



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



ITEM: 18.3

(ID # 27262)

MEETING DATE:

Tuesday, March 11, 2025

FROM : RUHS-MEDICAL CENTER

SUBJECT: RIVERSIDE UNIVERSITY HEALTH SYSTEM-MEDICAL CENTER: Ratify and Approve Medical Staff Appointments, Reappointments, Clinical Privileges, Proctoring, Change of Status, Additional Privileges, Withdrawal of Privileges, Leave of Absences, Resignations/Withdrawals, Automatic Termination, and Policies, Plans and Procedures, as Recommended by the Medical Executive Committee on July 11, 2024, August 8, 2024, September 12, 2024, October 10, 2024, November 14, 2024 and December 12, 2024, All Districts. [\$0].

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve medical staff appointments, reappointments, clinical privileges proctoring, change of status, additional privileges, withdrawal of privileges, leave of absence, resignations/withdrawals, automatic termination, and policies, plans and procedures as recommended by the Medical Executive Committee on July 11, 2024, August 8, 2024, September 12, 2024, October 10, 2024, November 14, 2024 and December 12, 2024.

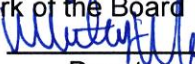
ACTION:Policy


Jennifer Cruikshank, Chief Executive Officer - Health System 2/25/2025

MINUTES OF THE GOVERNING BOARD

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

Ayes: Medina, Spiegel, Washington, Perez and Gutierrez
Nays: None
Absent: None
Date: March 11, 2025
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: FY24/25	

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 July 2024 through December 2024, 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 July 11, 2024, August 8, 2024, September 12, 2024, October 10, 2024, November 14, 2024, and December 12, 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 Partial Proctoring Complete Request for Extension, FPPE–Final Proctoring for Additional Privileges, Additional Privileges/Withdrawn Privileges, Change in Staff Reappointment Dates, Change in Staff Category, Automatic Termination, 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 (July 1, 2024, through December 31, 2024)
ATTACHMENT B	DEA WAIVER-AGREEMENT 10.10.24
ATTACHMENT C	MED_IM_SUBSPECIALTY_CLINICAL_PRIVILEGES 11.14.24
ATTACHMENT D	MSO PRACTITIONER REENTRY PLAN MEDICAL STAFF EXHIBIT 1 & 2 7.11.24
ATTACHMENT E	MSO PRACTITIONER REENTRY POLICY PLAN & PROCEDURE MEDICAL STAFF 7.11.24
ATTACHMENT F	MSWBC.BROCHURE_5.5X8.5_FINAL-PRINT
ATTACHMENT G	PI PLAN 2024-2025 FINAL APPROVED
ATTACHMENT H	RUHS UM PLAN 2024-2025 - APPROVED BY UMC 6-27-24 - GT REVIEW 9-12-24

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

Jacqueline Ruiz
Jacqueline Ruiz, Principal Analyst 3/4/2025

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 06/28/2024
MEC DATE: 07/11/2024
BOARD DATE: 07/11/2024

Date: July 11, 2024

To: File

From: Medical Staff Executive Committee

Subject: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – July 11, 2024 – June 30, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Alkotob, Umrom R., DO	Provisional	Emergency Medicine	Emergency Medicine	Eligible
Arfeen, Safa, MD	Provisional	Ophthalmology	Ophthalmology	Eligible
Camacho-Santos, Armando, MD	Provisional	Internal Medicine	Medicine	Eligible
Gau, Alexander J., DO	Provisional	Emergency Medicine	Emergency Medicine	Eligible
Haase, Tyler, MD	Provisional	Internal Medicine	Medicine	Eligible
Lewsadder, Charles W., DO	Provisional	Emergency Medicine	Emergency Medicine	Eligible
Jin, Ji Sung, MD	Provisional	Psychiatry	Psychiatry	Eligible
Liang, Ellen DO	Provisional	Family Medicine	Family Medicine	Family Medicine
Lu, Jackson, DO	Provisional	Emergency Medicine	Emergency Medicine	Eligible
McCain, Joshua, MD	Provisional	Teleradiology	Emergency Medicine	Diagnostic Radiology
Patel, Raj A., DO	Provisional	Emergency Medicine	Emergency Medicine	Eligible
Paulos, Riva, CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	NBCRNA
Reiner, David, MD	Provisional	Teleradiology	Radiology	Diagnostic Radiology
Salaiz, Oscar D., DO	Provisional	Emergency Medicine	Emergency Medicine	Eligible
Shiah, Kevin P., DO	Provisional	Internal Medicine	Medicine	Eligible
Tom, Jonathan N., DO	Provisional	Emergency Medicine	Emergency Medicine	Eligible
Uyesugi, Walter, DO	Provisional			

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 06/28/2024
MEC DATE: 07/11/2024
BOARD DATE: 07/11/2024

REAPPOINTMENTS – June 1, 2024 – May 31, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT	BOARD STATUS
Baker, Nancy A., MD	Active	Neurology	Medicine/Neurology	Neurology Clinical Neurology
Balsamo, Dalia N., MD	Administrative	Psychiatry	Psychiatry	Psychiatry Child & Adolescent Psychiatry Forensic Psychiatry Addiction Medicine
Brenner, Meagan L., MD	Active	Surgical Critical Care	Surgery/Vascular	Surgery
Cacho, Bradley J., MD	Active	Neonatology	Pediatrics	Neonatal-Perinatal Medicine Pediatrics
Chamberlin, David A., MD	Active	Urology	Surgery/Urology	Urology/Ped Urology
Chamberlin, Joshua D., MD	Active	Urology	Surgery/Urology	Urology/Ped Urology
Chau, Minh-Hang T.,	Courtesy	Urology	Surgery/Urology	Urology/Ped Urology
Choudhury, Baishakhi, MD	Active	Otolaryngology	Surgery/Head & Neck Otolaryngology	Otolaryngology/Neurotology
Cohen, Mallory E., MD	Active	Gastroenterology	Pediatrics	Pediatrics Pediatric Gastroenterology
Cramer, Anthony M., PA	AHP	Physician Assistant	Orthopedic Surgery	NCCPA
Douglawi, Antoin, MD	Active	Urology	Surgery/Urology	Urology
Floresca, Jon W., MD	Active	Interventional Radiology	Radiology	Diagnostic Radiology
French, Michael H., DO	Active	Orthopedic Surgery	Orthopedic Surgery	Orthopedic Surgery
Genobaga, Christopher G., MD	Active	Ob-Gyn	Ob-Gyn	Ob-Gyn
Hofmann, Martin R., MD	Active	Urology	Surgery/Urology	Urology
Kidd, Stephanie C., MD	Active	Otolaryngology	Surgery/Head & Neck Otolaryngology	Otolaryngology
Larco, Kathlyn T., PA	AHP	Physician Assistant	Clinical Neurological Sciences	NCCPA
Leong, Beatriz V., MD	Active	Vascular Surgery	Surgery/Vascular	General Surgery/Vascular
Loeb, Joshua, D., MD	Active	Neurology	Pediatrics	Neurology with Special Qualifications in Child Neurology Epilepsy
Losey, Travis E., MD	Active	Neurology	Medicine/Neurology	Neurology Clinical Neurophysiology
Martinez, Juan J., MD	Active	Critical Care Medicine	Pediatrics	Pediatrics Pediatric Critical Care
Nguyen, Christopher V., MD	Active	Diagnostic Radiology	Radiology	Diagnostic Radiology Neuroradiology

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 06/28/2024
MEC DATE: 07/11/2024
BOARD DATE: 07/11/2024

Nguyen, Khahn K., MD	Active	Otolaryngology	Surgery/Head & Neck Otolaryngology	Otolaryngology
Peterson, Nancy, NP	AHP	Nurse Practitioner	Emergency Medicine	AANP
Rhee, Alice MD	Active	Pediatrics	Pediatrics	Pediatrics Pediatric Hospital Medicine
Sauceda, Uziel I., MD	Active	Family Medicine	Family Medicine	Family Medicine Sports Medicine
Schoepflin, Charles W., MD	Active	Anesthesia	Anesthesia	Anesthesiology
Skoretz, Lynetta E., MD	Active	Internal Medicine	Medicine	Internal Medicine
Teitelbaum, George P., MD	Active	Neuroradiology	Radiology	Interventional and Diagnostic Radiology Neuroradiology
Thomson, Bryan D., DO	Active	Diagnostic Radiology	Radiology	Diagnostic Radiology
Tom, Michelle., MD	Active	Psychiatry	Psychiatry	Psychiatry
Tsai, Janice, MD	Active	Pediatrics	Pediatrics	Pediatrics Pediatric Hospital Medicine
Waheed, Osmond, MD	Active	Psychiatry	Psychiatry	Psychiatry
Yang, Almira J., DO	Active	Endocrinology	Medicine/Endocrinology	Internal Medicine Endocrinology

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Dadani, Farhan, MD	Provisional	Internal Medicine	Medicine	Remain on Provisional until Eligible for Advancement
Duan, Sarah, DO	Provisional	Family Medicine	Family Medicine	Remain on Provisional until Eligible for Advancement
Kim, Cherine H., MD	Provisional	Otolaryngology	Surgery/Head & Neck Otolaryngology	Remain on Provisional until Eligible for Advancement
Patil, Shakuntala S., MD	Provisional	Nephrology	Medicine/Nephrology	Remain on Provisional until Eligible for Advancement
Pedouim, Farzin B., MD	Provisional	Neurology	Medicine/Neurology	Remain on Provisional until Eligible for Advancement

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Eichenberg, Brian J., MD	Provisional	Plastic Surgery	Surgery/Plastic Surgery	Advance to Active Status
Giang, Michael, MD	Provisional	Pediatrics	Pediatrics/Critical Care Medicine	Advance to Active Status
Kumar, Vikram, MD	Provisional	Pediatrics	Pediatrics	Advance to Active Status
Mattheis, Jay K, MD	Provisional	Ophthalmology	Ophthalmology	Advance to Active Status
Sheski, David E. MD	Provisional	Psychiatry	Psychiatry	Advance to Active Status
Stevens, Paige, MD	Provisional	Pediatric Critical Care Medicine	Pediatric/Critical Care Medicine	Advance to Active Status

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 06/28/2024
MEC DATE: 07/11/2024
BOARD DATE: 07/11/2024

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Contreras, Jessica V., NP	AHP-Provisional	Nurse Practitioner	Emergency Medicine	Complete
Reyes, Gina, CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete
Romero, Lidia, Aud	AHP-Provisional	Audiology	Surgery/Head & Neck Otolaryngology	Complete

FPPE PARTIAL PROCTORING COMPLETE REQUEST FOR EXTENSION

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Darioosh, Roya P., DO	Provisional	Internal Medicine	Medicine	Pending • ACCU

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
None				

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Dadani, Farhan, MD	Provisional	Internal Medicine	Medicine	Withdraw of Privilege: • Ambulatory
Heath, Doris, NP	AHP-Provisional	Nurse Practitioner	Clinical Neurological Sciences Anesthesia/ Perioperative Services/Pain Management	Additional Privileges: • Perioperative Services/Pain Medicine Privileges (Dept. Of Anesthesia)
Patil, Shakuntala S., MD	Provisional	Nephrology	Medicine/Nephrology	Withdraw of Privilege: • Ambulatory
Reyes, Gina, CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Withdraw of Privilege: • Ambulatory

