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

Riverside University HEALTH SYSTEM Medical Center

ITEM: 15.1
(ID # 25880)
MEETING DATE:
Tuesday, September 10, 2024

FROM : RUHS-MEDICAL CENTER

SUBJECT: RIVERSIDE UNIVERSITY HEALTH SYSTEM-MEDICAL CENTER: Ratify and Approve Medical Staff Appointments, Reappointments, Clinical Privileges Proctoring, Additional Privileges, Withdrawal of Privileges, Leave of Absences, Resignations/Withdrawals, and Automatic Termination, as Recommended by the Medical Executive Committee on January 11, 2024, February 8, 2024, March 14, 2024, April 11, 2024, May 9, 2024 and June 13, 2024; All Districts. [$0].

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve medical staff appointments, reappointments, clinical privileges proctoring, additional privileges, withdrawal of privileges, leave of absence, resignations/withdrawals, and automatic termination, as recommended by the Medical Executive Committee on January 11, 2024, February 8, 2024, March 14, 2024, April 11, 2024, May 9, 2024, and June 13, 2024.

ACTION:Policy

Jennifer Cruikshank
Jennifer Cruikshank, Chief Executive Officer – Health System 8/27/2024

MINUTES OF THE GOVERNING BOARD

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

Ayes:	Jeffries, Spiegel, Washington, Perez and Gutierrez
Nays:	None
Absent:	None
Date:	September 10, 2024
xc:	RUHS-Medical Center

Kimberly A. Rector
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: Hospital Enterprise Fund - 40050			Budget Adjustment: No	
			For Fiscal Year: FY23/24	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

The Riverside University Health System Medical Center (RUHS-MC) is a licensed and accredited acute care hospital serving the needs of County residents since 1893. As an acute care hospital, RUHS-MC is required by the State of California and its Department of Public Health to have a "governing body" separate from its administrative leaders and medical staff leadership.

Per California Code of Regulations §70035 (see also 42 CFR 482.12 and Joint Commission Standard LD.01.03.01), the "governing body" is "the person, persons, board of trustees, directors or other body in whom the final authority and responsibility are vested for conduct of the hospital." On February 23, 1988 (Motion 3-35), the Board of Supervisors (Board) declared itself to be the "governing body" for the hospital.

Subsequently, on April 12, 1998 (Resolution No. 88-166), the Board also determined that it would hold at least one regularly scheduled meeting each month, acting as the Medical Center Governing Board, to "review hospital policy, quality of care, medical staff credentialing, institutional planning and continuing education matters" in accordance with hospital bylaws; which lay out the procedures and practices by which the Board of Supervisors, acting as the governing body of RUHS-MC, exercises that authority and meets the expectations of the State, the medical center's accrediting bodies and the federal healthcare programs.

The hospital bylaws were most recently reviewed and revised on November 14, 2017 (Item 3.22). In accordance with Article II and Article IV, of these bylaws, a hospital Medical Executive Committee is currently in place and composed of the Chief of Medical Staff, immediate past Chief of Medical Staff, Chief of Medical Staff elect, Secretary-Treasurer, Medical Director, Chair of the Performance Improvement Committee, and the Chair and Vice Chair of departments.

Pursuant to the duties of the hospital Medical Executive Committee to make recommendations directly to the Governing Board pertaining to recommendations regarding medical staff initial appointments, reappointments, and clinical privileges for eligible individuals, the Medical Executive Committee met monthly between January 2023 through June 2023, in consideration of its bi-annual submission to the Board.

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

During the meetings on January 11, 2024, February 8, 2024, March 14, 2024, April 11, 2024, May 9, 2024 and June 13, 2024, the Medical Executive Committee recommended to refer the following RUHS-MC Medical Staff recommendations to the Board of Supervisors for review and action:

A.

Approval of Medical Staff Initial Appointments, Reappointments and Clinical Privileges, FPPE/Reciprocal* Complete Remain on Provisional, Final FPPE/Reciprocal* Advancement of Staff Category, FPPE–Final Proctoring for Allied Health Professionals, FPPE–Final Proctoring for Additional Privileges, Additional Privileges/Withdrawn Privileges, Change in Staff Reappointment Dates, Change in Staff Category, Voluntary Resignations/Withdrawals*.

The attached RUHS-MC Chief Executive Officer approvals provide information related to these topics. Their presentation and review by the Board not only helps the RUHS-MC to meet regulatory requirements, but also to be transparent about its operations, successes, and challenges.

ATTACHMENTS:

ATTACHMENT A	RUHS-MC CEO APPROVALS FOR MEDICAL STAFF ATTESTATION APPOINTMENT, REAPPOINTMENTS, AND CLINICAL PRIVILEGES (January 1, 2024 thru June 30, 2024)
ATTACHMENT B	AHP GENERAL SURGERY PA CLINICAL PRIVILEGES 3.14.24
ATTACHMENT C	APP EMERGENCY MEDICINE NP PA CLINICAL PRIVEGE FORM 5.9.24
ATTACHMENT D	EMERGENCY MEDICINE ADV PRIVILEGE FORM 2.8.24
ATTACHMENT E	EMERGENCY MEDICINE CORE PRIVILEGE FORM 2.8.24
ATTACHMENT F	EXTERNAL PROCTOR ATTESTATION AND RELEASE 3.14.24
ATTACHMENT G	EXTERNAL PROCTOR HIPAA CONFIDENTIALITY STATEMENT 3.14.24
ATTACHMENT H	MED IM SUBSPECIALTY CLINICAL PRIVILEGES 6.13.24
ATTACHMENT I	MEDICAL STAFF COORDINATOR LIST 2.8.2024
ATTACHMENT J	MEDICAL STAFF EXTERNAL PROCTORS POLICY 3.14.24
ATTACHMENT K	MSA 100 INITIAL APPOINTMENT CREDENTIALING PROCESS 4.11.2024
ATTACHMENT L	MSA 101 REAPPOINTING CREDENTIALING PROCESS 4.11.2024
ATTACHMENT M	MSA 106 FOCUSED PROFESSIONAL PRACTICE EVALUATION POLICY (FPPE-PROCTORING) 5.9.24
ATTACHMENT N	MSO MEDICAL STAFF WELL BEING POLICY 03.14.24

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

ATTACHMENT O	MSO SCOPE OF SERVICE MEDICAL STAFF ADMINISTRATION 5.9.24
ATTACHMENT P	RUHS INITIAL APPLICATION CHECKLIST 4.11.24
ATTACHMENT Q	RUHS MEDICAL STAFF BYLAWS R&R 24-25 ADOPTED 6.6.24
ATTACHMENT R	RUHS REAPPLICATION CHECKLIST 4.2024

Jacqueline Ruiz

Jacqueline Ruiz, Principal Analyst 8/30/2024

Confidential Medical Staff Committee Report
Protected by California Evidence Code 1157

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 01/11/24
MEC DATE: 01/11/24
BOARD DATE: 01/11/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Date: January 11, 2024

To: File

From: Medical Staff Executive Committee

Subject: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – January 11, 2024 – December 31, 2025

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Cantu, Daae, PA	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
Contreras, Jessica V., NP	AHP-Provisional	Nurse Practitioner	Medicine	AANP
Dadani, Farhan, MD	Provisional	Internal Medicine	Medicine	Internal Medicine
Froehlich, Katherine A., CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	NBCRNA
Kim, Cherine H., MD Temporary Privilege 1/9/24	Provisional	Otolaryngology	Surgery	Otolaryngology
Matsumoto, Lauren, CPNP	AHP-Provisional	Nurse Practitioner	Surgery	PNCB
Olson, Caitlin P., MD	Provisional	Otolaryngology	Surgery	Eligible
Patil, Shakuntala S., MD	Provisional	Nephrology	Medicine	Internal Medicine Nephrology
Pham, Ngoc Minh, MD	Provisional	Psychiatry	Psychiatry	Psychiatry
Rendon, Juan L., MD	Provisional	Plastic Surgery	Surgery	Plastic Surgery
Salib, Michael, F., MD	Provisional	Psychiatry	Psychiatry	Psychiatry Addiction Medicine
Shin, John Y., MD	Provisional	Hematology/Oncology	Medicine	Internal Medicine Hematology Medical Oncology
Tama, Maher, MD	Provisional	Gastroenterology	Medicine	Internal Medicine Gastroenterology
Thomas, Amber M., CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	NBCRNA
Thurman, Michael, MD	Provisional	Psychiatry	Psychiatry	Child & Adolescent Psychiatry Psychiatry
Wu, Brian W., MD	Provisional	Psychiatry	Psychiatry	Psychiatry

REAPPOINTMENTS - February 1, 2024 – January 31, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Abejuela, Kristofer R., PA	AHP	Physician Assistant	Emergency Medicine	NCCPA
Ali, Arham, MD	Active	Critical Care	Pediatrics	Pediatrics
Goldstein, Mitchell R., MD	Active	Neonatal/Perinatal	Pediatrics	Neonatal/Perinatal Medicine Pediatrics
Gupta, Supriya, MD	Tele-Health	Radiology	Radiology	Diagnostic Radiology-General
Hamade, Wael L., MD	Active	Family Medicine	Family Medicine	Family Medicine Geriatric Medicine
Henshaw, Kimberly, PA	AHP	Physician Assistant	Emergency Medicine	NCCPA
Hoang, Phuong T., MD	Active	Endocrinology	Pediatrics	Pediatrics Pediatric Endocrinology
Kazi, Aasif A., MD	Provisional	Surgery	Surgery	Eligible
Kerr, William K., PA	AHP	Physician Assistant	Medicine	NCCPA
Ledbetter, Rodney A., PA	AHP	Physician Assistant	Emergency Medicine	NCCPA
Minahan, Thomas F., DO Additional Privilege: • TEE	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine
Mora, Llesenia, PA	AHP	Physician Assistant	Medicine	NCCPA
Nader, Laura M., MD	Active	Family Medicine	Family Medicine	Family Medicine
Oshiro, Bryan T., MD	Active	Ob-Gyn	Obstetrics & Gynecology	Obstetrics & Gynecology
Ploesser, Markus, MD	Active	Psychiatry	Psychiatry	Brain Injury Medicine Forensic Psychiatry Prevention Medicine Psychiatry

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 01/11/24
MEC DATE: 01/11/24
BOARD DATE: 01/11/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Reeves, Mark E., MD	Courtesy	Surgery	Surgery	ABO Surgery
Simmons, Emma M., MD	Active	Family Medicine	Family Medicine	Family Medicine
Wang, Hua, MD	Active	Genetics	Pediatrics	Clinical Genetics and Genomics

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Alsyouf, Muhannad, MD	Provisional	Urology	Surgery	Remain on Provisional until 10/2024
Wong, Alan K., MD	Provisional	Urology	Surgery	Remain on Provisional until 7/2024
Zarecki, Ester N., MD	Provisional	Family Medicine	Family Medicine	Remain on Provisional until 3/2024

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Fung, Nathaniel S., MD	Provisional	Surgical Critical Care	Surgery	Advance to Active
Galvis, Alvaro E., MD	Provisional	Pediatric Infectious Diseases	Pediatrics	Advance to Active
Kazi, Aasif A., MD	Provisional	Otolaryngology	Surgery	Advance to Active
Yala, Linda I., MD	Provisional	Surgical Critical Care	Surgery	Advance to Active

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Egan, Katherine, CRNA	AHP-Provisional	Certified Registered Nurse Anesthetist	Anesthesia	Complete
Jerez-Aguilar, Brenda, NP	AHP-Provisional	Nurse Practitioner	Family Medicine	Complete
Millet, Kevin J., CRNA	AHP-Provisional	Certified Registered Nurse Anesthetist	Anesthesia	Complete

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Yala, Linda I., MD	Provisional	Surgical Critical Care	Surgery	Additional Privileges Proctoring Complete

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				•

CHANGE IN STAFF REAPPOINTMENT DATES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Kerr, William K., PA	AHP	Physician Assistant	Emergency Medicine	05/31/2024 change to 01/31/2024

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				

NAME CHANGE

NAME	STATUS	SPECIALTY	DEPARTMENT	CHANGE TO:
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
None				

Confidential Medical Staff Committee Report
Protected by California Evidence Code 1157

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 01/11/24
MEC DATE: 01/11/24
BOARD DATE: 01/11/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT	EFFECTIVE/REASON
Austin, Mark H., MD	Provisional	Anesthesiology	Anesthesia	12/13/2023
Hanak IV, Brian E., MD	Active	Neurological Surgery	Clinical Neurological Sciences	12/31/2023
Hong, Christopher J., DO	Provisional	Psychiatry	Psychiatry	01/09/2024
Nwachukwu ,Oluwafisayomi, DO	Active	Pediatrics	Pediatrics	Voluntary – 11/30/2023
Petrick, Travis M., NP	AHP-Provisional	Nurse Practitioner	Radiology	Voluntary- 12/28/2023
Win, Theresa, MD*	Applicant	Internal Medicine	Medicine	Application Withdrawn

I hereby:
1) Attest that the medical center's Medical Executive Committee meeting on December 14, 2023 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

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT - REVISED

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

CRED DATE: 01/26/24
MEC DATE: 02/08/24
BOARD DATE: 02/08/24

Date: February 8, 2024

To: File

From: Medical Staff Executive Committee

Subject: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – February 8, 2024 – January 31, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Derakhshan, Adeeb, MD • **Temporary Privileges eff 1/16/24**	Provisional	Otolaryngology	Surgery	Otolaryngology
Dreger, Nicholas MD	Provisional	Cardiology	Pediatrics	Pediatrics Pediatric Cardiology
Nguyen, Nina N., CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	NBCRNA
Rajpoot, Ravi, MD	Provisional	Radiology	Radiology	Diagnostic Radiology
Romero, Lidia AuD	AHP-Provisional	Audiology	Surgery	Not Applicable
Saldana, Mario A., MD	Provisional	Internal Medicine	Medicine	Internal Medicine
Sharbidre Kedar G., MD	Tele-Health	Radiology	Radiology	Diagnostic Radiology
Stablein, Gary W., MD • **Temporary Privileges eff 1/20/24**	Provisional	Psychiatry	Psychiatry	Eligible
Tran, Victoria M., MD	Provisional	Physical Medicine & Rehabilitation	Medicine	Physical Medicine & Rehabilitation

REAPPOINTMENTS - March 1, 2024 – February 28, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Caudill, Benjamin J., FNP **Additional Privilege:** • Obtaining Informed Consent	AHP	Nurse Practitioner	Medicine	AANP
Chawla, Harmanpreet S., MD	Active	Critical Care	Pediatrics	Pediatrics Pediatric Critical Care Medicine
Chitsazan, Morteza, DO	Active	Internal Medicine	Medicine	Internal Medicine
Heath, Doris, NP	AHP	Nurse Practitioner	Clinical Neurological Sciences	AANP
Kadri, Munaf M., MD	Active	Neonatology	Pediatrics	Pediatrics Neonatal-Perinatal Medicine
Knox, Christie K., DO	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

CRED DATE: 01/26/24
MEC DATE: 02/08/24
BOARD DATE: 02/08/24

Legaspi, Elaine Marie N., PA	AHP	Physician Assistant	Emergency Medicine	NCCPA
Munden, Susan K., MD	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine
Pasca, Ioana F., MD	Active	Anesthesiology	Anesthesia	Anesthesiology Critical Care Medicine Neurocritical Care
Plosker, Ari D., MD	Tele-Health	Radiology	Radiology	Diagnostic Radiology
Pruitt, Laura N., MD	Active	Critical Care	Pediatrics	Pediatrics Pediatric Critical Care Medicine
Rakoski, Mina O., MD **Withdraw of Privileges:** • Colonoscopy w/biopsy • EEG w/biopsy • Moderate sedation	Active	Gastroenterology	Medicine	Gastroenterology Transplant Hepatology
Raval, Ronak, MD **Withdraw of Privilege:** • Pediatric Anesthesia	Active	Anesthesiology	Anesthesia	Anesthesiology Critical Care Medicine
Reed, Peilin, MD	Tele-Health	Radiology	Radiology	Diagnostic Radiology
Sanchez-Kazi, Cheryl P., MD	Active	Nephrology	Pediatrics	Pediatrics Pediatric Nephrology
Schiraldi, Michael, MD **Additional Privilege:** • Moderate Sedation	Active	Neurological Surgery	Clinical Neurological Sciences	Eligible

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Cho, Alexander L., MD	Provisional	Diagnostic Radiology	Radiology	Complete Remain Provisional until 10/12/2024
Eichenberg, Brian J., MD	Provisional	Plastic Surgery	Surgery	Complete Remain Provisional until 7/01/2024
Gentry, Tanya N., DO	Provisional	Pediatrics	Pediatrics	Complete Remain Provisional until 8/10/2024
Hou, Gina, MD	Provisional	Pediatrics	Pediatrics	Complete Remain Provisional until 8/10/2024
Kohbodi, GoleNaz A., MD	Provisional	Neonatology/Pediatrics	Pediatrics	Complete Remail Provisional until 9/14/2024
Stevens, Paige, MD	Provisional	Pediatric Critical Care Medicine	Pediatrics	Complete Remain Provisional until 07/13/2024
Vance, Kristofer J., MD	Provisional	Pediatrics	Pediatrics	Complete Remain Provisional until 8/10/2024

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

CRED DATE: 01/26/24
MEC DATE: 02/08/24
BOARD DATE: 02/08/24

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Batton, Emily M., MD	Provisional	Pediatrics/Neonatology	Pediatrics	Advance to Active
Olavarry, Carolina C., MD	Provisional	Pediatrics	Pediatrics	Advance to Active
Peterson, Joseph D., MD	Provisional	Otolaryngology	Surgery	Advance to Active
Stout, Charles E., MD	Provisional	Interventional Vascular Radiology	Radiology	Advance to Active
Zarecki, Ester N., MD	Provisional	Family Medicine	Family Medicine	Advance to Active

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Alzubaidi, Qammer T., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	Complete
Bock, Alexandra M., CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete
Shimmon, Ariel A., CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete
Vu, Ivy, NP	AHP-Provisional	Family Medicine	Family Medicine	Complete

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Pasca, Ioana F., MD	Active	Anesthesiology	Anesthesia	• Pediatric Anesthesiology

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Alzubaidi, Qammer T., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	Withdraw of Privilege: • Paracentesis
Bock, Alexandra M., CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Withdraw of Privilege: • Pediatric Anesthesiology
Davis-Bates, Theresa L., NP	AHP	Nurse Practitioner	Surgery/Clinical Neurological Sciences	Withdraw of Privileges: • Dept. of Clinical Neurological Sciences
Olavarry, Carolina C., MD	Provisional	Pediatrics	Pediatrics	Withdraw of Privilege: • Moderate Sedation
Peterson, Joseph D, MD	Provisional	Otolaryngology	Surgery	Withdraw of Privileges: • Neurotology Core Procedures • CO2 • KTP
Sugiyama, Akihiro, MD	Provisional	Surgery	Surgery	Withdrawal of Privileges: • Vascular Privileges Core
Stout, Charles E., MD	Provisional	Interventional Vascular Radiology	Radiology	Withdrawal of Privileges: • Core Diagnostics

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

CRED DATE: 01/26/24
MEC DATE: 02/08/24
BOARD DATE: 02/08/24

Truong-N, Khoa T., MD	Provisional	Anesthesiology	Anesthesia	Withdraw of Privilege: • Pediatric Anesthesiology
Vance, Kristofer J., MD	Provisional	Pediatrics	Pediatrics	Withdraw of Privileges: • Moderate Sedation
Ventro, George J., Jr., MD	Provisional	Surgical Critical Care	Surgery	Withdraw of Privileges: • Vascular Surgery Core • Trauma Endovascular Core • Thyroid / Parathyroid

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				

CHANGE IN STAFF REAPPOINTMENT DATES TO ALIGN WITH CHC

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Alexander, Katherine A., NP	AHP	Nurse Practitioner	Emergency Medicine	12/31/2024 change to 06/30/2024
Scott, Jonathan H., MD	Active	Internal Medicine	Medicine	07/31/2024 change to 06/30/2024

NAME CHANGE

NAME	STATUS	SPECIALTY	DEPARTMENT	CHANGE TO:
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
None				

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT	EFFECTIVE/REASON
Ardiles, Yona R., DO	Active	Internal Medicine	Medicine	2/09/2024 / Voluntary
Hagan, Natalie, NP	AHP-Provisional	Critical Care	Surgery	1/23/2024 / Voluntary
Huang, Chris, MD	Active	Anesthesiology	Anesthesia	1/26/24 / Voluntary
Saint-Preux, Fabienne, MD	Provisional	Pain Medicine	Anesthesia	2/5/2024 / Voluntary

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 01/26/24
MEC DATE: 02/08/24
BOARD DATE: 02/08/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

End of Report

1) Attest that the medical center's Medical Executive Committee meeting on August 10, 2023, recommended approval of the appointment, reappointments, proctoring, change of status, withdrawal 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

CRED DATE: 02/23/24
MEC DATE: 03/14/24
BOARD DATE: 03/14/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Date: **March 14, 2024**

To: **File**

From: **Medical Staff Executive Committee**

Subject: **Medical Staff Attestation Appointment, Reappointments and Clinical Privileges**

INITIAL APPOINTMENT – March 14, 2024 – February 28, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Le, Natalie N., PA	AHP-Provisional	Physician Assistant	Surgery	NCCPA
Pacheco, Cynthia L., NP	AHP-Provisional	Nurse Practitioner	Surgery	AACN
Ratajczak, Celeste J., NP	AHP-Provisional	Nurse Practitioner	Clinical Neurological Sciences	ANCC
Saunders, Jeffrey, MD	Provisional	Diagnostic Radiology	Radiology	Diagnostic Radiology

