staff or the involved medical staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve arbitrator. The arbitrator shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The arbitrator shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The arbitrator shall be entitled to determine the order of, or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence.

If the arbitrator determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the arbitrator may take such discretionary action as seems warranted by the

circumstances. At the conclusion of the hearing the aArbitrator will present to the Medical Executive Committee proposed findings of fact and conclusions of law related to all matters raised in the hearing.

9.3-6 FAILURE TO APPEAR OR PROCEED

Failure of the member to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.,

9.3-7 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws and set forth in any Order by the Arbitrator may be permitted by the Arbitrator on a showing of good cause

9.4 HEARING PROCEDURE

9.4-1 PREHEARING PROCEDURE

(a) The appointed Arbitrator shall enter one or more prehearing orders including specific deadlines addressing the matters covered in this section, after providing an opportunity for hearing the parties or their representatives.

(b) If either side to the hearing requests in writing a list of witnesses, of such request, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing.

(c) The member shall have the right to inspect and copy documents or other evidence upon which the charges are based, and shall also have the right to receive, to the hearing, a copy of the evidence forming the basis of the charges, including all evidence which was considered by the Medical Executive Committee in determining whether to proceed with the adverse action, and any exculpatory evidence in the possession of the hospital or medical staff.

(c) The Medical Executive Committee shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the member has in his or her possession or control.

(d) The failure by either party to provide access to this information before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the members under review.

(e) **Objections to Introduction of Evidence Previously Not Produced for the Medical Staff.** The Medical Executive Committee may object to the introduction of the evidence that was not provided during an appointment, reappointment or privilege application review or during corrective action despite the requests of the peer review body for such information. The information will be barred from the hearing by the Arbitrator unless the practitioner can prove he or she previously acted diligently and could not have submitted the information.

(f) The Arbitrator shall establish a schedule for the exchange of lists of witnesses, the inspection and copying of documents or other information; The Arbitrator shall consider and rule upon any objection to production of requested information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the Arbitrator shall consider:

(i) whether the information sought may be introduced to support or defend the charges;

(ii) the exculpatory or inculpatory nature of the information sought, if any;

(iii) the burden imposed on the party in possession of the information sought, if access is granted; and

(iv) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(g) Before the hearing, the member shall be entitled to a reasonable opportunity to question and challenge the impartiality of Arbitrator. Challenges to the impartiality of a Arbitrator shall be submitted in writing and decided by the Governing Board

(h) It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the Arbitrator of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

9.4-2 REPRESENTATION

The hearings provided for in these bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character.

The member shall be entitled to representation by legal counsel in any phase of the hearing, should the member so choose. Instead of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing by an individual, who is not an attorney, of the member's choosing, and the Medical Executive Committee shall appoint a representative, who is not an attorney, to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions.

-9.4-3 RECORD OF THE HEARING

A record of the hearing proceedings and any pre-hearing proceedings shall be created if deemed appropriate by theArbitratorArbitrator or requested by either party. The cost of the transcript, if any, shall be borne by the party requesting it. The Arbitrator may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

9.4-4 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The member may be called as a witness by the Medical Executive Committee and examined as if under cross-examination.

In addition, the affected practitioner who has been summarily suspended shall have the following rights:

(a) Any affected practitioner shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether or not the facts stated in the notice present a reasonable possibility of "imminent danger" to an individual. Initially, the practitioner may present this challenge to the Medical Executive Committee at the meeting held within one (1) week of imposition of the suspension. If the MEC's decision is to continue the summary suspension, beyond 14 days, then any practitioner who has properly requested a hearing under the medical staff bylaws may request that the hearing be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters, including the propriety of summary suspension.

(b) At the conclusion of the procedural portion of the hearing, the Arbitrator shall issue a written opinion on the issues raised, including whether or not the facts stated in the written notice to the affected practitioner adequately support a determination that failure to summarily restrict or suspend could reasonably result in "imminent danger" to an individual. Such written opinion shall be transmitted to both the affected practitioner and the Medical Executive Committee within one (1) week of the date of the procedural hearing.

(c) If the Arbitrator's determination is that the facts stated in the notice required by Section 8.2-2 do not support a reasonable determination that failure to summarily restrict or suspend the practitioner's privileges could result in imminent danger, the summary suspension shall be immediately stayed pending the outcome of the hearing and any appeal.

(d) If the Arbitrator determines that the facts stated in the notice required by Section 8.2-2 support a reasonable determination that summary suspension was necessary to avoid imminent danger to an individual, the summary suspension shall remain in effect pending conclusion of the hearing and any appellate review.

9.4-5 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Arbitrator may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Arbitrator may request or permit both sides to file written arguments.

9.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

(a) At the hearing, the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

(b) An applicant shall bear the burden of persuading the Arbitrator, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the medical staff, which was not produced during the application process, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the Arbitrator, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

9.4-8 ADJOURNMENT AND CONCLUSION

After consultation with the parties, the Arbitrator may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing arguments, if submitted, the hearing shall be closed.

9.4-9 BASIS FOR DECISION

The decision of the Medical Executive Committee shall be based on the evidence introduced at the hearing, including logical and reasonable inferences from the evidence and the testimony. The decision of the Medical Executive Committee shall be subject to such rights of appeal as described in these bylaws, but shall otherwise be affirmed by the governing board as the final action if it is supported by substantial evidence, arrived at by following a fair procedure.

9.4-10 DECISION OF THE MEDICAL EXECUTIVE COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the Arbitrator shall render a report in writing of his / her findings of fact and proposed conclusions of law regarding the matters heard to the Medical Executive Committee. A copy of said report also shall be forwarded to the hospital director, the governing board and to the member. The report shall contain a concise statement of the findings of fact and a proposed conclusion(s) articulating the connection between the evidence produced at the hearing and the conclusion reached. If the final proposed action adversely affects the clinical privileges of a physician or dentist for a period longer than thirty (30) days and is based on competence or professional conduct, the decision shall state that the action if adopted will be reported to the National Practitioner Data Bank, and shall state the text of the report proposed by the Arbitrator. The Medical Executive Committee shall then meet to consider whether to adopt the findings of fact and related conclusions and the effect of the report on the original decision reached by the MEC. The MEC may also , upon review, request that the hearing be reopened and additional findings be made by the Arbitrator upon matters not addressed in the original report. The member may provide the Medical Executive Committee and the Governing Board with a written response to the report and the final action recommended by the MEC.

9.6 EXCEPTIONS TO HEARING RIGHTS

9.6-1 MEDICO ADMINISTRATIVE OFFICER

The fair hearing rights of Articles VIII and IX do not apply to those persons serving the hospital in a medico administrative capacity. Removal from office of such persons shall instead be governed by the terms of their individual contracts and agreements with the hospital or Riverside County Ordinance 440 where applicable. However, the hearing rights of the preceding sections of this Article IX and of Article VIII shall apply to the extent that medical staff membership status or clinical privileges, which are independent of the practitioner's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

9.6-2 __FAIR HEARING AND APPEALS FOR ALLIED HEALTH PRACTITIONERS (AHPs)

AHPs are not entitled to the hearing and appeals procedures set forth in the medical staff bylaws. In the event one of these practitioners receives notice of a recommendation by the Medical Executive Committee that will adversely affect his/her exercise of clinical privileges, the practitioner and his/her supervising physician shall have the right to meet personally with two physicians and a peer assigned by the Chief of Staff to discuss the recommendation. The practitioner and the supervising physician must request such a meeting in writing to the Medical Staff Office within 10 working days from the date of receipt of such notice. At the meeting, the practitioner and the supervising physician must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing and none of the procedural rules set forth in this Article IX of the medical staff bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected practitioner, the Medical Director and the Medical Executive Committee

The practitioner and the supervising physician may request an appeal in writing to the Medical Staff Office within 10 days of receipt of the findings of the review body. Two members of the Medical Executive Committee assigned by the President of the Medical Staff shall hear the appeal from the practitioner and the supervising physician. A representative from the medical staff leadership may be present. The decision of the appeal body will be forwarded to the Board for final decision. The practitioner and the supervising physician will be notified within 10 days of the final decision of the Board.

9.6-3 __AHP AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

In the following instances, the allied health professional privileges may be immediately suspended or limited as described, and all patient care activity shall immediately cease, if requested, shall be limited to the question of whether the grounds for automatic suspension as set forth below have occurred.

(a) The medical staff membership of the supervising physician, if any, is terminated, whether such termination is voluntary or involuntary.

(b) The supervising physician, if any, no longer agrees to act as the supervising physician, for any reason, or the relationship between the AHP and the supervising physician, if any, is otherwise terminated, regardless of the reason therefore.

(c) The AHP's certification or license expires, is revoked or suspended.

9.6 3 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Section 8.3-1 (a). In other cases described in Section 8.3-1 and 8.3-2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority of the DEA was unwarranted, but only whether the member may continue practice in the hospital with those limitations imposed.

ARTICLE X - CLINICAL DEPARTMENTS AND DIVISIONS

10.1 ORGANIZATION OF DEPARTMENTS AND DIVISIONS

The medical staff shall be organized into clinical departments. Each department shall be organized as a separate component of the medical staff and shall have a department chair selected and entrusted with authority, duties and responsibilities as specified in Section 11.3; and a department vice chair elected and entrusted with the authority, duties and responsibilities as specified in Section 11.4. A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which it functions, and shall have a division chair selected and entrusted with the authority, duties and responsibilities specified in Section 11.5. The clinical department or division may meet separately or jointly.