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Akanda, Marib I., MD	Provisional	Ophthalmology	Ophthalmology	Advance to Active Status
Cleland, Derick A. DO	Provisional	Internal Medicine	Medicine	Advance to Active Status
Edwards, Mark S., MD	Provisional	Neurology	Medicine/Neurology	Advance to Active Status
Goldman, Matthew A., MD	Provisional	Ophthalmology	Ophthalmology	Advance to Active Status
Loyola, Kevin, MD	Provisional	Neurology	Medicine/Neurology	Advance to Active Status
Mejaddam, Ali Y., MD	Provisional	Pediatric Surgery	Surgery	Advance to Active Status
Nguyen, Brian H., MD	Provisional	Neurology	Medicine/Neurology	Advance to Active Status
Nguyen, Thai H., DO	Provisional	Internal Medicine	Medicine	Advance to Active Status
Schmitz, Joseph W., MD	Provisional	Ophthalmology	Ophthalmology	Advance to Active Status

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

MEDICAL EXECUTIVE COMMITTEE GOVERNING BOARD

CRED DATE: 06/28/2024
MEC DATE: 07/11/2024
BOARD DATE: 07/11/2024

Shafizadeh, Stephen F., MD	Provisional	Neurological Surgery	Clinical Neurological Sciences	Advance to Active Status
Starkey, Marc N., MD	Provisional	Neurology	Medicine/Neurology	Advance to Active Status
Trinh, Viet, DO	Provisional	Anesthesia	Anesthesia	
Yang, Eric., PA	AHP-Provisional	Physician Assistant	Surgery	Returning from 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
Burciaga, Calderoni, Constanza, MD	Active	Pediatrics	Pediatrics	Voluntary Resignation 07/17/2024
Chaves, Kristen N., MP	AHP-Provisional	Nurse Practitioner	Surgical/Critical Care	Voluntary Resignation 09/01/2024
Cleland, Derrick A., DO	Provisional	Internal Medicine	Medicine	Voluntary Resignation 07/01/2024
Nguyen, Thai H. DO	Provisional	Internal Medicine	Medicine	Voluntary Resignation 07/01/2024
Truong, Alexander H., MD	Provisional	Psychiatry	Psychiatry	Voluntary Resignation 06/05/2024
Tsang, Alexander H., MD	Provisional	Psychiatry	Psychiatry	Voluntary Resignation 06/05/2024

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 06/28/2024
MEC DATE: 07/11/2024
BOARD DATE: 07/11/2024

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

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 08/23/2024
MEC DATE: 09/12/2024
BOARD DATE: 09/12/2024

Date: September 12, 2024
To: File
From: Medical Staff Executive Committee
Subject: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – September 12, 2024 – August 31, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Artounian Milagerdi, Rita, PA	Provisional	Physician Assistant	Clinical Neurological Sciences	NCCPA
Calaguas, Shannon O., MD	Provisional	Surgery	Surgery/Head & Neck/Otolaryngology	Eligible
Choi, Da-Eun MD	Provisional	Pediatrics	Pediatrics	Eligible
Temps Granted 8/7/2024				
Imam, Danyal O., MD	Provisional	Internal Medicine	Medicine	Eligible
Larson, Stephanie S., MD	Provisional	Ob-Gyn	Ob-Gyn	Eligible
Requested Temps 9/1/2024				
Muraki, Alan S., MD	Provisional	Teleradiology	Radiology	Diagnostic Radiology Internal Medicine Neuroradiology
Ojo, Temitayo O., FNP	AHP-Provisional	Nurse Practitioner	Emergency Medicine	ANCC
Patel, Monalisa H., MD	Provisional	Neonatal/Perinatal medicine	Pediatrics/Neonatology	Pediatrics Neonatal/Perinatal Medicine
Phan, Minh A., MD	Provisional	Pediatrics	Pediatrics	Eligible
Temps Granted 8/7/2024				
Rana, Prachi, MD	Provisional	Transplant Hepatology	Medicine/ Gastroenterology	Internal Medicine Gastroenterology
Whitehead, Anaia C., NP	AHP-Provisional	Nurse Practitioner	Radiology	ANCC

REAPPOINTMENTS – October 1, 2024 – September 30, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Bent, Christopher K., MD	Active	Diagnostic Radiology	Radiology	Diagnostic Radiology Interventional Radiology
Clark, Robin D., MD	Active	Clinical Cytogenetics	Pediatrics	Pediatrics Clinical Genetics Clinical Cytogenetics
Cutler, Drew C., MD	Active	Nephrology	Pediatrics	Pediatrics
Davidge, Rachel E., DO	Active	Pediatrics	Pediatrics/Genetics	Pediatrics
Dukes, William S., MD	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine Emergency Medical Services

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 08/23/2024
MEC DATE: 09/12/2024
BOARD DATE: 09/12/2024

Fong, Matthew B., MD	Active	Pediatrics	Pediatrics	Pediatrics
Garberoglio, Carlos	Active	Surgery	Surgery	Surgery
Gillespie, Heather J., MD	Active	Rheumatology	Medicine/ Rheumatology	Internal Medicine Rheumatology
Ha, Tiffany A., PA Withdraw of Privilege: • Abdominal Paracentesis	AHP	Physician Assistant	Medicine	NCCPA
Hu, Tony Y., DO	Active	Anesthesiology	Anesthesia	Anesthesiology
Khan, Naila A., DO	Active	Internal Medicine	Medicine	Internal Medicine
Kim, Young M., MD	Active	Neurology	Pediatrics	Neurology with Special Qualifications in Child Neurology Epilepsy
Kim-Paglingayen, Jin Seon MD	Active	Family Medicine	Family Medicine	Family Medicine
LeClair, Garth, AuD	AHP	AUD	Head Neck & Otolaryngology	Audiology
Lewis, Christina, NP	AHP	Nurse Practitioner	Surgery/Critical Care	ANCC
Pan, Min S., PA Withdraw of Privilege: • Abdominal Paracentesis	AHP	Physician Assistant	Medicine	NCCPA
Patel, Shalin R., MD	Active	Psychiatry	Psychiatry	Child & Adolescent Psychiatry Psychiatry
Rudisaile, Daren G., MD	Active	Internal Medicine	Medicine	Eligible
Shah, Manoj C., MD	Active	Gastroenterology	Pediatrics	Pediatrics Pediatric Gastroenterology
Shen, Bailey Y., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Topping, Katie L., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Tran, Diem Kieu T., MD	Active	Pediatric Neurosurgery	Clinical Neurological Sciences	Eligible
Vazquez, Jennifer A., NP Additional Privilege: • Obtaining Informed Consent	AHP	Nurse Practitioner	Medicine	AANP
Ventro, George Jr., MD	Active	Surgery	Surgery/Critical Care	Surgery
Yu, Minho, DO	Active	Internal Medicine	Medicine	Internal Medicine

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 08/23/2024
MEC DATE: 09/12/2024
BOARD DATE: 09/12/2024

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Camelo, Monica S., MD	Provisional	Surgery	Surgery/General Surgery	Remain on Provisional until eligible for advancement
Karidas, Steven J., MD	Provisional	Radiology	Radiology/ TeleRadiology	Remain on Provisional until eligible for advancement
Mccain, Joshua W., MD	Provisional	Teleradiology	Radiology/ TeleRadiology	Remain on Provisional until eligible for advancement
Reiner, David P., MD	Provisional	Teleradiology	Radiology/ TeleRadiology	Remain on Provisional until eligible for advancement

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Giang, Beverly A., MD	Provisional	Neonatology	Pediatrics/Neonatology	Advance to Active Status
Kohbodi, GoleNaz A., MD	Provisional	Neonatology	Pediatrics/Neonatology	Advance to Active Status
Mercado, Kristina, MD	Provisional	Obstetrics & Gynecology	Obstetrics & Gynecology	Advance to Active Status

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Ramirez, Camille A., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	Complete

FPPE PARTIAL PROCTORING COMPLETE REQUEST FOR EXTENSION

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Cantu, Daae, PA	AHP-Provisional	Physician Assistant	Emergency Medicine	Pending: <ul style="list-style-type: none"> Central Line/PICC Placement Lumbar Puncture Endotracheal Intubation Arterial Cannulation Thoracentesis Paracentesis

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Choi, David M., MD	Active	Ophthalmology	Ophthalmology	Additional Privilege: Ophthalmology Core Procedure: <ul style="list-style-type: none"> Intra and extracapsular cataract extraction with/without lens

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 08/23/2024
MEC DATE: 09/12/2024
BOARD DATE: 09/12/2024

				implants, or phacoemulsification
Van Hal, Michele A., MD	Active	Anesthesiology	Anesthesia	Withdraw of Privilege: • Pediatric Anesthesia

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Batra, Sahil, DO	Provisional	Internal Medicine	Medicine	Advance to Active Status
Kim, Bobae L., MD	Provisional	Internal Medicine	Medicine	Advance to Active Status
Pathak, Sujay R., DO	Provisional	Internal Medicine	Medicine	Advance to Active Status

CHANGE IN STAFF REAPPOINTMENT DATES TO ALIGN WITH CHC

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Chen, Kevin G., MD	Active	Emergency Medicine	Emergency Medicine	08/31/2026 to 04/30/2026

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				

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

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Batish, Suraj R., MD	Active	Pediatrics	Pediatrics/Neonatology	9/30/2024

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	REASON/EFFECTIVE
Chau, Thanh, CRNA	AHP	Nurse Anesthetist	Anesthesia	Voluntary Effective 9/16/2024
Cho, Alexander, MD	Provisional	Diagnostic Radiology	Radiology	Voluntary Effective 8/09/2024
Susleck, Dacia C., CRNA	AHP	Nurse Anesthetist	Anesthesia	Voluntary Effective 8/31/2024

End of Report

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 08/23/2024
MEC DATE: 09/12/2024
BOARD DATE: 09/12/2024

I hereby:

- 1) Attest that the medical center's Medical Executive Committee meeting on September 12, 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 Chukshank
Chief Executive Officer – RUHS Medical Center

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 09/27/2024
MEC DATE: 10/10/2024
BOARD DATE: 10/10/2024