REAPPOINTMENTS – April 1, 2024 – March 31, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Alzubaidi, Qammer T., PA **Withdraw of Privilege:** • Paracentesis	AHP	Physician Assistant	Emergency Medicine	NCCPA
Dickson, Megan E., MD	Provisional	Emergency Medicine	Emergency Medicine	Emergency Medicine
Ellis, John G., MD	Active	Orthopedic Surgery	Orthopedic Surgery	Orthopedic Surgery
Jun, Aaron H., MD	Tele-Health	Diagnostic Radiology	Radiology	Diagnostic Radiology
McCarty, Zachary D., MD	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine
McNeill, Jeanine A, MD **Withdraw of Privilege:** • Transcranial Doppler Interpretation	Active	Diagnostic Radiology	Radiology	Diagnostic Radiology
Mitchell, Tyler B., DO	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine
Miulli, Dan E., DO	Active	Neurological Surgery	Clinical Neurological Sciences	Neurological Surgery
Patel, Atul J., MD	Tele-Health	Diagnostic Radiology	Radiology	Diagnostic Radiology
Powers, Bret C., DO	Active	Orthopedic Surgery	Orthopedic Surgery	Orthopedic Surgery
Salabat, Reza, MD	Provisional	Thoracic Surgery	Surgery	General Surgery Thoracic Surgery
Solomon, Naveenraj, MD	Active	Surgery	Surgery	General Surgery
Tabangcura, Demy F., PA	AHP	Physician Assistant	Emergency Medicine	NCCPA
Tsay, Eric, MD	Active	Pediatric Endocrinology	Pediatrics	Pediatrics Pediatric Endocrinology

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Akanda, Marib I., MD	Provisional	Ophthalmology	Ophthalmology	Remain on Provisional until Eligible for Advancement
Aravagiri-Do, Arunmozhi S., MD	Provisional	Internal Medicine	Medicine	Remain on Provisional until Eligible for Advancement
Chang, Andrew C., MD	Provisional	Gastroenterology	Medicine	Remain on Provisional until Eligible for Advancement
Edwards, Mark S., MD	Provisional	Neurology	Medicine	Remain on Provisional until Eligible for Advancement
Escutin Jr., Rodolfo O., MD	Provisional	Neurology	Medicine	Remain on Provisional until Eligible for Advancement
Goldman, Matthew A., MD	Provisional	Ophthalmology	Ophthalmology	Remain on Provisional until Eligible for Advancement

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 02/23/24
MEC DATE: 03/14/24
BOARD DATE: 03/14/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Gomez-Mustafa, Carlos E., MD	Provisional	Internal Medicine	Medicine	Remain on Provisional until Eligible for Advancement
Holsclaw, Matthew E., MD	Provisional	Anesthesiology	Anesthesia	Remain on Provisional until Eligible for Advancement
Kim, Bobae L., MD	Provisional	Internal Medicine	Medicine	Remain on Provisional until Eligible for Advancement
Martin, Joshua J., MD	Provisional	Neurology	Medicine	Remain on Provisional until Eligible for Advancement
Momohara, Michael M., MD	Provisional	Physical Medicine & Rehab.	Medicine	Remain on Provisional until Eligible for Advancement
Nguyen, Brian H., MD	Provisional	Neurology	Medicine	Remain on Provisional until Eligible for Advancement
Pathak, Sujay R., DO	Provisional	Internal Medicine	Medicine	Remain on Provisional until Eligible for Advancement
Roldan, Ashley N., MD	Provisional	Ophthalmology	Ophthalmology	Remain on Provisional until Eligible for Advancement
Schmitz, Joseph W., MD	Provisional	Ophthalmology	Ophthalmology	Remain on Provisional until Eligible for Advancement
Shafizadeh, Stephen F., MD	Provisional	Neurological Surgery	Clinical Neurological Sciences	Remain on Provisional until Eligible for Advancement

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Dickson, Megan E., MD	Provisional	Emergency Medicine	Emergency Medicine	Advance to Active Status
Greas, Michael R., MD	Provisional	Pathology	Pathology	Advance to Active Status
Huynh, Bichtram, MD	Provisional	Pediatrics	Pediatrics	Advance to Active Status
Istrate, Laura E., MD	Provisional	Neurology	Medicine	Advance to Active Status
Le, Anh Vu, MD	Provisional	Pediatrics	Pediatrics	Advance to Active Status
Montesinos, Montserrat, MD	Provisional	Pediatric Neurology	Pediatrics	Advance to Active Status
Serrano, Ryan M., MD	Provisional	Pediatric Cardiology	Pediatrics	Advance to Active Status
Shukla, Medha, MD	Provisional	Pediatric Gastroenterology	Pediatrics	Advance to Active Status
Tran, Diem Kieu T., MD	Provisional	Pediatric Neurosurgery	Clinical Neurological Sciences	Advance to Active Status
White, Steven C., MD	Provisional	Diagnostic Radiology	Radiology	Advance to Active Status
Zarecki, Esther N., MD	Provisional	Family Medicine	Family Medicine	Advance to Active Status

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Buthorne, Rachel E., PA	AHP-Provisional	Physician Assistant	Medicine	Complete
Chau, Thanh, CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete
Hawkey, Rebecca, CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete
Javier, Rommel, CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete
Johnson, Craig M., CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete
Mendez, Mallory E., CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete
Pachinko, Brittany A., CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete
Susleck, Dacia, CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Elledge, Nathan R., DO	Active	Ophthalmology	Ophthalmology	Corneal Procedures
Enghelberg, Moises, DO	Active	Ophthalmology	Ophthalmology	Surgical Vitreoretinal
Koshy, Ruby E., MD	Active	Neurology	Medicine	EEG
Nathaniel, Brandon L., MD	Active	Internal Medicine	Medicine	Moderate Sedation
Washburn, Destry G., MD	Active	Pulmonary Critical Care	Medicine	Fluoroscopy

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Abou-Zamzam Jr, Ahmed M., MD	Active	Surgery	Surgery	Additional Privilege: • TCAR
Alfaro Quezada, Jose E., MD	Provisional	Surgery	Surgery	Additional Privilege: • Bariatric Surgery
Armon, Carmel, MD	Active	Neurology	Medicine	Withdraw of Privilege:

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 02/23/24
MEC DATE: 03/14/24
BOARD DATE: 03/14/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

				• PCU • Ambulatory
Bianchi, Christian, MD	Active	Vascular Surgery	Surgery	Additional Privilege: • TCAR
Burgdorff, Courtney J., MD **Temps granted on 3/5/2024**	Active	Anesthesiology	Anesthesia	Additional Privilege: • Pediatric Anesthesiology
Buthorne, Rachel E., PA	AHP-Provisional	Physician Assistant	Medicine	Withdraw of Privilege: • Obtaining Informed Consent
Edwards, Mark S., MD	Provisional	Neurology	Medicine	Withdraw of Privileges: • PCU • Ambulatory • Neurology Non-Core Procedures
Escutin Jr., Rodolfo O., MD	Provisional	Neurology	Medicine	Withdraw of Privileges: • PCU • Ambulatory • Neurology Non-Core Procedures
Huynh, Bichtram, MD	Provisional	Pediatrics	Pediatrics	Withdraw of Privilege: • Moderate Sedation
Istrate, Laura E., MD	Provisional	Neurology	Medicine	Withdraw of Privileges: • PCU • Ambulatory
Kim, Bobae L., MD	Provisional	Internal Medicine	Medicine	Withdraw of Privilege: • Ambulatory
Koh, Han, MD	Active	Hematology Oncology	Medicine	Withdraw of Privilege: • Ambulatory
Koshy Ruby E., MD	Active	Neurology	Medicine	Withdraw of Privilege: • Ambulatory
Kuo, Benjamin, MD **Temps granted on 3/4/2024**	Active	Anesthesiology	Anesthesia	Additional Privilege: • Pediatric Anesthesiology
Leong, Beatriz, MD	Active	Vascular Surgery	Surgery	Additional Privilege: • TCAR
Leung, Alexander, MD	Provisional	Thoracic Surgery	Surgery	Withdraw Privilege: • Moderate Sedation
Long, Wen, PA	AHP	Physician Assistant	Medicine	Withdraw of Privilege: • Obtaining Informed Consent
Mannoia, Kristyn A., MD	Active	Vascular Surgery	Surgery	Additional Privilege: • TCAR
Martin, Joshua J., MD	Provisional	Neurology	Medicine	Withdraw of Privileges: • PCU • Ambulatory • Neurology Non-Core Procedures
Molkara, Afshin M., MD	Active	Surgery	Surgery	Additional Privilege: • TCAR
Murga, Allen, MD	Active	Vascular Surgery	Surgery	Additional Privilege: • TCAR
Nguyen, Brian H., MD	Provisional	Neurology	Medicine	Withdraw of Privileges: • PCU • Ambulatory
Pathak, Sujay R., DO	Provisional	Internal Medicine	Medicine	Withdraw of Privileges: • Ambulatory • Exercise Testing • Moderate Sedation
Schoepflin, Charles W., MD **Temps granted on 3/5/2024**	Active	Anesthesiology	Anesthesia	Additional Privilege: • Pediatric Anesthesiology
Shafizadeh, Stephen F., MD	Provisional	Neurological Surgery	Clinical Neurological Sciences	Withdraw of Privilege: • Fluoroscopy
Solaimani, Pejman, MD	Active	Gastroenterology	Medicine	Withdraw of Privilege: • Ambulatory
Sugiyama, Akihiro, MD	Provisional	Critical Care Surgery	Surgery	Withdraw of Privileges: • Advanced Laparoscopic

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 02/23/24
MEC DATE: 03/14/24
BOARD DATE: 03/14/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

				• Thyroid/Parathyroid
Susleck, Dacia C., CRNA	AHP	Nurse Anesthetist	Anesthesia	Withdraw of Privilege: • Pediatric Anesthesiology
Tabibian, Benjamin, DO	Active	Critical Care Medicine	Medicine	Withdraw of Privileges: • Pulmonology • Moderate Sedation • Fiberoptic Bronchoscopy • Percutaneous • Tracheostomy
Tran, Diem Kieu T., MD	Provisional	Pediatric Neurosurgery	Clinical Neurological Sciences	Withdraw of Privileges: • Neurological Surgery • Moderate Sedation

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Gillespie, Heather J., MD	Provisional	Rheumatology	Medicine	Advance to Active Status

CHANGE IN STAFF REAPPOINTMENT DATES TO ALIGN WITH CHC

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Katsaros, Emmanuel P., DO	Active	Rheumatology	Medicine	5/31/2024 to 4/30/2024
Serrao, Steve, MD	Active	Gastroenterology	Medicine	6/30/2024 to 5/31/2024

NAME CHANGE

NAME	STATUS	SPECIALTY	DEPARTMENT	CHANGE TO:
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
None				

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT	EFFECTIVE/REASON
Ardiles, Yona R., DO	Active	Internal Medicine	Medicine	2/9/2024
Kwan, Josh D., FNP	AHP	Family Nurse Practitioner	Clinical Neurological Sciences	1/30/2024
Min, Alexander K., MD	Active	Pediatrics	Pediatrics	7/1/2024
White, Craig A., MD	Active	Ophthalmology	Ophthalmology	3/31/2024

End of Report

I hereby:
1) Attest that the medical center's Medical Executive Committee meeting on March 14, 2023, 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

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 03/22/24
MEC DATE: 04/11/24
BOARD DATE: 04/11/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Date: April 11, 2024

To: File

From: Medical Staff Executive Committee

Subject: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – April 11, 2024 – March 31, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Bu, Liming, PA	AHP-Provisional	Physician Assistant	Clinical Neurological Sciences	NCCPA
Ghosh, Pradipta, MD	Provisional	Rheumatology	Medicine	Rheumatology
Hipkin, Courtney, CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	NBCRNA
Ishimitsu, David N., MD	Provisional	Diagnostic Radiology	Radiology/TeleRad	Diagnostic Radiology
Keyes, Brian O., DO	Provisional	Anesthesiology	Anesthesia	Anesthesiology
Kwon, Sue Min, MD	Provisional	Internal Medicine	Medicine	Internal Medicine
Naeni, Kourosh, MD	Provisional	Diagnostic Radiology	Radiology	Diagnostic Radiology
Nelson, Grant E., MD	Provisional	Emergency Medicine	Emergency Medicine	Emergency Medicine Emergency Medicine Ultrasonography
Walsh, Natalie, AuD	AHP-Provisional	Audiologist	Surgery/ Otolaryngology	American Speech-Language-Hearing Association
Winter, Aaron W., MD	Provisional	Ophthalmology	Ophthalmology	Ophthalmology Royal College of Physicians

REAPPOINTMENTS – May 1, 2024 – April 30, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Akhtari, Mojtaba, MD Status changed from Active to Courtesy	Courtesy	Hematology/Oncology	Medicine	Hematology Medical Oncology
Bekalo-Quinlan, Krystle S., FNP **Additional Privilege:** • Perform intramuscular injections of botulinum toxin for the treatment of migraine headaches • Perform local infiltration of anesthetic solutions for the treatment of musculoskeletal headaches	AHP	Family Nurse Practitioner	Medicine	AANP
Bianchi Christian, MD	Active	Vascular Surgery	Surgery	American Board of Surgery Vascular Surgery
Chang, Matthew, MD	Administrative	Psychiatry	Psychiatry	Child & Adolescent Psychiatry Forensic Psychiatry Psychiatry
Dick, Dallas M., MD **Additional Privilege:** • Moderate Sedation	Active	Internal Medicine	Medicine	Internal Medicine
Dunbar, Jennifer A., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Garrison, Roger C., DO	Active	Internal Medicine	Medicine	Internal Medicine
Glivar, Phillip J., MD **Additional Privilege:** • Artificial Disc Replacement	Active	Orthopedic Surgery	Orthopedic Surgery	Orthopedic Surgery

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 03/22/24
MEC DATE: 04/11/24
BOARD DATE: 04/11/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Huang, Kathie K., MD	Active	Internal Medicine	Medicine	Internal Medicine
Hurley, Shawn R., NP **Withdraw Privileges:** • Informed Consent	Active	Nurse Practitioner	Radiology	AANP
Jukaku, Faheem M., MD	Active	Family Medicine	Family Medicine	Family Medicine Hospice and Palliative Medicine
Katsaros, Emmanuel P., DO	Active	Rheumatology	Medicine	Internal Medicine Rheumatology
Lee, Samuel J., MD	Active	Physical Medicine & Rehab.	Medicine	Physical Medicine & Rehab.
Lima, Kathleen B., DO	Active	Pediatrics	Pediatrics	Pediatrics
Mahoney, Lisa M., MD **Withdraw of Privileges** • Transcranial Doppler Interpretation	Active	Diagnostic Radiology	Radiology	Diagnostic Radiology
Moellmer, Rebecca A., DPM	Active	Podiatry	Orthopedic Surgery	Foot Surgery Podiatric Medicine
Moores, Donald C., MD	Active	Surgery	Surgery	American Board of Surgery
Nune, Sunitha L., MD	Active	Neurology	Pediatrics	Neurology w/special qualifications in Child Neurology Pediatric Sleep Medicine
Sheth, Rita D., MD	Courtesy	Nephrology	Pediatrics	Pediatrics Pediatric Nephrology
Stout, Charles E., MD	Active	Neuroradiology	Radiology	Diagnostic Radiology
Yue, Connie J., MD **Withdraw of Privilege:** • Moderate Sedation	Active	Pain Medicine	Anesthesia	Anesthesiology Pain Medicine

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Giang, Beverly A., MD	Provisional	Neonatology	Pediatrics	Remain on Provisional until Eligible for Advancement
Hwang, Jay L., MD	Provisional	Internal Medicine	Medicine	Remain on Provisional until Eligible for Advancement
Mahdavi Fard, Ali, MD	Provisional	Ophthalmology	Ophthalmology	Remain on Provisional until Eligible for Advancement
Patel, Ami N., MD	Provisional	Hematology/Oncology	Medicine	Remain on Provisional until Eligible for Advancement.

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Salabat, Reza, MD	Provisional	Thoracic Surgery	Surgery	Advance to Active Status

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Hawkey, Rebecca, CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete
Hurley, Shawn R., NP	AHP-Provisional	Nurse Practitioner	Radiology	Complete

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Hata, Justin T., MD	Active	Physical Medicine & Rehab.	Medicine	• Physical Medicine & Rehab.
Labha, Joel A., DO	Active	Emergency Medicine	Emergency Medicine	• TEE
Paterno, Francesca R., MD	Provisional	Internal Medicine	Medicine	• ACCU

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 03/22/24
MEC DATE: 04/11/24
BOARD DATE: 04/11/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Bent, Christopher K., MD	Active	Diagnostic Radiology	Radiology	Withdraw of Privilege: • Transcranial Doppler Interpretation
Hwang, Jay L., MD	Provisional	Internal Medicine	Medicine	Withdraw of Privilege: • Ambulatory
Heilbronn, Jackson L., DO	Active	Internal Medicine	Medicine	Withdraw of Privilege: • Moderate Sedation
Huang, Ming J., DO	Active	Anesthesiology	Anesthesia	Additional Privilege: • Pediatric Anesthesiology
Kief-Garcia, Monika L., MD	Active	Diagnostic Radiology	Radiology	Withdraw of Privilege: • Transcranial Doppler Interpretation
Liu, David X., MD	Active	Diagnostic Radiology	Radiology	Withdraw of Privilege: • Transcranial Doppler Interpretation
Mahoney, Lisa, MD	Active	Diagnostic Radiology	Radiology	Withdraw of Privilege: • Transcranial Doppler Interpretation
McNeill, Jeanine A., MD	Active	Diagnostic Radiology	Radiology	Withdraw of Privilege: • Transcranial Doppler Interpretation
Nguyen, Christopher V., MD	Active	Diagnostic Radiology	Radiology	Withdraw of Privilege: • Transcranial Doppler Interpretation
Olson, Caitlin MD	Provisional	Head Neck & Otolaryngology	Surgery	Withdraw of Privilege: • Laser • C02 • KTP • ND: Yag
Pomerantz, Maxwill D., MD	Provisional	Anesthesiology	Anesthesia	Additional Privilege: • Pediatric Anesthesiology
Stump, Robert P., MD	Provisional	Anesthesiology	Anesthesia	Additional Privilege: • Pediatric Anesthesiology

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Loo, Lawrence K., MD	Active	Internal Medicine	Medicine	Status change to Administrative

CHANGE IN STAFF REAPPOINTMENT DATES TO ALIGN WITH CHC - None

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS

NAME CHANGE - None

NAME	STATUS	SPECIALTY	DEPARTMENT	CHANGE TO:

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
Abad, Danny, PA	AHP	Physician Assistant	Emergency Medicine	3/15/2024– Voluntary Resignation
Agruwal, Vikash, MD	Active	Neonatology	Pediatrics	6/20/2024 – Voluntary Resignation
Duong, Kelvin NP	AHP	Nurse Practitioner	Surgery	3/13/2024– Voluntary Resignation
Favis, Roxanne M., DO	Provisional	Anesthesiology	Anesthesia	9/15/2023 – Voluntary Resignation
Pappalardo, Ashley, NP	AHP	Nurse Practitioner	Surgery	5/3/2024 – Voluntary Resignation

End of Report

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 03/22/24
MEC DATE: 04/11/24
BOARD DATE: 04/11/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

I hereby:
1) Attest that the medical center's Medical Executive Committee meeting on March 14, 2023, 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

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 04/26/24
MEC DATE: 05/09/24
BOARD DATE: 05/09/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Date: April 26, 2024

To: File

From: Medical Staff Executive Committee

Subject: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – May 09, 2024 – April 30, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Carrillo, Alfonso, J., MD	Provisional	Tele-Radiology	Radiology	Diagnostic Radiology
Matthews, Troy A., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
Magsamen, Karl E., MD	Provisional	Radiology	Radiology	American Board of Radiology
Ramirez, Camille A., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
Rao, Veena A., MD	Provisional	Rheumatology	Medicine	Rheumatology
Rubin, J P., MD	Provisional	Teleradiology	Radiology	Diagnostic Radiology
Tomagan, Renaleen, NP	AHP-Provisional	Nurse Practitioner	Surgery/Urology	AANP
Tran, Duc A., MD	Provisional	Physical Medicine & Rehab.	Medicine	Physical Medicine & Rehab. Brain Injury
Wang, Sharon D., NP	AHP-Provisional	Nurse Practitioner	Emergency Medicine	AANP

REAPPOINTMENTS – June 1, 2024 – May 31, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Acevedo, Vivian, PA	AHP	Physician Assistant	Emergency Medicine	NCCPA
Affeldt, John C., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Aguilera, Adolfo MD	Active	Family Medicine	Family Medicine	Family Medicine
Anderson, Kristen M., MD	Active	Obstetrics & Gynecology	Obstetrics & Gynecology	Ob-Gyn
DinNicola, David D., MD	Active	Psychiatry	Psychiatry	Grandfathered
Dixit, Sudhakar, MD	Active	Obstetrics & Gynecology	Obstetrics & Gynecology	Ob-Gyn
Hawy, Eman E., MD	Active	Neuro-Ophthalmology	Ophthalmology	Neurology
Ilano, Earl P., MD	Active	Internal Medicine	Medicine	Internal Medicine
Lampert, Paul, MD	Active	Diagnostic Radiology	Radiology	Diagnostic Radiology
Lodhi, Shaina K., MD	Active	Neonatology	Pediatrics	Pediatrics Neonatal-Perinatal Medicine
Martinez, Kimberly A., CRNA	AHP	Nurse Anesthetist	Anesthesia	NBCRNA
Mendoza, Tiffany D., PA	AHP	Physician Assistant	Emergency Medicine	NCCPA
Motabar, Ali, MD	Active	Internal Medicine	Medicine	Internal Medicine
Nathaniel, Brandon L., MD	Active	Internal Medicine	Medicine	Internal Medicine
Nguyen, Andrew T., MD	Active	Critical Care	Surgery	Surgery

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 04/26/24
MEC DATE: 05/09/24
BOARD DATE: 05/09/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Peterson, Nathaniel R., MD	Active	Head Neck & Otolaryngology	Surgery	Otolaryngology
Pina, Gabrielle A., DO	Active	Pediatrics	Pediatrics	Pediatrics
Olee, Tsungui, MD	Active	Otolaryngology	Surgery	Otolaryngology
Reyes-Garcia, Breanna R., PA	AHP	Physician Assistant	Medicine	NCCPA
Serrao, Steve, MD	Active	Gastroenterology	Medicine	Internal Medicine Gastroenterology
Silva, Rodolfo, MD	Active	Gastroenterology	Pediatrics	Pediatrics Pediatric Gastroenterology
Singh, Santokh, MD	Active	Psychiatry	Psychiatry	Psychiatry
Smits, Jonathan W., MD	Active	Pediatrics	Pediatrics	Pediatrics Sports Medicine
Thompson, Gary J., DO	Active	Internal Medicine	Medicine	Internal Medicine
Ulrich, Michael T., MD	Active	Internal Medicine	Medicine	Internal Medicine
Weng, Bruce H., DO	Active	Infectious Disease	Medicine	Internal Medicine Infectious Disease
Xu, Helen X., MD	Active	Head Neck & Otolaryngology	Surgery	Otolaryngology
Yang, Vivian	Active	Family Medicine	Family Medicine	Family Medicine