10.2 DESIGNATION

The departments and divisions are:

(a) Anesthesiology

(b) Emergency Medicine

(c) Family Medicine

(d) Medicine with Divisions of General Internal Medicine, Cardiology, Gastroenterology, Geriatrics, Hematology/Oncology, Nephrology, Neurology, Pulmonary & Critical Care Services, Inpatient Medicine Services, and Ambulatory Care Services with subdivisions of Dermatology, Endocrinology, Infectious Disease, and Rheumatology, Palliative Care.

(e) Clinical Neurological Sciences (Neurological Surgery)

(f) Obstetrics and Gynecology

(g) Ophthalmology

(h) Orthopaedic Surgery and Rehabilitation and Divisions of Spine Surgery and Podiatry

(i) Pathology, including Clinical Laboratory

(j) Pediatrics with Division of Neonatology and Division of Critical Care

(k) Psychiatry

(l) Radiology, including Diagnostic, Therapeutic, Nuclear Medicine, and Neuroradiology

(m) Surgery with Divisions of General Surgery/Trauma/ Acute Care, Thoracic Surgery, Vascular Surgery, ~~Hyperbaric Medicine~~, Plastic Surgery, ~~Dental~~, Oral & Maxillofacial Surgery, Head, Neck Surgery & Otolaryngology, Urology, Pediatric Surgery, Surgical Oncology

10.3 DEPARTMENT/DIVISION FORMATION OR ELIMINATION

A medical staff department/division can be formed or eliminated only following a determination by the medical staff of appropriateness of department/division elimination or formation. The governing board decision shall uphold the medical staff's determination unless the governing board makes specific written findings that the medical staff's determination is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

The medical staff shall determine the formation or elimination of a department/division to be appropriate based upon consideration of its effects on quality of care in the facility and/or community. A determination of the appropriateness of formation or elimination of a department/division must be based upon the preponderance of the evidence, viewing the record as a whole, presented by any and all interested parties, following notice and opportunity for comment .

10.4 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

A member shall be assigned membership in at least one department or division, as applicable, and may also be granted membership and/or clinical privileges in other departments or divisions consistent with the practice privileges that have been granted. The exercise of clinical privileges in any department is subject to the rules and regulations of that department and to the authority of the relevant department chair and vice chair.

10.4 FUNCTIONS OF DEPARTMENTS

The primary responsibility delegated to the department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and appropriateness of patient care provided in the department.

To carry out this responsibility the department shall:

(a) Conduct patient care reviews to analyze and evaluate the quality of care and appropriateness of treatment provided to patients within the department. The number of such reviews conducted during the year shall be reviewed by the Medical Executive Committee and shall be conducted in accordance with such procedures as may be adopted by the Professional Practice Evaluation Committee. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work subject to review is a member of that department. The criteria to be used in these reviews shall be objective and reflect current knowledge and clinical experience. The department shall also identify actions that should be taken in order to

resolve identified problems in patient care and clinical performance and evaluate the effectiveness of actions which have been taken in resolving such problems.

(b) Submit written reports to the Medical Executive Committee concerning:

(1) The department's review, monitoring and evaluation activities, actions taken thereon, and the result of such action taken.

(2) Recommendations for maintaining and improving the quality of care provided in the department and the hospital.

(c) Meet at least quarterly to receive, review, and consider patient care review findings and the results of other department's review, evaluation, and monitoring activities, as well as reports about other departments and staff functions.

(d) Conduct, participate, and make recommendations regarding continuing education programs pertinent to the department's clinical practice, changes in state of the art, and findings of review, evaluation and monitoring activities.

(e) Review, evaluate and monitor on a continuous and concurrent basis, the department's adherence to:

(1) Medical staff and hospital policies and procedures.

(2) Requirements for alternate coverage and for consultations.

(3) Sound principles of clinical practice.

(4) Fire and other regulations designed to promote patient safety.

(f) Coordinate patient care provided by the department members with nursing and ancillary patient care services and administrative support services.

(g) Establish such committees or other mechanisms as necessary and desirable to perform properly the functions assigned to it, including clinical privileges and proctoring protocols.

(h) Formulate recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval of the Medical Executive Committee.

10.5 FUNCTIONS OF DIVISIONS/SUBDIVISIONS

Subject to approval of the Medical Executive Committee, the division/subdivision shall perform the functions assigned to it by the department chair. Such functions may include, without limitation, retrospective patient care reviews, continuous evaluation and monitoring of patient care practices, credentials review and privileges delineation, peer reviews, and continuing education programs. The division/subdivision shall systematically transmit quality assessment/improvement reports and other pertinent reports to the department chair on the conduct of its assigned functions. The department shall specify the timetable for quality assessment/improvement reports in its

departmental rules and regulations. Quality assessment/ improvement reports shall be submitted at least annually.

10.6 MODIFICATIONS IN CLINICAL ORGANIZATION UNIT

When deemed appropriate, the Medical Executive Committee may create, eliminate, subdivide, further subdivide, or combine departments, divisions and/or subdivisions as follows:

(a) Creation of a Division or Subdivision:
  (i) A sufficient number of practitioners are available for appointment to, and will be appointed to, and/or actively participate in the new organizational component to enable accomplishment of the functions generally assigned to such components in these bylaws, and relevant rules and regulations adopted pursuant hereto; and,
  (ii) the patient or service activity to be associated with the new component is substantial enough to impose on its members the responsibility to accomplish those functions.

(b) Elimination: The number of members available is no longer adequate, and will not be so in the foreseeable future, to accomplish assigned functions, or when the patient or service activity associated with the component to be dissolved is no longer substantial enough to warrant the responsibility imposed on members of each division/subdivision to accomplish those functions.

(c) Combination: The union of the two or more organizational components will result in more effective and efficient accomplishment of assigned functions and the patient or service activity to be associated with the combination is substantial enough, without being unwieldy, to warrant the responsibility imposed on the members of such combined components to accomplish those assigned functions.

In all instances of modification, the hospital's written plan of development, as currently being implemented, and any constraints or mandates imposed by external planning authorities, shall also be considered.

ARTICLE XI - OFFICERS

11.1 GENERAL OFFICERS OF THE MEDICAL STAFF

11.1-1 IDENTIFICATION

The general officers of the medical staff shall be the chief of medical staff, the chief of medical staff elect, the immediate past chief of medical staff, the secretary treasurer, and the medical director.

11.1-2 QUALIFICATIONS

General officers must be members of the active staff category at the time of nomination and election, and they must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. All officers must be licensed as physicians and surgeons, given the nature of their duties in office.

11.1-3 NOMINATIONS

(a) Nominating Committee: Medical staff elections shall be held biennially. The Nominating Committee shall consist of seven (7) members of the medical staff: the chief of medical staff, the immediate past chief of medical staff, the chief of medical staff elect, the medical director, and three (3) active staff category members elected from the floor at the preceding year of nomination. The chief of medical staff-elect shall preside at this meeting. The nominations of the committee ~~shall be reported to the Medical Executive Committee at least sixty (60) days prior to the Annual Meeting and~~ shall be delivered or mailed to the active staff category members at least twenty (20) days prior to the election.

(b) Slate of Nominees: The Nominating Committee shall prepare a slate of at least one (1) nominee for each of the elective officers of the medical staff: the chief of medical staff elect, the secretary treasurer, and the member at large of the Credentials Committee. Nominees for office should be selected on the basis of leadership and administrative ability, scientific achievement, and ability to work with confreres.

11.1 4 ELECTION

Officers shall be elected at the Annual Medical Staff Meeting. Only active staff category members shall be eligible to vote. Voting shall be by voice, show of hands, or if there are two (2) or more nominees for any office, by secret written ballot. The nominee receiving a majority of the valid votes cast shall be elected. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two (2) candidates receiving the highest number of votes. If the second ballot is also a tie, the Medical Executive Committee, by majority vote, shall decide the election by secret ballot at its next meeting or at a special meeting called for that purpose.

11.1 5 CHIEF OF MEDICAL STAFF AND IMMEDIATE PAST CHIEF OF MEDICAL STAFF PROVISIONS

Sections 11.1 3 and 11.1 4 shall not apply to the chief of medical staff and the immediate past chief of medical staff. The chief of medical staff elect, upon completion of term of office, shall immediately succeed to the office of chief of medical staff and then to the office of immediate past chief of medical staff.

11.1 6 TERM OF ELECTED OFFICERS

Officers shall serve for a term of two (2) medical staff years, commencing on the first day of the medical staff year following their election. The officers shall serve until the end of their term and until successors are elected, unless they shall sooner resign or are removed from office. A general officer may not hold the same office for more than two (2) consecutive terms.

11.1 7 REMOVAL OF ELECTED OFFICERS

Any officer whose election is subject to these bylaws may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral

turpitude. Except as otherwise provided in these bylaws, removal of a general officer may be initiated by the Medical Executive Committee or by a petition signed by at least one third (1/3) of the medical staff members eligible to vote for officers. Removal shall be considered by the Medical Executive Committee or by a special meeting called for that purpose. Removal shall require a two-third (2/3) vote of the medical staff members eligible to vote for medical staff officers; who actually cast votes at the special meeting in person or by mail ballot. Voting on removal of an elected officer shall be by secret written mail ballot, as defined in Article XV, Section 15.10. The written mail ballots shall be sent to each voting member at least twenty one (21) days before the voting date and the ballots shall be counted by the secretary treasurer of the medical staff (except when the secretary-treasurer is the subject of the balloting, in which case the chief of medical staff shall count the ballots) and the medical staff services manager.