Date: October 10, 2024

To: File

From: Medical Staff Executive Committee

Subject: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – October 10, 2024 – September 31, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Aguilar Portillo Georgina MD	Provisional	Family Medicine	Family Medicine	Family Medicine
Ahmed, Ayesha MD	Provisional	Infectious Disease	Pediatrics / Infectious Disease	Pediatrics Pediatric Infectious Disease
Anyu, Tse F. DO	Provisional	Diagnostic Radiology	Radiology	Diagnostic Radiology
Apuzzo, Sergio, MD	Provisional	Teleradiology	Radiology	Diagnostic Radiology
Davis, Clarence S., MD	Provisional	Teleradiology	Radiology	Diagnostic Radiology
Fenster, April, PA Temp Privileges 10/1/2024	AHP- Provisional	Physician Assistant	Surgery/Plastic Surgery	NCCPA
Huang, Jane Y., DO	Provisional	Neonatology	Pediatrics / Neonatal- Perinatal Medicine	Pediatrics
Jin, Ji Sung, MD	Provisional	Psychiatry	Psychiatry	Eligible
Layvas, Cory M., NP IDPC & CC Evote on 10/10/2024	AHP- Provisional	Nurse Practitioner	Surgery	ANCC
Loi, Michael T., DO	Provisional	Internal Medicine	Medicine	Eligible
Moretta, Carlos., DDS	Provisional	Oral & Maxillofacial surgery	Surgery	Oral & maxillofacial Surgery
Ramos-Santillan, Vicente O., MD Temp Privileges 10/01/2024	Provisional	Oncology	Surgery	Surgery
Rossaro, Lorenzo, MD	Provisional	Gastroenterology/ Transplant Hepatology	Medicine/ Gastroenterology	Gastroenterology
Nguyen, Catherine, MD	Provisional	Urology	Department/Urology	Eligible
Taylor, Timothy M., NP	AHP- Provisional	Nurse Practitioner	Surgery/Critical Care	ANCC/AACN
Zamir, Syed, MD	Provisional	Teleradiology	Radiology	Interventional Radiology

REAPPOINTMENTS – November 1, 2024 – October 31, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Calaguas, Daniel K., MD	Active	Pediatrics	Pediatrics	Pediatrics
Chinnock, Richard E., MD	Active	Pediatrics	Pediatrics	Pediatrics

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 09/27/2024
MEC DATE: 10/10/2024
BOARD DATE: 10/10/2024

Clark, Alexandra M., MD	Active	Pediatrics	Pediatrics	Pediatrics
Clarkson, Lois C., NP	AHP	Critical Care	Pediatrics	PNCB AACCN
Dastjerdi, Mohammad, MD	Active	Neurology	Medicine/Neurology	Neurology Epilepsy
Eguchi, Jim H., MD	Active	Critical Care	Pediatrics / Critical Care	Pediatrics Pediatric Critical Care Medicine
Garrido, Esmeralda J., PA	AHP	Physician Assistant	Orthopedic Surgery	NCCPA
Griffith, Jean W., MD Status Change from Provisional to Administrative	Provisional	Psychiatry	Psychiatry	General Psychiatry
Gnass, Ronaldo., MD	Active	Pathology	Pathology	Anatomic Pathology
Hanson, Rodolfo J., NP	AHP	Nurse Practitioner	Anesthesia	AANP
Hu, Eugene W., MD	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine
Johnson, Onyinye Y., NP	AHP	Nurse Practitioner	Psychiatry	AANP
Khan, Mahbuba, MD	Administrative	Family Medicine	Family Medicine	Family Medicine
Kim, Hahns Y., MD	LOA	Plastic Surgery	Surgery	Plastic Surgery
Lee, Steve C., MD	Active	Head/Neck & Otolaryngology	Surgery/Head & Neck Otolaryngology	Otolaryngology
Leung, Alexander, MD	Active	Thoracic Surgery	Surgery/Thoracic Surgery	Surgery/Thoracic Surgery
Mejaddam, Ali Y., MD	Active	Pediatric Surgery	Surgery/Pediatric Surgery	Surgery
Noel, Jerry, DO Status changed from Active to Courtesy due to no patient volume	Courtesy	Neurosurgery	Clinical Neurological Sciences	Neurological Surgery
Nycholat, Desiree R., MD	Active	Pediatrics	Pediatrics	Pediatrics
Perea, Samantha E., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Peterson, Joseph D., MD	Active	Head/Neck & Otolaryngology	Head/Neck & Otolaryngology	Otolaryngology
Radulescu, Andrei, MD	Active	Pediatric Surgery	Surgery/Pediatric Surgery	Surgery/Pediatric Surgery
Rivera Landeros, Willie, PA	AHP	Physician Assistant	Emergency Medicine	NCCPA
Sandman, Lester M., MD	Active	Psychiatry	Psychiatry	General Psychiatry
Sherman, Christopher L., DO	Active	Orthopedic Surgery	Orthopedic Surgery	Orthopedic Surgery
Van Hal, Michele A., MD	Active	Anesthesiology	Anesthesia	Eligible
Yao, Ruofan, MD	Active	Ob-Gyn	Ob-Gyn	Ob-Gyn/Maternal Fetal Med
Zarecki, Esther N., MD	Active	Family Medicine	Family Medicine	Family Medicine

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Keyes, Brian O., DO	Provisional	Anesthesiology	Anesthesia	Remain on Provisional until eligible for advancement

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 09/27/2024
MEC DATE: 10/10/2024
BOARD DATE: 10/10/2024

Makhlouf, Michel MD, PhD	Provisional	Obstetrics & Gynecology	Obstetrics & Gynecology	Remain on Provisional until eligible for advancement
Tama, Maher, MD	Provisional	Gastroenterology	Medicine/ Gastroenterology	Remain on Provisional until eligible for advancement

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Afroz, Sana, MD	Provisional	Rheumatology	Medicine/Rheumatology	Advance to Active Status
Alsyounf, Muhannad M, MD	Provisional	Urology	Surgery/Urology	Advance to Active Status
Cho, Alexander L., MD	Provisional	Diagnostic Radiology	Radiology	Advance to Active Status
Garcia, Renee M., MD	Provisional	Psychiatry	Psychiatry	Advance to Active Status
Sheski, David E., MD	Provisional	Psychiatry	Psychiatry	Advance to Active Status

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Froehlich, Katherine A., CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete
Leimbach, Danielle N., PA	AHP-Provisional	Physician Assistant	Clinical Neurological Sciences	Complete
Matthews, Troy A., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	Complete
Miles, Geoffrey B., CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete
Nguyen, Nina N., CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete
Thomas, Amber M., CRNA	AHP-Provisional	Nurse Anesthetist	Anesthesia	Complete
Wang, Sharon D., NP	AHP-Provisional	Nurse Practitioner	Emergency Medicine	Complete

FPPE PARTIAL PROCTORING COMPLETE REQUEST FOR EXTENSION

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Cervantes, Richard J., MD	Provisional	Anesthesiology	Anesthesia	Pending: • 1 Pediatric Case
Nagappan, Meena, MD	Provisional	Anesthesiology	Anesthesia	Pending: • 3 Pediatric Cases

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Afroz, Sana, MD	Provisional	Rheumatology	Medicine/Rheumatology	Withdraw of Privileges: • Internal Medicine Core • Ambulatory
Choi, David M., MD	Active	Ophthalmology	Ophthalmology	Additional privilege: • Intra and extracapsular cataract extraction with/without lens implant, or phacoemulsification

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 09/27/2024
MEC DATE: 10/10/2024
BOARD DATE: 10/10/2024

Leimbach, Danielle N., PA	AHP-Provisional	Physician Assistant	Clinical Neurological Sciences	Withdraw of Privilege: • Obtaining Informed Consent
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CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Escutin Jr., Rodolfo O., MD	Provisional	Neurology	Medicine/Neurology	Advance to Active Status
Lien, Donna, MD	Provisional	Anesthesiology	Anesthesia	Advance to Active Status
Martin, Joshua J., MD	Provisional	Neurology	Medicine/Neurology	Advance to Active Status
Momohara, Michael M., MD	Provisional	Physical Med & Rehab.	Medicine/PM&R	Advance to Active Status
Pedouim, Farzin B., MD	Provisional	Neurology	Medicine/Neurology	Advance to Active Status
Pomerantz, Maxwell D., MD	Provisional	Anesthesiology	Anesthesia	Advance to Active Status
Propp, Dennis, MD	Provisional	Anesthesiology	Anesthesia	Advance to Active Status
Rivera, Dylan, MD	Provisional	Anesthesiology	Anesthesia	Advance to Active Status

CHANGE IN STAFF REAPPOINTMENT DATES TO ALIGN WITH CHC

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

MODIFICATION OF PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Truong-N, Khoa T., MD	Provisional	Anesthesiology	Anesthesia	To most recent privilege form.

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				

AUTOMATIC TERMINATION, PER BYLAWS 3.5-b (FAILURE TO MEET MEMBERSHIP/PRVILEGE CRITERIA)

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Singh, Saloni, MD	Active / Suspended	Psychiatry	Psychiatry	30 day suspension no malpractice insurance.

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 09/27/2024
MEC DATE: 10/10/2024
BOARD DATE: 10/10/2024

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	REASON/EFFECTIVE
Del Prado, Daniel, MD	Active	Diagnostic Radiology	Radiology	Voluntary Effective 9/23/2024
Khamsi, Babak R., MD	Courtesy	Orthopedic Surgery	Orthopedic Surgery	Voluntary Effective 9/10/2024
Nguyen, Brian H., MD	Active	Neurology	Medicine/ Neurology	Voluntary Effective 6/28/2024
Nguyen, Truclinh T., DO	Active	Internal Medicine	Medicine	Voluntary Effective 11/1/2024

End of Report

I hereby:

1) Attest that the medical center's Medical Executive Committee meeting on October 10, 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

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 10/25/2024
MEC DATE: 11/14/2024
BOARD DATE: 11/14/2024

Date: November 14, 2024

To: File

From: Medical Staff Executive Committee

Subject: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – November 14, 2024 – October 31, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Camara, Justin R., MD Temporary Privilege Request Effective 10/28/2024 *	Provisional	Interventional Radiology	Radiology	Board Eligible
Dang, Alexander, MD	Provisional	Pediatrics	Pediatrics	Pediatrics
Farber, Benjamin, MD	Provisional	Surgery/Pediatric Surgery	Surgery/Ped surgery	Surgery/Pediatric surgery
Isani, Mubina A., MD	Provisional	Surgery	Surgery	Surgery/Ped surgery
Kamassah, Mawusi, MD Temporary Privilege Request Effective 11/1/2024	Provisional	Anesthesia	Anesthesia	Eligible
Kasturi, Vellore G, MD Temporary Privilege Effective 10/11/2024	Provisional	Genetics	Pediatrics	Obstetrics & Gynecology Clinical Genetics & Genomics
Martes Gomez, Maria P., DO	Provisional	Neonatology	Pediatrics	Pediatrics
May, William N., MD Re-Entry Plan	Provisional	Ophthalmology	Ophthalmology	Ophthalmology
Nguyen, Vinh T., MD	Provisional	Allergy & Immunology	Pediatrics	Pediatrics
Patel, Dhara, NP	AHP- Provisional	Nurse Practitioner	Surgery/Ped Urology	PNCB
Sharma, Karan, DO Temporary Privilege Request Effective 11/1/2024	Provisional	Anesthesiology	Anesthesia	Eligible
Tang, Jessica, MD	Provisional	Head & Neck/Otolaryngology	Surgery/Head & Neck/Otolaryngology	Otolaryngology
Yom, Jessica MD	Provisional	Neonatology	Pediatrics	Pediatrics

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 10/25/2024
MEC DATE: 11/14/2024
BOARD DATE: 11/14/2024