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Batra, Sahil, DO	Provisional	Internal Medicine	Medicine	Remain on Provisional until Eligible for Advancement
Dreger, Nicholas J., MD	Provisional	Pediatric Cardiology	Pediatrics	Remain on Provisional until Eligible for Advancement.
Garcia, Renee M., MD	Provisional	Psychiatry	Psychiatry	Remain on Provisional until Eligible for Advancement
Giang, Michael, MD	Provisional	Pediatrics Critical Care	Pediatrics	Remain on Provisional until Eligible for Advancement.
Lee, Brandon K., DO	Provisional	Emergency Medicine	Emergency Medicine	Remain on Provisional until Eligible for Advancement
Morris, Susie L., MD	Provisional	Psychiatry	Psychiatry	Remain on Provisional until Eligible for Advancement
Olson, Caitlin P., MD	Provisional	Head Neck & Otolaryngology	Surgery	Remain on Provisional until Eligible for Advancement

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Clarey, Karen S., MD	Provisional	Psychiatry	Psychiatry	Advance to Active Status
Finley, John M., DO	Provisional	Rheumatology	Medicine	Advance to Active Status
Friedler, Eli E., MD	Provisional	Psychiatry	Psychiatry	Advance to Active Status
Leung, Alexander, MD	Provisional	Thoracic Surgery	Surgery	Advance to Active Status
Rossie, Daniel J., MD	Provisional	Emergency Medicine	Emergency Medicine	Advance to Active Status.
Saavedra, Madeline, MD	Provisional	Psychiatry	Psychiatry	Advance to Active Status
Stump, Robert P., MD	Provisional	Anesthesia	Anesthesiology	Advance to Active Status
Teitelbaum, George T., MD	Provisional	Neuroradiology/ Interventional Radiology	Radiology	Advance to Active Status
Ventro, George J., MD	Provisional	Surgery	Surgery/Critical Care	Advance to Active Status

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 04/26/24
MEC DATE: 05/09/24
BOARD DATE: 05/09/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Alexander, Katherine A., NP	AHP-Provisional	Nurse Practitioner	Emergency Medicine	Complete
Garrido, Esmeralda J., PA	AHP-Provisional	Physician Assistant	Orthopedic Surgery	Complete
Medina, Kelly D., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	Complete

FPPE PARTIAL PROCTORING REMAIN PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Burgdorff, Courtney J., MD	Active	Anesthesia	Anesthesiology	Pediatric Anesthesia
Schoepflin, Charles W., MD	Active	Anesthesia	Anesthesiology	Pediatric Anesthesia

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Batra, Sahil, DO	Provisional	Internal Medicine	Medicine	Withdraw of Privilege: • Ambulatory
Kpaduwa, Chinwe S., MD	Provisional	Plastic Surgery	Surgery/Plastic Surgery	Withdraw of Privileges • Laser Surgery • Moderate Sedation • Fluoroscopy
Lee, Brandon K., DO	Provisional	Emergency Medicine	Emergency Medicine	Withdraw of Privilege: • TEE
Medina, Kelly D., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	Withdraw of Privilege: • Central Line/PICC Placement • Lumbar Puncture • Endotracheal Intubation • Arterial Cannulation • Thoracentesis • Paracentesis
Sugiyama, Akihiro, MD	Provisional	Surgery	Surgery/Critical Care	Withdraw of Privilege: • Colorectal
Ventro, George J., MD	Provisional	Surgery	Surgery/Critical Care	Withdraw of Privileges • Thoracic • Advanced Laparoscopic Surgery

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Alfaro Quezada, Jose, MD	Provisional	Surgery	Surgery	Advance to Active status
Bang, Sunny, MD	Provisional	Emergency Medicine	Emergency Medicine	Advance to Active status
Chamberlin, David A., MD	Provisional	Urology	Surgery	Advance to Active status
Chan, Eric H., MD	Provisional	Ophthalmology	Ophthalmology	Advance to Active Status
Hofmann, Martin R., MD	Provisional	Urology	Surgery	Advance to Active status
Sugiyama, Akihiro, MD	Provisional	Surgical Critical Care	Surgery	Advance to Active status
Tom, Michelle, MD	Provisional	Psychiatry	Psychiatry	Advance to Active Status

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 04/26/24
MEC DATE: 05/09/24
BOARD DATE: 05/09/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Yu, Grace, MD	Active	Plastic Surgery	Surgery	Status Change to LOA

CHANGE IN STAFF REAPPOINTMENT DATES TO ALIGN WITH CHC -

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				

MODIFICATION OF PRIVILEGES -

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				

NAME CHANGE -

NAME	STATUS	SPECIALTY	DEPARTMENT	CHANGE TO:
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
None				

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT	EFFECTIVE/REASON
Abad, Danny, PA	AHP	Physician Assistant	Emergency Medicine	3/15/2024 - Voluntary
Anugo, Davis U., MD	Applicant	Ophthalmology	Ophthalmology	Deceased
Cao, Huynh L., MD	Courtesy	Hematology/Oncology	Medicine	5/17/2024 - Voluntary
Moran, Jonathan O., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	11/29/2023 - Voluntary
Neff, Kenneth W., MD	Active	Anesthesia	Anesthesiology	3/28/2024 - Voluntary
Sanchez, Luis A., DO	Active	Anesthesia	Anesthesiology	3/21/2024 - Voluntary
Shin, Benjamin S., MD	Provisional	Psychiatry	Psychiatry	4/26/2024 - Voluntary

End of Report

I hereby:
1) Attest that the medical center's Medical Executive Committee meeting on May 09, 2024, 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

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 05/24/24
MEC DATE: 06/13/24
BOARD DATE: 06/13/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

June 13, 2024

To: File

From: Medical Staff Executive Committee

Subject: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – June 13, 2024 – May 31, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Cervantes, Richard J., MD	Provisional	Anesthesia	Anesthesiology	Eligible
Karidas, Steven J. MD	Provisional	Diagnostic Radiology	Radiology/Tele-Radiology	Diagnostic Radiology
Rios, Ana D., PA	AHP-Provisional	Physician Assistant	Surgery/General	NCCPA
Wilson, Thaddeus E., MD	Provisional	Physical Medicine & Rehab.	Medicine/PM&R	Physical Medicine & Rehab. Pediatric Rehabilitation

REAPPOINTMENTS – July 1, 2024 – June 30, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Abou-Zamzam Jr, Ahmed, MD	Active	Vascular Surgery	Surgery	Surgery
Alexander, Katherine A., NP	AHP	Nurse Practitioner	Emergency Medicine	AANP
Beem, Ashley, MD	Active	Ob-Gyn	Ob-Gyn	Ob-Gyn
Burgdorff, Courtney J., MD	Active	Anesthesia	Anesthesiology	Anesthesiology
Casassa, IV, Charles M., MD	Active	Neurology	Medicine/Neurology	Neurology Clinical Neurophysiology
Cortez, Vladimir A., DO	Active	Neurological Surgery	Clinical Neurological Sciences	Neurological Surgery
Despujos Harfouche, Fariruz C., MD	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine
Gupta, Subhas C., MD	Active	Plastic Surgery	Surgery	Plastic Surgery
Harris, Kurt, PA	AHP	Physician Assistant	Emergency Medicine	NCCPA
Heilbronn, Jackson L., DO	Active	Internal Medicine	Medicine	Internal Medicine
Jeu, Kelly A., MD	Active	Pediatrics	Pediatrics	Pediatrics
Jin, Daniel H., MD	Active	Interventional Vascular Radiology	Radiology	Diagnostic Radiology/ Interventional Radiology
Kwon, Ohwook, MD	Active	Interventional Vascular Radiology	Radiology	Diagnostic Radiology/ Interventional Radiology
Koshy, Ruby E., MD	Active	Neurology	Medicine/Neurology	Neurology Clinical Neurophysiology
Lawandy, Shokry N., DO	Courtesy	Neurological Surgery	Clinical Neurological Sciences	Neurological Surgery
Lee, Vallent, MD	Active	Pediatrics	Pediatrics	Pediatrics
Lum, Sharon S., MD	Active	Surgery	Surgery	Surgery
Mackintosh, Tia C., MD **Provisional proctoring complete, Advance to Active**	Provisional	Emergency Medicine	Emergency Medicine	Eligible

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 05/24/24
MEC DATE: 06/13/24
BOARD DATE: 06/13/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Min, Jonathan K., MD	Active	Internal Medicine	Medicine	Internal Medicine
Miranda, Kelly M., PA	AHP	Physician Assistant	Orthopedic Surgery	NCCPA
Mooradian, Ryan D., MD	Active	Pediatrics	Pediatrics	Pediatrics
Mukadam, Seema, MD	Active	Internal Medicine	Medicine	Internal Medicine
Ngo, Larry, MD	Active	Pediatrics	Peds: Neonatology	Pediatrics Neonatal-Perinatal Medicine
Noda, Jason P., NP	AHP	Nurse Practitioner	Surgery/Critical Care	AACN
Raae-Nielsen, Jennifer E., MD	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine
Scott, Jonathan H., MD **Withdraw of Privilege:** • Moderate Sedation	Active	Internal Medicine	Medicine	Internal Medicine
Seiberling, Kristin A., MD	Active	Otolaryngology	Surgery	Otolaryngology
Shah, Shivang H., MD	Active	Cardiology	Medicine/Cardiology	Internal Medicine Cardiovascular Disease
Shrestha, Manish P., MD **Additional Privilege:** • Hepatology • Ambulatory	Active	Gastroenterology	Medicine	Internal Medicine Gastroenterology
Spady, Michi R., MD	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine
Srikureja, Wichit, MD	Active	Gastroenterology	Medicine/ Gastroenterology	Internal Medicine Gastroenterology
Suarez Solarte, Melissa D., CRNA	AHP	Nurse Anesthetist	Anesthesia	NBCRNA
Sy, Rolando D., MD	Active	Family Medicine	Emergency Medicine	Family Medicine
Tsao, Bryan E., MD	Active	Neurology	Medicine/Neurology	Neurology Clinical Neurophysiology Neuromuscular Medicine
Walker, Paul C., MD	Active	Otolaryngology	Surgery	Otolaryngology

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Dhillon, Navpreet K., MD	Provisional	Trauma/Surgery	Surgery/Critical Care	Remain on Provisional until Eligible for Advancement
Mercado, Kristina, MD	Provisional	Obstetrics & Gynecology	Obstetrics & Gynecology	Remain on Provisional until Eligible for Advancement

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Chatterjee, Anish, MD	Provisional	Diagnostic Radiology	Radiology/Teleradiology	Advance to Active Status
Hampson, Christopher, MD	Provisional	Diagnostic Radiology	Radiology	Advance to Active Status
Mackintosh, Tia C., MD	Provisional	Emergency Medicine	Emergency Medicine	Advance to Active Status
Morris, Susie L., MD	Provisional	Psychiatry	Psychiatry	Advance to Active Status
Singh, Saloni, MD	Provisional	Psychiatry	Psychiatry	Advance to Active Status

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 05/24/24
MEC DATE: 06/13/24
BOARD DATE: 06/13/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

Yeager, Violet, DO	Provisional	Psychiatry	Psychiatry	Advance to Active Status

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Mupanduki, Media R., FNP, PNP	AHP Provisional	Nurse Practitioner	Psychiatry	Complete

FPPE PARTIAL PROCTORING COMPLETE REQUEST FOR EXTENSION

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Reyes, Gina, CRNA	AHP	Nurse Anesthetist	Anesthesia	Pending: • Pediatric Anesthesiology

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DVISION	COMMENTS
Skoretz, Lynnetta E., MD	Active	Internal Medicine	Medicine	Additional Privilege: • ACC
Washburn, Destry G., DO	Active	Pulmonary Critical Care Medicine	Medicine	Withdraw of Privilege: • Fluoroscopy

CHANGE IN STAFF CATEGORY-

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Chang, Andrew C., MD	Provisional	Gastroenterology	Medicine	Advance to Active Status
Patel, Ami N., MD	Provisional	Hematology/Oncology	Medicine	Advance to Active Status
Lee, Sarah J., DO	Provisional	Psychiatry	Psychiatry	Advance to Active Status

CHANGE IN STAFF REAPPOINTMENT DATES TO ALIGN WITH CHC -

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Lodhi, Shaina, MD	Active	Neonatology	Pediatrics	Align reappointment date to 5/31/2026
Yang, Vivian, MD	Active	Family Medicine	Family Medicine	Align reappointment date to 5/31/2026

MODIFICATION OF PRIVILEGES -

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

NAME CHANGE -

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	CHANGE TO:
None				

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

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

CRED DATE: 05/24/24
MEC DATE: 06/13/24
BOARD DATE: 06/13/24

MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD

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

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	EFFECTIVE/REASON
Clumpner, Cori I., DO	Active	Pediatrics	Pediatrics	5/13/2024 – Voluntary Resignation
Filler, Taylor N., MD	Active	Emergency Medicine	Emergency Medicine	6/30/2024 – Voluntary Resignation
Jody, Nicole M., MD	Provisional	Ophthalmology	Ophthalmology	6/15/2024 – Voluntary Resignation
Min, Alexander MD	Active	Pediatrics	Pediatrics	7/1/2024 – voluntary resignation
Namm, Juke, MD	Courtesy	Surgery	Surgery	05/08/2024 – Voluntary Resignation
Nguyen, My V., DO	Active	Pediatrics	Pediatrics	8/1/2024 – Voluntary Resignation
Ortega, Edgar, MD	Provisional	Psychiatry	Psychiatry	5/15/2024 – Voluntary Resignation
Ronney, Alexis M., AuD	AHP	AUD	Surgery/Otolaryngology	5/6/2024 – Voluntary Resignation
Schultz, Gerald R., MD	Active	Ophthalmology	Ophthalmology	6/30/2024 – Voluntary Resignation
Subramanian, Meenakshisundaram, DO	Active	Ophthalmology	Ophthalmology	6/30/2024 – Voluntary Resignation
Tabibian, Benjamin, DO	Active	Critical Care Medicine	Medicine	5/6/2024 – Voluntary Resignation
Tan, Gordon L., MD	Active	Pediatrics	Pediatrics	9/6/2024 – Voluntary Resignation
Tarver, Christopher C., MD*	Applicant	Physical Medicine & Rehab.	Medicine	Application Withdrawn
Thimmappa Vikrum, MD	Active	Head & Neck Otolaryngology	Surgery	8/16/2024 – Voluntary Resignation
Torralba, Karina Marianne D., MD	Active	Rheumatology	Medicine	1/6/2024 – Voluntary Resignation

End of Report

I hereby:
1) Attest that the medical center's Medical Executive Committee meeting on June 13, 2024, 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

Riverside University HEALTH SYSTEM Medical Center

PHYSICIAN ASSISTANT (PA)

GENERAL SURGERY PRIVILEGES

Name:_____ Staff Category: **AHP**
(Last, First, Initial)

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

☐ Initial Appointment

☐ Reappointment

Applicant: **CHECK (✓)** the "Requested" box for each privilege requested and **SIGN** and **DATE** this form as indicated. New 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 the hospital 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 PHYSICIAN ASSISTANT

CRITERIA: To be eligible to apply for clinical privileges as a Physician Assistant, the applicant must meet the following criteria:

Current demonstrated competence and an adequate level of current experience documenting the ability to provide services at an acceptable level of quality and efficiency,

AND

Graduate from an ARC-PA (Accreditation Review Commission for the Physician Assistant) approved program. (Additional education may be required for some specialty areas),

AND

Current certification by the National Commission on Certification of Physician Assistants (NCCPA),

AND

Current licensure to practice as a physician assistant issued by the California Board of Medicine,

AND

Current BLS and ACLS card approved by American Heart Association (AHA)

AND

Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the governing body.

AND

County employment by or an agreement with a physician(s) currently appointed to the medical staff of this hospital to supervise the PA's practice in the hospital.

According to the Practice agreement, the physician must:

- Assume responsibility for supervision or monitoring of the PA's practice as stated in the appropriate hospital or medical staff policy governing PA's.
- 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 PA or required by this policy or in the interest of patient care.

Riverside University HEALTH SYSTEM Medical Center

PHYSICIAN ASSISTANT (PA)

GENERAL SURGERY PRIVILEGES

Name:_____ Staff Category: **AHP**
(Last, First, Initial)

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

CATEGORIES OF PATIENTS PRACTITIONER MAY TREAT
May provide services consistent with the policies stated herein to patients of medical staff member(s) with whom the APP has a documented formal affiliation or to patients assigned by the chair of the department to which the APP is assigned.

SUPERVISION
The exercise of these clinical privileges requires a designated collaborating/supervising physician with clinical privileges at this hospital. All practice is performed under the supervision of the physician/designee and in accordance with written policies and protocols developed and approved by the relevant clinical department or service, the Medical Executive Committee, Nursing Administration, and the Governing Body. Collaborating/supervising physician must be physically present, on hospital/clinic premises or readily available by electronic communication.

MEDICAL RECORD CHARTING RESPONSIBILITIES
Clearly, legibly, completely, and in timely fashion, describe each service the APP provides to a patient in the hospital or clinic setting and relevant observations. Standard rules regarding authentication of, necessary content of, and required time frames for preparing and completing the medical record and portions thereof are applicable to all entries made.

GENERAL RELATIONSHIP TO OTHERS
Advanced Practice Provider 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 APP 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.

To the applicant: If you wish to **exclude** any procedures, please strike through those procedures which you do not wish to request, initial, and date.

PHYSICIAN ASSISTANT- CLINICAL PRIVILEGES — GENERAL

☐ **Request** Patients within age group of collaborating physician except as specifically excluded from practice. 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:

- Obtain and document medical, surgical, social and medication history and perform physical examination as indicated according to established standardized procedures and protocol as agreed upon by the APP and supervising physician (to be countersigned by collaborating physician within 24hours).
- Obtain 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.
- Preliminary interpretation of simple plain radiological films and EKG's with final interpretation by supervising physician.
- Order and interpret laboratory tests and diagnostic procedures results.
- Develop treatment plan and implements plan, educating patient and family members as applicable.

- Order treatment modalities such as medications, IV fluids, electrolytes etc. in accordance with standardized procedures, protocols and formulary as agreed upon by APP ad supervising physician.
- Counsel and instruct patients and significant others on disease processes, medications, preventative health and treatment plan including pre and post procedure teaching.
- Monitor and manage acute and chronic illnesses of the population consulting with supervising physician regarding acute, unstable patients as per SP.
- Monitor and refer to consulting services as deemed necessary such as dietician, physical therapy, social worker/case management, palliative care, etc.
- Write discharge summaries (to be countersigned by the collaborating physician).

- Round on inpatients daily observing and evaluating the patient's vital signs, intake and output, laboratory and imaging results, nutritional plan, medication review, pain level, activity, psychiatric or behavioral issues.
- Write new orders and/or change orders that are within scope of practice and notify responsible physician of changes in patient's condition or any concerns.
- Act as a liaison between the nursing department and other clinical departments, promoting teamwork and communication.
- Advanced Cardiac Life Support
- Defibrillation
- Bladder decompression and catheterization techniques
- GI decontamination (emesis, lavage, charcoal)
- Simple wound debridement and repair
- Perform medical screening exams
- Perform histories and physicals
- Develop treatment plan
- Perform electrocardiogram tracing, preliminary electrocardiogram interpretation with final interpretation by supervising physician
- Arterial puncture
- Bladder decompression and catheterization techniques
- Insertion and removal of nasogastric tube
- Order diagnostic testing and therapeutic modalities such as medications treatments, IV fluids, and electrolytes, etc.
- Patient education and counseling covering such things as health status, test, results, disease processes, and discharge planning
- Provide pre- and post-operative surgical care
- Record progress notes
- Suture lacerations
- Perform venipuncture
- Write discharge summaries
- Telemedicine: Provide services remotely through telemedicine capabilities

Arrange appropriate outpatient follow up within department outpatient clinics as needed

Approved (Initials):_____

SPECIAL NON-CORE PRIVILEGES (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 for maintenance of clinical competence.

Riverside University HEALTH SYSTEM Medical Center

PHYSICIAN ASSISTANT (PA)

GENERAL SURGERY PRIVILEGES

Name:_____ Staff Category: **AHP**
(Last, First, Initial)

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

FIRST ASSISTANT

CRITERIA: Direct supervision and those technical and management skills, which qualify the Physician Assistant to perform First Assistant by virtue of training and experience.
REQUIRED PREVIOUS EXP*ERIENCE*: Demonstrate current competence and evidence of the performance of at least three (3) procedures in the past 12 months.
MAINTENANCE OF PRIVILEGE: Demonstrate current competence and the performance of at least one (1) procedure in the past 24 months.

☐ **Requested** Assist Attending Physician with Surgical Procedures as a First Assistant

Approved (Initials):_____

OBTAINING INFORMED CONSENT

CRITERIA: Completion of module on informed consent with completion of post-test with 100% score
AND
- Direct observation/proctoring of informed consent when proctoring of each privilege is granted that required informed consent.

REQUIRED PRIOR EXPERIENCE: None
MAINTENANCE OF PRIVILEGE: Successful completion of informed consent module with renewal of privileges.

☐ **Requested** Obtaining Informed Consent **Approved (Initials):**_____

PRESCRIPTIVE AUTHORITY AS DELEGATED BY A PHYSICIAN IN A COLLABORATIVE PRACTICE AGREEMENT IN ACCORDANCE WITH STATE AND FEDERAL LAW

☐ **Requested** **Prescriptive Authority**

The delegation to the NP to administer or dispense drugs shall include the prescribing of controlled substances. **Approved (Initials)**:_____

Riverside University HEALTH SYSTEM Medical Center

PHYSICIAN ASSISTANT (PA)

GENERAL SURGERY PRIVILEGES

Name:_____ Staff Category: **AHP**
(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 which I wish to exercise at RUHS.