11.1 8 VACANCIES IN ELECTED OFFICE

Vacancies, other than the chief of medical staff, shall be appointed by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of chief of medical staff, the existing chief of medical staff elect shall complete the remaining term and shall then serve as chief of medical staff the following year. If there is a vacancy in the office of immediate past chief of medical staff, that office need not be filled, except that the Medical Executive Committee may appoint a qualified successor to serve as the chair and/or member of any committee that the immediate past chief of medical staff is automatically appointed to pursuant to these bylaws or the Medical Staff Committees and Functions Manual.

11.2 DUTIES OF GENERAL OFFICERS

11.2-1 MEDICAL DIRECTOR

The hospital will appoint a physician as the medical director to act in a liaison capacity between hospital administration and medical staff departments and/or divisions.

The medical director shall:

(a) Plan, organize, direct and coordinate the medical staff services and medical training programs at the hospital.
(b) Cooperate with and assist the chief of medical staff in carrying out responsibility for the clinical organization functions of the hospital and supervision over clinical work in each department and division.
(c) Evaluate and transmit the appropriate recommendations concerning the qualifications of applicants who request initial adjunct staff appointments and biennial reappointments.
(d) Evaluate and transmit to the appropriate authorities, recommendations concerning initial medical membership appointment, clinical privileges, classification and reappointment of the department chair.
(e) Serve as a voting member of the Medical Executive Committee, the Medical Executive Committee Council, the Performance Improvement Committee, the Bylaws Committee, the Credentials Committee, and an ex-officio member of all other medical staff committees with the power to vote unless otherwise specified in these bylaws and in the Medical Staff Committees and Functions Manual.

(f) Perform such other functions as may be assigned by these bylaws, the Credentials Policies and Procedures Manual, the Medical Executive Committee, the ~~h~~Hospital D~~d~~irector or the governing board.

11.2 2 CHIEF OF MEDICAL STAFF

The chief of medical staff shall serve as the chief executive officer of the medical staff. The chief of medical staff shall:

(a) Act in coordination and cooperation with the ~~h~~Hospital ~~d~~Director and/or the medical director in all matters of mutual concern within the hospital.

(b) Call, preside at, and be responsible for the agenda of the Annual Medical Staff meeting and special meetings of the medical staff.

(c) Serve as chair of the Medical Executive Committee and the Medical Executive Committee Council; and a voting member of the Performance Improvement Committee, the Bylaws Committee, the Credentials Committee, and the Joint Conference Committee.

(d) Be responsible and serve as an ex officio member of all other medical staff committees with the power to vote unless otherwise specified in these Bylaws and in the Medical Staff Committees and Functions Manual.

(e) Appoint committee members to all standing, special, ad hoc and multidisciplinary medical staff committees, except the Medical Executive Committee or unless otherwise specified in these bylaws or in the Medical Staff Committees and Functions Manual.

(f) Enforce the medical staff bylaws and rules and regulations, implement sanctions when indicated, and promote compliance with procedural safeguards when corrective action has been requested or initiated against a practitioner.

(g) Present the views, policies, needs and grievances of the medical staff to the governing board and to hospital administration.

(h) Receive and interpret the policies of the governing board to the medical staff and report to the governing board on the performance and maintenance of quality with respect to the medical staff's delegated responsibility to provide medical care.

(i) Be a spokesperson for the medical staff in external, professional, and public relations.

(j) Be responsible for the educational activities of the medical staff.

(k) Perform such other functions as may be assigned by these bylaws, the Credentials Policies and Procedures Manual, the medical staff membership, the Medical Executive Committee or the governing board.

11.2 3 CHIEF OF MEDICAL STAFF ELECT

The chief of medical staff elect, in the absence of the chief of medical staff, shall assume all duties and authority of the chief of medical staff.

The chief of medical staff-elect shall:

(a) Chair the Bylaws Committee.

(b) Be a voting member of the Medical Executive Committee, the Medical Executive Committee Council, the Performance Improvement Committee, and the Credentials Committee.

(c) Serve as an ex-officio member of the Joint Conference Committee without the power to vote unless serving as the alternate for the chief of medical staff or the immediate past chief of medical staff.

(d) Be an ex officio member of all other medical staff committees with the power to vote, unless otherwise specified in these bylaws or in the Medical Staff Committees and Functions Manual.

(e) Perform other supervisory duties as assigned by the chief of medical staff.

(f) Automatically succeed the chief of medical staff if the chief of medical staff fails to serve for any reason.

11.2 4 IMMEDIATE PAST CHIEF OF MEDICAL STAFF

The immediate past chief of medical staff shall:

(a) Be a voting member of the Bylaws Committee, the Medical Executive Committee, and the Medical Executive Committee Council, the Credentials Committee, the Performance Improvement Committee and the Joint Conference Committee.

(b) Be an ex officio member of all other medical staff committees with the power to vote unless otherwise specified in these bylaws or in the Medical Staff Committees and Functions Manual.

(c) Perform such other functions and duties as assigned by the chief of medical staff or delegated by these bylaws, the medical staff membership or the Medical Executive Committee.

11.2 5 SECRETARY TREASURER

The secretary treasurer shall:

(a) Be a voting member of the Medical Executive Committee and the Medical Executive Committee Council.

(b) Maintain a roster of members.

(c) Keep accurate and complete minutes of all Medical Executive Committee and medical staff meetings.

(d) Call meetings on the order of the chief of medical staff or the Medical Executive Committee.

(e) Attend to all appropriate correspondence and notices on behalf of the medical staff.

(f) Receive, safeguard, and be accountable for all funds of the medical staff.

(g) Excuse absence from meetings on behalf of the Medical Executive Committee.

(h) Perform such other duties that ordinarily pertain to the office or are assigned by the chief of medical staff or the Medical Executive Committee.

11.3 DEPARTMENT CHAIR

11.3-1 QUALIFICATIONS

The department chair shall be a member of the active medical staff and a member of the department that the practitioner will head. The department chair shall be qualified by licensure,

training, experience, interest, and demonstrated current ability in the clinical area covered by the department, and shall be willing and able to discharge the administrative responsibilities of the office. The department chair shall be certified by an appropriate specialty board or recognized equivalent. In the event that there is no qualified active staff member, a provisional chair may be appointed to perform the functions of the department. The chief of medical staff, in consultation with the medical director, may assign an active staff member of a department to act as a mentor to the provisional chair.

11.3-2 SELECTION

The hospital will appoint a physician to act as the department chair, with the concurrence of the involved department and the Medical Executive Committee. The department chair shall be responsible to the medical director and work in cooperation with the department vice chair.

11.3-3 TERM OF OFFICE

The department chair shall serve commencing on appointment and shall serve until a successor is chosen, unless the department chair shall sooner resign or be removed from office. A department chair may be removed by the governing board or the Medical Executive Committee.

11.3-4 DUTIES

The department chair shall:

(a) Be responsible for all administratively related activities of the department, unless otherwise provided by the hospital, and be accountable to the medical director and to the Medical Executive Committee for the effective operation of the department.

(b) Develop, implement, and maintain the department's quality control programs as appropriate.

(c) Have continuing surveillance of the professional performance of all individuals who have delineated clinical or practice privileges in the department.

(d) Make recommendation for a sufficient number of qualified and competent persons to provide care, treatment, and services.

(e) Determine the qualifications and competency of department service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services and transmit information to appropriate authorities.

(f) Recommend to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department; participate in the evaluation of practitioners practicing within the department and transmit to the appropriate authorities the department's recommendations concerning membership appointment, clinical privileges, classification, reappointment, monitoring and proctoring, and corrective action. .

(g) Be responsible for orientation and continuing education of all persons in the department or service.

(h) Make an evaluation of the health status for initial appointments, reappointments and/or clinical privileges. In those instances where there is doubt about an applicant's health, an evaluation by someone other than the applicant's department chair or vice chair may be

necessary to resolve the issue. The request for such an evaluation will rest with the Medical Executive Committee.

(i) Develop and implement policies and procedures that guide and support the provision of care, treatment, and services.
(j) Be responsible for all clinically-related activities of the department and exercise general supervision of all clinical work performed within the department, including review of medical records.
(k) Act as the presiding officer at all departmental meetings.
(l) Have oversight responsibility for each of the department division's quality assessment/improvement activities if applicable.
(m) Assess and recommend to the relevant hospital authority off-site resources for needed patient care services not provided by the department/service or the hospital.
(n) Integration of the department or service into the primary function of the hospital.
(o) Recommends space and other resources needed by the department or service.
(p) Provides continuous assessment and improvement of the quality of care, treatment, and services.
(q) Coordination and integration of inter-department and intra-department services.
(r) Perform other duties commensurate with the office as may from time to time be reasonably requested by the medical director, the Medical Executive Committee or the governing board.

11.4 DEPARTMENT VICE CHAIR

11.4 1 QUALIFICATIONS

The department vice chair shall be a member of the active medical staff and shall be qualified by licensure, training, experience and demonstrated ability in at least one of the clinical areas covered by the department. The department vice chair shall be certified by an appropriate specialty board or recognized equivalent. The department vice chair shall be willing and able to faithfully discharge the functions of the position. In the event that there is no qualified active staff member, a provisional vice chair may be elected to perform the functions of the department.

11.4 2 SELECTION

The department vice chair shall be elected by the department members who are eligible to vote for general officers of the medical staff with the concurrence of hospital administration and the Medical Executive Committee. The election of the vice chair shall occur at the departmental meeting and only active staff members of the department may vote.

11.4 3 TERM OF OFFICE

The department vice chair shall serve a two (2) year term that coincides with the medical staff year or until a successor is chosen, unless the vice chair shall sooner resign, be removed from office, or lose medical staff membership in that department. A department vice chair shall be eligible to succeed himself/herself.