REAPPOINTMENTS – December 1, 2024 – November 30, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Batton, Emily M., MD	Active	Neonatology	Pediatrics	Pediatrics Neonatal/Perinatal Medicine
Chow, Conroy, MD	Active	Dermatology	Medicine/ Dermatology	Dermatology Micrographic Dermatology
Davila, Gessica L., PA	AHP	Physician Assistant	Medicine	NCCPA
Hsueh, Chung-Tsen, MD	Courtesy	Hematology/ Oncology	Medicine/ Hematology Oncology	Internal Medicine Medical Oncology
Hwang, Frank S., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Johnson, Ronald, MD	Active	Ob-Gyn	Ob-Gyn	Obstetrics & Gynecology
Medina, Kelly D., PA	AHP	Physician Assistant	Emergency Medicine	NCCPA
Nagaraj, Gayathri, MD	Courtesy	Hematology/ Oncology	Medicine/ Hematology Oncology	Hematology Medical Oncology
Rausser, Michael E., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Rossie, Daniel J., MD	Active	Emergency Medicine	Emergency Medicine	Emergency Medicine
Shu, Richard G., MD	Active	Cardiology	Medicine/Cardiology	Internal Medicine Cardiovascular Disease
Sohail, Sindy, PA	AHP	Physician Assistant	Medicine/ Gastroenterology	NCCPA
Swain, Kyle A., PA	AHP	Physician Assistant	Emergency Medicine	NCCPA
Williams, Lance MD	Telehealth	Teleradiology	Radiology	Diagnostic Radiology Neuroradiology
Winter, Timothy W. DO	Active	Ophthalmology	Ophthalmology	Ophthalmology

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Duan, Sarah, DO	Provisional	Family Medicine	Family Medicine	Advance to Active Status
Holsclaw, Matthew. E., MD	Provisional	Anesthesiology	Anesthesia	Advance to Active Status
Makhlouf, Michel, MD	Provisional	Obstetrics & Gynecology	Obstetrics & Gynecology	Advance to Active Status

FPPE FINAL PROCTORING FOR ALLIED HEALTH PROFESSIONALS

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
None				

FPPE PARTIAL PROCTORING COMPLETE REQUEST FOR EXTENSION

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Nelson, Grant E., MD	Provisional	Emergency Medicine	Emergency Medicine	Pending: • 2 Live TEE cases

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 10/25/2024
MEC DATE: 11/14/2024
BOARD DATE: 11/14/2024

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
DeWoskin, Ruth E., PA	AHP	Physician Assistant	Detention Health	Withdraw of Privilege: <ul style="list-style-type: none">Dept. of Emergency Medicine (Resigned)
Jerez-Aguilar, Brenda NP	Allied Health Professional	Family Medicine	Family Medicine	Withdraw Privilege: <ul style="list-style-type: none">INJECTION OF MEDICATION INTO TRIGGER POINTS, NON-COREI&D OF ABSCESSSES, NON-CORESKIN TAG REMOVAL, NON-COREPUNCH BIOPSY, NON-CORE

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Holsclaw, Matthew E., MD	Provisional	Anesthesiology	Anesthesia	Advance to Active Status

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	REASON/EFFECTIVE
Cacho, Bradley MD	Active	Pediatrics	Pediatrics	Resign – 1/6/2025
Hamra, William S., MD	Active	Pediatrics	Pediatrics	Resign – 5/31/2024
Hou, Gina MD	Active	Pediatrics	Pediatrics	Resign - 1/3/2025
Huynh, Bichtram MD	Active	Pediatrics	Pediatrics	Resign - 10/1/2024
Kerr, William K., PA	AHP	Physician Assistant	Medicine/Cardiology	Resign- 10/18/2024
Montejano, Arianna, NP	AHP	Nurse Practitioner	Surgery	Resign- 9/6/2024
Montesinos, Monteserrat MD	Active	Pediatrics	Pediatrics	Resign- 11/30/2024
Siddighi, Sam, MD	Active	Ob-Gyn	Ob-Gyn	Resign- 10/18/2024

End of Report

I hereby:

- 1) Attest that the medical center's Medical Executive Committee meeting on October 10, 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 Crnkshank
Chief Executive Officer – RUHS Medical Center

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 11/22/2024
MEC DATE: 12/12/2024
BOARD DATE: 12/12/2024

Date: December 12, 2024
To: File
From: Medical Staff Executive Committee
Subject: Medical Staff Attestation Appointment, Reappointments and Clinical Privileges

INITIAL APPOINTMENT – December 12, 2024 – November 30, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Cabrera, Cristian, PA	AHP-Provisional	Physician Assistant	Surgery	NCCPA
Chow, Nathan H., PA Temp Request Eff. 11/25/2024	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
Churchill, Himelda R., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
Contreras Rojas, Leslie P., PA	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
Galley, Christopher J., MD	Provisional	Pediatrics	Pediatrics	Eligible
Johnson, J.Evan, MD	Provisional	Diagnostic Radiology	Radiology	Diagnostic Radiology Interventional Radiology
Le, Jocelyn H., PA Temps Granted on 11/1/2024	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
Learman, Cameron R., PA Temps Granted on 11/1/2024	AHP-Provisional	Physician Assistant	Emergency Medicine	NCCPA
Nelch, Heather R., NP Temp Request Eff. 12/1/2024	AHP-Provisional	Nurse Practitioner	Medicine/Neurology	AANP
Park, Min Jung, DO	Provisional	Neonatology	Pediatrics	Pediatrics
Song, Joseph W., MD	Provisional	Diagnostic Radiology	Radiology	Diagnostic Radiology
Vishwanath, Anu MD	Provisional	Endocrinology	Pediatrics	Pediatrics Pediatric Endocrinology

REAPPOINTMENTS – January 1, 2025 – December 31, 2026

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	BOARD STATUS
Bacot Carter, Sharon NNP	AHP	Neonatology	Pediatrics	NCC
Bowes, Larry D., MD	Active	Ophthalmology	Ophthalmology	Ophthalmology
Huynh, Paul T., DO	Active	Nephrology	Medicine/Nephrology	Nephrology
Istrate, Laura E., MD	Active	Neurology	Medicine/Neurology	Neurology
Jutzy, Kenneth R., MD	Active	Cardiology	Medicine/Cardiology	Internal Medicine Cardiovascular Disease Interventional Cardiology
Kar, Ashok J., MD	Active	Urology	Surgery/Urology	Urology

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 11/22/2024
MEC DATE: 12/12/2024
BOARD DATE: 12/12/2024

Koh, Han A., MD	Active	Hematology/ Oncology	Medicine/ Hematology Oncology	Internal Medicine Hematology Medical Oncology
Lucas, Daniel N. MD	Active	Diagnostic Radiology	Radiology	Diagnostic Radiology
Meadows, LaVonne M., MD	Active	Dermatology	Medicine/ Dermatology	Dermatology
Momeni, Mazdak, MD	Active	Ob-Gyn	Ob-Gyn	Ob-Gyn
Nelson, Scott C., MD	Courtesy	Orthopedic Surgery	Orthopedic Surgery	Orthopedic Surgery
Olson, Jeffrey T., MD	Active	Pediatrics	Pediatrics	Pediatrics Internal Medicine
Otsuka, Kimberly N., MD	Active	Pulmonology	Pediatrics	Pediatrics Pediatric Pulmonology
Plantak, Natasha S., PA	AHP	Physician Assistant	Clinical Neurological Sciences	NCCPA
Prasad, Vinoy S., MD	Active	Cardiology	Medicine/Cardiology	Internal Medicine Cardiovascular Disease Interventional Cardiology
Ray, Andrea O., MD	Active	Plastic Surgery	Surgery/Plastic Surgery	Plastic Surgery
Siddiqi, Javed, MD	Active	Neurosurgery	Clinical Neurological Sciences	Neurological Surgery
Speer, Brittany N., PA	AHP	Physician Assistant	Medicine	NCCPA
To, Dat D., MD	Active	Internal Medicine	Medicine	Internal Medicine

FPPE/RECIPROCAL* COMPLETE REMAIN ON PROVISIONAL

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Choi, Da-Eun, DO	Provisional	Pediatrics	Pediatrics	Remain on Provisional until eligible for advancement
Davis, Clarence S., MD	Provisional	Diagnostic Radiology	Radiology	Remain on Provisional until eligible for advancement
Evers, Marisa R., MD	Provisional	Emergency Medicine	Emergency Medicine	Remain on Provisional until eligible for advancement
Larson, Stephanie S., MD	Provisional	Obstetrics & Gynecology	Obstetrics & Gynecology	Remain on Provisional until eligible for advancement
Liang, Ellen, DO, MPH	Provisional	Family Medicine	Family Medicine	Remain on Provisional until eligible for advancement
Phan, Minh A., D	Provisional	Pediatrics	Pediatrics	Remain on Provisional until eligible for advancement
Rossi, Jordan M., MD	Provisional	Obstetrics & Gynecology	Obstetrics & Gynecology	Remain on Provisional until eligible for advancement
Uyesugi, Walter Y., DO	Provisional	Teleradiology	Radiology/ TeleRadiology	Remain on Provisional until eligible for advancement

FINAL FPPE/RECIPROCAL* ADVANCEMENT OF STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Camelo, Monica S., MD	Provisional	Surgery	Surgery/General Surgery	Advance to Active Status
Kim, Cherine H., MD	Provisional	Otolaryngology	Surgery/ Head Neck & Otolaryngology	Advance to Active Status
Olson, Caitlin P., MD	Provisional	Head/Neck Surgery & Otolaryngology	Surgery/ Head Neck & Otolaryngology	Advance to Active Status

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 11/22/2024
MEC DATE: 12/12/2024
BOARD DATE: 12/12/2024

FPPE FINAL PROCTORING FOR ADDITIONAL PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT	COMMENTS
Moellmer, Rebecca A., DPM	Active	Podiatry	Orthopedic Surgery	Ambulatory Privileges
Schoepflin, Charles W., MD	Active	Anesthesia	Anesthesiology	Pediatric Anesthesia
Van Putten, Douglas J., MD	Active	Ophthalmology	Ophthalmology	Oculoplastic/Orbital/Neuro-Ophthalmology

ADDITIONAL PRIVILEGES/WITHDRAWN PRIVILEGES

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Bang, Sunny, MD	Active	Pain Medicine	Anesthesia	Withdraw of Privilege: • Moderate Sedation
Klein, Walter F., MD Temp Request Eff. 11/25/2024	Active	Pulmonary Critical Care Medicine	Medicine/Pulmonary	Additional Privilege: • Robotic Assisted Bronchoscopy

CHANGE IN STAFF CATEGORY

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Aravagiri-Do, Arunmozhi S., MD	Provisional	Internal Medicine	Medicine	Advance to Active Status

AUTOMATIC TERMINATION, PER BYLAWS 3.5-b (FAILURE TO MEET MEMBERSHIP/PRVILEGE CRITERIA)

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	COMMENTS
Ratajczak, Celeste J., NP	AHP	Nurse Practitioner	Clinical Neurological Sciences	Failed to provide malpractice coverage. Termination effective 11/7/2024

VOLUNTARY RESIGNATIONS/WITHDRAWALS*

NAME	STATUS	SPECIALTY	DEPARTMENT/ DIVISION	REASON/EFFECTIVE
Azizi, Faramarz, MD	Active	Pathology	Pathology	Voluntary Resignation 11/12/2024
Hilliard, Anthony A., MD	Active	Cardiology	Medicine/Cardiology	Voluntary Resignation 1/1/2025
Honore, Alexander, CRNA	AHP	Nurse Anesthetist	Anesthesia	Voluntary Resignation 11/08/2024
Le, Nathalie, PA	AHP	Physician Assistant	Surgery	Voluntary Resignation 12/30/2024
Millet, Kevin J., CRNA	AHP	Nurse Anesthetist	Anesthesia	Voluntary Resignation 10/24/2024
Ochoa, Humberto R., MD	Active	Emergency Medicine	Emergency Medicine	Voluntary Resignation (Retired) 1/1/2025
Susleck, Dacia C., CRNA	AHP	Nurse Anesthetist	Anesthesia	Voluntary Resignation 1/1/2025
Tabangcura, Demy F., PA	AHP	Physician Assistant	Emergency Medicine	Voluntary Resignation 10/24/2024
Yamanishi, Pamela E., MD	Administrative	Internal Medicine	Medicine	Voluntary Resignation 11/12/2024

End of Report

RUHS-MEDICAL CENTER CREDENTIALS COMMITTEE REPORT

**MEDICAL EXECUTIVE COMMITTEE
GOVERNING BOARD**

CRED DATE: 11/22/2024
MEC DATE: 12/12/2024
BOARD DATE: 12/12/2024

I hereby:

- 1) Attest that the medical center's Medical Executive Committee meeting on October 10, 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



Prescribing Arrangements for DEA eligible Practitioners who do not have a certificate

This form is applicable to practitioners who are qualified to write prescriptions. Medical Staff Administration must verify that the practitioners Drug Enforcement Administration (DEA) certificate is valid and current in the state.