I understand that:

a. In exercising any clinical privileges granted and in carrying out the responsibilities assigned to me, 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 policies governing allied health professionals or related documents.

_____ _____
Practitioner Signature **Date**

ENDORSEMENT OF PHYSICIAN EMPLOYER / SUPERVISOR

Signature: _____ Date: _____

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

_____ _____
Department Chair/Designee Signature **Date**

_____ _____
IDPC Chair/Designee Signature **Date**

Riverside University HEALTH SYSTEM Medical Center

PHYSICIAN ASSISTANT (PA)

GENERAL SURGERY PRIVILEGES

Name:_____ Staff Category: **AHP**
(Last, First, Initial)

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

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

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

DEPARTMENT CHAIR/DESIGNEE: For the above-named applicant, please indicate below the privileges/ procedures and the number of cases to be proctored, including the method of proctoring.
Please print legibly.

Privileges / Procedures to be Proctored	Number of Cases to be Proctored	Method of Proctoring A. Direct Observation B. Retrospective Chart Review C. Simulation
PHYSICIAN ASSISTANT GENERAL CORE	5	A,B,C
FIRST ASSISTANT	3	A, B
INFORMED CONSENT	1	A

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

Riverside University HEALTH SYSTEM Medical Center

ADVANCED PRACTICE PROVIDER (APP)
EMERGENCY MEDICINE CLINICAL PRIVILEGES

Name:_____ Staff Category: **APP**
(Last, First, Initial)

Department:_____

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

☐ Initial Appointment

☐ Reappointment

Applicant: **CHECK (✓)** the "Requested" box for each privilege requested and **SIGN** and **DATE** this form as indicated. New 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 the hospital 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 NURSE PRACTITIONER (NP)

CRITERIA: To be eligible to apply for clinical privileges as a Nurse Practitioner (NP), the applicant must meet the following criteria:

Current demonstrated competence and an adequate level of current experience, documenting the ability to provide services at an acceptable level of quality and efficiency.

AND

Hold a valid and active registered nurse license in the State of California and a current active certificate by the California Board of Registered Nursing (CA BRN) as a nurse practitioner.

AND (for initial certification prior to January 1. 2008)

Completion of a master's degree in nursing or satisfactorily completed a nurse practitioner program approved by the CA BRN.

OR (for initial certification after January 1, 2008)

Completion of a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing and to have satisfactorily completed a nurse practitioner program approved by the CA BRN.

AND

Current Basic Life Support (BLS), Pediatric Advanced Life Support (PALS), and Advanced Cardiac Life Support (ACLS) for healthcare provider recognized by the American Heart Association

AND

Current certification by the American Academy of Nurse Practitioners (AANP) or the American Nurses Credentialing Center (ANCC), or any other accredited recognized board.

AND

Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the governing body.

AND

County employment or employment by or a formal agreement with a physician(s) currently appointed to the active or consulting medical staff of this hospital with scope of practice in the same area of specialty practice. According to a written agreement, the physician must:

- Assume responsibility for supervision or monitoring of the NP's practice as stated in the appropriate hospital or medical staff policy governing nurse practitioners.
- 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 NP or required by this policy or in the interest of patient care;
- Review all orders entered by the NP on the medical record of all patients seen or treated by the NP.

QUALIFICATIONS FOR PHYSICIAN ASSISTANT

To be eligible to apply for clinical privileges as a Physician Assistant in Emergency Medicine, the applicant must meet the following criteria:

Current demonstrated competence and an adequate level of current experience documenting the ability to provide services at an acceptable level of quality and efficiency

AND

Graduate from a ARC-PA (Accreditation Review Commission for the Physician Assistant approved program)

AND

Current certification by the National Commission on Certification of Physician Assistants (NCCPA)

AND

Current Basic Life Support (BLS), Pediatric Advanced Life Support (PALS), and Advanced Cardiac Life Support (ACLS) for healthcare provider recognized by the American Heart Association

AND

Current licensure to practice as a physician assistant issued by the California Board of Medicine

AND

Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the Governing Body

AND

Employment by or an agreement with a physician(s) currently appointed to the medical staff of this hospital to supervise the PA's practice in the hospital. According to the written agreement, the physician must:

Assume responsibility for supervision or monitoring of the Physician Assistant's (PA) practice as stated in the appropriate hospital or medical staff policy governing PAs;

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 PA or required by this policy or in the interest of patient care;

Cosign all orders entered by the PA on the medical record of all patients seen or treated by the PA in accordance with regulations governing the supervision of PAs.

Categories of Patients Practitioner May Treat.
May provide services consistent with the policies stated herein to patients of medical staff member(s) with whom the PA has a documented formal affiliation or to patients assigned by the chair of the department to which the PA is assigned.

Supervision
The supervising physician(s) provides general supervision of the activities and services of the APP. The supervising physician(s) provides supervision and direction on any specific patient. The privileges of the PA's practice correspond to the supervising physician's practice. The APP is not allowed to perform any procedures that are not within the clinical privileges of the supervising physician(s) and for which the APP is not specifically granted. The supervising physician(s) must be immediately available by electronic communication or on hospital premises for consultation/direction of the APP.

Medical Record Charting Responsibilities
Clearly, legibly, completely, and in timely fashion, describe each service the APP provides to a patient in the hospital and relevant observations. Standard rules regarding authentication of, necessary content of, and required time frames for preparing and completing the medical record and portions thereof are applicable to all entries made. The supervising physician(s) personally review all charts and patient records and co-signs all records in accordance with regulations governing the supervision of APPs.

General Relationship to Others
The APP has 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 APP 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.

Riverside University HEALTH SYSTEM Medical Center

ADVANCED PRACTICE PROVIDER (APP)
EMERGENCY MEDICINE CLINICAL PRIVILEGES

Name:_____ Staff Category: **APP**
(Last, First, Initial)

Department:_____

Effective: _____ Page 4
(From—To) (To be completed by MSO)

ADVANCED PRACTICE PROVIDER (APP) CLINICAL PRIVILEGES — GENERAL

❒ **Requested** Initial and ongoing assessment of medical, physical, and psychosocial status for patients within age group of supervising physician except as specifically excluded from practice, including:

- 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.
- Advanced Cardiac Life Support
- Defibrillation
- Bladder decompression and catheterization techniques
- GI decontamination (emesis, lavage, charcoal)
- Simple wound debridement and repair
- Perform medical screening exams
- Perform histories and physicals (To be countersigned by the supervising physician within 24 hrs)
- Develop treatment plan
- Perform electrocardiogram tracing, preliminary electrocardiogram interpretation with final interpretation by supervising physician
- Arterial puncture
- Insertion and removal of nasogastric tube
- Order diagnostic testing and therapeutic modalities such as medications treatments, IV fluids and electrolytes, etc. (To be countersigned by supervising physician in accordance with regulatory guidelines governing PA supervision.)
- Patient education and counseling covering such things as health status, test, results, disease processes, and discharge planning
- Provide pre- and post-operative surgical care
- Record progress notes
- Suture lacerations
- Perform venipuncture
- Write discharge summaries (To be countersigned by the supervising physician within 24 hrs)

Approved (Initials):_____

Riverside University HEALTH SYSTEM Medical Center

ADVANCED PRACTICE PROVIDER (APP)
EMERGENCY MEDICINE CLINICAL PRIVILEGES

Name:_____ Staff Category: **APP**
(Last, First, Initial)

Department:_____

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

QUALIFICATIONS FOR ADVANCED PRACTICE PROVIDER (APP) — EMERGENCY MEDICINE

To be eligible to apply for clinical privileges as an APP in Emergency Medicine, the applicant must meet the following criteria:

Applicant must satisfy the qualification requirements for the physician assistant,

AND

Documented training and experience in Emergency Medicine and demonstrated current competence and that they have provided emergency medicine services for at least 50 patients in the past 12 months.

AND

Current BLS, ACLS and PALS

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 recommended/required as mandated by licensure.

To the applicant: If you wish to **exclude** any procedures, please strike through those procedures which you do not wish to request, initial, and date.

Riverside University HEALTH SYSTEM Medical Center

ADVANCED PRACTICE PROVIDER (APP)
EMERGENCY MEDICINE CLINICAL PRIVILEGES

Name:_____ Staff Category: **APP**
(Last, First, Initial)

Department:_____

Effective: _____ Page 6
(From—To) (To be completed by MSO)

ADVANCED PRACTICE PROVIDER (APP) CLINICAL PRIVILEGES — EMERGENCY MEDICINE

(Includes Advanced Practice Provider (APP) 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
- 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

Approved (Initials):_____

SPECIAL NON-CORE PRIVILEGES (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 for maintenance of clinical competence.

OBTAINING INFORMED CONSENT

CRITERIA: To be eligible to provide informed consent, the applicant must have.

- Completion of module on informed consent with completion of post-test with 100% score.
  AND
- Proctoring of informed consent when proctoring of each privilege is granted that required informed consent.

REQUIRED PRIOR EXPERIENCE: None
MAINTENANCE OF PRIVILEGE: Successful completion of informed consent module with renewal of privileges.

❒ **Requested** **Obtaining Informed Consent**
For treatment/procedures the Allied Health Professional is authorized to perform.

Approved (Initials):_____

CENTRAL LINE/PICC PLACEMENT

Criteria: Direct supervision and those technical and management skills which qualify the APP to perform central line/PICC placements and successful completion of proctoring of 2 procedures by a RUHS physician holding this privilege.
Previous Experience: Demonstrated current competence and evidence of the performance of at least 2 procedures in the past 12 months.
Maintenance of Privilege: Demonstrated current competence and the performance of at least 4 procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

❒ **Requested** **Central Line/PICC Placement**

Approved (Initials):_____

Riverside University HEALTH SYSTEM Medical Center

ADVANCED PRACTICE PROVIDER (APP)
EMERGENCY MEDICINE CLINICAL PRIVILEGES

Name:_____ Staff Category: **APP**
(Last, First, Initial)

Department:_____

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

LUMBAR PUNCTURE

Criteria: Direct supervision and those technical and management skills which qualify the APP to perform a lumbar puncture and successful completion of proctoring of 2 procedures by a RUHS physician holding this privilege.
Previous Experience: Demonstrated current competence and evidence of the performance of at least 2 procedures in the past 12 months.
Maintenance of Privilege: Demonstrated current competence and the performance of at least 4 procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

❒ **Requested** **Lumbar Puncture**

Approved (Initials):_____

ENDOTRACHEAL INTUBATION

Criteria: Direct supervision and those technical and management skills, which qualify the APP to perform an endotracheal intubation by virtue of training and experience.

Required Previous Experience: Demonstrate current competence and evidence of the performance of at least 8 procedures in the past 12 months.

Maintenance of Privilege: Demonstrate current competence and the performance of at least 4 procedures in the past 24 months.

❒ **Requested** **Endotracheal Intubation**

Approved (Initials):_____

ARTERIAL CANNULATION

Criteria: Direct supervision and those technical and management skills, which qualify the APP to perform an arterial puncture and blood gas sampling by virtue of training and experience.

Required Previous Experience: Demonstrate current competence and evidence of the performance of at least 8 procedures in the past 12 months.

Maintenance of Privilege: Demonstrate current competence and the performance of at least 4 procedures in the past 24 months.

❒ **Requested** **Arterial Cannulation**

Approved (Initials):_____

Riverside University HEALTH SYSTEM Medical Center

ADVANCED PRACTICE PROVIDER (APP)
EMERGENCY MEDICINE CLINICAL PRIVILEGES

Name:_____ Staff Category: **APP**
(Last, First, Initial)

Department:_____

Effective: _____ Page 9
(From—To) (To be completed by MSO)

THORACENTESIS

Criteria: Direct supervision and those technical and management skills, which qualify the APP to perform a thoracentesis by virtue of training and experience.

Required Previous Experience: Demonstrate current competence and evidence of the performance of at least 8 procedures in the past 12 months.

Maintenance of Privilege: Demonstrate current competence and the performance of at least 4 procedures in the past 24 months.

❒ **Requested** **Thoracentesis**

Approved (Initials):_____

PARACENTESIS

Criteria: Direct supervision and those technical and management skills, which qualify the APP to perform a paracentesis by virtue of training and experience.

Required Previous Experience: Demonstrate current competence and evidence of the performance of at least 8 procedures in the past 12 months.

Maintenance of Privilege: Demonstrate current competence and the performance of at least 4 procedures in the past 24 months.

❒ **Requested** **Paracentesis**

Approved (Initials):_____

PRESCRIPTIVE AUTHORITY AS DELEGATED BY A PHYSICIAN IN A SUPERVISING AGREEMENT IN ACCORDANCE WITH STATE AND FEDERAL LAW

❒ **Requested** The delegation to the Physician Assistant to administer or dispense drugs shall include the prescribing of controlled substances.

Approved (Initials):_____

Riverside University HEALTH SYSTEM Medical Center

ADVANCED PRACTICE PROVIDER (APP)
EMERGENCY MEDICINE CLINICAL PRIVILEGES

Name:_____ Staff Category: **APP**
(Last, First, Initial)

Department:_____

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

ACKNOWLEDGEMENT OF PRACTITIONER

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

I understand that:

a. In exercising any clinical privileges granted and in carrying out the responsibilities assigned to me, 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 policies governing allied health professionals or related documents.

_____ _____
Practitioner's Signature **Date**

ENDORSEMENT OF PHYSICIAN EMPLOYER / SUPERVISOR

Signature: _____ Date: _____

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

_____ _____
Department Chair/Designee Signature **Date**

_____ _____
IDPC Chair/Designee Signature **Date**

Riverside University HEALTH SYSTEM Medical Center

ADVANCED PRACTICE PROVIDER (APP)
EMERGENCY MEDICINE CLINICAL PRIVILEGES

Name:_____ Staff Category: **APP**
(Last, First, Initial)

Department:_____

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

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

Mechanism that may be used to confirm competency (including providing appropriate informed consent) of new applicants and/or privileges or to address potential competency issues referred from Ongoing Professional Practice Evaluation (OPPE). Proctoring of informed consent will occur as each privilege is proctored. Proctoring indicates that all elements of informed consents are met.

Department Chair/Designee: For the above-named applicant, please indicate below the privileges/procedures and the number of cases to be proctored, including the method of proctoring.

Please print legibility.

Basic Privileges / Procedures to be Proctored	Number of Cases to be Proctored	Method of Proctoring A. Direct Observation B. Retrospective Chart Review C. Simulation
Basic - Core Varied Cases	10	A or B

Advanced Privileges / Procedures to be Proctored	Number of Cases to be Proctored	Method of Proctoring D. Direct Observation E. Retrospective Chart Review F. Simulation
Basic - Core Varied Cases	10	A or B
Procedural - Musculoskeletal	1	A
Infectious Disease	1	A or B
Pediatrics	1	A or B
Injury	1	A or B
Cardiovascular	1	A or B
Obtaining Informed Consent	1	A
Central Line/PICC Placement	5 2 may be sim	A
Lumbar Puncture	5 2 may be sim	A
Endotracheal Intubation	5 2 may be sim	A
Arterial Cannulation	5 2 may be sim	A
Thoracentesis	10 2 may be sim	A
Paracentesis	5 2 may be sim	A

RIVERSIDE UNIVERSITY HEALTH SYSTEM

EMERGENCY MEDICINE ADVANCED CLINICAL PRIVILEGES

Name:_____ ❒ Initial Appointment
(Last, First, Initial) ❒ 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 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
ADVANCED EMERGENCY MEDICINE PRIVILEGES

EMERGENCY MEDICINE ADVANCED PRIVILEGES

Criteria: To be eligible to apply for advanced privileges in **emergency medicine**, the 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 emergency medicine.

AND

- Current certification or active participation in the examination process leading to certification in emergency medicine by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine or the Royal College of Physicians and Surgeons of Canada.

Required Previous Experience: An applicant for initial appointment must be able to demonstrate:

- Active practice in an Emergency Department (ED), reflective of privileges requested, in the past 12 months.

OR

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

Reappointment Requirements: To be eligible to renew advanced privileges in emergency medicine, the applicant must meet the following maintenance of privilege criteria:

- Current demonstrated competence and an adequate volume of experience 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). Submit copies of CME certificates.

AND

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

Description of Emergency Medicine Advanced Privileges

❒ **Requested** **Emergency Medicine Advanced Privileges**

Assess, evaluate, diagnose and initially treat patients of all ages, except as specifically excluded from practice, who present in the ED with any symptom, illness, injury or condition and provide services necessary to ameliorate minor illnesses or injuries; stabilize patients with major illnesses or injuries and to assess all patients to determine if additional care is necessary. Privileges do not include long-term care of patients on an in-patient basis. No privileges to admit *with the exception of writing preliminary admission orders* or perform scheduled elective procedures with the exception of procedures performed during routine emergency room follow-up visits. Privileges include performance of 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.

EMERGENCY MEDICINE ADVANCED CLINICAL PRIVILEGES

Name:_____
(Last, First, Initial)

Effective: _____ Page 2

(From—To) (To be completed by MSO)

ADVANCED 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.

- Abscess incision and drainage, including Bartholin's cyst
- Airway management and intubation
- Administration of sedation and analgesia
- Administration of thrombolytic therapy for myocardial infarction, stroke
- Anoscopy
- Application of splints and plaster molds
- Arterial puncture and cannulation
- Arthrocentesis
- Anesthesia: intravenous (upper extremity, local, and regional)
- Bladder decompression and catheterization techniques
- Blood component transfusion therapy
- Burn management, including escharotomy
- Cannulation, artery and vein
- Cardiac pacing to include, but not limited to, external, transthoracic, transvenous
- Cardiac massage, open or closed
- Cardioversion (synchronized counter shock)
- Central venous access: femoral, jugular, peripheral, internal, subclavian and cutdowns
- Management of restraints
- Cricothyrotomy
- Defibrillation
- Delivery of newborn, emergency
- Dislocation/fracture reduction/immobilization techniques, including splint and cast applications
- Electrocardiography interpretation
- Endotracheal intubation techniques
- External Transcutaneous pacemaker
- GI decontamination (emesis, lavage, charcoal)
- Hernia reduction
- Immobilization techniques
- Irrigation and management of caustic exposures
- Insertion of emergency transvenous pacemaker
- Intracardiac injection
- Intraosseous infusion
- Laryngoscopy, direct, indirect
- Lumbar puncture
- Management of epistaxis
- Nail trephine techniques
- Nasal cautery/packing
- Nasogastric/orogastric intubation
- Ocular tonometry
- Oxygen therapy
- Paracentesis
- Pericardiocentesis
- Peripheral venous cutdown
- Peritoneal lavage
- Preliminary interpretation of imaging studies

- Removal of foreign bodies, airway including nose, eye, ear, soft instrumentation/irrigation, skin or subcutaneous tissue
- Removal of IUD
- Repair of lacerations
- Resuscitation
- Slit lamp used for ocular exam, removal of corneal foreign body
- Splint or cast application after reduction of fracture or dislocation
- Spine immobilization
- Thoracentesis
- Thoracostomy tube insertion
- Thoracotomy, open for patient in extremis
- Tracheostomy
- Use of manual and mechanical ventilators and resuscitators
- Variceal/nonvariceal hemostasis
- Wound debridement and repair
- Moderate Sedation
- Telemedicine: Provide services remotely through telemedicine capabilities

QUALIFICATIONS FOR NON-CORE PRIVILEGES

- 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.

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. (*Note: This definition is adapted from Bernard J.M., & Goodyear, R.K., Fundamentals of Clinical Supervision, 2nd Ed. Needham Heights, MA: Allyn & Bacon 1998.*)

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** **Participate in Teaching Program**

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 RCRMC 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.

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**

Emergency Ultrasound Non-Core Privilege

Criteria: All emergency physicians should complete a training program in both image acquisition and image interpretation approved by the department. This training may take form in one of the following forms:

- Completion of an emergency medicine residency program that has emergency ultrasonograpy as an integral part of its curriculum.

OR

- Completion of an ACEP-approved course on emergency sonography.

OR

- Completion of training approved by the Emergency Medicine chair.

Required Previous Experience: Demonstrated current competence and evidence of the performance of at least five (5) ultrasound interpretations in the past 12 months.
Maintenance of Privilege: Demonstrated current competence and evidence of the performance of at least five (5) ultrasound interpretations in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Description of Non-Core Privilege

❒ **Requested** **Emergency Ultrasound**

DEEP SEDATION

Criteria: To be eligible for non-core privileges in **deep sedation**, the applicant must meet the following requirements delineated by Patient Care Policy 628, Privileging Criteria and Delineation for Moderate/Deep Sedation.

For Initial Privileges

- Be a M.D. or D.O. licensed independent practitioner who is board certified or actively pursuing board certification ("board prepared") in Emergency Medicine
- Have current knowledge of both adult and pediatric airway management as demonstrated by **one of the following:**

    1. Residency training in Emergency Medicine
    2. Take the RUHS Airway Management for Sedation Course

- Take the RUHS Online Moderate/Deep Sedation Training.
- Successfully pass the Moderate/Deep Sedation Written Exam with a score of 85% or better correct.
- Successfully complete two (2) deep sedation cases under the direct supervision of an RUHS practitioner holding appropriate clinical privileges in deep sedation.

To Maintain Privileges at the Time of Reappointment

- Completion of a minimum of two (2) deep sedation cases during his or her reappointment period.
- Take the RUHS Online Training for Moderate/Deep Sedation.

Description of Non-Core Privilege

❒ **Requested** **Deep Sedation**
Administration of sedation and analgesia

EMERGENCY / LIMITED TEE

Criteria: To be eligible to apply for **Emergency / Limited TEE** privileges, the applicant must meet the membership requirements of Riverside University Health System and the following privileging criteria:
Initial Appointment Requirements: For initial appointment in Emergency / Limited TEE privileges, the applicant must meet the following criteria:

- A total of five proctored TEE cases, two of which must be live patients. The remaining three proctored cases may be either/or live patients or simulation cases

Reappointment Requirements: To be eligible to renew Emergency / Limited TEE privileges, the applicant must meet the following maintenance of privilege criteria:

- Current demonstrated competence of 1 TEE cases within the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Description of Emergency / Limited TEE

❒ **Requested Emergency / Limited TEE**

EMERGENCY MEDICINE MOONLIGHTING

Criteria: To be eligible to apply for core privileges in emergency medicine, the initial applicant must meet the following criteria:

Per diem/moonlighting resident medical staff membership shall be held by post-doctoral residents who 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) who are not eligible for another staff category and 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 license to practice medicine within the State of California.