11.4 4 REMOVAL

A department vice chair may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. The request of the removal of a department vice chair from office may be initiated by the Medical Executive Committee or by written request from the majority members of that department who are eligible to vote. The request of the removal maybe effected by a majority vote of the Medical Executive Committee and a majority vote of the department members eligible to vote on department matters. Voting shall be by secret mail ballot as defined in Article XV, Section 15.10, and ballots shall be sent to those eligible to vote within forty five (45) days after the initiation of removal pursuant to this section. The ballots must be received no later than twenty one (21) days after they are mailed and shall be counted by the chief of medical staff, the secretary treasurer, and the medical staff services administrative supervisor. Removal shall be effective upon the approval of the Medical Executive Committee.

11.4 5 DUTIES

The department vice chair shall have the following authority, duties, and responsibilities:

(a) Serve on the Medical Executive Committee and give guidance on the overall medical policies of the medical staff and hospital and make specific recommendations and suggestions regarding the department.
(b) Assist the department chair in ongoing review of the professional performance of all practitioners granted clinical privileges in the department and report thereon to the Medical Executive Committee.
(c) Assist the department chair in the enforcement of the hospital and medical staff bylaws, rules and regulations, and policies within the department, including initiation of corrective action, and investigation of clinical performance and consultation orders when necessary.
(d) Assist the department chair in implementation of department actions taken by the Medical Executive Committee and the governing board.
(e) Assist the department chair in administration of the department, including cooperation with nursing service and hospital administration.
(f) Assist the department chair in the preparation of such annual reports, including budget planning, relating to the department as may be required by the Medical Executive Committee or the governing board.
(g) Serve as an ex officio member of all committees in the department and give guidance and help when needed.
(h) Available for consultation in the vice chair's field.
(i) Represent the department in a medical advisory capacity to hospital administration.
(j) Perform other duties commensurate with the office as may from time to time be reasonably requested by the department chair, the chief of medical staff, the Medical Executive Committee or the governing board.

11.5 DIVISION/SUBDIVISION CHAIR

11.5-1 QUALIFICATIONS

The division/subdivision chair shall be a member of the active medical staff and a member of the division/subdivision that the practitioner is to head. The chair shall be qualified by licensure, training, experience, interest and demonstrated current ability in the clinical area covered by the division/subdivision and shall be willing and able to discharge the administrative responsibilities of the office. The division/ subdivision chair shall be certified by an appropriate specialty board or affirmatively established through the Credentials Committee that the individual possesses comparable competence based on the practitioner's practice. In the event that there is no qualified active staff member, a provisional division/subdivision chair shall be appointed to perform the functions of the division/subdivision.

11.5-2 SELECTION

The department chair may, with the concurrence of administration, appoint a physician to act as the chair of a division or subdivision. The division/subdivision chair will be responsible to the department chair.

11.5-3 TERM OF OFFICE

The division/subdivision chair shall serve commencing on appointment and shall serve until a successor is chosen, unless the division/subdivision chair shall sooner resign or be removed from office.

11.5-4 DUTIES

The division/subdivision chair shall perform the functions assigned by the department chair. Such functions may include, without limitation:

(a) Retrospective patient care reviews.
(b) Continuous evaluation and monitoring of patient care practices.
(c) Credentials review and recommendation, privileges delineation, monitoring and proctoring.
(d) Continuing education programs.

ARTICLE XII – COMMITTEES

12.1 GENERAL

The medical staff organization shall have a Medical Executive Committee and such other committees as are necessary to carry out the functions of the medical staff. At a minimum these functions shall include executive review, credentialing, medical records, tissue review, utilization management, infection control, pharmacy and therapeutics, performance improvement and patient safety, and assisting the medical staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services. The composition, officers, duties and meetings of the Medical Executive Committee are described in Section 12.2. Other medical staff committees are described in committee descriptions, which must be approved by the Medical Executive Committee. Committee descriptions are maintained in the Medical Staff Committees and Functions Manual. Committee descriptions must, at a minimum, describe the purpose of the

Commented [KM14]: Title 22 Sec. 70703 "The medical staff by-laws, rules, and regulations shall include, but shall not be limited to, provision for the performance of the following functions: executive review, credentialing, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting the medical staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services. These functions may be performed by individual committees, or when appropriate, all functions or more than one function may be performed by a single committee. Reports of activities and recommendations relating to these functions shall be made to the executive committee and the governing body as frequently as necessary and at least quarterly."

committee, regulatory requirements, composition (including voting and non-voting members), reporting relationships, quorum requirements and committee responsibilities. The committees named in the Medical Staff Committees and Functions Manual shall be constituted as committees of the medical staff.

Unless otherwise specified in the committee description, the chairs and members of all medical staff committees shall be appointed by the chief of medical staff, after consultation with and approval by the Medical Executive Committee. Medical staff committees shall ultimately report to and be responsible to the Medical Executive Committee.

12.1-1 AD HOC COMMITTEES

Ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. These committees shall terminate at the end of the medical staff year unless renewed by the Medical Executive Committee. The membership of an ad hoc committee shall be appointed by the chief of medical staff, after consultation with and approval by the Medical Executive Committee.

12.1-2 TERMS AND REMOVAL OF COMMITTEE CHAIRS

Unless otherwise specified in the committee description, committee chairs shall be appointed for a term of two (2) medical staff years, and shall serve until the end of this period or until a successor is appointed, unless the chair shall sooner resign or be removed from the committee. Committee chairs may be reappointed. Committee chairs are encouraged to accrue expertise in the area of their committee purview.

12.1-3 TERMS AND REMOVAL OF COMMITTEE MEMBERS

Unless otherwise specified in these bylaws or in the committee description, a committee member's term shall be for two (2) medical staff years, and the member shall serve until the end of this period or until a successor is appointed, unless the member shall sooner resign or be removed from the committee. Any committee member appointed by the chief of medical 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 the individual is a general officer or other official shall be governed by the provisions pertaining to removal of that officer or official.

12.1-4 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that of an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

12.1-5 CONDUCT AND RECORDS OF MEETINGS

Committee meetings shall be conducted and documented in the manner specified in Article XIII (Meetings).

12.2 MEDICAL EXECUTIVE COMMITTEE (MEC)

12.2-1 COMPOSITION

The Medical Executive Committee shall consist of the chief of medical staff, the immediate past chief of medical staff, the chief of medical staff elect, the secretary-treasurer, the medical director, the and the vice chair and chair of clinical departments. When the department vice chair and chair are both present at the meeting, only one vote will be cast, with the vice chair having the vote. When either the chair or vice chair is also an elected officer of the medical staff (i.e., chief of medical staff, immediate past chief of medical staff, chief of medical staff-elect, or secretary-treasurer), their presence and vote will be counted as an elected officer of the medical staff. The chief executive officer or designee and the chief nursing officer shall be ex officio members without the power to vote. The associate medical director shall serve as medical director designee (with vote) in the absence of the medical director.

12.2-2 OFFICERS

The chief of medical staff, the chief of medical staff elect, and the secretary treasurer shall serve as chair, vice chair, and secretary treasurer of the Medical Executive Committee, respectively.

12.2-3 DUTIES

Duties of the Medical Executive Committee include, but are not limited to the following:

(a) Recommendations made directly to the governing board pertaining to the following:

   (1) The structure of the medical staff.
   (2) The mechanism used to review credentials and to delineate individual clinical privileges.
   (3) Recommendations regarding medical staff initial appointments, reappointments, and clinical privileges for eligible individuals.
   (4) The organization of quality care activities of the medical staff as well as the mechanism used to conduct, evaluate and revise such activities.
   (5) The mechanism in which membership on the medical staff may be terminated.
   (6) The mechanism for fair hearing procedures.
   (7) The MEC's review of actions on reports of medical staff committees, departments, and other assigned activity groups.

(b) Represent and empowered to act on behalf of the medical staff between meetings of the organized medical staff.

(c) Coordinate and implement the professional and organizational activities and policies of the medical staff.

(d) Upon good cause, and in consultation with hospital administration, eliminate, establish and determine the composition and duties of medical staff committees. Said actions shall be incorporated into the Medical Staff Committees and Functions Manual as approved by the Medical Executive Committee.

(e) Participate in the development of medical staff and hospital policy, practice and planning.

(f) Take reasonable steps to promote ethical conduct and competent clinical performance on part of all members and AHPs to the extent required by these bylaws, including the initiation of and participation in medical staff corrective or review measures when warranted.

(g) Fulfill the medical staff's accountability to the governing board for medical care rendered to patients at the hospital.

(h) Take reasonable steps to develop continuing education activities and programs for the medical staff.

(i) Report to the medical staff at the regular staff meeting.

(j) Assure the medical staff is informed about the accreditation program and status of the Hospital, and assist in obtaining and maintaining of hospital accreditation.

(k) Evaluate the medical care provided to patients at the hospital.

(l) Receive and review reports and recommendations of the Environment of Care Committee, including methods for the protection and care of patients and others in the event of internal or external disaster.

(m) Appoint such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the medical staff.

(n) Request evaluation of practitioners privileged through the medical staff process in instances where there is doubt about a practitioner's ability to perform the privileges requested.

(o) Perform other functions as may be assigned to it by these bylaws, the medical staff or the governing board.

(p) Affirmatively implement, enforce, and safeguard the self-governance rights of the medical staff to the fullest extent permitted by law; such rights of the medical staff include, but are not limited to, the ability to retain and be represented by independent legal counsel at the expense of the medical staff.