For DEA eligible practitioners who do not have a valid DEA certificate, and for whom prescribing controlled substances is in the scope of their practice, Medical Staff Administration must obtain your written arrangements of the designated practitioner who will be writing prescriptions on your behalf, that includes:

*I, _____ agree that during the time that I do not have a current/valid DEA Certificate, **I will not write prescriptions for drugs that require a DEA Certificate.***

Reason for not having a valid DEA/CDS certificate:

Provider Signature: _____ **Date:** _____

I, _____ will write all prescriptions requiring a DEA certificate for _____ until a valid CA DEA certificate is issued.

Prescriber: _____

Prescriber DEA #: _____

Prescriber NPI: _____

Prescribing Provider Signature: _____ **Date:** _____

You can quickly update / change your DEA address and / or schedules online at
<https://www.dea diversion.usdoj.gov/drugreg/registration.html>

MEDICINE DEPARTMENT**INTERNAL MEDICINE & SUB-SPECIALTY CLINICAL PRIVILEGE**

Name: _____

(Last, First, Initial)

☐ Initial Appointment☐ Reappointment

Effective: _____

Page 1

(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, hematopoietic 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.

RIVERSIDE UNIVERSITY HEALTH SYSTEM
MEDICINE DEPARTMENT
INTERNAL MEDICINE & SUB-SPECIALTY CLINICAL PRIVILEGES

Page 2

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

RIVERSIDE UNIVERSITY HEALTH SYSTEM
MEDICINE DEPARTMENT
INTERNAL MEDICINE & SUB-SPECIALTY CLINICAL PRIVILEGES

Page 3

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

- | | |
|---|--|
| <input type="checkbox"/> Requested | Admit and manage the medical care of patients in the progressive care unit. |
| <input type="checkbox"/> Approved | Except as specifically excluded from practice, the core privileges in this specialty include the |
| <input type="checkbox"/> Not Approved* | 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

- | | |
|---|--|
| <input type="checkbox"/> Requested | Management of life-threatening disorders in intensive care units including but not limited to |
| <input type="checkbox"/> Approved | shock, coma, heart failure, trauma, respiratory arrest, drug overdoses, massive bleeding, |
| <input type="checkbox"/> Not Approved* | 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. |

RIVERSIDE UNIVERSITY HEALTH SYSTEM
MEDICINE DEPARTMENT
INTERNAL MEDICINE & SUB-SPECIALTY CLINICAL PRIVILEGES

Page 4

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

- | | |
|---|---|
| <input type="checkbox"/> Requested | 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. |
| <input type="checkbox"/> Approved | |
| <input type="checkbox"/> Not Approved* | |

RIVERSIDE UNIVERSITY HEALTH SYSTEM
MEDICINE DEPARTMENT
INTERNAL MEDICINE & SUB-SPECIALTY CLINICAL PRIVILEGES

Page 5

**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 ***

RIVERSIDE UNIVERSITY HEALTH SYSTEM
MEDICINE DEPARTMENT
INTERNAL MEDICINE & SUB-SPECIALTY CLINICAL PRIVILEGES

Page 6

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

<input type="checkbox"/> Requested <input type="checkbox"/> Approved <input type="checkbox"/> 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.)
--	---

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Genetics | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Critical Care Medicine | <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Palliative Care |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Hematology/Oncology | <input type="checkbox"/> Physical Medicine & Rehab. |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Hepatology | <input type="checkbox"/> Pulmonology* |
| <input type="checkbox"/> Gastroenterology* | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Vascular Medicine | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Telemedicine |

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

RIVERSIDE UNIVERSITY HEALTH SYSTEM
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INTERNAL MEDICINE & SUB-SPECIALTY CLINICAL PRIVILEGES

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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

RIVERSIDE UNIVERSITY HEALTH SYSTEM
MEDICINE DEPARTMENT
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OTHER SUBSPECIALTY PROCEDURES

- | | |
|--|--|
| <input type="checkbox"/> Requested | <input type="checkbox"/> Fluoroscopy – (State Certificate Required) |
| <input type="checkbox"/> Approved | <input type="checkbox"/> Peritoneal dialysis (including cannula placement), Renal biopsy, Renal dialysis (including cannula placement) |
| <input type="checkbox"/> Not Approved* | <input type="checkbox"/> Thyroid biopsy |
| | <input type="checkbox"/> Electroencephalogram Interpretation, Electromyography w/ Interpretation |
| | <input type="checkbox"/> 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

- | | |
|--|--------------------|
| <input type="checkbox"/> Requested | EKG Interpretation |
| <input type="checkbox"/> Approved | |
| <input type="checkbox"/> Not Approved* | |

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.

RIVERSIDE UNIVERSITY HEALTH SYSTEM
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INTERNAL MEDICINE & SUB-SPECIALTY CLINICAL PRIVILEGES

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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***

RIVERSIDE UNIVERSITY HEALTH SYSTEM
MEDICINE DEPARTMENT
INTERNAL MEDICINE & SUB-SPECIALTY CLINICAL PRIVILEGES

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ROBOTIC – ASSISTED BRONCHOSCOPY

CRITERIA: To be eligible for Robotic assisted Bronchoscopy privileges, the initial applicant must meet the privilege criteria:

- Meet the qualifications for 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
- Evidence of successful completion of an ACGME post-residency fellowship in Pulmonology, Critical Care Medicine which included training in Robotic-assisted Bronchoscopy

AND

- Must have privileges to perform Bronchoscopy

AND

- Must have privileges for Fluoroscopy use and supervision (current and valid State of California Fluoroscopy Certificate required)

AND

WITHOUT PREVIOUS EXPERIENCE:

- Applicants must provide a certificate of completion of the appropriate Robotic-Assisted Bronchoscopy Training Course

AND

- Provide documentation of the successful completion of on-site training course provided by the manufacturer of the Robotic-Assisted Bronchoscopy
- Direct proctoring of the first three (3) cases performed at RUHS by a RUHS approved proctor (i.e. RUHS physician already holding privileges in robotic bronchoscopy or a proctor who meets criteria for proctoring.

OR

WITH REQUIRED PREVIOUS EXPERIENCE:

- If Fellowship/Residency Training Included robotic-assisted bronchoscopy: letter from training director to support competency in procedure or documentation of twenty-five (25) cases

OR

- Provide documentation of the successful completion of on-site training course provided by the manufacturer of the Robotic-Assisted Bronchoscopy.
- Direct proctoring of the first three (3) cases performed at RUHS by a RUHS approved proctor (i.e. RUHS physician already holding privileges in robotic bronchoscopy or a proctor who meets criteria for proctoring

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

- Demonstrated current competence and evidence of the performance of at least ten (10) Robotic-Assisted Bronchoscopy cases in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Description of Non-Core Privilege

- ☐ **Requested** Robotic-Assisted Bronchoscopy
- ☐ **Approved**
- ☐ **Not Approved***

RIVERSIDE UNIVERSITY HEALTH SYSTEM
MEDICINE DEPARTMENT
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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

RIVERSIDE UNIVERSITY HEALTH SYSTEM
MEDICINE DEPARTMENT
INTERNAL MEDICINE & SUB-SPECIALTY CLINICAL PRIVILEGES

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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	5 varied cases	A,B,C as applicable
<ul style="list-style-type: none"> Hyperbaric Chamber Transesophageal Echocardiography (TEE) 	3 cases 5 cases	
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
Robotic-assisted Bronchoscopy	3 cases	A

***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; 11/24/24



**EXHIBIT I
RIVERSIDE UNIVERSITY HEALTH SYSTEM
PRACTITIONER RE-ENTRY PLAN
ACKNOWLEDGMENT BY THE RE-ENTERING PRACTITIONER**

I, _____ (Please Print Full Name), seek a return to clinical practice and acknowledge that, in order to do so, I must comply with all of the requirements of the RUHS-MC Practitioner Re-Entry Plan ("PRP"), as follows:

As a re-entering practitioner, I agree to comply with all of the following responsibilities, :

- A. To be bound by the terms of the RUHS-MC Medical Staff Re-Entry Plan Policy;
- B. To secure, with assistance from my Department Chair/Division Chief, a qualified proctor/mentor;
- C. To continuously participate in the PRP for the length of time established by my Department Chair/Division Chief;
- D. To consistently maintain contact with my proctor/mentor (or covering designee) while I am involved in patient care activities at the Riverside University Health System Medical Center;
- E. To provide full cooperation to my proctor/mentor and to follow his/her guidance and instructions;
- F. To comply with all requirements of the PRP, including full completion of the required volume of cases to be proctored;
- G. To accept and to abide by the decision to extend the duration of my participation in the PRP in order to fully assess my performance, if such an extension is deemed required by my proctor/mentor, Department Chair, Division Chief, the RUHS-MC Credentials Committee or the RUHS-MC PPE Committee;
- H. To provide safe, quality care for patients;
- I. To cease patient care activities should my proctor/mentor withdraw from the PRP until such time as a replacement proctor/mentor is approved by my Department Chair / Division Chief. I acknowledge that cessation of my practice under these circumstances is not a suspension of clinical privileges for medical disciplinary cause or reason; therefore, no hearing rights shall be afforded to me under Article 9 of the Medical Staff Bylaws.
- J. To resign from the Riverside University Health System Medical Center if a replacement proctor cannot be found within sixty (60) days after departure of my assigned proctor/mentor. I understand that I may re-apply for membership per Medical Staff Bylaws, Article 6 of the Medical Staff Bylaws;

I further acknowledge and agree that the PRP is a part of the Medical Staff's peer review and quality improvement process. My proctor/mentor (and any covering-designee) is entitled to all of the immunities and protections from liability afforded to individuals who participate in this process.