(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 program approved by and in conformity with the Accreditation Council on Graduate Medical Education of the American Medical Association, the American Osteopathic Association, or the American Dental Association's Commission Dental Accreditation.

(c) Appointment to the per diem resident medical staff shall be for (1) one year and may be renewed annually. Per diem resident medical staff membership may not be considered as the observational period required to be completed by provisional staff. 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.

Description of Core Privilege

❒ **Requested** **Emergency Medicine Moonlighting**

Privileges as stated above

In requesting these privileges, I certify that I am an emergency medicine resident in training (PGY-III or higher) in an approved training program and will perform the requested privileges only under the supervision of a fully qualified emergency medicine physician.

Emergency Medicine Moonlighting

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
- 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

Name:_____
(Last, First, Initial)
Effective: _____ Page 9
(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**

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
1. Procedural – Musculoskeletal, Chest, or Airway	1	A or B
2. Procedural – Ultrasound	1	B or B
3. Procedural Sedation: Deep	2	A
4. Injury	1	A or B
5. Pediatrics	1	A or B
6. Cardiovascular	1	A
7. Emergency / Limited TEE	2 Live Patients 3 SIM cases	B

RIVERSIDE UNIVERSITY HEALTH SYSTEM

EMERGENCY MEDICINE CORE CLINICAL PRIVILEGES

Name:_____ ❒ Initial Appointment

(Last, First, Initial) ❒ Reappointment

Effective: _____

(From—To)

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 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 EMERGENCY MEDICINE PRIVILEGS

EMERGENCY MEDICINE CORE PRIVILEGES

Criteria: To be eligible to apply for core privileges in **emergency medicine,** the 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 emergency medicine, internal medicine, or family medicine.

AND

- Current certification or active participation in the examination process leading to certification in emergency medicine, internal medicine, or family medicine by the relative American Board specialty or the relative American Osteopathic Board specialty or the Royal College of Physicians and Surgeons of Canada.

Required Previous Experience: An applicant for initial appointment must be able to demonstrate:

- Active practice in an Emergency Department (ED), reflective of privileges requested, in the past 12 months.

OR

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

Reappointment Requirements: To be eligible to renew core privileges in emergency medicine, the applicant must meet the following maintenance of privilege criteria:

- Current demonstrated competence and an adequate volume of experience 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) requirements 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.

AND

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

Description of Core Privilege	
❒ **Requested**	**Emergency Medicine Privileges** Assess, evaluate, diagnose, and initially treat patients of all ages, except as specifically excluded from practice, who present in the ED with any symptom, illness, injury or condition and provide services necessary to ameliorate minor illnesses or injuries, stabilize patients with major illnesses or injuries, and assess all patients to determine if additional care is necessary. Privileges do not include long-term care of patients on an in-patient basis. No privileges to admit *with the exception of writing preliminary admission orders* or perform scheduled elective procedures with the exception of procedures performed during routine emergency room follow-up visits. Privileges include performance of history and physical exam.

EMERGENCY MEDICINE CORE CLINICAL PRIVILEGES

Name:_____
(Last, First, Initial)

Effective: _____
(From—To)

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.

- Anoscopy
- Application of splints and plaster molds
- Arterial puncture and cannulation
- Arthrocentesis
- Anesthesia: intravenous (upper extremity, local, and regional)
- Bladder decompression and catheterization techniques
- Local burn management
- Cannulation, artery and vein
- 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
- Lumbar puncture
- Management of epistaxis
- Nail trephine techniques
- Nasal cautery/packing
- Nasogastric/orogastric intubation
- Ocular tonometry
- Oxygen therapy
- Paracentesis
- Preliminary interpretation of imaging studies
- Removal of foreign bodies, airway including nose, eye, ear, soft instrumentation/irrigation, skin or subcutaneous tissue
- Removal of IUD
- Repair of lacerations
- Slit lamp used for ocular exam, removal of corneal foreign body
- Splint or cast application after reduction of fracture or dislocation
- Spine immobilization
- Thoracentesis
- Variceal/nonvariceal hemostasis
- Wound debridement and repair
- Telemedicine: Provide services remotely through telemedicine capabilities

QUALIFICATIONS FOR NON-CORE PRIVILEGES

- 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.

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. (*Note: This definition is adapted from Bernard J.M., & Goodyear, R.K., Fundamentals of Clinical Supervision, 2nd Ed. Needham Heights, MA: Allyn & Bacon 1998.*)

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** **Participate in Teaching Program**

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.

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**

Emergency Ultrasound Non-Core Privilege

Criteria: All emergency physicians should complete a training program in both image acquisition and image interpretation approved by the department. This training may take form in one of the following forms:

- Completion of an emergency medicine residency program that has emergency ultrasonograpy as an integral part of its curriculum.

OR

- Completion of an ACEP-approved course on emergency sonography.

OR

- Completion of training approved by the Emergency Medicine chair.

Required Previous Experience: Demonstrated current competence and evidence of the performance of at least five (5) ultrasound interpretations in the past 12 months.
Maintenance of Privilege: Demonstrated current competence and evidence of the performance of at least five (5) ultrasound interpretations in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Description of Non-Core Privilege

❒ **Requested** **Emergency Ultrasound**

MODERATE SEDATION

Criteria: To be eligible for moderate sedation, the applicant must:

- Meet the qualification as required in the Privileging Criteria and Delineation for Moderate Sedation and the Patient Care Services Policy, 628: Moderate Sedation/Analgesia.

AND

- View the Sedation Care training video or the online sedation training presentation.

AND

- Take and pass a written moderate sedation exam. This can be done online www.rcrmc.org, click on Education Services for the moderate sedation site, which has the instructions, inservice video, and test.

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 four (4) moderate sedation cases in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Description of Non-Core Privilege

❒ **Requested** **Moderate Sedation**
Administration of sedation and analgesia

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**

Name:_____
(Last, First, Initial)

Effective: _____ Page 7
(From—To)

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 FPPE Cases	Method of FPPE A. Direct Observation B. Retrospective C. Reciprocal
1. Procedural – Musculoskeletal, Chest, or Airway	1	A or B
2. Procedural - Ultrasound	1	A or B
3. Procedural - Moderate Sedation	1	A
4. Injury	1	A or B
5. Pediatrics	1	A or B
6. Cardiovascular	1	A or B

EXTERNAL PROCTOR AUTHORIZATION, ATTESTATION AND RELEASE

I am seeking approval to serve as an External Proctor for the Medical Staff of Riverside University Health System. I understand that, in order to serve as an External Proctor, I must provide the Medical Staff with information concerning my knowledge, training, experience and qualifications to serve as an External Proctor.

I understand that it is my responsibility to provide adequate and accurate information so that my request to serve as an External Proctor may be properly evaluated. I represent and warrant that all of the information I provide to the Medical Staff of Riverside University Health System in connection with my request to serve as an External Proctor is accurate and complete. I agree to immediately notify the Chief of the Medical Staff and Department Chair within one (1) business day of my knowledge of any changes in the information I have provided to the Medical Staff of Riverside University Health System, including, without limitation: (i) any investigations by a state licensure agency; (ii) any change in my professional liability insurance coverage; (iii) the filing of a professional liability lawsuit against me; (iv) any change in my status at any other health care organization; (v) any change in my eligibility for participation in the Medicare or Medicaid programs or DEA registration status; or (vi) any change in my ability to competently serve as an External Proctor for whatever reason.

I acknowledge that I have been provided with access to the Medical Staff Bylaws, Medical Staff Rules and Regulations and I agree to abide by all of their applicable provisions with respect to my service as an External Proctor. I acknowledge that I am neither applying for nor being considered for Medical Staff membership or privileges, but am rather only seeking to serve as an External Proctor for those procedures as are approved by the Credentials Committee or the Medical Executive Committee. I acknowledge and agree that I am not entitled to any hearing or appellate rights in the event my request to serve as an External Proctor is denied for any reason.

I acknowledge that any approval to serve as an External Proctor does not confer upon me the status of a Member of the Medical Staff of Riverside University Health System, and that I am not entitled to any of the rights or prerogatives of Medical Staff membership by virtue of being approved to serve as an External Proctor. I acknowledge and agree that I may not and will not admit, treat, examine, consult, write or give verbal orders, perform or assist (except verbally) with procedures, write or record in the medical record, or otherwise participate directly in the care of any patient in my capacity as an External Proctor at Riverside University Health System.

I acknowledge and agree that I am required to abide by all applicable laws, rules and regulations applicable to confidentiality and patient privacy, and that I must assure the confidentiality of the Proctoring Form.

I authorize the Medical Staff of Riverside University Health System and its authorized agents and representatives to: (i) to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, health/ability to practice safely, ethics, conduct, experience, patient care practices, and/or any other matter bearing on my qualifications to serve as an External Proctor; and (ii) to obtain, retain and/or use any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions.

I hereby authorize third parties, including each hospital and the medical staff of each hospital in which I have maintained medical staff membership or privileges, as well as their members, agents, employees, and representatives, to provide the Medical Staff of Riverside University Health System, and its agents, employees, and representatives, with any and all information and documentation regarding my professional qualifications. This authorization specifically includes, but is not limited to, information in connection with the status of my medical staff membership and privileges, any and all *California Business & Professions Code* Section 805 reports, any and all suspensions of my medical staff privileges, and any and all information and documentation relating to my clinical competence, my professional conduct and/or any peer review activities involving me. I hereby release all such third parties from any and all liability, hereby grant them immunity to the fullest extent permitted by law, and agree not to sue any of them for (1) providing the above-referenced information and documentation to the Medical Staff of Riverside University Health System and (2) any action that may arise out of, relate to or result from the provision of that information and documentation to the Medical Staff of Riverside University Health System.

By my signature below, I expressly agree to the fullest extent permitted by law, that I hereby extend absolute immunity to, and release from any and all liability, Riverside University Health System, the Medical Staff of Riverside University Health System, Medical Staff Officers, Medical Staff members, authorized representatives and agents, employees, and/or any third parties who provide information for any matter relating to my request to serve as an External Proctor. This grant of immunity and release covers any actions, recommendations, reports, statements, communications and/or disclosures involving me that are made, taken, received or used by the Riverside University Health System and/or the Medical Staff of Riverside University Health System and their authorized agents or employees in the course of any review and/or decisions associated with my request for approval to serve as an External Proctor.

I acknowledge that I have read and understand the foregoing External Proctor Authorization, Attestation and Release. I understand and agree that a facsimile, photocopy or electronic copy of this Authorization, Attestation and Release shall be as effective as the original.

_____ _____

SIGNATURE SSN #

_____ _____

PRINTED NAME DOB:

_____

DATE

MEC: 08/13/2020 Rev 3/14/24

RIVERSIDE UNIVERSITY HEALTH SYSTEM

Confidentiality Agreement

I understand that during the course of my involvement in providing services or functions for or on behalf of Riverside University Health System (RUHS), that I may come in contact with patient identifiable or other confidential or sensitive information (confidential information). By signing this form, I agree to keep all confidential information private.

I will not disclose any confidential information to others who are not authorized to have the information, such as friends or family members, the media or others. I agree that I will not post any confidential information to any social media websites (such as Facebook, Twitter or other sites).

I further agree that I will not send any confidential information in an email or text message. I understand that all patient information is strictly confidential and is protected under state and federal laws which require that such information is safeguarded at all times from any unauthorized access, use or disclosure.

If I learn of any loss or theft of any confidential information I am provided with, I agree to immediately inform my supervisor, coordinator or person in charge of the event I am participating in.

Name (Print)	Signature
Date	Department/Event

RIVERSIDE UNIVERSITY HEALTH SYSTEM

MEDICINE DEPARTMENT

INTERNAL MEDICINE & SUB-SPECIALTY CLINICAL PRIVILEGES - *DRAFT*

Name:_____ ❒ Initial Appointment

(Last, First, Initial) ❒ Reappointment

Effective: _____

(From—To)

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 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.

INTERNAL MEDICINE CORE

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

- Successful completion of a postgraduate training program in internal medicine accredited by Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA)

AND

- Current certification or active participation in the examination process leading to certification in internal medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine or the Royal College of Physicians and Surgeons of Canada.

REQUIRED PREVIOUS EXPERIENCE:

- Care of at least 20 inpatients and/or outpatients reflective of the privileges requested in the last 12 months

OR

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

MAINTENANCE OF PRIVILEGE: To be eligible to renew core privileges in internal medicine, the applicant must meet the following maintenance of privilege criteria:

- Current competence and evidence of the performance of 20 cases with acceptable results in the privileges requested during the past 24 months based on results of the hospital's ongoing professional practice evaluation and outcomes.
- 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).

INTERNAL MEDICINE CORE

❒ **Requested**
❒ **Approved**
❒ **Not Approved***

Admit, perform medical history and physical examination, evaluate, diagnose, treat, refer for specialty care, and provide consultation to patients 12 years of age and older with common and complex illnesses, diseases, and functional disorders of the neurologic, cardiovascular, respiratory, gastrointestinal, genitourinary, endocrine, metabolic, musculoskeletal, hemato-poietic systems, and skin. Privileges to assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. Backup coverage is required admitting to inpatient services per Medical Staff Bylaws.

Exercise privileges in one or more of the following settings: basic medical-surgical units, ambulatory clinics, emergency department, and procedure rooms.

Except as specifically excluded from practice, 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 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.

- Airway maintenance and emergency intubation
- Arterial puncture and cannulation
- Arthrocentesis and joint injections
- Bladder catheterization
- Bone marrow biopsy & aspiration
- Cardiac pacemaker (transvenous)
- Cardioversion, non-emergent and emergent
- Central venous line: femoral, subclavian, jugular
- Chest tube
- Excision of skin and subcutaneous tumors, nodules, and lesions
- I & D abscess
- Management of pneumothorax (needle insertion and drainage systems)
- Perform simple skin biopsy or excision
- Placement of nasogastric tubes
- Flexible sigmoidoscopy
- Preliminary interpretation of electrocardiograms, own patient
- Lumbar puncture
- Paracentesis
- Percutaneous needle aspiration
- Pericardiocentesis - emergent
- Pleural biopsy
- Skin Biopsy
- Swan-Ganz catheterization
- Temporary emergent cardiac pacemaker insertion and application
- Thoracentesis
- Use of reservoir masks and continuous positive airway pressure masks for delivery of supplemental oxygen, humidifiers, nebulizers, and incentive spirometry
- Ventilator Management
- Telemedicine: Provide services remotely through telemedicine capabilities

PROGRESSIVE CARE UNIT CORE

CRITERIA: To be eligible to apply for core privileges in the adult progressive care unit (PCU), the applicant must:

- Meet the qualifications for core privileges in internal medicine

REQUIRED PREVIOUS EXPERIENCE:

- Demonstrated current competence and evidence of management of 15 inpatients in the PCU or ACCU (or similar Critical Care Unit) within the past 12 months

OR

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

OR

- Privileges may be granted at the discretion of the Medicine department chair with additional proctoring

MAINTENANCE OF PRIVILEGE: To be eligible to renew core privileges in the progressive care unit, the applicant must meet the following maintenance of privilege criteria:

- Demonstrated current competence and evidence of 30 PCU/ACCU(or similar Critical Care Unit) cases in the past 24 months based on ongoing professional practice evaluation and outcomes

Description of Progressive Care Unit Core

❒ **Requested**
❒ **Approved**
❒ **Not Approved***

Admit and manage the medical care of patients in the progressive care unit.

Except as specifically excluded from practice, 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.

ADULT CRITICAL CARE UNIT CORE

CRITERIA: To be eligible to apply for core privileges in the adult critical care unit (ACU), the applicant must:

- Meet the qualifications for core privileges in internal medicine

AND

- Evidence of a minimum of 4 months critical care training experience with at least 2 months experience in the capacity of a senior resident

REQUIRED PREVIOUS EXPERIENCE:

- Demonstrated current competence and evidence of management of 15 critical care patients within the past 12 months

OR

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

OR

- Privileges may be granted at the discretion of the Medicine department chair with additional proctoring

MAINTENANCE OF PRIVILEGE: To be eligible to renew core privileges in the adult care unit, the applicant must meet the following maintenance of privilege criteria:

- Demonstrated current competence and evidence of 30 adult critical care cases to include at least 4 ventilator experiences, 4 acute coronary syndromes, and 4 systemic inflammatory response syndromes or shock in the past 24 months based on ongoing professional practice evaluation and outcomes.

Description of Adult Care Unit Core

❒ **Requested**
❒ **Approved**
❒ **Not Approved***

Management of life-threatening disorders in intensive care units including but not limited to shock, coma, heart failure, trauma, respiratory arrest, drug overdoses, massive bleeding, diabetic acidosis, and kidney failure. Except as specifically excluded from practice, 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.

AMBULATORY ONLY

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

- Meet the criteria for core privileges in internal medicine or subspecialty.

REQUIRED PREVIOUS EXPERIENCE:

- Meet the criteria for core privileges in internal medicine or subspecialty.

MAINTENANCE OF PRIVILEGE:

- Demonstrated current competence and evidence of 10 cases in the past 24 months based on ongoing professional practice evaluation and outcomes

Description of Ambulatory

❒ **Requested**
❒ **Approved**
❒ **Not Approved***

Includes privileges to see, treat, refer for specialty care and otherwise manage patients in the RUHS Clinics. Includes the ability to perform diagnostic and other procedures normally performed in the ambulatory care setting.

QUALIFICATIONS FOR SPECIAL NON-CORE PRIVILEGES

- 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.

PARTICIPATION 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. (*Note: This definition is adapted from Bernard J.M., & Goodyear, R.K., Fundamentals of Clinical Supervision, 2nd Ed. Needham Heights, MA: Allyn & Bacon 1998.*)

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, 45 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** Participate in Teaching Program
❒ **Approved**
❒ **Not Approved ***

SUBSPECIALTY CARE PROCEDURES

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

- Meet the qualifications for core privileges in internal medicine
- Must have completed an Internal Medicine Subspecialty training program

REQUIRED PREVIOUS EXPERIENCE:

- Satisfactory completion of the educational requirements necessary for Board certification in the relevant specialty and be certified or an active candidate for certification in the respective certifying Board;
  AND
- Demonstrated current competency and evidence of management of 10 patients within the sub-specialty during the past 12 months;
  OR
- Privileges may be granted at the discretion of the Medicine department chair with additional proctoring

MAINTENANCE OF PRIVILEGE: To be eligible to renew core privileges in the Subspecialty, the applicant must meet the following maintenance of privilege criteria:

- Demonstrated current competence and evidence of 10 cases in the past 24 months based on ongoing professional practice evaluation and outcomes

Description of Subspecialty Care Procedures

❒ **Requested**
❒ **Approved**
❒ **Not Approved***

Serve as an attending physician in an inpatient and outpatient setting for patients with conditions/problems of up to critical severity in the subspecialty listed at the bottom of this page. (Includes minor procedure routinely identified with and performed by this subspecialty.)

□ **Allergy**	□ **Genetics**	□ **Neurology**
□ **Critical Care Medicine**	□ **Geriatrics**	□ **Palliative Care**
□ **Dermatology**	□ **Hematology/Oncology**	□ **Physical Medicine & Rehab.**
□ **Endocrinology**	□ **Hepatology**	□ **Pulmonology***
□ **Gastroenterology***	□ **Infectious Disease**	□ **Rheumatology**
□ **Vascular Medicine**	□ **Nephrology**	□ **Telemedicine**

***See Procedural Core for Sub-Specialty requirements**

GASTROENTEROLOGY LAB PROCEDURES*

❒ **Requested**
❒ **Approved**
❒ **Not Approved***

□ Anorectal manometry
□ Colonoscopy with biopsy ***(includes Moderate Sedation)***
□ Endoscopic ultrasound
□ Endoscopic coagulation/schlerotherapy for GI bleeding
□ Endoscopic dilation of stricture
□ Esophageal dilation
□ Esophageal manometry
□ Esophageal pH studies
□ Esophagogastroduodenoscopy (EGD) with biopsy ***(includes Moderate Sedation)***
□ Gastroduodenal manometry
□ Percutaneous endoscopic gastrostomy (PEG)
□ Percutaneous liver biopsy
□ Proctosigmoidoscopy
□ Rigid
□ Sigmoidoscopy
□ Flexible
□ Small bowel enteroscopy
□ Endoscopic retrograde cholangiopancreatography (ERCP) including Fluoroscopy ***(includes Moderate Sedation & State Certificate Required)***
□ Endoscopic retrograde cholangiopancreatography (ERCP) with placement of stent ***(includes Moderate Sedation)***
□ Endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy ***(includes Moderate Sedation & State Certificate Required)***
□ Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency)

PULMONARY CRITICAL CARE*

❒ **Requested**
❒ **Approved**
❒ **Not Approved***

□ Interpret pulmonary function tests
□ Perform supervise and interpret Cardiopulmonary Exercise Testing, CPET **(evidence of training such as a letter from fellowship program director or training certificate is required)**
□ Fiberoptic Bronchoscopy ***(includes Moderate Sedation)***
□ Rigid Bronchoscopy ***(includes Deep Sedation)***
□ Percutaneous Tracheostomy
□ Deep Sedation
□ Hyperbaric Chamber Services
□ Transesophageal Echocardiography TEE ***(with appropriate training and experience to be determined by the Chair and/or Director of Critical Care)***

VASCULAR MEDICINE PROCEDURES

❒ **Requested**
❒ **Approved**
❒ **Not Approved***

□ Perform and interpret non-invasive vascular lab studies

OTHER SUBSPECIALTY PROCEDURES

❒ **Requested**
❒ **Approved**
❒ **Not Approved***

□ Fluoroscopy – ***(State Certificate Required)***
□ Peritoneal dialysis (including cannula placement), Renal biopsy, Renal dialysis (including cannula placement)
□ Thyroid biopsy
□ Electroencephalogram Interpretation, Electromyography w/ Interpretation
□ Skin Biopsy with repair

EKG INTERPRETATION – COORDINATED BY THE DIVISION CHAIR/DESIGNEE OF CARDIOLOGY

CRITERIA: To be eligible for non-core privilege in EKG interpretation, the applicant must meet the membership requirements of Riverside University Health System and the following privileging criteria:

- Meet the criteria for core internal medicine privileges

AND

- Requires coordination and assignment of privileges by the division chair/designee of cardiology

***REQUIRED PREVIOUS EXPERIENCE*:**

- Demonstration of EKG interpretation skills by successful completion of EKG testing

AND

- Accurate interpretation of at least **100** EKGs during the past 12 months

OR

- Privileges may be granted at the discretion of the cardiology division chair with additional proctoring

MAINTENANCE OF PRIVILEGE: To be eligible to renew privileges in EKG interpretation, the applicant must meet the following maintenance of privilege criteria:

- Current competence and adequate volume 100 of EKGs with acceptable results during the past 24 months based on results of ongoing professional evaluation and outcomes.