By action of 2/3 of the medical staff members present and entitled to vote, the medical staff may, at a regular or special meeting, pursuant to Section 13.1, at which a quorum is achieved, remove and reassign a duty or duties delegated to the Medical Executive Committee for a stated period of time, for a reason identified and supported by the meeting.

12.2 4 MEETINGS

The MEC shall meet as often as necessary, but at least ten (10) times a year, and shall maintain a record of its proceedings and actions. Fifty (50) percent of the membership shall constitute a quorum. The requirements for a quorum of the Medical Executive Committee shall be bifurcated. In order to meet urgent requirements of any department for credentialing and granting of clinical

privileges or when necessary to meet requirements of any regulatory agency, a meeting of the MEC may be called by any medical staff officer, and three (3) members will be sufficient to constitute a quorum. Any actions taken will be reported at the next regularly scheduled MEC meeting.

ARTICLE XIII – MEETINGS

13.1 MEETINGS

13.1-1 ANNUAL STAFF MEETING

There shall be an annual meeting of the medical staff held in June. The election of officers shall take place at this meeting on a biennial basis as required by these bylaws. The chief of medical staff shall report on actions taken by the Medical Executive Committee during the preceding year and on matters believed to be of interest and value to the members. Notice of this meeting shall be given to the members at least twenty (20) days prior to the meeting. The chief of medical staff shall preside at this meeting. Attendance at the Annual Staff Meeting will be strongly encouraged of all active staff members.

13.1-2 AGENDA

The order of business shall be determined by the chief of medical staff and the Medical Executive Committee. The agenda shall include, at a minimum:

(a) Review and acceptance of the minutes of the last Annual Staff Meeting and all special meetings held since the last Annual Staff Meeting.
(b) Administrative reports from the chief of medical staff, the medical director, departments, committees, and the Hhospital dDirector.
(c) Election of officers when required by these bylaws.
(d) Reports by responsible officers, committees, and departments on the overall results of patient care audit and other quality review, evaluation, and monitoring activities of the medical staff and on the fulfillment of the other required staff functions.
(e) Recommendations for improving patient care at the hospital.
(f) Old Business.
(g) New Business.

13.1 3 SPECIAL MEETINGS

Special meetings of the medical staff may be called at any time by the chief of medical staff or the Medical Executive Committee, or shall be called upon the request of ten percent (I0%) of the active medical staff members. The Medical Executive Committee, upon written request of the governing board, shall call a special meeting of the medical staff. The person calling or requesting the special meeting shall state the purpose of such a meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request. No later than seven (7) days prior to the meeting, notice shall be mailed or delivered to the members of the staff which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

13.2 COMMITTEE AND DEPARTMENT MEETINGS

13.2 1 REGULAR MEETINGS

Committees and departments, by resolution, may be provided the time for holding regular meetings and no notice other than such resolution shall then be required.

13.2 2 SPECIAL MEETINGS

A special meeting of any medical staff committee, department or division may be called by the chair thereof, the Medical Executive Committee or the chief of medical staff, and shall be called by written request of one third of the current members of the medical staff that are eligible to vote.

13.3 NOTICE OF MEETINGS

When notice stating the place, day, and hour of any regular or special medical staff meeting or of any regular or special committee or department meeting not held pursuant to resolution shall be delivered either personally or by mail to each person entitled to be present thereat not less than seven (7) days nor more than twenty (20) days before the date of such meeting, in the manner specified in Section 15.10, hereof. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

13.4 QUORUM

13.4-1 DEPARTMENT AND COMMITTEE MEETINGS

Commented [KM15]: CMA Model bylaws suggest using specific percentages; CHA recommends 30% of the committee membership, but no less than 3 voting members.

The number of active staff members present at any meeting shall constitute a quorum, said quorum shall apply to regular, department, division and committee meetings for which proper notification has been given to all voting members, except as otherwise specified in these bylaws or in the Medical Staff Committees and Functions Manual.

13.4 2 ANNUAL STAFF MEETING

The presence of 51% of the total members of the active medical staff at any regular or special meeting of the medical staff shall constitute a quorum for the purpose of removing and reassigning a duty or duties delegated to the Medical Executive Committee. For all other actions, the number of active staff members present at any regular or special meeting of the medical staff shall constitute a quorum.

13.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting, at which a quorum is present, shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee

action may be conducted by telephone, audio or video conference which shall be deemed to constitute a meeting for the matters discussed in that telephone, audio or video conference. Valid action may be taken without a meeting by a department, committee, or the Medical Executive Committee by a writing setting forth the action so taken which is signed by each member entitled to vote thereat.

13.6 MINUTES

Minutes of all meetings shall be prepared and retained as specified in these bylaws and in the Medical Staff Committee and Department Meetings Policy and Procedure. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. The minutes shall be signed by the presiding officer of the meeting and forwarded to the Medical Executive Committee. Each committee and department shall maintain a file copy of its minutes. The Medical Staff Services Office shall be responsible for maintaining the original set of department and standing committee minutes.

13.7 ATTENDANCE REQUIREMENT

13.7 1 REGULAR ATTENDANCE

The active staff member shall be strongly encouraged to attend:

(a) The Annual Medical Staff meeting.
(b) General medical staff meetings duly convened pursuant to these bylaws.
(c) Meetings of the department, division, and committee of which the practitioner is a member.

All members of the medical staff shall be encouraged to attend departmental meetings, the Annual Medical Staff meeting, and to participate in scientific presentations of the medical staff.

13.7 2 ABSENCE FROM MEETINGS

Any member who is compelled to be absent from any medical staff, department, division, or committee meeting shall promptly provide to its regular presiding officer thereof the reason for such absence.

13.7 3 SPECIAL APPEARANCE

A member shall be notified, in advance, when his/her patient's clinical course of treatment is scheduled for discussion at a regular department, division, or committee meeting. If an apparent or suspected deviation from standard clinical practice is involved, notice shall be sent to the member by certified mail, return receipt requested, at least seven (7) days prior to the meeting, Said notice shall include the time and place of the meeting, a statement of the issue involved and that the member's appearance is mandatory. If a member fails to appear at any meeting for which notice was given, unless excused by the Medical Executive Committee on a showing of good cause, all or such portion of the member's clinical privileges, as the Medical Executive Committee shall

direct, shall be automatically suspended. This suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee as provided in Section 8.2 5.

13.8 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order, Newly Revised; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

ARTICLE XIV - CONFIDENTIALITY, IMMUNITY, AND RELEASES

14.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges (or practice privileges) at this hospital, an applicant:

(a) Authorizes representatives of the hospital and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications.

(b) Authorizes persons and organizations to provide information concerning such practitioner to the medical staff and hospital.

(c) Agrees to be bound by the provisions of this article and to waive all legal claims against any representatives of the medical staff or the hospital who acts in accordance with the provisions of this article.

(d) Acknowledges that the provisions of this article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at this hospital.

(e) Acknowledges medical staff participation with the hospital in an Organized Health Care Arrangement (OHCA) under the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), and agrees to be bound by the provisions of the Notice of Privacy Practices given to hospital patients when they access care at any hospital and county affiliated facility.

14.2 CONFIDENTIALITY OF INFORMATION

14.2 1 GENERAL

Medical staff, department, division and committee minutes, files, records, and oral discussions, including information regarding staff members or applicants to this medical staff, including AHPs, collected or prepared for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical research, shall be confidential to the fullest extent permitted by law. Dissemination of this information and these records shall only be made when expressly required by law, pursuant to officially adopted policies of the medical staff and the hospital or, if no officially adopted policy exists, only with the express approval of the Medical Executive Committee or the governing board. This information shall be a part of the medical staff committee files and shall not become part of any particular patient's file or of the general hospital records.

14.2 2 BREACH OF CONFIDENTIALITY

Inasmuch as effective quality assessment, peer review and consideration of the qualifications of medical staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions, deliberations, or other communications of medical staff departments, divisions, or committees, except in conjunction with other hospital, professional society, or licensing authorities, is outside appropriate standards of conduct for this medical staff and will be deemed disruptive to the operations of the hospital. If it is determined that a breach has occurred, the Medical Executive Committee shall undertake such corrective action as it deems appropriate.

14.2 3 CONFIDENTIALITY AGREEMENT

By signing the application form for appointment or reappointment to the medical staff, or by participation in medical staff activities, a practitioner agrees to be bound by both this article and the following statement of hospital policy, which is in amplification, and not limitation, of other parts of this article.

Confidentiality is vital to the free, open and candid discussions necessary for medical staff quality assessment and peer review activities designed to improve the quality of care at the hospital. The medical staff member's participation in such activities is in reliance on the confidential treatment of those activities by all members of the medical staff and other individuals involved. For these reasons, a practitioner agrees to keep confidential all information (oral or written) communicated in connection with medical staff quality assessment and peer review activities. Disclosure of such information except as specifically required by law, pursuant to medical staff and hospital policy, to law enforcement agencies, or to professional or institutional licensing agencies, is prohibited. Corrective action including suspension or termination of medical staff membership or eligibility to hold office, to serve on committees, or to hold clinical privileges may be taken against any practitioner who fails to maintain the confidentiality of such information. Agreement to keep medical staff information confidential is a material condition to appointment or reappointment to the medical staff. The practitioner agrees to notify the medical staff of any request or demand made (whether by subpoena or otherwise) to disclose confidential information related to the practitioner's participation as a member of the staff or any committee thereof, and agrees to not voluntarily disclose confidential medical staff information except as specifically provided in this article. The practitioner further agrees that the medical staff or the hospital may seek to enjoin his/her violation of this article if necessary.