Signature: _____ Date: _____
(Stamped signature is not acceptable)



EXHIBIT 2
RIVERSIDE UNIVERSITY HEALTH SYSTEM
PRACTITIONER RE-ENTRY PLAN
ACKNOWLEDGMENT BY THE PROCTOR/MENTOR

I agree to serve as a proctor/mentor for _____ (Print Name) who is seeking a return to clinical practice. I agree to comply with all of the following responsibilities during the entire duration of the RUHS-MC Re-Entry plan ("PRP"):

1. Once the re-entering practitioner has submitted all mandatory documentation required for evaluation and/or credentialing (e.g., request for reinstatement from leave of absence, application for appointment or reappointment) to the RUHS-MC, Medical Staff Services Department, I will provide a letter to RUHS-MC, Medical Staff Credentials Committee with the following information:
 - A. My acceptance of the responsibility to serve as proctor/mentor for the entire period of time the practitioner is in the PRP unless and until an acceptable replacement is found.
 - B. My agreement to evaluate the performance of all privileges to be exercised by the practitioner and to personally observe all patients under the practitioner's care as required on a continuing basis.
 - C. My assurance to provide evaluation of the practitioner's performance to the appropriate Department Chair/Division Chief at least once a month during the PRP term.
2. If the practitioner-applicant is approved for invasive and diagnostic procedures, I agree to be physically present at all times when the practitioner applicant is performing these procedures until proctoring requirements are satisfied.
3. I will review all orders written by the practitioner.
4. I will immediately communicate all concerns regarding the practitioner's performance to the appropriate Department Chair/Division Chief.
5. If I will be away from Riverside University Health System Medical Center, I agree to designate another Active Staff member who possesses the same privileges as the re-entering practitioner. To cover for a defined and agreed upon period of time who shall be responsible to report on the practitioner's activities. The name of the covering designee will be timely communicated in writing to the RUHS-MC Medical Staff Services Department and approved by the Department Chair/Division Chief.

I further acknowledge and agree that the PRP is a part of the Medical Staff's peer review and quality improvement process. As a proctor/mentor, I and any designated covering proctor-mentor am entitled to all of the immunities and protections from liability to individuals who participate in this process.

Print Name: _____ Print Department/Division: _____

Signature: _____ Date: _____
(Stamped signature is not acceptable)

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Medical Staff Office

		Document No: [Subject]	Page 1 of 5
Title: Practitioner's Re-Entry Plan Policy & Procedure (Medical Staff)	Effective Date: 8/8/2013 Revised: 7/11/24	<input type="checkbox"/> RUHS – Behavioral Health <input type="checkbox"/> RUHS – Community Health Centers <input type="checkbox"/> RUHS – Hospital Based Clinics <input type="checkbox"/> RUHS – Medical Center <input type="checkbox"/> RUHS – Public Health <input checked="" type="checkbox"/> Departmental	
Approved By: Medical Executive Committee		<input checked="" type="checkbox"/> Policy <input type="checkbox"/> Procedure <input type="checkbox"/> Guideline	

1. Purpose/Background:

- 1.1 An increasing number of physicians and other licensed independent practitioners (“practitioners”) face the challenge of obtaining staff membership and privileges after extended absences from the practice of clinical medicine. By example, such practitioners may be away from clinical practice for the following reasons:
 - a. To start a family
 - b. Due to personal illness
 - c. To care for an ill family member
 - d. Have been previously retired and now wish to re-enter practice
 - e. To engage in an extended period of medical research
 - f. To carry out medical-administrative functions
 - g. To participate in medical missions outside the USA
- 1.2 Riverside University Health System offers a Practitioner Re-Entry Plan (“PRP”) to support a safe return to clinical practice by those practitioners who meet the qualifications for membership on the Riverside University Health System Medical Staff but who have been clinically inactive for a period of two (2) year or more.

2. Policy

- 2.1 Riverside University Health System recognizes the importance of retaining highly qualified practitioners and supports the design and implementation of a Practitioner Re-Entry Plan (“PRP”) to promote a successful return to clinical practice.
- 2.2 Appointments are conditional upon timely completion and satisfactory performance of the conditions of the PRP. The PRP is part of the Medical Staff’s peer review and quality improvement process. The proctor and his/her covering designee are entitled to all of the immunities and protections from liability afforded to individuals who participate in the PRP.
- 2.3 The design and duration of the PRP, and the number of cases to be reviewed and/or proctored, will be as recommended by the Department Chair/Division Chief and subject to approval by the Credentials Committee.

- 2.4 The PRP process is to be completed within twelve (12) months of the date that the privileges are granted. The Credentials Committee may extend this time for good cause at the recommendation of the Department Chair.
- 2.5 Successful completion of the PRP requires the re-entering practitioner to have documentation of completion of the required number of cases within the accepted standard of care. See Medical Staff Bylaws, Completion of Proctoring.
- 2.6 Results of failure of the re-entering practitioner to comply with the terms of the PRP:
 - a. A failure to have reviewed the required number of cases and/or proctored within the 12-month time frame will be deemed a voluntary withdrawal of staff membership and privileges. The MEC, for good cause may grant a time-limited extension. The re-entering practitioner's inability to obtain such an extension does not give rise to procedural rights as described in Article 9 of the Medical Staff Bylaws.
 - b. A failure of the re-entering practitioner to satisfactorily perform the requirements of the PRP (including required proctoring)
 - c. If the denial is for a "medical disciplinary cause or reason", the re-entering practitioner will be afforded hearing rights under Article 9 of the Medical Staff Bylaws.
- 2.7 Eligibility for Participation in the RUHS-MC Re-Entry Plan (PR): In order to participate in the PRP, a re-entering practitioner must:
 - a. Be an existing RUHS-MC Medical Staff Member in good standing or, if a new Applicant, satisfy all credentialing requirements for appointment to the Provisional category of the RUHS-MC Medical Staff; and:
 - b. Agree to abide by, the *Practitioner Acknowledgement of Responsibilities – Exhibit 1.0*
 - c. Obtain a proctor/mentor who is currently, and will remain, a member in good standing of the Active Medical Staff during the term of the PRP, this proctor/mentor must meet the following criteria:
 - Have demonstrable clinical competence in his/her field of the practitioner seeking reentry.
 - Be approved by the Department Chair/Division as a proctor/mentor;
 - Have all privileges to be exercised by the practitioner.
 - Have had no disciplinary action imposed by the MEC as per the Medical Staff Bylaws during the twelve (12) months preceding the initiation of the PRP term;
 - Be willing to participate in the PRP and sign-off on all duties prescribed under the Proctor Acknowledgement - Exhibit 2.

2.8 Leave of Absence-Existing RUHS-MC Medical Staff/AHP Member – More Than Twenty-Four (24) Months:

- a. All existing RUHS-MC Medical Staff/AHP Members returning from a leave of absence must follow the Medical Staff Bylaws requirements and relevant Medical Staff policies.
- b. The PRP will, if deemed appropriate by the Department Chair or Division Chief, include a Focused Professional Practice Evaluation (FPPE), to evaluate medical knowledge, decision-making, and clinical skills of the re-entering practitioner. The Department Chair or Division Chief will also determine if direct proctoring will be required. Recommendations of the approved mentor/proctor are to be shared with the Department Chair/Division Chief, the Credentials Committee.
- c. An existing RUHS-MC Medical Staff Member returning to work following a leave of absence due to medical illness or accident must provide documentation to the MEC that a thorough fitness to work assessment (tailored to the type of illness or injury which addresses current cognitive capabilities, physical factors such as endurance and fatigue, emotional status and capacity to practice with or without accommodation) has been performed by a qualified and appropriate physician. The practitioner will provide a signed medical “return to work” clearance from said physician.
- d. At the discretion of the Department Chair/Division Chief, a re-entering practitioner may be referred to the Physician Well Being Committee (PWBC) for evaluation and/or monitoring.

2.9 Practitioner's Re-entering as New Applicants to the RUHS-MC Medical Staff With no Clinical Practice for Two (2) Years or More:

- a. All new applicants to the Provisional category of the RUHS-MC Medical Staff; must meet the basic qualifications for membership.
- b. Documentation to evidence completion of fifty (50) hours of Credit I Continuing Medical Education within the last twenty-four (24) months, with at least twenty-five (25) of those hours within the last twelve (12) months, must be provided to the RUHS-MC Medical Staff Services Department.
- c. For a practitioner who has been clinically inactive more than 3 years and fit the re-entry criteria, the chair may require that with his/her application for appointment that documentation of completion of a formal re-entry program approved by Department Chair/Division Chief and Credentials Committee. This documentation must address the practitioner's current medical knowledge, clinical reasoning, conceptualization, communication skills and ability to work with others. Tuition and/or other fees associated with the outside re-entry program are the responsibility of the practitioner seeking a return to clinical practice. If in the judgment of the chair that a formal program is not necessary for the scope of practice, the chair may request from the Credentials Committee approval to recommend additional Focused Professional Practice Evaluation (FPPE) for privileging purposes.
- d. At the discretion of the Department Chair/Division Chief, a re-entering practitioner may be referred to the Physician Well Being Committee (PWBC) for evaluation and/or monitoring.

2.10 Ongoing Professional Practice Evaluation (OPPE)/Proctoring:

- a. Proctoring will begin within the first one hundred twenty (120) days when privileges are initially granted, whether at the time of initial appointment, additional privileges, or the granting of temporary privileges (Bylaws Section 3.8-3 and RUHS-MC OPPE/FPPE Policy & Procedure).
- b. A minimum of 25% of proctoring cases will include Concurrent Proctoring: Direct observation of the procedure being performed, or medical management either through observation of the practitioner's interactions with the patient and staff, or review of clinical history and physical and treatment orders during the patient's hospital stay or clinic visit.
- c. At the conclusion of proctoring, the department chair shall provide a summary report to the Credentials Committee documenting a sufficient number of varied cases have been done at RUHS-MC to properly evaluate the clinical privileges requested.
- d. If there are insufficient cases or no patient care to properly evaluate the clinical privileges requested, the period of proctoring will be extended at the discretion of the Department Chair.

3. REFERENCES

- 3.1 State of California Title 22; Organized Medical Staff 70703 (d)
- 3.2 The Joint Commission: Hospitals; Medical Staff MS.01.01.01
- 3.3 California Evidence Code 1157
- 3.4 California Business and Professional Code 805

4. ATTACHMENTS

- 4.1 Exhibit 1 – Practitioner Re-Entry Plan Acknowledgement by the Re-Entering Practitioner
- 4.2 Exhibit 2 – Practitioner Re-Entry Plan Acknowledgement by the Proctor/Mentor

Document History:

Prior Release Dates: 8/8/2013, 1/2015, 1/1/2019; 3/11/2021		Retire Date: N/A	
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			three or more years changed to two (2) Years or More
7/11/2024	MEC	N	



Medical Staff
Well-Being Committee

Impairment at the Workplace

When a colleague needs help...

Medical Staff Impairment

All people, including medical care providers, are vulnerable to illness and stress which can lead to impairment in one's personal, social or work life. Healthcare professionals may be more susceptible than others to certain causes of impairment.