Description of Non-Core Privilege

❒ **Requested**
❒ **Approved**
❒ **Not Approved***

EKG Interpretation

EXERCISE TESTING – COORDINATED BY THE DIVISION CHAIR/DESIGNEE OF CARDIOLOGY

CRITERIA: To be eligible for non-core exercise testing privilege, the applicant must meet the membership requirements of Riverside University Health System and the following privileging criteria:

- Meet the criteria for core internal medicine privileges

AND

- Requires coordination and assignment of privileges by the division chair/designee of cardiology.

REQUIRED PREVIOUS EXPERIENCE:

- Evidence of a minimum of four (4) weeks training during residency

AND

- Performance of at least **12** exercise tests in the past 12 months

OR

- Privileges may be granted at the discretion of the cardiology division chair with additional proctoring

MAINTENANCE OF PRIVILEGE: To be eligible to renew core privileges in exercise testing, the applicant must meet the following maintenance of privilege criteria:

- Current competence and adequate volume of experience of **25** exercise tests with acceptable results during the past 24 months based on results of ongoing professional evaluation and outcomes.

Description of Non-Core Privilege

❒ **Requested** Exercise Testing
❒ **Approved**
❒ **Not Approved***

ADMINISTRATION OF MODERATE SEDATION AND ANALGESIA

CRITERIA:

- Meet the qualification as required in the Privileging Criteria and Delineation for Moderate Sedation and the Patient Care Services Policy, 628: Moderate Sedation/Analgesia
- View the online sedation care training presentation and take and pass a written moderate sedation exam. This can be done on website www.rcrmc.org, click on Education Services for the moderate sedation site, which has the instructions, inservice video, and test

Successful completion of one (1) proctored moderate sedation case under the direct supervision of an RUHS practitioner holding this privilege. Successful completion of two (2) proctored deep sedation cases under the direct supervision of an RUHS practitioner holding appropriate clinical privileges in deep sedation.

REQUIRED PREVIOUS EXPERIENCE:

- Knowledge of airway management

MAINTENANCE OF PRIVILEGE: To be eligible to renew core privileges in moderate sedation, the applicant must meet the following maintenance of privilege criteria:

- Demonstrated current competence and evidence of the performance of at least 2 moderate sedation cases in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Description of Non-Core Privilege

❒ **Requested** Administration of Moderate Sedation and Analgesia
❒ **Approved**
❒ **Not Approved***

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and which I wish to exercise at RUHS.

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

_____ _____

Department Chair/Designee Signature **Date**

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: Please indicate below the privileges/procedures and the number of cases to be proctored of the above-named practitioner, including the method of proctoring.
Please print legibility.

Privileges/Procedures to be Proctored	Number of Cases to be Proctored*	Method of Proctoring A. Direct Observation B. Retrospective C. Reciprocal
Internal Medicine Core	5 varied cases to include procedures	A,B,C as applicable
Progressive Care Unit Core	5 varied cases	A,B,C as applicable
Adult Critical Care Core	5 varied cases	A,B,C as applicable
Gastroenterology Lab	5 varied cases	A,B,C as applicable
Pulmonary Lab • Hyperbaric Chamber • Transesophageal Echocardiography (TEE)	5 varied cases 3 cases 5 cases	A,B,C as applicable
Other Subspecialty Procedures (see pg.6)	5 varied cases for each procedure requested	A,B,C as applicable
EKG Interpretation	2 varied cases	A,B,C as applicable
Exercise Testing	2 varied cases	A,B,C as applicable
Moderate Sedation / Deep Sedation	1 case	A,B,C as applicable
Procedure under Fluoroscopy	1 case	A,B,C, as applicable
Ambulatory	5 varied cases	A,B,C, as applicable

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

MEC Approved: 2/14/2013, 7/9/15, 3/10/16, 6/9/16, 9/8/16, 4/13/17, 9/14/17, 9/13/18, 7/11/19
Rev. 01/24/14, 7/9/15, 3/10/16, 5/27/16, 8/26/16, 3/24/17, 8/25/17, 8/22/18, 3/20/19, 6/28/19, 7/23; 6/13/24

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Revised 11/17/22; 12/21/22; 3/9/23; 6/12/23; 2/8/24

Riverside University Health System Medical Center
MEDICAL STAFF ORGANIZATION

Subject: MEDICAL STAFF EXTERNAL PROCTORS POLICY	Issued: 08/13/20 Revised: 3/14/24 Effective Date: 08/13/20	Medical Staff
Department Consulted: Medical Staff Administration	Reviewed & Approved by: Credentials Committee and Medical Executive Committee	

I. Purpose:

To define the qualifications and process for the selection of the physicians who will serve as External Proctors for Focused Professional Practice Evaluation ("FPPE") in accordance with the Medical Staff Bylaws and the applicable Rules and Regulations of the Medical Staff.

Definitions:

- Practitioner: any medical staff member or allied health professional (AHP) granted clinical privileges.
- Proctoree: The practitioner undergoing proctoring
- Proctor: The individual assigned to serve as the proctor
- Department Chair: The department chair or his/her designee
- FPPE: Also means proctoring

II. Procedures for Approval of External Proctors

1. Each External Proctor shall complete and return the following documentation to the Medical Staff Office:

   a. Current *curriculum vitae*;
   b. Copy of his/her driver's license;
   c. Proof of licensure from the California Medical Board;
   d. Proof of current malpractice insurance coverage;
   e. Verification of immunizations and a TB test within the past twelve (12) months;
   f. Current influenza vaccine if observing during flu season (if declined influenza vaccine, external proctor must wear mask as per required protocols);
   g. Signed authorization for release of information from his/her primary practice facility, which shall include authorization for release of information concerning current medical staff standing,
   h. a listing of current privileges and activity relating to the procedure(s) for which he/she will be serving as a Proctor;
   i. Provide SSA# and Date of Birth for NPDB Report;

j. Signed HIPAA Confidentiality Agreement; and

k. Such other documentation as is deemed reasonable and appropriate by the Medical Staff President and/or Department Chair to evaluate the qualifications of the External Proctor.

2. The Medical Staff Administration Department shall:

a. Verify the status of the license through the Medical Board of California website;
b. Query the Office of Inspector General and confirm that the External Proctor is not an excluded provider;
c. Request a letter from the External Proctor's primary practice location showing that he/she is in good standing;
d. Request from the External Proctor's primary practice location confirmation of current privileges and activity relating to the procedure(s) for which he/she will be serving as a Proctor;
e. Request from the External Proctor such additional documentation as may be deemed reasonable and appropriate by the Medical Staff President and/or Department Chair; and
f. Request written explanations and/or additional information as is necessary to verify the qualifications of the External Provider in accordance with this Policy.
g. Query the National Practitioner Data Bank.

3. The Medical Staff Chief of Staff or Department Chair shall review the information obtained by the Medical Staff Administration Department and make a determination as to whether to approve the External Proctor.

4. Only those External Proctors who are approved by the Medical Staff Chief of Staff or Department Chair may serve as a Proctor.

5. An External Proctor may only serve as a Proctor for those procedures as are approved by the Credentials Committee and/or the Medical Executive Committee. Use of internal medical staff members as proctors will be considered before using an external proctor.

III. Duties of Proctors

1. All Proctors should be impartial and have documented training and/or experience, demonstrated abilities, and current competence in the service or procedure that is the subject of the Proctoring.

2. The Proctor shall directly observe the procedure being performed and timely complete the appropriate Proctoring Form.

3. The Proctoring Form for each procedure should address the indications and preparation of the patient for the procedure and the technical skill demonstrated by the Practitioner in performing the procedure.

4. The Proctor's primary responsibility is to observe and evaluate performance. As an observer, the Proctor may not be involved in patient care.

5. The Proctor must assure the confidentiality of the Proctoring Form. The Proctoring Form should be held by the Proctor during any periods of review and should not be attached to the patient's medical record. When Proctoring is completed, the Proctor must promptly deliver the Proctoring Form to the Medical Staff Administration Department.

6. If at any time during the Proctoring period a Proctor has concerns about the Practitioner's competency to perform specific clinical privileges or care related to specific patients, the Proctor shall promptly notify the Department Chair or his/her designee.

7. The Proctoring Form shall remain confidential and shall be handled in the same manner as other Medical Staff peer review information.

IV. Restrictions Applicable to External Proctors

1. External Proctors are not members of the Medical Staff and shall not be entitled to any of the rights or prerogatives of Medical Staff membership; however, they shall abide by all applicable Hospital and Medical Staff Bylaws, Rules and Regulations, Policies and Procedures, and other governing documents.

2. External Proctors shall only act in the capacity as an observer.

3. External Proctors may not admit, treat, examine, consult, write or give verbal orders, perform or assist (except verbally) with procedures, write or record in the medical record, or otherwise participate directly in the care of any patient at the Hospital.

V. Methods

The appropriate Proctoring methods and levels of Proctoring will be determined by the Credentials Committee or the Medical Executive Committee as applicable.

CREDENTIALING PROCESS DESCRIPTION
INITIAL APPOINTMENT CREDENTIALING PROCESS

THIS PROCESS APPLIES TO ALL PRACTITIONERS AND ALLIED HEALTH PROFESSIONALS

STEP	DESCRIPTION	COMMENTS	DATA BASE ACTIVITIES
	APPLICATION REQUEST		
1.	The Medical Staff Administration Department (MSA) may be contacted as follows to send out an application for medical staff membership and clinical privileges: a. New Provider Onboarding Form signed by RUHS Department Chair / Designee, CHC Medical Director of Operation, HR Recruiter or Detention Health Medical Director. The Medical Staff Services Professional (MSSP) determines the appropriate clinical privilege delineation form(s) to send to the provider (if the provider is applying for privileges). **NOTE:** Applications will not be sent to providers in specialties of which privileges have not been developed (i.e., those services are not offered at RUHS). If such a request is made, it will be referred to the medical director for transmittal to the Credentials Committee.	Credentialing performed for Detention Health will be for membership only – no clinical privileges at RUHS.	
2.	The Medical Staff Services Professional (MSSP) will authorize the electronic application, cover letter (which details initial application criteria), and additional application materials to the applicant. ➢ Instructions for completing application ➢ Initial Application ➢ Health Information Form ➢ Medicare Acknowledgment Statement Form ➢ Relevant privilege delineation form(s) if applicable ➢ California Children's Services Application Information ➢ RUHS Moodle training instructions flyer	*Exhibit I-1:* Medical Staff/ Allied Health Professional Application Packet.	Database entry of preliminary information about a potential applicant occurs at this point. Minimum data to be entered: applicant's name, specialty, and mailing address. Database Status Code: *Potential Applicant*
3	Additional information sent (but not included as an exhibit to this policy and procedure): Medical Staff Bylaws, Rules & Regulations; Governing Board Bylaws, Physician		The MSSP will use the database timeline/tracking checklist and

CREDENTIALING PROCESS DESCRIPTION
INITIAL APPOINTMENT CREDENTIALING PROCESS

THIS PROCESS APPLIES TO ALL PRACTITIONERS AND ALLIED HEALTH PROFESSIONALS

STEP	DESCRIPTION	COMMENTS	DATA BASE ACTIVITIES
	Reference Manual, etc.		update with follow-up activities/dates as they occur.
4.	The MSSP notifies the department chair/secretary, the individual who requested that an application be sent (if other than the provider), and Contracts Administration, if appropriate, of the date that the packet was emailed by one of the following mechanisms: ▪ Telephone ▪ E-mail		Update database checklist.
	Processing of Application		
5.	When an application is received from a provider, the MSSP reviews the application within five (5) business days to ensure the provider meets criteria to apply and that the application is complete.		Database Status Code: "*Applicant"* indicates the application was received.
6.	If it is apparent that the provider does not meet criteria to apply for membership and/or clinical privileges, the provider is sent a letter from the Credentials Committee Chair explaining that the provider is not eligible to apply for membership and/or clinical privileges and the reason(s) for ineligibility.	Applicant-specific letter to be developed and used as the need arises.	Update database checklist.
7.	The following must be complete and/or enclosed with the application in order for the MSSP to accept and begin processing the application: A. The application must be completed in its entirety and must be signed and dated. The "Professional Liability Action Explanation Form (*Addendum B*)" must be completed and enclosed with the application. B. Application fee must be enclosed (alternatively, a copy of the invoice for payment should be included). C. DEA registration with California address and all schedules included (2, 2N, 3, 3N, 4, 5) (unless a DEA is not required because of clinical privileges being requested). D. Certificate of professional liability insurance (face sheet) showing coverage, dates of coverage, and exclusions if any or a fully completed County Risk Management packet for professional liability coverage if malpractice will be provided by the County of Riverside. E. If privileges are requested, the relevant privilege form(s) must be appropriately completed and signed. F. The applicant must submit documentation of the relevant department-specific	Online electronic document, certain fields are designed as "required" (i.e., the date of completion of a residency program), but other fields are discretionary (i.e., name of spouse, etc.). At that point in time the application will not be able to be submitted electronically until the required items are completed. *Exhibit I-5:* Email notifying applicant of incomplete items (Electronic copy). MSSP will keep a copy of all documents returned and follow-up	Update database checklist will all follow-up correspondence and place in physician credential file.

CREDENTIALING PROCESS DESCRIPTION
INITIAL APPOINTMENT CREDENTIALING PROCESS

THIS PROCESS APPLIES TO ALL PRACTITIONERS AND ALLIED HEALTH PROFESSIONALS

STEP	DESCRIPTION	COMMENTS	DATA BASE ACTIVITIES
	requirements as indicated on the privilege form(s). G. Health Status Form. H. Evidence of current TB and other health screening requirements – to be completed through the Occupational Health Department I. Medicare Acknowledgement Statement. J. System Access Request Form. K. RUHS Moodle Initial Compliance Training Certificate L. Informed Consent online training certificate for NP/CRNA/PA (if applicable) M. Moderate Sedation if applicable N. American Heart Association Certificates BLS, ACLS, PALS, ATLS, NRP (if applicable) An email will be sent electronically to the applicant when required items are missing, requesting that the application be made complete in its entirety.	correspondence to the applicant.	
8.	The Health Status form – Reviewed by Department Chair, Medical Director or designee as part of the credential file review.	Included with application Virtual Committee.	
	Verification of the Application		
9.	Once an application has been determined to be complete, the verification process begins. The application is verified in accordance with Verification Methods and Requirements (see Table of Contents for location). The first round of verifications (letters and queries) is sent immediately and no later than five-working days of receiving all required information that determines a complete application. When the first-round of verifications (letters and queries) is sent, the database checklist is updated.	See Verification Methods.	Complete database entry of the applicant's demographic information, education, training, etc. Update database checklist.

CREDENTIALING PROCESS DESCRIPTION
INITIAL APPOINTMENT CREDENTIALING PROCESS

THIS PROCESS APPLIES TO ALL PRACTITIONERS AND ALLIED HEALTH PROFESSIONALS

STEP	DESCRIPTION	COMMENTS	DATA BASE ACTIVITIES
10.	Twenty (20) working days (4 weeks) after the first round of queries/letters are sent, a second attempt to obtain the required verification will be made. Telephone follow-up is made to peer references, hospital affiliations, etc., in an attempt to obtain information in a timely manner. It is understood that depending upon departmental needs and the urgency to complete the application process, time frames may be shortened.	Call, email and / or fax the same letters, marked *"Second Request".*	Update database checklist.
11.	At the time that the second-round queries are sent, the applicant is sent a communication advising of the status of the application and soliciting the applicant's assistance in obtaining verification responses, when applicable.	Exhibit I-6: E-mail sent to applicant and cc Executive Assistant.	Update database checklist.
12.	If additional information is determined to be required at any point during the verification or evaluation/decision-making process, the applicant will be notified of what is required and the date by which it must be submitted.	Applicant-specific letter/email.	Update database if applicable.
	Evaluation and Decision Making Process		
13.	If the application remains incomplete after within 60 days after the application is received, the applicant shall be notified, and the application shall remain pending until either the material is received by the Medical Staff Administration 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 and deemed a voluntary withdrawal of application. The applicant will be sent a letter, from the Credentials Committee chair, requesting that the information be provided within a period not to exceed 30 days. If the information is not provided within the 30-day period, the application will be conserved to be withdrawn by the applicant. If the information is provided, the evaluation and decision-making process will proceed.	*Exhibit I-10:* Status report to Credentials Committee or designee. If sent via email or fax, a f/u call will be made and documented that applicant received the correspondence.	Update database.

CREDENTIALING PROCESS DESCRIPTION
INITIAL APPOINTMENT CREDENTIALING PROCESS

THIS PROCESS APPLIES TO ALL PRACTITIONERS AND ALLIED HEALTH PROFESSIONALS

STEP	DESCRIPTION	COMMENTS	DATA BASE ACTIVITIES
14.	Files eligible for "expedited review" will go through an expedited credentialing evaluation process, which will consist of department chair/designee, to the Credentials Committee Chair/designee, to the MEC, and then to the Governing Body. The MSSP will notify the department chair via e-mail that a file is ready for review in Virtual Committee. **NOTE:** For applicants in Adjunct Staff Category (membership only – no clinical privileges), the medical director/designee will fulfill the role of the department chair. The department chair/designee may conduct an interview with the applicant, will complete the Virtual Committee, and approve the privilege delineation form.	Email to the department chair. *Exhibit I-9:* Expedited Designation Memo Recommendations & Actions via Virtual Committee (MS & AHP)	Update database with notifications and approval date as they occur.
15.	Ten (10) working days after the MSSP has notified the department chair that the file is ready for review, the MSSP will contact the department chair if the application packet has not yet been reviewed. The MSSP will request an anticipated date of completion from the department chair and the reason(s) for delay.	E-mail to department chair and f/u with phone call if necessary	Update database.
16.	Files that are ineligible for expedited review will go from department chair, to the Credentials Committee, to the Medical Executive Committee, and then to the Governing Body.		
17.	The Department Chair or designee will review the application, supporting documentation and document the recommendation for clinical privileges and membership to transmit to the Credentials Committee.	Recommendations/Action through Virtual Committee (MS & AHP)	
18.	The Credentials Committee will review the application, and supporting documentation, and the Department Chairs recommendation and the Credentials Committee chair or designee will document the committee's recommendation on the Credentials Committee report. The recommendation will be transmitted to the MEC.	Credentials Chair signs the credentials report. (MS & AHP)	Update database.
19.	After review and recommendation by the Credentials Committee/designee, the file is transmitted to the Medical Executive Committee for review of the department chair and Credentials Committee reports and recommendation. The MEC's recommendation shall be documented in the minutes of the MEC.	(MS & AHP)	Update database.

CREDENTIALING PROCESS DESCRIPTION
INITIAL APPOINTMENT CREDENTIALING PROCESS

THIS PROCESS APPLIES TO ALL PRACTITIONERS AND ALLIED HEALTH PROFESSIONALS

STEP	DESCRIPTION	COMMENTS	DATA BASE ACTIVITIES
20.	The MEC shall review the department chair/designee and the Credentials Committee report as well as all other relevant information available. If the recommendation by the MEC is favorable, the hospital director/CEO will transmit MEC's recommendations to the Governing Board for final decision. MEC's recommendation shall be documented in the minutes of the MEC.	*Exhibit I-12:* Form 11	Update database.
21.	If the recommendation by the Medical Executive Committee is not favorable in any respect, the file is transmitted by the chief of medical staff to the designated legal counsel for RUHS so that proper procedures related to the Fair Hearing Plan can be initiated.		Notation that application or some part of it has been denied and referred to County Counsel.
22.	Once the Governing Body has made a favorable determination, the applicant is notified by the hospital director or designee.	*Exhibit I-13:* Appointment letter.	Update database with approval date, staff category, department assignment, reappointment date, and FPPE due dates.
23.	RUHS departments are notified of an addition to the medical staff/AHP and clinical privileges granted are uploaded to the E priv as notification to internal customers of privileges granted.	*Exhibit I-14:* Memorandum to RUHS departments via email.	

REAPPOINTMENT CREDENTIALING PROCESS

THIS PROCESS APPLIES TO ALL PRACTITIONERS AND ALLIED HEALTH PROFESSIONALS

STEP	GENERAL PROCESS DESCRIPTION	ADDITIONAL COMMENTS	DATA BASE ACTIVITIES
	REAPPOINTMENT		
1.	Six (6) months prior to the expiration date of a provider's current medical staff appointment, the Medical Staff Services Professional (MSSP) sends out a reappointment packet. The packet includes: • Cover letter to the provider • Reappointment application form including attestation page and Addendum B and release of information • Health Information Form • Relevant privilege delineation form(s) if applicable • Copy of previous privilege form if applicable • OPPE Release Form • Criminal Conviction Disclosure Form • CME Attestation Form • CME per privilege delineation form if applicable • Practice Agreement for APP Doc600 and Doc 500.03 if applicable • PA Practice Agreement • Mandatory Compliance Moodle training flyer for Physicians / Providers • Informed Consent online training flyer (NP/CRNA/PA) • Occupational Health letter • Moderate Sedation information (provided in MDApp) • CPI Training Step-by Step flyer • HealthStream Compliance Instructions • Copy of current medical license • Copy of current DEA certificate • Copy of current government issued identification • Copy of current fluoroscopy certificate if applicable Copies of applicable licensures/certifications shall be requested. The reapplication will contain pre-populated data from the credentialing information system.	*Exhibit R-1:* Medical Staff Reappointment Packet. *Exhibit R-2:* AHP Reappointment Application. Relevant privilege form(s) if applicable.	Database monthly reports are produced on reappointments scheduled to expire in six (6) months (180 days). Assemble relevant reapplication packet. Electronically sent to the provider. Create database checklist for each provider to include date when reapplication was sent and f/u actions.