14.3 IMMUNITY FROM LIABILITY

14.3 1 FOR ACTION TAKEN

The representative of the medical staff and hospital shall be exempt from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the medical staff or hospital.

14.3 2 FOR PROVIDING INFORMATION

The representative of the medical staff and hospital and all third parties, acting pursuant to these bylaws, shall be exempt from liability to an applicant or member for damages or other relief by reason of providing information, actions taken or statements or recommendations made within the scope of duties, or for providing information concerning any person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this hospital.

14.4 ACTIVITIES AND INFORMATION COVERED

14.4 1 ACTIVITIES

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facilities or organization's activities concerning, but not limited to:

(a) Applications for appointment and reappointment, clinical privileges (practice privileges) and prerogatives and periodic reappraisals of members' status, privileges, and/or prerogatives.
(b) Corrective action.
(c) Hearing and appellate reviews.
(d) Utilization reviews.
(e) Other department or division, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.
(f) The National Practitioner Data Bank queries and reports, peer review organizations, the Medical Board of California, and similar reports.

14.5 RELEASES

The applicant or member shall, on the request of the medical staff or hospital, execute general and specific releases in accordance with the express provisions and general intent of this article. The execution of such releases shall not be deemed a prerequisite to the effectiveness of this article.

ARTICLE XV - GENERAL PROVISIONS

15.1 BYLAWS, RULES AND REGULATIONS, POLICIES AND GOVERNING BOARD BYLAWS

The medical staff bylaws, rules and regulations, policies and procedures, and the Medical Center governing board bylaws do not conflict.

15.1-1 MEDICAL STAFF RULES AND REGULATIONS

The medical staff shall initiate and adopt such rules and regulations as it may deem necessary and shall periodically review and revise its rules and regulations to comply with current medical staff practice. Recommended changes to the rules shall be submitted to the Medical Executive Committee for review and approval. Following approval by the Medical Executive Committee, a rule and regulation shall become effective following approval of the governing board. Neither the medical staff nor the governing body may unilaterally amend the medical staff bylaws or rules and regulations. Applicants and members of the medical staff shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the bylaws and the medical staff rules and regulations, the bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff rules and regulations. Copies of the Rules and Regulations documents / manual may be found on the intranet.

15. 1-2 DEPARTMENTAL RULES AND REGULATIONS

Each department shall formulate its own rules and regulations for the conduct of its affairs and for the supervision of the house staff. Departmental rules and regulations will be reviewed and amended periodically. Proposed changes to the departmental rules shall be submitted to the Medical Executive Committee for review and approval and then to the governing board for review and approval. Departmental rules and regulations shall be consistent with these bylaws, the general rules and regulations of the medical staff, and other policies of the hospital.

15.2 MEDICAL STAFF COMMITTEES AND FUNCTIONS ~~MANUAL~~DOCUMENT

The Medical Executive Committee shall initiate and adopt committee descriptions for all medical staff standing and ad hoc committees. The committee descriptions shall be periodically reviewed and revised to comply with current medical staff practice and regulatory requirements. Recommended changes to the Medical Staff Committees and Functions Manual shall be submitted to the Medical Executive Committee for review and approval.

~~The Medical Staff Committees and Functions Manual shall be submitted annually to the governing board for review and approval.~~

~~The Medical Executive Committee may make periodic changes in the Medical Staff Committees and Functions Manual in the intervals between the annual governing board review and approval. These changes shall be to reflect current medical staff organization practice and to remain in compliance with regulatory requirements.~~

~~15.3 CREDENTIALING POLICIES AND PROCEDURES MANUAL~~

~~This manual describes the process for credentialing, re-credentialing, and privileging licensed independent practitioners and allied health professionals, including the process for appointment and reappointment to membership on the medical staff. Other processes included in the manual are the granting of temporary privileges and emergency disaster privileges, provisional evaluation, focused professional practice evaluation, etc. This manual is reviewed periodically by the Credentials Committee of the medical staff organization and recommendations for revisions are~~

forwarded to the Medical Executive Committee and the governing board for approval and adoption.

15.4 MEDICAL STAFF POLICIES AND PROCEDURES MANUAL

This manual describes the policies and procedures of the medical staff including the process for resolving conflicts between the medical staff and the Medical Executive Committee, impaired physicians, etc. This manual is reviewed periodically by the Bylaws Committee and recommendations for revisions are forwarded to the Medical Executive Committee and the governing board for approval and adoption.

15.5 FEES/DUES

All members of the medical staff and allied health staff, except for honorary staff, shall be required to pay biennial fees/dues, unless waived by the Medical Executive Committee. Fees/dues shall become delinquent if not paid within 30 days from when notice is sent for payment. A failure to pay fees/dues shall result in those actions specified in Section 8.3 3.5 (Failure to Pay Dues/Assessments). The Medical Executive Committee shall have the power to set the amount of fees/dues for each medical staff category, the amount of the processing fee for initial application, application for temporary privileges, and reapplication, and the amount to be paid by a practitioner whenever any unusual expenses are involved. The Medical Executive Committee shall determine the expenditure of all medical staff funds.

15.6 CONSTRUCTION OF TERMS AND HEADINGS

Commented [KM16]: Moved to preamble

Words used in these bylaws shall be read as the masculine or feminine gender and as the singular or plural as the context and circumstances require. The captions and headings in these bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these bylaws.

15.67 AUTHORITY TO ACT

Action of the medical staff in relation to any person other than the members thereof shall be expressed only through the chief of medical staff or the Medical Executive Committee, or its designee, and they shall first confer with the H hospital Ddirector. Any member or members who act in the name of the medical staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee or governing board may deem appropriate.

15.78 ACCEPTANCE OF PRINCIPLES

The member regardless of class or category, by application for medical staff membership, agrees to be bound by the provisions of these bylaws, a copy of which shall be delivered to the member upon request for an initial medical staff application, and thereafter a copy of all amendments to be

promptly delivered after adoption and made available at all times on the Medical Center Intranet site. Any violation of these bylaws shall subject the applicant or member to such disciplinary action as the Medical Executive Committee or governing board may deem appropriate.

15.9 DIVISION OF FEES

The practice of the division of professional fees under any guise whatsoever is forbidden, and any such division of fees shall be cause for exclusion or expulsion from the medical staff.

15.10 MEDICAL STAFF REPRESENTATION BY LEGAL COUNSEL

Upon the authorization of the medical staff or of the Medical Executive Committee acting on its behalf, the medical staff may retain and be represented by independent legal counsel at the expense of the medical staff.

15.11 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests, or other communications required or permitted sent by email to the address provided by each member for that purpose. ~~to be mailed, pursuant to these bylaws, shall be in writing, properly sealed, and shall be sent through the United States Postal Service, first class postage prepaid, certified or registered, return receipt requested~~. In the case of notice to the ~~hospital, governing board~~, medical staff or its officers or committees, the notice shall be addressed as follows:

~~Riverside University Health System - Medical Center~~
~~26520 Cactus Avenue~~
~~Moreno Valley, CA 92555~~
[need official MS email address]

~~Mailed n~~Notices to~~-~~ an~~a member~~, applicant, or other party shall be to the addressee at the address as it last appears on the official records of the medical staff .~~or the hospital.~~ If personally delivered, such notice shall be effective upon delivery. If sent via US postal mail~~ed as provided above~~, such notice shall be effective two (2) days after it is placed in the mail. ~~Any party may change its address as indicated above, by giving written notice of such change to the other party in the manner as above indicated.~~

15.12 SECRET WRITTEN BALLOT

Whenever these bylaws require a secret, mail ballot vote, the mail ballots shall be returned in an unmarked envelope. The ballot shall be placed inside a properly identified return envelope and the staff member will print and sign his/her name. The staff member's name shall be verified against the medical staff records.

ARTICLE XVI - ADOPTION AND AMENDMENT OF BYLAWS

16.1 ADOPTION AND AMENDMENT

The medical staff adopts and amends medical staff bylaws, rules and regulations. The adoption or amendment of medical staff bylaws cannot be delegated.

The medical staff bylaws will be reviewed periodically. These bylaws may be adopted, amended, or repealed at any regular or special meeting of the medical staff, provided that notice of such business is sent to all members no later than twenty (20) days before such meeting. The notice shall include the exact wording of the proposed addition or amendment, if applicable, and the time and place of the meeting. In order to enact a change, the affirmative vote of a majority of the active medical staff members present at the meeting shall be required. The amendment shall become effective when approved by the governing board. Neither the medical staff nor the governing board may unilaterally amend the medical staff bylaws or rules and regulations. The governing board shall approve and comply with the medical staff bylaws. The organized medical staff shall comply with and enforce the medical staff bylaws, rules and regulations, and policies.

The organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, policies, and amendments thereto, and to propose them directly to the governing board.

If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they first communicate the proposal to the Medical Executive Committee. If the Medical Executive Committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff; when it adopts a policy or an amendment thereto, it communicates this to the medical staff.

In cases of documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the Medical Executive Committee, as delegated by the voting members of the organized medical staff, may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the Medical Executive Committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment at the annual medical staff meeting. If there is no conflict between the organized medical staff and the Medical Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the Medical Executive Committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

The organized medical staff has a process which is implemented to manage conflict between the medical staff and the Medical Executive Committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. This process begins with the Conflict Management Committee. Nothing in the foregoing is intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the Medical Executive Committee. The governing body determines the method of communication.

16.2 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee shall have the power to adopt such amendments to the bylaws as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the medical staff or the governing board within 90 days after adoption by the Medical Executive Committee. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated in writing to the medical staff and to the governing board.