The primary goal of this brochure is to assist you in taking action if you are concerned that a colleague may be in need of help. Your compassion and action can have a positive effect on the safety and welfare of your colleague, patients, and community. This brochure describes impairment and ways to intervene appropriately.

The American Medical Association defines "impairment" as an inability to practice medicine with reasonable skill and safety due to physical or mental illness or excessive use or abuse of drugs, including alcohol. Impairment may be due to:

1. Substance Abuse

Alcohol abuse is the most common problem, but abuse of prescription and illicit drugs also occurs.

2. Psychosocial Stressors

Occupational stress, anxiety, depression, divorce and other relationship problems are the most common issues.

3. Physical Illness

Addiction, a treatable illness of the brain, and other acute and chronic medical conditions can lead to impaired functioning.

4. Cognitive Impairment

Problems with learning new things, remembering, concentrating or decision-making can have an adverse impact on functioning.



The Warning Signs

The person who is impaired often acts in an unusual manner and exhibits behaviors which can serve as warning signs of impairment. Indicators of impairment may include, but are not limited to, the following:

- **Loss of enthusiasm**
- **Negative attitude**
- **Changes in work habits**
- **Missed appointments and meetings**
- **Complaints from staff, patients, families**
- **Insomnia / appears tired**
- **Personal hygiene changes**
- **Change in demeanor: depressed, agitated, angry, restless or forgetful**

Why Help a Colleague

Early intervention is critical.

When left alone, impairment tends to worsen and can lead to drastic consequences, including divorce, financial disaster, job loss, or suicide. Severely impaired physicians are endangering the safety of not only themselves but also patients and colleagues on a daily basis. Early intervention helps save lives.

Outcomes:

In a five-year cohort study of U.S. physicians with substance use disorders, about 75% of those engaged in active recovery programs had favorable professional and health outcomes. (McLellan A, Skipper GS, Campbell M, DuPont RL. BMJ 2008; 337:2038).

How YOU Can Help

Impaired professionals may rationalize their behavior or deny that a problem exists. Therefore, many impaired medical care providers do not seek help on their own.

When warning signs of impairment are accompanied by denial or lack of insight, it is even more critical that you, the concerned colleague, take the initiative to ensure that help is made available to the ailing physician.

There are several steps you can take which respect confidentiality and also offer opportunity for your colleague to get help:

First

Approach your colleague in a quiet and confidential setting. Mention the specific behaviors which underlie your concerns about your colleague. Be direct and ask whether there is a problem.

Second

If your colleague denies there is a problem but you still suspect one, then call a reliable resource listed on this brochure for advice. This call can be done anonymously.

Third

Use your own observations, the advice from reliable resources, and your colleague's response to decide whether a problem still exists.

Fourth

If you are convinced your colleague is impaired, you must act. Call for help. The potential for a successful outcome is far greater with early intervention.

Contact Information

If there is imminent risk of harm to patients or others, please call the House Supervisor immediately at:

Freeset 18660 or
Pager 951-344-2907



If there is no imminent risk of harm, but you are convinced that your colleague has a problem and is not acknowledging it, then you must express your concerns to someone who can intervene. Your report is confidential. Please contact:

RUHS MEDICAL STAFF WELL-BEING COMMITTEE

The Medical Staff Well-Being Committee at RUHS Medical Center is dedicated to helping medical staff and resident physicians who may have an impairment that may affect their ability to practice medicine safely and effectively. Your report is confidential.

Dalia Balsamo, MD (Chair)

Phone: (951) 357-8763

E-mail: dbalsamo@ruhealth.org

RUHS MEDICAL STAFF ADMINISTRATION

Latisha Chavez, CPCS

Medical Staff Administration Director

Phone: (951) 486-4671

E-mail: latisha.chavez@ruhealth.org

Resources

RUHS EMPLOYEE ASSISTANCE

(951) 778-3970

CALIFORNIA MEDICAL ASSOCIATION

Confidential Physician Assistance

Hotline

(213) 383-2691

ALCOHOLICS ANONYMOUS

(909) 628-4428

NARCOTICS ANONYMOUS

(909) 795-0464

GAMBLERS ANONYMOUS

(855) 222-5542

SAMHSA (SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES)

NATIONAL HELPLINE

(800) 662-HELP (4357)

VETERANS CRISIS LINE

(800) 273-8255 and Press 1

NATIONAL SUICIDE PREVENTION LIFELINE

(800) 273-TALK (8255)

NATIONAL EATING DISORDERS ASSOCIATION

(800) 931-2237

ANAD (ANOREXIA NERVOSA AND ASSOCIATED DISORDERS) HELPLINE

(630) 577-1330

TREVOR LIFELINE (LGBTQ)

(866) 488-7386

TRANS LIFELINE

(877) 565-8860



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**Riverside University Health System- Medical Center
Performance Improvement and Patient Safety Plan
July 2024 - June 2025**

I - INTRODUCTION

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

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

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

II - PURPOSE AND GOALS

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

The goals of the plan include:

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

III - SCOPE OF SERVICES

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

IV - ORGANIZATION AND ACCOUNTABILITY

Board of Supervisors

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

Medical Staff Organization

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

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

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

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

Administration

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

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

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

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

Hospital Managers/Directors

Hospital managers/directors are responsible for:

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

Quality Management Department

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

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

Patient Safety Officer

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

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

Employees, medical staff members and volunteers

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

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

The Performance Improvement and Patient Safety Committee

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

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

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

V - PERFORMANCE IMPROVEMENT

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

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

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

Performance Measurement and Monitoring

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

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

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

Performance and Patient Safety Assessment

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

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

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

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

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

FMEA approved for 2024-2025: Transitions of Care VSA: Heart Failure Readmission Reduction

Assessment of Findings Related to the Performance of an Individual

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

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

Prioritization of Performance Improvement Opportunities

Prioritization of performance improvement initiatives are based on the following:

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

Performance Improvement Priorities for 2024-2025 (see attachment A):

- Transitions of Care
- Maintaining a Culture of Safety through implementation of:
 - RUHS Cares
 - TeamSTEPPS

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

- Quality Reporting including Core Measures and Claims-based measures by CMSI
- Improving Experience:
 - Patient satisfaction (HCAHPS and CG-CAHPS)
 - Employee/provider satisfaction
- Primary Stroke Center Core Measures
- Sepsis management and mortality
- Pressure injury prevention and management
- Reduction in hospital Patient Safety Indicator (PSI) Events

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

Reduce risk and all-cause harm to patients

- Antibiotic stewardship
- Opioid stewardship
- Collaboration with Medication Safety program
- Infection prevention and control
- Compliance with new and existing National Patient Safety Goals (NPSG)
- Inpatient and OR Glycemic control
- Leapfrog safety measures

Improve care efficiencies and expand Lean methodology

- Implementation of hospital-wide management of daily improvement (MDI) daily huddle and performance boards
- Leadership rounding
- Value Stream Steering Committee
- Nursing Staffing Effectiveness Committee

VI - PATIENT SAFETY

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

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

Identification of patient safety issues

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

Response to a patient safety incident

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

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

The incident will be reported as described below.

Incident reporting

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

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

Managing serious, potentially serious and sentinel events

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

Communication of unanticipated outcomes

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

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

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

Sentinel Event Alerts

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

Root Cause Analysis (RCA) and Quality Case Conference

Significant adverse events are reviewed for need of an RCA. A root cause analysis requires a comprehensive systematic analysis which seeks to go beyond individual performance issues to determine the gaps in systems and processes that contributed to the significant adverse event and to identify strong corrective actions. Significant incidents that do not rise to the level of an RCA may still need a multidisciplinary detailed review which will occur during a Quality Case Conference, using the continuous quality improvement approach. At RUHS-Medical Center, a multidisciplinary subcommittee of the PIPSC is put in place for completion of the Root Cause Analysis and/or Quality Case Conferences.

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

Patient safety education

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

- General Orientation
- Nursing and New Graduate Nursing Orientation
- GME/Resident Orientation
- RUHS Cares/ Culture of Safety Debriefing Sessions
- TeamSTEPPS

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

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

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

VII - CONFIDENTIALITY

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

VIII - ANNUAL EVALUATION

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

**Riverside University Health System (RUHS)
Utilization Management Committee & Utilization Review Plan
Fiscal Year (FY) 2024 – 2025**

APPLICABILITY

This policy (and any attachments) applies to the RUHS Moreno Valley Medical Campus and Arlington Psychiatric Hospital

POLICY

The Utilization Management (UM) Committee and Utilization Review (UR) plan provides a comprehensive and integrated review of services furnished by RUHS and members of the RUHS medical staff to patients receiving benefits under the Medicare and Medicaid programs. The UM Committee supports the mission, vision, and values of RUHS through commitment to high quality care in a safe environment while promoting appropriate and effective service through ongoing monitoring, trending and review of resource utilization, discharge planning and education programs. The UR plan is written in compliance with Social Security Amendments of 1983, as implemented by 42 CFR (Code of Federal Regulations) §482.30 Conditions of Participation of the Centers for Medicare and Medicaid Services (CMS) and complies with 42 CFR Part 456 Chapter C, Subpart D and CCR Title 9 Chapter 11, Title 22 Medi-Cal of California, Administration Code for Arlington Psychiatric Hospital.

PURPOSE

The UM committee is a hospital-wide multidisciplinary effort to monitor and evaluate hospital resource utilization to promote timely, optimal, and medically necessary patient care in the most appropriate setting. The UR plan applies to all individuals receiving inpatient or outpatient observation care at RUHS regardless of payor source. The responsibilities and purpose of the UM Committee include but are not limited to:

- I. Evaluation of the medical necessity and appropriateness of acute hospital and psychiatric hospital admission, level of care, timeliness of admissions and necessity of continued acute stay including the efficient provision of professional services, imaging, medications, and biologicals.
- II. Provision of effective and high-quality patient care in the most cost-effective manner, regardless of payment source.
- III. Review for over-utilization, under-utilization, inefficiency, and delays of care.
- IV. Provision of continuity of inpatient care and aftercare across all appropriate patient populations and healthcare settings through utilization of community resources when appropriate.
- V. Ensure conformity to established standards of care.

FUNCTIONS AND RESPONSIBILITIES

Utilization Management (UM) processes include, but are not limited to the following:

- Coordination and monitoring of all utilization management activities, including internal and external reviews by third party payors.
- Ensure that the Psychiatric UR review process complies with the requirements of The Joint Commission (TJC), Department of Health Services/Department of Mental Health, CCR Title 9 Chapter 11, Title 22 Medi-Cal of California, Administration Code, the Centers for Medicare, and Medicaid Services (CMS), and Code of Federal Regulations, Title 42, Subchapter C, Subchapter D (Arlington Psychiatric Hospital).
- Perform quality of care reviews according to the standards and criteria implemented by the State of California (Arlington Psychiatric Hospital). (Is quality review really a function of UM committee??)
- Review the Psychiatric Administrative Days Report by the UR Committee at designated meetings including audit sample reviews for the accuracy of admissions, continued stays, and adverse decision previously reviewed by the BH (Behavioral Health) QI Coordinator, Utilization Review Nurse, and the Physician Advisor (Arlington Psychiatric Hospital).
- Medical necessity review before, at, or after admission and concurrently to ensure appropriate admission level of care, continued stay, resource utilization and reduction in delays of care.
- Retrospective review and analysis of denials and appeal trends.