STEP	GENERAL PROCESS DESCRIPTION	ADDITIONAL COMMENTS	DATA BASE ACTIVITIES
	RECEIVING AND TRACKING REAPPOINTMENT APPLICATIONS		
2.	If a reapplication has not been returned to the MSSP within 30 days, a written second notice is sent to the provider advising that the application is overdue and that it must submitted within 15 days of notice; copy Chair on this notice. If a reappointment application is not received 75 days **prior to a provider's appointment expiration date**, the provider shall be deemed to have voluntarily resigned effective the date of his/her last reappointment date and the provider will so be notified. If a provider subsequently wishes to apply for membership/privileges, s/he shall be required to apply as a new applicant.	Each time the database status report is updated, and prior to sending the following notices to the applicant, the admin services supervisor will be given a database status report. *Exhibit R-4:* 30-day notice letter. *Exhibit R-7:* 75 days before expiration, **Certified – Return Receipt letter**. Copy dept chair to also acknowledge receipt of letter.	Send reminder email when aged 30 days. Send email when aged 45 days. Update database checklist with next f/u date. Resend email, "Final Request". If aged 60 days. Update database checklist with next f/u date. Send Letter when aged 120 days (four months). Database and file shall reflect that all f/u has been done in accordance with specified procedures and hard copy of correspondence shall be placed in the applicant's file.
3.	The Nursing Staff Office maintains a privilege binder-and will be notified of voluntarily resignations and new providers/reappointments via email. Copies of approved privilege forms will be sent to Nursing Office on a monthly basis in order for them to update their binder.	*Exhibit R-9:* Provider Notification Memo to departments advising of resignation.	Distribute Provider Notification memo to departments advising of resignations.

STEP	GENERAL PROCESS DESCRIPTION	ADDITIONAL COMMENTS	DATA BASE ACTIVITIES
	PROCESSING OF REAPPLICATION		
4.	The following must be complete and/or enclosed with the reapplication in order for the MSSP to begin processing for reappointment. A. The reapplication must provide all required information and must be signed and dated (the date of signature must be within 90 days of receipt of the reapplication by the MSSP). If the applicant indicates that s/he has any professional liability settlement, judgments, or currently pending claims, the "Professional Liability Action Explanation Form" must be completed and enclosed with the application. B. If clinical privileges are requested, the privilege form must be appropriately completed and signed within 90 days of receipt. C. The provider must submit documentation of department-specific requirements as indicated on the privilege form. D. The reapplication fee must be received. E. Health Status Form must be completed and enclosed. F. Evidence of current TB screening – to be completed through Occupational Health Department. G. RUHS Reappointment Moodle Training Certificate (department specific) H. Health Stream (HIPPA, RUHS Compliance, EMTALA) I. Informed Consent online training certificate CRNA/NP/PA if applicable Moderate Sedation if applicable J. Clinical Activity log The reapplication and attachments/enclosures will be returned to the applicant only if the application is incomplete. The letter will be sent to the applicant electronically when required items are missing, requesting that the application be made complete.	Do not hold or return a reapplication to the applicant if information is missing that can be obtained by RUHS. I When the reapplication became an online electronic document, certain fields were designed as "required" (i.e., peer references), but other fields are discretionary. The reapplication will not be able to be submitted electronically until the required items are completed. In the spirit of customer service, only items that actually prevent a reapplication from being processed should be brought to the attention of the applicant. *Exhibit R-10:* Email notification returning the reapplication to the applicant. *Exhibit R-11:* Email notifying the applicant of incomplete items. MSSP will keep a copy of all documents returned and follow-up correspondence to the applicant.	Update the database checklist and note follow-up dates if the reapplication is incomplete. The database checklist shall note the follow-up task items to ensure that follow-up occurs and responses are received. From this point forward, the MSSP will follow procedures as detailed in item #4.
5.	The following applies only if malpractice coverage is to be provided by County Risk Management (CRM). Request claims history letter from (CRM) A copy of the claim's history letter will be kept in the provider's file.		Update database.
	VERIFICATION OF REAPPLICATION		
6..	Once an application has been determined to be completed, the verification process begins. The application is verified in accordance with Verification Methods and Requirements (see Table of Contents for location). The first round of verifications (letters and queries) is sent within one week of receiving all required information that determines a complete reapplication.	See Verification Methods.	Database entry of information submitted on the application occurs at this point. Send verification queries (references, affiliations, etc). Update database checklist and note follow-up dates.

7.	Thirty (30) days after the first-round queries/letters are sent, a second attempt to obtain the required verification will be made.	Use the same email, mark "Second Request" and date.	When the weekly report reflects that date is aged 30 days, send second request on all items that have not yet been received. Database will reflect the date when second request was sent.
8.	At the time that the second-round queries are sent, the applicant is sent a communication informing of the status of the application and soliciting the applicant's assistance in obtaining verification responses, when applicable.	*Exhibit R-12:* Status email to applicant.	Update database.
9.	If additional information is determined to be required at any point during the verification or evaluation/decision-making process, the applicant will be notified of what is required and the date by which it must be submitted.		Update database if applicable.
10.	Once all items are received and the file is completed, the file is ready for the evaluation and decision-making process.		Update database.
	EVALUATION AND DECISION-MAKING PROCESS		
11.	When all verifications are complete, the MSSP will review each reapplication file using the "expedited" credentialing criteria (see table of contents for location in this manual) to assign each file a designation of "eligible" or "ineligible" for expedited review.	*Exhibit R-13:* Designation Memo	Update database checklist.
12.	Files eligible for "expedited review" will go through an expedited credentialing evaluation process as needed, which will consist of department chair/designee, to the Credentials Committee chair/designee, to the Medical Executive Committee, and then the Governing Body. The MSSP will notify the department chair/designee via e-mail that a file is ready for review and will notify the department chair/designee by email to review the complete and verified reapplication, including the provider's report card from QM department in Virtual Committee. **NOTE:** For applicants for Adjunct Staff Category (membership only – no clinical privileges), the medical director/designee will fulfill the role of the department chair. The department chair/designee will review the reapplication credentialing documents via Virtual Committee and approve / recommend / deny the Reappointment and review and recommend or deny the privilege delineation request . Department Chair shall transmit to the Credentials Committee are commendation via Virtual Committee to include review of peer review performance and quality assessment activities.	Email to department chair/designee. *Exhibit R-17:* MS Reappointment Recommendations via Virtual Committee. *Exhibit R-18:* Physician and AHP Reappointment Recommendations/via Virtual Committee.	Update database checklist with review dates and identify delays in review by the chair of greater than 15 days if applicable.

STEP	GENERAL PROCESS DESCRIPTION	ADDITIONAL COMMENTS	DATA BASE ACTIVITIES
13.	Two (2) weeks after the MSSP has notified the department chair/designee that the file was ready for review Via Virtual Committee, but chair/designee has not responded, the MSSP will request an anticipated date of completion from the department chair/designee and the reason(s) for delay.	Email to dept chair and copy to Executive Assistant, Director Medical Staff.	When aged 14 days, contact the department chair/designee and inform Executive Assistant.
14.	Files that are ineligible for expedited review will go from Division Chair if applicable, to department chair, to the Credentials Committee, to MEC, and then to the Governing Body.		Update database with approval dates.
15.	Following receipt of the department chair report concerning the application for reappointment, the recommendation of the Credentials Committee (either by the Credentials Committee designee or the full committee) the report is signed by the Credentials Chair.	. Credentials Chair signs the credentials report.	Update database with Credentials/designee approval date.
16.	After review and recommendation by the Credentials Committee, the file is transmitted to the Medical Executive Committee for review of the department chair and Credentials Committee reports as well as other relevant information available and shall forward its recommendation to the governing board. The MEC's recommendation shall be documented in the minutes of the MEC.		Update database with MEC approval date.
17.	If the recommendation by the MEC is <u>not</u> favorable in any respect, the Chief of medical staff shall give the applicant written notice and of the applicant's right to request a hearing		Update database~~.~~
18.	Once the Governing Body has made a favorable determination, the applicant is notified by the CEO/designee.	*Exhibit 19:* Reappointment letter; copy to department chair.	Update database with new reappointment dates, privilege updates and staff category change if applicable.
19.	The decision to grant, deny, revise, or revoke privileges is disseminated and made available through E-priv.		
20.	RUHS departments are notified of an addition to the medical staff/AHP, and clinical privileges granted are uploaded to the E priv as notification to internal customers of privileges granted.	*Exhibit I-14:* Memorandum to RUHS departments via email.	

Riverside University Health System Medical Center
MEDICAL STAFF ORGANIZATION

Subject: **FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) POLICY** **(Proctoring)**	Issued: 07/12/07 Revised: Cred. Cmte 4/26/24 MEC 5/9/24 Effective Date: 6/11/20	Medical Staff
Department Consulted: Medical Staff Administration	Reviewed & Approved by: Credentials Committee and Medical Executive Committee	

I. Purpose:

To establish a systematic process to assure there is sufficient information available to confirm the current competency of practitioners initially granted privileges at Riverside University Health System (RUHS). This process, termed Focused Professional Practice Evaluation (FPPE) by the Joint Commission, will provide the basis for obtaining organization-specific information that substantiates current competence for those practitioners. This process may also be used when a question arises regarding a currently privileged practitioner's ability to provide, safe, high-quality patient care (JC Standard MS.4.30)

Definitions:

- Practitioner: any medical staff member or allied health professional (AHP) granted clinical privileges.
- Proctoree: The practitioner undergoing proctoring
- Proctor: The individual assigned to serve as the proctor
- Department Chair: The department chair or his/her designee
- FPPE: Also means proctoring

II. Medical Staff Position on Proctoring:

The proctor's role is typically that of an evaluator, not a consultant or mentor. A practitioner serving as a proctor for the purpose of assessing and reporting on the competence of another practitioner is an agent of RUHS. The proctor shall receive no compensation directly or indirectly from any patient for this service. The proctor is expected to report immediately to the appropriate department chair or RUHS authority (i.e., medical director) any concerns regarding the care being rendered by the proctored practitioner that has the potential for imminent patient harm. The proctor or any other practitioner may render emergency medical care to a patient for medical complications arising from the care provided by a proctored practitioner. RUHS will defend and indemnify any practitioner who is subjected to a claim or suit arising out of his/her acts or omissions in the role of proctor.

III. MEDICAL STAFF OVERSIGHT

The Credentials Committee is charged with the responsibility of monitoring the compliance with this policy and procedure. It accomplishes this oversight by receiving monthly status reports related to the progress of all practitioners required to be proctored as well as any issues or problems involved in implementing this policy and procedure.

The department chair shall be responsible for overseeing the proctoring process for all practitioners assigned to his/her department who have clinical privileges.

The Quality Management Department will provide the Professional Practice Evaluation Committee (PPEC) with data systematically collected for OPPE that is appropriate to confirm current competence for RUHS practitioners on a biannual basis, and at reappointment. The PPEC then reports this information directly to the MEC for their review and action. The Medical Staff Administration Department is also provided with the practitioner's OPPE profile for inclusion in their credential file.

The PPEC is involved with focused professional practice review and ongoing professional practice evaluation (peer review).

IV. SCOPE OF THE PROCTORING PROGRAM

A. Definition of Proctoring

For the purpose of this policy, proctoring is a focused professional practice evaluation (FPPE) to confirm a practitioner's current competence at the time new clinical privileges are granted, either at initial appointment or as a current member of the medical staff or an allied health professional. In addition to specialty-specific issues, proctoring will also address the six general competencies of the practitioner's performance:

1. Patient Care
2. Medical Knowledge
3. Practice-Based Learning and Improvement
4. Interpersonal and Communication Skills
5. Professionalism
6. Systems-Based Practice

Practitioners requesting staff membership only (no clinical privileges) are not subject to the provisions of this policy. They are not proctored and may not act as proctors.

The decision and process to perform a focused practice review for current practitioners, with existing privileges, is based on trends or patterns of performance identified by OPPE and are outside the scope of this policy. (See the Professional Practice Evaluation Program and the PPE Committee Description.)

B. Selection of Methods for Each Specialty

The appropriate proctoring methods to determine current competency for an individual practitioner will be part of the recommendation for granting of clinical privileges by the department chair and will be reviewed and approved by the Credentials Committee, the Medical Executive Committee, and recommended to the Governing Board for final approval. Each specialty will define the appropriate methods on the approved privilege delineation form and will include the type of proctoring to be used and the number of cases to be proctored, depending upon the privileges requested by an applicant. Joint Commission states a period of FPPE is required for all new privileges requested by new applicants and all newly requested privileges for existing practitioners. There is no exemption based on board certification, documented experience, or reputation.

C. Proctoring Methods

Proctoring may utilize a combination of the following methods to obtain the best understanding of the case provided by the practitioner:

- Prospective Proctoring: Presentation of cases with planned treatment outlined for treatment concurrence, review of case documentation for treatment concurrence, or completion of a written or oral examination, or case simulation.
- Concurrent Proctoring: Direct observation of the procedures being performed or medical management either through observation of the practitioner's interactions with patients and staff or review of clinical history and physical and treatment orders during the patient's hospital stay or clinic visit.
- Retrospective Evaluation: Review of case record after the case has been completed. May also involve discussion with other personnel directly involved in the care of the patient.
- 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. (Exhibit A – Reciprocal Proctoring Observation/Evaluation Form and Consent)

  Joint Commission: When practitioner activity at the "local" level is too low or limited, supplemental 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 should assess and determine the supplemental data's relevance, timeliness, and accuracy.

  Examples where supplemental data could be used may include, but are not limited to:

  a) Activity is limited to periodic on call coverage for other physicians or groups
  b) Occasional consultations for a clinical specialty

D. Source of Data

Joint Commission requires the data source used for the FPPE process must include practitioner activities performed at the organization where privileges have been requested. This may include activities performed at any location that falls under the organization's single CMS certification number. For example, if an organization operates two hospitals that fall under the same CCN number, data from both hospital locations may be used.

Proctoring data may include:

- Personal interaction with the practitioner by the proctor.
- Detailed medical record review by the proctor.
- Discussion with hospital staff interacting with the practitioner.

The data obtained by the proctor will be recorded on the applicable FPPE (Proctoring) form for consistency and inter-rater reliability.

E. Proctoring Data Analysis

The department chair will review the data and provide the Credentials Committee with an interpretation as to whether a practitioner's performance was acceptable, in need of further data to complete the evaluation, or unacceptable.

F. Proctoring Period

Proctoring will begin when privileges are initially granted, whether at the time of initial appointment or the granting of temporary privileges (Bylaws Section6.5-3). Based on the specialty of the practitioner, proctoring shall be for a period of twelve months or for a specific number of cases/procedures as determined by the department chair. The term of proctoring may be extended not more than twelve (12) months, for a total proctoring period of not more than twenty-four (24)) months.

If temporary privileges are granted, there should be submission of proctoring within 60 days of when these privileges were initially granted. Failure to do so may result in not granting any future requests from the department for temporary privileges until the proctoring is current.

In the case of initial appointment or new privilege(s), submission of proctoring should be sixty (60) days after the first day of work (clinical activity) at RUHS.

The medical staff may take into account the practitioner's previous experience in determining the approach and extent of proctoring needed to confirm current competency. The practitioner's experience may fall into one of the following categories:

- RUHS training-program graduate, completing training within the past two (2) years;
- Recent training-program graduate from another facility; or
- Practitioner with experience at another medical center for at least one year and who has satisfactorily completed that institution's proctoring requirements.

G. Results and Recommendations/Actions

At the conclusion of proctoring, the department chair shall provide a summary report to the Credentials Committee that shall include one or more of the following:

- Documentation of a sufficient number of varied cases done at RUHS-MC to properly evaluate the clinical privileges requested.
- If an insufficient number of cases is presented for review, the department chair's opinion whether the proctoring period should be extended for an additional period.
- Reciprocal proctoring to make a recommendation on the privileges requested.
- Documentation of reciprocal proctoring to make a recommendation on the privileges requested.
- If sufficient treatment of patients has occurred to properly evaluate the clinical privileges requested, the department chair's report concerning the appointee's qualifications and competence to exercise the privileges.
- To automatically terminate medical staff membership or particular clinical privilege(s) because of failure to complete the number of minimum cases (Bylaws Section6.5-3) and/or the inability to obtain proctoring information from another institution. This is an administrative action and is not reportable to the NPDB.

If there is a recommendation by the MEC to terminate the practitioner's appointment or additional clinical privileges due to questions about qualifications, behaviors, or clinical competence, the practitioner shall be entitled to the hearing and appeal process outlined in the medical staff bylaws.

V. RESPONSIBILITIES

A. Responsibilities of the Proctor

The proctor(s) must be Active members in good standing of the medical staff of RUHS and should have clinical privileges in the specialty area relative to the clinical privilege(s) to be evaluated. Proctors may not be in a provisional status. The proctor shall:

- Use appropriate methods and tools approved by the Medical Executive Committee.
- Assure the confidentiality of the proctoring results and forms, and deliver the completed proctoring forms to the applicable department chair's office.
- Submit any summary reports or additional information requested by the department chair.

If the practitioner being proctored is not sufficiently available or lacks sufficient cases to complete the proctoring process in the prescribed time frame, the department chair may recommend to the Credentials Committee an extension of proctoring period to complete the report. The extension of proctoring shall not exceed the proctoring period described in this policy and the medical staff bylaws.

If at any time during the proctoring period, the proctor has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), the proctor shall immediately notify the department chair.

B. Responsibilities of the Practitioner Being Proctored

Per the Medical Staff Bylaws, proctoring arrangements shall be the responsibility of the appointee. The practitioner being proctored shall:

- For concurrent proctoring, the practitioner must make every reasonable effort to be available to the proctor, including notifying the proctor of each patient and where the case is to be evaluated, and give the proctor sufficient notice to allow for concurrent observation or review the care provided.
- For elective surgical or invasive procedures where direct observation may be required or the department requires proctoring to be completed before the practitioner can perform the procedure without a proctor present, the practitioner must secure agreement from the proctor to attend the procedure. In an emergency, the practitioner may admit and treat the patient and must notify the proctor as soon as reasonably possible.
- Provide the proctor with information about the patient's clinical history, pertinent physical findings, pertinent lab and radiology results, the planned course of treatment or management, and deliver directly to the proctor a copy of all histories and physicals, operative reports, consultation reports, and discharge summaries documented by the proctored practitioner.
- Have the prerogative of requesting from the department chair a change of proctor if disagreements with the current proctor may adversely affect his/her ability to satisfactorily complete the proctorship. The department chair will keep the Credentials Committee and the MEC informed about changes in proctors.
- Inform the proctor of any unusual incident(s) associated with his/her patients.

C. <u>Responsibilities of the Department Chair/Designee</u>

Each department chair/designee shall:

- The minimum number of cases to be proctored and type of proctoring required shall be made at the time privileges are recommended as established in each departments rules and regulations.
- Identify the practitioners eligible to serve as proctors and assign the proctor(s).

If at any time during the proctoring period, the proctor notifies the department chair/designee that s/he has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), based on the recommendations of the proctor, the department chair/designee shall then review the medical records of the patient(s) treated by the practitioner being proctored and shall:

1. Intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient.
2. Review the case for possible referral to the Professional Practice Evaluation Committee.
3. Submit a report to the Medical Executive Committee that:
    a. Describes the types and number of cases observed, an evaluation of the appointee's performance and a statement with recommendation for Additional or revised proctoring requirements be imposed upon the practitioner; and
    b. Corrective action be undertaken pursuant to applicable corrective-action procedures.

D. Responsibilities of the Department Chair's Support Staff

These activities will be carried out as noted below:

- Department chair or his/her staff will inform the practitioner of the assigned proctor(s).
- Department chair's staff will periodically contact both the proctor and practitioner being proctored to ensure that proctoring is being conducted as required.
- Medical Staff Administration Department staff will submit a monthly proctoring status report to the Credentials Committee and the department chairs related to proctorship activity.

E. Responsibilities of the Credentials Committee

The Credentials Committee shall:

- Have the responsibility of monitoring compliance with this policy and procedure.
- Review at each meeting status reports related to the progress of all practitioners requiring proctoring, as well as any issues or problems involved in implementation of this policy and procedure.
- Make recommendation to the MEC regarding clinical privileges based on information obtained from the proctoring process.

F. Failure to Complete Proctoring Requirements

Failure to complete the minimum number of cases and/or furnish the certification required, the appointee's medical staff membership or particular clinical privilege, as applicable, shall be automatically terminated. The initial appointee shall receive written notice that the MEC has recommended automatic termination of medical staff membership/clinical privileges based on failure to satisfactorily complete the proctoring requirements. This is not a reportable action to the National Practitioner Data Bank.

Reference:
Medical Staff Bylaws, Sections 6.5-1, 6.5-3 and 6.5-4
Professional Practice Evaluation Plan
Joint Commission Standard MS.4.30

Document History:

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Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
04/2024	Medical Staff Director	Yes	The term of proctoring may be extended not more than twelve (12) months, for a total proctoring period of not more than twenty-four (24)) months. Formatting
4/26/2024	Credentials Committee	Y	F. proctoring shall be for a period of twelve months
5/9/2024	Medical Executive Committee	N	

Riverside University Health System Medical Center
MEDICAL STAFF ORGANIZATION

Subject: **MEDICAL STAFF WELL BEING COMMITTEE POLICY**	Issued: 12/10/20 Revised: 3/14/24 MEC: 3/14/24 09/9/2021 Revised 09/09/21; 3/14/24 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 CENTER

Medical Staff Office

	Document No: [Subject]	Page 1 of 3
Title: Scope of Services – Medical Staff Administration	**Effective Date:** 4/8/21 Revise: 5/9/24	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☐ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☒ **Departmental**
Approved By: Medical Executive Committee		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. Scope

   1.1 The Medical Staff Administration (MSA) Department of Riverside University Health System (RUHS) provides credentialing and privileging services to the Medical Staff and Allied Health Professional (AHP) staff in a professional and timely manner. The MSA Staff serve as content experts for all things related to the Organized Medical Staff, Regulatory Compliance, Survey Readiness, Bylaws, and Medical Staff Policies & Procedures.

   1.2 Services include all clinical sites within Riverside University Health System.

   1.3 Confidentiality of protected information related to clinicians, patients and the organization is strictly maintained.