ADOPTED by the Medical Staff on ________________ ~~June 8, 2017~~

Gary Thompson, DO ___________________________
Gary Thompson, D.O., Chief of Medical Staff

Alexandra Clark, M.D. ___________________________
Alexandra Clark, M.D., Chief of Medical Staff-Elect

Commented [KM17]: Needs updating

APPROVED by the Governing Board on _________
Board of Supervisors of Riverside County

____
, Chair, Riverside County Board of Supervisors

*Signature on file

RULES AND REGULATIONS

The medical staff shall adopt such rules and regulations as may be necessary for the proper conduct of its work. The rules and regulations of the medical staff shall be adopted by the medical staff and approved by the governing board prior to becoming effective. Neither the medical staff nor the governing board may unilaterally amend the medical staff bylaws or rules and regulations.

1. **Assignment of Patients**. Patients shall be admitted only upon the order and under the care of a member of the medical staff of the hospital who is lawfully authorized to diagnose, prescribe and treat patients. The patient's condition and provisional diagnosis shall be established at the time of admission by the member of the medical staff who admits the patient. The house staff may perform these functions as outlined in the Rules and Regulations, Graduate Education Programs. The medical staff member shall be responsible for the following: the medical care and treatment of the member's patient at the hospital; the prompt completeness and accuracy of the medical record, including medical history and physical examination to be done not more than thirty (30) days prior to admission or within 24 hours after admission; for necessary special instructions; and for transmitting reports of the patient's condition to the referring practitioner and to the patient's relatives. If these responsibilities are transferred to another staff member, a note documenting the transfer of responsibility shall be entered on the order form of the medical record. Assignment of patient care duties shall be in accordance with departmental rules and regulations.

2. **Attending Physician** – A patient's attending physician is the medical staff physician responsible for rendering, coordinating and directing care and services provided to a patient while hospitalized. Expertise and training relative to the principal diagnosis precipitating hospitalization generally determines initial pairing of patients to attending physicians.

   A patient may have more than one attending physician over the course of a hospitalization, but should have only one attending physician at a time. One physician must be in charge. Transfer of responsibility from one attending physician to another must be clearly specified in the medical record, whether it will be for weekend or holiday coverage within a department, or whether it be a transfer from one medical service to another

3. **Attending Staff Notes**. Each department attending staff member should use the Multidisciplinary Note to chart his/her notes and recommendations.

43. **Attending Staff Private Patient Charges**.

    An attending staff member may admit and charge for identifiable services rendered to the member's private patients, including those under Medicare and Medi Cal. An attending staff member may not charge for County indigent patients except to the extent that these patients are covered by Medi Cal or other insurance. Identifiable medical services may be construed as those services normally provided to private patients, as evidenced by histories, physicals, progress notes, physician's orders, etc.

Commented [KM18]: From "Definitions" section – term is not used in the Bylaws

(b) An attending staff member may charge the County of Riverside for special services rendered to indigent patients, who are referred to the member's private office by the hospital director, for services that the attending medical staff may deem important to patient care and not provided at this hospital.

54. **Autopsies**. All autopsies shall be obtained as specified in the Protocol for Autopsy Request, Administrative Patient Care Services Manual, Policy No. 653, Autopsy Consent Documentation. An autopsy should not be performed without the proper written consent of the responsible relative or legal authorized agent. All autopsies shall be performed by the hospital pathologist or by a physician delegated this responsibility. Also, refer to the Laboratory Policy No. 3.1, Pathology Department for additional direction.

65. **Clinic Patients**. Service patients referred to the hospital clinic solely for diagnostic laboratory studies shall be followed as hospital clinic patients.

6. Consent Form. Written, signed, and informed consent shall be obtained by the physician prior to the procedure except in those situations where the patient's life is in jeopardy and suitable signatures cannot be obtained due to the emergency condition of the patient. In an emergency, in which a consent cannot be immediately obtained, the circumstance should be fully explained on the patient's medical record. A consultation, in such instance, may be desirable before the emergency operative procedure is undertaken if time permits.

Commented [KM19]: Now covered by housewide policy – HW 602

7. **Consultation Criteria**.

Inpatient Consultation Criteria. The primary service shall request consultation as required for optimal patient care. In addition, each consulting department may indentify criteria that trigger automatic consultation to expedite care. Written consultation is considered complete only when signed/co-signed by the attending physician and placed in the medical record.
Routine Consults. The consult should be completed within 24 hours of request unless otherwise agreed upon by the Primary Attending Physician and/or Consultant. The primary service will place a written order in the chart and also verbally notify the consultant. Notification of consult completion must occur. The consultant may ask a non-physician (i.e. nurse, unit clerk, etc.) to contact the primary service.

Urgent/Emergent Consults
The consult will be performed as soon as possible to ensure patient safety but not to exceed 24 hours from time of request, unless specified by another policy. The primary service will place a written order in the chart and also verbally notify the consultant. The consultant will contact the primary attending or senior level resident and give verbal notification of consult completion and recommendations in addition to written recommendations.

8. **Drugs**. All drugs and medications administered to patients shall be those as listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluation. Drugs for bona fide clinical investigations may be exceptions, and these shall be used in full accordance with the Statement of Principles Involved in the Use of Investigation Drugs in Hospitals and all regulations of the Federal Drug Administration. The hospital drug formulary is to be used for prescribing medicine. See RUHS Policy HW 842 Drug

Formulary Process. When drugs that are not listed on the hospital formulary are ordered for private patients, as signed for by the attending medical staff physician, said drugs will be secured and a special charge will be made to the patient.

Commented [KM20]: Current practice??

9. **Graduate Education Programs**: The following shall apply to the hospital's graduation education programs:

(a) The departments who participate in professional graduate education programs shall in their departmental rules and regulations and policies specify the mechanism by which house staff members are supervised by medical staff members in carrying out their patient care responsibilities.

(b) The hospital shall not permit any physician, dentist, podiatrist, or resident, intern or student to perform any service for which a license, certificate or registration or other form of approval is required unless such person is licensed, registered, approved or exempted, unless such services are performed under the direct supervision of a licensed practitioner wherever so required by law.

(c) If patient care is provided by residents~~, interns~~ and medical students, such care shall be in accordance with the provisions of an approved program.

(d) Except in an emergency, all other patient care by ~~interns~~, house officers, residents or persons with equivalent titles, not provided as specified in (c) of this section, must be provided by a practitioner with current license to practice in California.

(e) The departmental residency requirements are subject to review by the Graduate Medical Education (GME) Committee. The department shall present an annual report, outlining its residency requirements, to the GME Committee.

(f) House staff members may write orders as outlined in Records Authentication, Rule #28.

(g) The Family Medicine (FM) chair may assign residents to serve on medical staff committees. FM residents will serve on committees without the power to vote, unless otherwise specified in the Medical Staff Committees and Functions Manual.

10. **Non-inpatient medical history**. A Non-inpatient medical history and physical examination includes the following: HPI, describing Chief Complaint, PMH, PSH, Allergies to medication, SH/FH, ROS and physical examination and, assessment and plan.

11. **Media Release**. Release of information concerning activities at Riverside University Health System Medical Center to the public media will be done only with the approval of hospital administration.

12. **Medical Record**. All patients' charts shall be completed fourteen (14) days after discharge. The summary of case is to be completed at the time of discharge. The house staff and attending staff will be notified of the time frame for record completion as noted in the HIM ~~Medical Records~~ Policy, No. 701 Chart Completion. Also, see RUHS Policy No. 600.3, Patient Medical Records, for additional information regarding components of a complete patient medical record, record authentication, timeliness, urgent/emergent care services, operative and high-risk procedures, summary/problem lists, discharge information, etc.

13. **Medical Records Property of the Hospital**. All medical records are the property of the hospital and shall not be removed from the hospital's jurisdiction and safekeeping except in accordance with a court order, subpoena or statute. ~~In the case of multiple admissions, all of the patient's previous records shall be made available to the treating physician. This shall apply whether the same or another physician sees the patient. All medical records needed for patient care or review must be requested and issued in the computer by the medical records staff before removing them from the Medical Records Department. All medical records must be returned before the end of the day. Returned medical records can be placed on "hold" in the Medical Records Department/Chart Room if needed again the next day.~~

Commented [KM21]: Not current practice, per L. Reese.

14. **Medical Screening Examination**: The depth of evaluation and level of expertise required to fulfill the Federal requirements to perform a Medical Screening Examination (MSE) is dependent on the patient's condition. Screening may be performed by a RUHSMC medical staff physician or by appropriately trained personnel or resident with oversight from the supervising attending physician. Refer to RUHS HW Policy No. 656 EMTALA Screening, Stabilizing and Transfer of Patients with Emergency Medical Conditions. ~~Administration Policy and Procedure Manual, Policy No. 600, "Inpatient Admitting and Emergency Department Consultations" and Policy No. 639, "Evaluation Treatment and/or Transfer of RCRMC Emergency Patients."~~

15. **Medical Staff Requirement.** Each member of the medical staff shall be required to serve when called upon by the practitioner's department/division chair or vice chair. A staff member who fails to serve, as requested, shall be reported to the MEC for action. A staff member who does not comply with this requirement may be dropped from the medical staff.

Commented [KM22]: "required to serve"?? Is this still the practice / needed?

16. **Notification of Attending Staff.** All seriously ill patients shall be seen by a member of the attending medical staff as soon as possible after notification and, in all such cases, within 24 hours.

17. **Operative Record**. An operative report or a brief operative report must be completed immediately at the conclusion of a case by either an attending, resident, or intern participating in the case. A complete operative report must be dictated or completed in the EHR within 24 hours. The operative report includes at least: Name and hospital identification number of patient. Date and times of surgery. Name of surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision). Pre-operative and post-operative diagnosis, names of the specific surgical procedure(s) performed. Type of anesthesia administered, and complications if any. Description of techniques, findings, and tissues removed or altered. Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioners. Significant surgical procedures include: opening and closing, harvesting or implanting grafts, dissecting tissue, removing tissue, implanting device(s) or prosthesis.

All tissues, excluding those exempted by the department of Health Services, Program Flexibility, under Section 70129 (a), Title 22, California Administrative Code, that are removed during the operation shall be sent to the hospital pathologist. The pathologist shall perform examinations that may be considered necessary to arrive at a pathological diagnosis. The report shall be signed by the pathologist. (See RUHS Perioperative Policy ~~No. 604, Surgery and~~ OR, Operating Room Scheduling and Block Time Utilization. ~~Room Schedulin~~.)

18. **Orders, Standing**. Standing orders may be formulated and may be changed as deemed necessary with the approval of the appropriate committees. Standing orders shall be signed by the house staff. Standing orders shall be posted or circulated to all patient units at the hospital and shall be a part of hospital manuals.

19. **Orders, Verbal**. Verbal orders (oral or by telephone) for administration of medications may be received and recorded by licensed health professionals who are expressly authorized under their practice acts to receive orders to administer drugs. This includes registered nurses, (RNs), pharmacists, physicians, physician assistants from supervising physician only, physical therapists (for certain topical drugs only), and respiratory therapists when the orders relate specifically to respiratory therapy. These orders are to be countersigned by the physician or any physician by the team caring for the patient within forty-eight (48) hours. (See RUHS HW Policy No. 680~~803,~~ ~~Verbal/~~Telephone and Verbal~~d~~ Orders ~~for Drugs~~.)

20. **Orders, Written**. All orders shall be written, dated, timed and signed by the ordering physician. The physician's order must be written clearly, legibly and completely. Orders that are illegibly or improperly written will not be carried out until rewritten or understood by the nurse. All automatic cancellation of orders will be done in accordance with the policy of the Pharmacy & Therapeutic Committee.

21. **Patients' Bill of Rights**. In accordance with Section 70707 of the CA Administrative Code, the medical staff will agree to honor the list of Patients' Rights in California. See HW Policy No. 601 Patient Rights and Responsibilities~~e~~.

22. **Pregnancy Test**.
    (a) A negative pregnancy test result on any patient is mandatory prior to any procedure that might adversely affect a pregnancy, e.g., hysterosalpingogram, hysteroscopy, hysterectomy.
    (b) A pregnancy test is desirable for any patient who might be pregnant prior to elective surgery, but may be waived at the attending physician's discretion.
    (c) No case with any urgency should be delayed to await a pregnancy test result.

23. **Preoperative Procedures**. A complete medical history and physical examination must be performed within thirty (30) days prior to the patient's admission or within 24 hours after inpatient admission. For a medical history and physical examination that was performed within thirty (30) days prior to inpatient admission, an update documenting any changes in the patient's condition shall be completed within 24 hours after inpatient admission or prior to surgery. Appropriate screening tests, based on the needs of the patient, shall be accomplished and recorded in the patient's chart within 72 hours prior to the patient's surgery. As in the ASA (American Society of Anesthesiology) Class I and II patients, appropriate screening tests will be considered acceptable if done within seven (7) days prior to the patient's surgery. (See RUHS MC Policies No. 600, Inpatient Admitting and Emergency Department Consultations, and No. 604, Surgery and Operating Room Scheduling.)

24. **Preoperative Record**. If a history and physical examination (to include blood pressure, urinalysis and blood count) is not completed and in the chart prior to the patient's operation, the operation

shall be canceled unless the attending physician states, in writing, that such delay would constitute a hazard to the patient.

25. **Private Patients**. A private patient who is admitted to the hospital may be attended by the patient's private physician and by the resident assigned to the division or department. A physician, who admits a private patient to the hospital, shall provide information and orders necessary to adequately and completely record the management of the private patient. The hospital shall have the right, through the medical director or the chief of medical staff, to require the attending private physician to obtain a consultation through the chair of the relevant department or designee.

26. **Provisional Diagnosis.** Except in an emergency, a patient shall not be admitted to the hospital until after a provisional diagnosis has been stated. In the case of an emergency, the provisional diagnosis shall be stated as soon as possible after admission.

27. **Publications.** Case reports (documenting 1-3 cases) may be submitted to the chair of the appropriate department and the medical director rather than the Institutional Review Board (IRB). All requests for permission to publish scientific papers, books or reports and photographs arising out of work performed at the hospital shall be in writing, utilizing the approved forms, stating the specific purposes for which the material will be employed, and shall be approved in writing by the chair of the relevant department. ~~before being presented to the Institutional Review Board Committee. These forms can be obtained from the chair of the IRB. No member shall offer for publication any scientific paper, book or report arising out of work done at the hospital without first securing approval of the Institutional Review Board Committee.~~ Case reports may be submitted to the IRB if the author(s) would like a letter from the IRB to accompany their journal ubmission. All publications arising out of work done at the hospital shall give credit to the hospital. A copy of every article or book approved for publication shall be furnished to the medical director for inclusion in the medical library file devoted to contributions from the attending medical staff. A violation of any of the regulations of this rule, in regard to research orf publication, shall subject the offender to such disciplinary action as the Medical Executive Committee may deem appropriate. All newspaper and/or television releases must be approved by hospital administration. See IRB Policy 1 – Scope of IRB Authority

Commented [KM23]: IRB is no longer performing this function.

28. **Records Authentication.** The attending physician shall be identified on the history and physical, consultation note, operative report, discharge summary and labor and delivery note. These notes must also be signed by an attending physician. Medical records shall be authenticated in accordance with the laws and regulations applicable to the hospital.

Commented [KM24]: Still needed in these EPIC days?

29. **Research Projects**. Medical staff members, ~~including~~ residents and medical students shall not undertake any type of biomedical or clinical research project within the jurisdiction of this hospital without first obtaining approval of the Riverside University Health System Medical Center (RUHS MC) Institutional Review Board (IRB) and the Medical Executive Committee (MEC). Research projects shall have the approval of the relevant department chair, the IRB, and the MEC respectively. ~~A quarterly progress report will be reviewed by the IRB on all ongoing hospital research projects~~. Closure of a research project must be reported to the IRB, within the ~~quarterly progress report~~ during which ~~time~~ the research was terminated. Retrospective Record Reviews

Commented [KM25]: Is this current practice – requiring dual approval ?

Commented [KM26]: Same

withby an outside source of funding shall not be undertaken without first obtaining approval of the RUHS MC IRB Design Review Subcommittee (DRs).

30. **Responsibility for Private Patients**. When a physician has a private patient in the hospital, a history and physical examination may be performed by a member of the house staff unless specifically not requested by the attending physician treating the case. The attending physician is required to provide a medical history and physical examination on the private patient. A physician who has a private patient in the hospital will be expected to abide by the bylaws, rules and regulations.

31. **Restraint and/or Seclusion**. The procedures relating to restraint and/or seclusion are in the RUHS MC HW Policy No. 630, 630.1 and 630.2 (Restraints and/or Seclusion) and shall apply to all units using restraint and/or seclusion.

32. **Retrospective Record Reviews**: Attending medical staff will encourage the use of the Design Review Subcommittee (DRs) of the RCRMC IRB to review and facilitate quality designee of proposed Retrospective Record Reviews at RCRMC. Any Retrospective Record Review to be done at RCRMC and that is to be funded by an outside source must have the review and approval of the DRs prior to start of the chart review.

Commented [KM27]: Duplicates # 29

33. **Sterilization.** The Obstetric Gynecology Department, Family Medicine Department, and the Urology Division will each have a policy regarding sterilization that will include appropriate informed consent, and it will also comply with all existing state and federal statutes pertaining to this procedure.

34. **Suicide.** An attempted suicide or chemical overdose patient shall be offered psychiatric consultation and it will be documented in the patient's medical record.

35. **Surgery Schedule**. When a surgical operation is scheduled by a resident physician, it shall be only after consultation with the attending member of the involved service.

36. **Surgical Assistants**. When it is necessary that two members of the attending medical staff scrub on the same case, one of them shall act as the second assistant if a resident is available as the first assistant, unless in the opinion of the operating surgeon such an arrangement would not be in the best interest of the patient.

37. **Symbols and Abbreviations**. Only symbols and abbreviations contained in Stedman's Medical Dictionaryapproved by the medical staff shall be regularly used. A list of symbols and abbreviations designated as "Do Not Use" by the Joint Commission because of potential dangerousness these shall be maintained by the Medical Records Department and shall be available to those authorized to make entries in the medical record.

38. **Tissue**. No tissue shall be removed from the hospital without the consent or permission of the pathologist and the medical director or in response to a subpoena or Court Order.

39. **Release of Body**. In the event of a patient's death, the deceased shall be pronounced dead by a licensed physician within a reasonable time. Policies with respect to releases of the body shall conform to state law. Documentation of death will adhere to RUHS HIM ~~medical records~~ policy 701-Chart Completion ~~012015~~.

40. ~~**Counter Signature**: The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the Physician Assistant functioning under the protocols within 30 days of the date of treatment by the Physician Assistant. The medical record of any patient cared for by a Physician Assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed, countersigned, and dated by a supervising physician and surgeon within seven days. By California law, telesignature for Nurse Practitioners is not a requirement.~~

Commented [KM28]: Law changed January 2020 – countersignatures no longer required, unless you want to keep the requirement?