2. Days/Hours of Operation

   2.1 The Medical Staff Administration Department provides services during the hours of 7:30 a.m. to 5:00 p.m., Monday through Friday. Staff also provide clerical, administrative and professional support for Medical staff meetings and events.

3. Customers Served

   3.1 Services are provided to the Chief Medical Officer, the Medical Staff and Allied Health Staff at RUHS, and employees of RUHS.

4. Staffing. Medical Staff Administration staffing includes:

   4.1 Director, Medical Staff Administration Services

   4.2 Medical Staff Coordinator positions which provide support in Credentialing/Privileging, FPPE/OPPE, and/or Provider Enrollment services for the following facilities:

      a. RUHS Medical Center (RUHS-MC)

      b. Community Health Center (CHC)

      c. Behavioral Health (BH)

      d. Detention Health (DH)

      e. Public Health (PH)

   4.3 Executive Assistant position for Medical Staff Administration Department

4.4 Executive Assistant positions and Office Assistants III positions exist, under oversight of RUHS Administration for each of the following Clinical Departments – providing support to Department Chairs/staff physicians.

a. Anesthesiology and Perioperative Medicine

b. Emergency Medicine

c. Family Medicine

d. Medicine and Divisions

e. Neurological Services

f. Obstetrics and Gynecology

g. Ophthalmology

h. Orthopaedic Surgery

i. Pediatrics and Divisions

j. Surgery and Divisions

4.5 There are few staffing variances for the Medical Staff Administration Department, with the exception of vacations and holidays.

4.6 Executive Assistant positions also exist, under oversight of other RUHS Departments, for the support of Department Chairs/physicians of the following clinical departments:

a. Pathology

b. Psychiatry

c. Radiology

5. Qualifications of Staff

5.1 Job descriptions outline the physical demands, required license(s) and certification(s) and working conditions for each category of jobs in the Medical Staff Administration Department.

5.2 All employees are required to complete and maintain hospital-wide required competencies as indicated by hospital policy, and to maintain certifications as applicable.

6. Standards of Practice

6.1 Medical Staff Administration employees demonstrate professional conduct which reflects the values, principles, and standards of RUHS Mission and Vision, as well as meeting all Behavioral Expectations of RUHS employees.

6.2 Medical Staff Administration employees shall NOT disclose confidential medical staff or peer review information per Medical Staff Bylaws, Confidentiality of Staff Records and as per the protection of medical staff records under Section 1157.

7. Department Goals

7.1 The Medical Staff Administration Department will aid in advancing RUHS as a leader among high quality providers. The department will assist the medical staff, administrative leaders, and hospital staff with a personalized, compassionate approach to patient care needs.

7.2 The Medical Staff Administration Department will support RUHS with dedication, honesty, integrity, respect, and collaboration. The Department will adhere to the highest standards in relationships with patients, co-workers, community, Medical and Allied Health Staff, to be deserving of their support and trust. The Department will work as an educated, informed, competent, and unified team in a workplace characterized by creativity and growth.

8. Performance Improvement

8.1 Performance improvement activities are to enhance existing processes and outcomes and continue to improve.

8.2 Performance improvement activities at RUHS are consist with the commitment of the hospital to provide the highest quality, comprehensive care to the community served. Improving quality of care is accomplished by identifying those issues that are high risk, high volume, problem prone, and high cost related to the care and services provided.

8.3 Performance monitoring and improvement activity processes are prioritized and based on aggregated and analyzed data.

8.4 Outcomes are consistently evaluated to determine effectiveness and provide feedback for improving care.

8.5 Hospital wide indicators that may involve individual departments are developed annually and assigned to the appropriate departments for data gathering and monitoring. (Refer to Professional Practice Evaluation Program document)

Document History:

Prior Release Dates: 4/2021	**Retire Date:** N/A		
Document Owner: Medical Staff Office	**Replaces Policy:** N/A		
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
4/2021	MEC	N	
4/2024	Medical Staff Director	Y	
4/26/2024	Credentials Committee	Y	Revise Secretary title to Executive Assistant Delete section 4.4; formatting
5/9/24	MEC	N	

Riverside University HEALTH SYSTEM

MEDICAL STAFF SERVICES/ADMINISTRATION

SUBJECT: RUHS MEDICAL STAFF/ ALLIED HEALTH STAFF INITIAL APPLICATION

Dear Applicant

Thank you for your interest in applying to Riverside University Health System – Medical Center (MC), Community Health Centers (CHC), and/or Behavioral Health (BH). Please use the following checklist below to gather required documents for the credentialing and provider enrollment process. You will be provided with additional instructions once your online application has been authorized.

- ☐ *NON-REFUNDABLE Application fee (**Medical Staff $600; AHP Staff $100**. Make check **payable to RUHS Medical Staff Fund**). The application will not be processed until the application fee is received.
- ☐ **Live Scan - RUHS requires Live Scan background checks on all Medical Staff and Allied Health Professional applicants**.
- ☐ Recent JPEG photograph
- ☐ Government issued Id
- ☐ Current curriculum vitae education, training and work history **must be in month/year to month/year format**
- ☐ Time Gaps greater than 6 months require written explanation
- ☐ Copy of ECFMG (if applicable)
- ☐ Copy of Board Certification
- ☐ Copy of Current CA medical license, (Fluoroscopy Certificate, American Heart Association ACLS, ATLS, BLS, NRP) *if applicable*
- ☐ DEA Certificate (if applicable) must have a California Address - DEA with an exempt fee is only valid at the exempting institution. If you are not treating RUHS patients at that facility, the provider needs to obtain a paid status DEA. Changes and updates to the DEA can be made at: DEA Diversion Control Division: https://www.deadiversion.usdoj.gov/
- ☐ Copy of Current Malpractice Insurance Certificate that shows dates and amount of coverage *(Must provide insurance carrier information for the past 5 years for each employer you were covered by for verification purposes)*
- ☐ *Reappointment Training for Physicians / Providers 2024 Moodle dept. specific bundle https://www.ruhstraining.org*
- ☐ *HealthStream HIPAA, RUHS Compliance, EMTALA Online Training for Practitioners (instructions provided after import)*
- ☐ *Mandatory CPI Non-Violent Crisis Intervention Training - **MANDATORY** for all practitioners (See MD App for instructions on Website training.) – Please direct any questions regarding this training to Nichole Walker, MA (951) 486-7609.*
- ☐ *Informed Consent Online training (NP's, PA's & CRNA's only) (See MD App for instructions on Website training.)*
- ☐ Clinical Delineation of Privilege Form *(MD App),* **except for Adjunct and Administrative Staff Category** *Carefully review the privilege delineation form for your specialty.
- ☐ Submit clinical activity log (prior experience) for the past two years as noted on the privilege form for each privilege being requested based on requirements listed. Activity log must be generated by the respective facility and include facility name, applicant name, timeframe, and privileges/procedures performed.
- ☐ *If you are requesting Moderate Sedation privileges you must successfully complete Moderate Sedation on-line course with a passing grade (85%) on the moderate sedation exam. *(See MD App for Website instructions.)*
- ☐ CCS/GHPP Individual Health Care Professional Paneling Instructions Sheet (*If applicable, based on privilege form, register directly at* https://cmsprovider.cahwnet.gov/PANEL/index.jsp)
- ☐ Security and Confidentiality Statement Form *(MD App DocuSign)*
- ☐ Remote Access & Mobile Agreement Form *(MD App DocuSign)*
- ☐ Medical Staff Bylaws & Attestation Form *(MD App DocuSign)*
- ☐ Health Status Form *(MD App DocuSign)*
- ☐ Occupational Health Letter must provide Occupational Health with current TB, MMRV, & Titers records *(MD App DocuSign)*
- ☐ Professional Liability Action Explanation Form / Addendum B (*MD App DocuSign, must be signed even if no claims.)*
- ☐ Medicare Acknowledgment Statement *(MD App DocuSign)*
- ☐ CME Attestation Form (*MD App DocuSign*)

If we can be of further assistance, below is a Medical Staff Coordinator Department List.

Sincerely,

RUHS Medical Staff Administration

26520 Cactus Avenue, Moreno Valley, Ca 92555
TELEPHONE: 951-486-5913 FAX: 951-486-5911 TDD: 951-486-4397

Medical Staff Coordinator Department List

Veronica Mosquera – Phone (951) 486-4457 Fax: (951) 486-5911 email: **v.mosquera@ruhealth.org**
Anesthesiology
Emergency Medicine
Medicine/Subspecialty Divisions
Ophthalmology
Orthopedic Surgery
Neurological Sciences

Sandra Ortiz - Phone: (951) 486-4449 Fax: (951) 486-5911 email: sa.ortiz@ruhealth.org
OB/GYN
Pathology
Surgery / Subspecialty Divisions

Karen Wickman - Phone (951) 486-5022 Fax: (951) 571-8940 email: **k.wickman@ruhealth.org**
Community Health Centers
Family Medicine
Pediatrics/Subspecialty Divisions
Detention Health

Judith Gonzalez – Phone: (951) 486-5435 Fax: (951) 571-8943 email: **ju.gonzalez@ruhealth.org**
Psychiatry
Radiology

Amy Brown – Phone (951) 486-4767 Fax: (951) 486-5911 email: **A.Brown@ruhealth.org**
Provider Enrollment
Behavioral Health Clinics A-M Alpha

Julio Curiel - Phone (951) 486-4802 Fax: (951) 571-8945 email: **j.curiel@ruhealth.org**
Provider Enrollment
Behavioral Health Clinics N-Z Alpha

Brenda Butler-O'Neal – Phone: (951) 486-64474 Fax: (951) 486-5911 Email: **b.butler@ruhealth.org**
FPPE/Proctoring
OPPE
Data Analyst

Riverside University HEALTH SYSTEM Medical Center

MEDICAL STAFF BYLAWS

AND

Rules and Regulations

2024 - 2025

RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER
MEDICAL STAFF BYLAWS, RULES AND REGULATIONS
2023-2024

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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

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, Certified Registered Nurse Anesthetist, 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. CHIEF OF MEDICAL STAFF or CHIEF OF STAFF means the chief administrative officer of the medical staff.

3. 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.

4. 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.

5. 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.

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

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

8. 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 Hospital Director's authorized representative.

9. 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.

10. 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.

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

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

13. 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.

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

15. 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.

16. 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.

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

18. 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 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.

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 Hospital Director.

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) Document their current licensure, experience, background, training, demonstrated ability, current professional competence and good judgment 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.

b) 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.

(c) 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;

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

(e) 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.

(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 amount satisfactory to the County of Riverside's Risk Management department.

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 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for honorary, retirees and Administrative members, all other members 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 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), payment of medical staff dues (Section 15.5), acceptance of principles (Section 15.8), and refraining from division of fees (Section 15.9).

(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) Complete and document a medical history and physical examination in accordance with the Medical Staff Rules and Regulations performed within (30) days prior to a patient's admission or within 24 hours after 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 examination of the patient, including any changes in the patient's condition, must be completed and documented by a Doctor of Medicine, osteopathy, surgeon, oral or maxillofacial surgeon, doctor of podiatry medicine or other qualified licensed practitioner, who has been granted privileges at RUHS MC.

(h) Aid in any educational programs for medical staff members, medical students, 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) 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 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 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.

3.6 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.

3.7 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:

3.7-1 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.

3.7-2 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 always behave in a professional manner 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.

3.8 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, honorary, 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 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) 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) 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 at the hospital during each medical staff year. Courtesy members whose activity meets the minimum volume set forth in 4.4-1 (b) may apply and qualify for active 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 HONORARY STAFF

4.5-1 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.

4.5-2 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.

4.5-3 RESPONSIBILITIES

Honorary staff members shall meet the basic responsibilities specified in Section 3.6, Paragraphs (c), (k), (m), (p), (r), and (s).

4.6 ADJUNCT STAFF

4.6-1 QUALIFICATIONS

The adjunct staff shall consist of practitioners who do not have clinical privileges.

4..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.

4.6-3 RESPONSIBILITIES

Adjunct staff members shall meet the basics 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 PER DIEM RESIDENT/MOONLIGHTING STAFF

4.7-1 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);

(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.

4.7-2 PREROGATIVES

(a) 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) 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.

(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.

4.8 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.

4.8-1 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 are professionally and ethically competent to exercise their duties.

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 cannot be a voting member of the Medical Executive Committee.

4.8-2 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.

4.8-3 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

4.8-3 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.

4.8-4 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.

4.8-5 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 Vll. (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.

4.8-6 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 3.5 (Basic Responsibilities of Medical Staff Membership) and 6.5 (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 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 Hospital Director 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

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.

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. 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 Hospital 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 Hospital Director 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 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.

(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 Hospital Director, 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.

6.3-11 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.

6.3-12 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 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

6.41 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 Hospital Director, 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 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.

6.4-9 CHANGES BETWEEN ROUTINE REAPPOINTMENT DATES

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 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.

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) months, for a total proctoring period of not more than twenty-four (24)) months. If an initial appointee fails within that period to complete the minimum number of cases 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 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.

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 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 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 Hospital Director 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 Evaluation (FPPE). The FPPE Policy describes the process and procedures to be followed.

8.1-3 EXTERNAL PEER REVIEW

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.

8.1-4 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.

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 8.16, 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 Governing Board, 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 Hospital Director 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 Governing Board, Hospital Director, Medical Executive Committee, the chair and vice chair of each department concerned, and the practitioner.

(c) If any proposed corrective action by the Governing Board 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 Governing Board determine that the Medical Executive Committee's failure to investigate, or initiate disciplinary action, is contrary to the weight of the evidence, the Governing Board 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 Governing Board, the Governing Board, 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 Governing Board. If such action is one of those set forth in Section 9.2, the Governing Board 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.

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 Governing Board, the Medical Executive Committee and the Hospital Director. 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.

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) involuntary change in medical staff category or membership status;
(d) suspension of medical staff membership;
(e) revocation of medical staff membership;
(f) denial of requested clinical privileges;
(g) involuntary restriction of clinical privileges;
(h) suspension of all clinical privileges;
(i) termination of all clinical privileges;
(j) 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
(k) 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 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 arbitrator 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 the Arbitrator 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 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 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 relying 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.

9.4-6 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.

9.4-7 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.

9.4-8 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.

9.4-9 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.

9.5 EXCEPTIONS TO HEARING RIGHTS

9.5-1 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.

9.5-2 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.

9.5-3 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.

9.5 4 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, Plastic Surgery, 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 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 Hospital Director 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 Hospital 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.

11.22 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.

11.23 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.

11.2-6 MEMBER AT LARGE, CREDENTIALS COMMITTEE

The Member at Large, Credentials Committee shall:

(a) Be a voting member, who does not hold a defined position within the medical staff. Instead, they serve as a general committee member without specific committee responsibilities unless assigned by the chair. The purpose of the Member at Large position is to represent and advocate for the medical staff distinct from the Departmental Chairs / Vice Chairs. Member at Large is separate from ex officio committee members, who typically don't have voting rights."

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 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 Hospital Director.
(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 (l0%) 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

13.21 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.

13.22 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

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. 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.

(d) 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 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.

15.3 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 8.3-5 (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.

15.4 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 Hospital Director. 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.

15.5 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.

15.6 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.

15.7 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.

15.8 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. . In the case of notice to the, medical staff or its officers or committees, the notice shall be addressed as follows:

Official MS email address

Notices to, applicant, or other party shall be to the addressee at the address as it last appears on the official records of the medical staff. If personally delivered, such notice shall be effective upon delivery. If sent via US postal mail, such notice shall be effective two (2) days after it is placed in the mail.

15.9 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 6, 2024

Shunling Tsang, MD
Chief of Medical Staff

Sara Edwards, MD
Chief of Medical Staff-Elect

APPROVED by the Governing Board on 5/9/2024
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.

4. **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.

5. **Autopsies**. All autopsies shall be obtained as specified in the, 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.

6. **Clinic Patients**. Service patients referred to the hospital clinic solely for diagnostic laboratory studies shall be followed as hospital clinic patients.

7. **Consultation Criteria**.

Inpatient Consultation Criteria. The primary service shall request consultation as required for optimal patient care. In addition, each consulting department may identify 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.

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 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, 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. **Medical History and Physical for Inpatient and Outpatient Services**. A 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 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.

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.

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.

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 OR, Operating Room Scheduling and Block Time Utilization.) .)

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 Telephone and Verbal Orders .)

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.

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.. Case reports may be submitted to the IRB if the

author(s) would like a letter from the IRB to accompany their journal submission. 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 or 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

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.

29. **Research Projects**. Medical staff members, 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. . Closure of a research project must be reported to the IRB. within the during which the research was terminated. Retrospective Record Reviews with an outside source of funding shall not be undertaken without first obtaining approval of the RUHS MC IRB.

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(Restraints and/or Seclusion) and shall apply to all units using restraint and/or seclusion.

32. **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.

33. **Suicide.** An attempted suicide or chemical overdose patient shall be offered psychiatric consultation and it will be documented in the patient's medical record.

34. **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.

35. **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.

36. **Symbols and Abbreviations**. Only symbols and abbreviations contained in Stedman's Medical Dictionary shall be regularly used. A list of symbols and abbreviations designated as "Do Not Use" by the Joint Commission because of potential dangerousness shall be maintained by the Medical Records Department and shall be available to those authorized to make entries in the medical record.

37. **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.

38. **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 policy 701 - Chart Completion .

Riverside University HEALTH SYSTEM

MEDICAL STAFF SERVICES/ADMINISTRATION

SUBJECT: RUHS MEDICAL STAFF/ ALLIED HEALTH STAFF RE- APPLICATION

Dear Provider:

Thank you for your interest in re-applying to Riverside University Health System – Medical Center (MC), Community Health Centers (CHC), and/or Behavioral Health (BH). Please use the following checklist below to upload required documents listed to MD App under Files.

Please complete the **Riverside University Health System (RUHS)** re-application for the current reappointment period. **It is important that you take the time to review and submit the completed reapplication and supporting documents, including those listed below to Medical Staff Administration Department in order for us to begin processing your reapplication:**

NON-REFUNDABLE Reapplication fee **(Medical Staff $250; AHP Staff $100). Make check payable to RUHS Medical Staff Fund.** The application will be considered **incomplete** if the reapplication fee is not received within 2 weeks of the reappointment being submitted.

- ☐ Current curriculum vitae **must be in Month/Year format** (upload)
- ☐ Current Government issued Id (upload)
- ☐ Recent JPEG photo
- ☐ Copy of DEA Certificate (upload)
- ☐ Copy of Fluoroscopy Certificate,
- ☐ American Heart Association ACLS/BLS/PALS/ATLS/NRP, etc. (if applicable) (upload)
- ☐ Copy of Current Malpractice Insurance Certificates other than County Risk (for the past two years) that shows dates and amount of coverage (upload)
- ☐ Reappointment Training for Physicians / Providers 2024 Moodle dept. specific bundle https://www.ruhstraining.org (upload)
- ☐ HealthStream HIPAA, RUHS Compliance, EMTALA Online Training for Practitioners http://www.healthstream.com/hlc/ruhs (upload)
- ☐ Informed Consent Online Training (NP's, PA's & CRNA's only) (Instructions via MD App) (upload)
- ☐ Upload Clinical Activity as noted on the privilege form for each privilege being requested. Department specific clinical activity templates are available in the Medical Staff Office and you may request a specific template via email from your coordinator. Activity logs from outside RUHS must be generated by the respective facility and include facility name, applicant name, timeframe, and privileges/procedures performed.
- ☐ *At the time of reappointment if you wish to maintain Moderate Sedation privileges you are required to have completed a minimum of four sedation cases during your appointment period AND review and complete the RUHS on-line course at www.rcrmctraining.org with a passing grade (85%) on the moderate sedation online exam. (upload)
- ☐ Clinical Delineation of Privilege Form (available on MD App), **except for Adjunct Staff Category**
  *Carefully review the privilege delineation for your specialty.
- ☐ Health Status Form (MD App)
- ☐ Occupational Health Letter (MD App) – Must be cleared by RUHS Occupational Health
- ☐ Professional Liability Action Explanation Form / Addendum B (MD App, must be signed even if no claims)
- ☐ CME Attestation Form (MD App) or Continuing Medical Education/Continuing Education Units (CME/CEU) as required by licensure by the applicable California Board or required per delineation of privilege.

****NOTE: Failure to submit a complete reapplication and delineation privilege within 60 days of reappointment the RUHS Medical Staff Administration Department may considered you as a non-reappointment at the end of the current reappointment period.**

If we can be of further assistance, below is a Medical Staff Coordinator Department List.

Sincerely,

Medical Staff Administration
RUHS

26520 Cactus Avenue, Moreno Valley, California 92555
TELEPHONE: 951-486-5913 • FAX: 951-486-5911 • TDD: 951-486-4397

Revised 2/2021; 3/2021; 2/15/23; 4/20/23; 6/12/23; 3/21/24

Riverside University HEALTH SYSTEM

Medical Staff Coordinator Department List

Veronica Mosquera – Phone (951) 486-4457 Fax: (951) 486-5911 email: **v.mosquera@ruhealth.org**
Anesthesia
Emergency Medicine
Medicine/Subspecialty Divisions
Ophthalmology
Orthopedic Surgery
Neurological Sciences

Sandra Ortiz - Phone: (951) 486-4449 Fax: (951) 486-5911 email: sa.ortiz@ruhealth.org
OB/GYN
Pathology
Surgery / Subspecialty Divisions

Karen Wickman - Phone (951) 486-5022 Fax: (951) 571-8940 email: **k.wickman@ruhealth.org**
Community Health Centers
Family Medicine
Pediatrics/Subspecialty Divisions
Detention Health

Judith Gonzalez – Phone: (951) 486-5435 Fax: (951) 571-8943 email: **ju.gonzalez@ruhealth.org**
Psychiatry
Radiology

Amy Brown – Phone (951) 486-4767 Fax: (951) 486-5911 email: **A.Brown@ruhealth.org**
Provider Enrollment
Behavioral Health Clinics A-M Alpha

Julio Curiel - Phone (951) 486-4802 Fax: (951) 571-8945 email: **j.curiel@ruhealth.org**
Provider Enrollment
Behavioral Health Clinics N-Z Alpha

Brenda Butler-O'Neal – Phone: (951) 486-64474 Fax: (951) 486-5911 Email: **b.butler@ruhealth.org**
FPPE/Proctoring
OPPE
Data Analyst