- Prospective review for preadmission screening as appropriate.
- Monitoring deviations from established care patterns and quality-of-care concerns.
- Review of outlier cases with extended length of stay or encounters and extraordinarily high cost including those for professional services, imaging, medications, and biologicals.
- Coordination with patients, family, physicians, and other hospital staff to achieve a plan that is consistent with the patient's aftercare needs and preferences (*refer to RUHS Patient Discharge Planning and Patient Discharge Policy HW 632 and Discharge Planning Homeless Patients Policy HW 632.1*).
- Review readmission data to address trends for avoidable return to hospital.
- Support issuance of mandated patient notices per Medicare, Medicaid and third-party payor guidelines and contracts as applicable (e.g., HINN, MOON, IMM, DND, etc.) (*refer to RUHS Medicare Notifications Policy HW 148*).
- Provide information and education to medical staff members and appropriate committees regarding utilization management issues and patterns.
- Facilitate compliance with the California DHCS (Department of Health Care Services) Superior Systems Waiver TAR-Free process and Acute Administrative day documentation as defined by Cal. Admin. Code tit. 22, § 51173, 22 CA ADC § 51173.
- Report activities and findings to the RUHS Medical Executive Committee.

MEETING FREQUENCY

The UM Committee will meet at least once per quarter per fiscal year. Additional meetings may be scheduled at the committee's discretion. Committee attendance and minutes are recorded and presented to the Medical Executive Committee quarterly.

ORGANIZATION AND COMPOSITION

The RUHS UM Committee ~~is a sub-committee of the~~ reports to the Medical Executive Committee. The UM Committee is delegated to perform utilization management functions for the organization. The committee chairperson is responsible for ensuring membership is adequate to address patient issues. RUHS Medical Center membership consists of a multidisciplinary team that includes representatives from the following:

- Two or more practitioners to carry out the UM (Utilization Management) function.
- At least two of the committee members must be a Doctor of Medicine or osteopathy.
- The Committee may also include other physician members as recommended by the UM Committee Chair, with approval of the Facility Medical Staff President.
- Non-physician representatives include Case management, Social Service, Utilization Review, Nursing, and Ancillary Departments (such as pharmacy, quality, revenue cycle, patient access, health information management, physical therapy, etc.) and executive hospital leadership such as the CFO (Chief Financial Officer), CNO (Chief Nursing Officer), or CMO (Chief Medical Officer).
- CM (Case Management) UM Committee members are appointed for a term of one year and may be reappointed for succeeding terms by the Chairman of the RUHS Medical Executive Committee.

The Arlington Psychiatric Hospital composition of the committee shall meet the requirements of Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D. The UM Committee consists of a multidisciplinary team from the Arlington Psychiatric Campus that includes:

- Two or more physicians, one of whom is knowledgeable in the diagnosis and treatment of mental diseases and assisted by other professional personnel. The committee is supported by other professional staff involved in the day-to-day process of utilization review. One (1) physician must be present as part of the quorum for the committee to meet.
- Non-physician representatives may include BHQI (Behavioral Health QI) Coordinator, Case Management, Social Service, Utilization Review, Nursing, and Ancillary Departments (such as quality, patient access, health information management, etc.) and hospital administrator or their designee.

REVIEW CRITERIA AND DELEGATION OF UTILIZATION REVIEW ACTIVITIES

The RUHS Case Management (CM) and Utilization Review (UR) nurses are authorized by the UM Committee to perform admission, pre-admission, concurrent and retrospective reviews for level of care

determination using nationally recognized, evidence-based medical criteria to ensure compliance with Federal, State, and County laws, mandates or regulations and third-party payer requirements. Cases that do not meet screening criteria are referred to a designated Physician Advisor for secondary review or evaluation. Non-physicians are not allowed to render a final decision regarding denial of continued care or services. CM and UR Nurses UR activities are outlined in ICM 201 Guidelines for Clinical Review.

The RUHS BHQI Coordinators and UR Case Managers at the Arlington Psychiatric Hospital are authorized by the UM Committee to perform admission, pre-admission, concurrent and continued stay, administrative day services and retrospective reviews for level of care determination using Title IX Subsections (a)(1)-(2) treatment standard for evaluating necessity for Short-Doyle Medi-Cal patients. Nationally recognized, evidence-based medical criteria are used for all other payors. RUHS BHQI Coordinators work directly with Medi-Cal for Short-Doyle reimbursement. BHQI Department staff coordinate concurrently with psychiatrists to ensure medical necessity for admission and continued stay is evident and documented in the patients' records. RUHS Behavioral Health QI (BHQI) Coordinators and designated RUHS Case Managers or Social workers will maintain daily oversight of clinical care coordination, utilization of services and quality trends of treatment for patients regardless of insurance type.

CONFLICT OF INTEREST

The committee's reviews may not be conducted by any individual who:

- i. Has a direct financial interest (for example, an ownership interest) in the organization or with respect to the case being reviewed.
- ii. Was professionally involved in the care of the patient whose case is being reviewed.

PROCESSES

RUHS Medical Center:

Method of Case Selection

Reviews are made based on the medical necessity of admission to inpatients, duration of stay by diagnosis, or other identified variances in care to promote the most efficient use of facilities and services. Reviews emphasize identification and analysis of care patterns to maintain consistent high quality of care. All diagnoses are sampled through the EMR (Electronic Medical Record) to include a cross-section of patients with similar medical problems. Patients who stay longer than the pre-established length of stay by diagnosis are reviewed. Review of cases includes diagnoses of special relevance to the aging population. Some review functions are carried out on a continuing basis. Reviews may be conducted before or after hospital admission including a sample of recertification of medical necessity.

For Hospitals excluded from the Medicare acute care prospective payment system (exempt facilities include rehabilitation, long-term, psychiatric, children's and cancer hospitals, as well as rehabilitation and psychiatric units in acute care hospitals), the Utilization Management Committee must conduct period reviews of patients during a continuous or extended stay. The timing of the scheduled reviews, as specified by the UR plan, may be the same for all cases or different for different classes of cases.

Arlington Psychiatric Hospital:

I. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

(a) For Medi-Cal reimbursement for an admission to a hospital for psychiatric inpatient hospital services, the beneficiary shall meet medical necessity criteria set forth in Subsections (a)(1)-(2) below:

(1) One of the following diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM-IV™ (1994)*, published by the American Psychiatric Association:

- (A) Pervasive Developmental Disorders
- (B) Disruptive Behavior and Attention Deficit Disorders
- (C) Feeding and Eating Disorders of Infancy or Early Childhood
- (D) Tic Disorders
- (E) Elimination Disorders
- (F) Other Disorders of Infancy, Childhood, or Adolescence

- (G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
- (H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
- (I) Schizophrenia and Other Psychotic Disorders
- (J) Mood Disorders
- (K) Anxiety Disorders
- (L) Somatoform Disorders
- (M) Dissociative Disorders
- (N) Eating Disorders
- (O) Intermittent Explosive Disorder
- (P) Pyromania
- (Q) Adjustment Disorders
- (R) Personality Disorders

(2) Both the following criteria:

(A) Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and

(B) Requires psychiatric inpatient hospital services due to a mental disorder, due to the indications in either Subsection (a)(2)(B)1. or 2. below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):

- a. Represent a current danger to self or others, or significant property destruction.
- b. Prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter.
- c. Present a severe risk to the beneficiary's physical health.
- d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:

- a. Further psychiatric evaluation.
- b. Medication treatment.
- c. Other treatment that can reasonably be provided only if the patient is hospitalized.

(b) Continued stay services in a hospital shall only be reimbursed when a beneficiary experience one of the following:

(1) Continued presence of indications that meet the medical necessity criteria as specified in (a).

(2) Serious adverse reactions to medications, procedures or therapies requiring continued hospitalization.

(3) Presence of new indications that meet medical necessity criteria specified in (a).

(4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a hospital.

Determination of admission or continued stay

RUHS Medical Center:

The case management and utilization review department utilize nationally recognized, evidence-based medical criteria to screen medical necessity for admission and continued hospital stay.

- If the screening criteria are not met the case is escalated for secondary review. The determination that an admission or continued stay is not medically necessary:
 - I. May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified in [§ 482.12\(c\)](#), concur with the determination, or fail to present their views when afforded the opportunity; and
 - II. Must be made by at least two members of the UM committee (must include Department of Psychiatry for Arlington Psychiatric Hospital) in all other cases.
- Before deciding that an admission or continued stay is not medically necessary, the UM committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in [§ 482.12\(c\)](#), and afford the practitioner or practitioners the opportunity to

present their views.

- If the committee decides that admission or continued stay in the hospital is not medically necessary, written notice must be given to the attending physician, the hospital, and the patient no later than 2 days after determination as specified in [§ 482.12\(c\)](#).

Arlington Psychiatric Hospital:

The beneficiary's continued inpatient psychiatric stay is reviewed by the BH QI Coordinator or UR Nurse, in accordance with the requirements of Title IX Subsections (a)(1)-(2) treatment standard for evaluating necessity for Short-Doyle MediCal, nationally recognized, evidence-based medical criteria and administrative day guidelines, as applicable.

- 1) Once continued inpatient psychiatric stay is determined, the next review date is **assigned based on anticipated discharge date or at least every 3 working days if no discharge is anticipated**.
- 2) The patient's continued stay is reviewed on or before the expiration of each assigned continued stay review date.
- 3) For each continued inpatient stay a review of the documentation and criteria above is performed and the next review date is documented in the patient's record.
- 4) If continued stay does not meet the criteria the physician advisor process is followed.
- 5) At each continued stay review, Short-Doyle funded inpatients shall be re-evaluated for eligibility for other funding.

Extended stay review

The UM committee reviews outlier cases when the length of stay exceeds the threshold criteria for the diagnosis, as specified in [§ 412.80\(a\)\(1\)\(i\)](#). The UM Committee is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis. The UM committee must make the periodic review no later than 7 days from the outlier date.

Medicare part A for inpatient hospital services (other than inpatient psychiatric facility services) for patients that are 20 inpatient days or more require recertification for outlier payment. Recertification requirements for patients needing continued clinical care are as follows:

1. Continued hospitalization for medical treatment or medically required diagnostic study; or
2. Special or unusual services or cost outlier cases
3. The estimated time the patient will need to remain in the hospital.

Certification or recertification must be documented in the medical record by the physician responsible for the case or another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff. Subsequent recertifications are required at intervals of every 30 days.

Recertification requirements for continued hospitalization when a skilled nursing facility (SNF) bed is not available:

1. The physician may certify or recertify the need for continued hospitalization if the patient could seek treatment in a SNF but that there is no bed available.
2. If this is the basis for the physician's certification or recertification, the required statement must so indicate; and, continued efforts to place the patient in a SNF bed as soon as possible must be documented in the medical record.

Definition of Period of Extended Duration

Statistical reports kept by the Case Management Department indicate the average length of stay for patients on each service. These standards are utilized along with the judgment of the physicians who conduct medical record review to determine which patients stay in the hospital overly long and which patients are discharged too early. Any continuous hospitalization of Medicare patients over 30 days is considered extended.

Medi-Cal Acute Administrative Day

RUHS Medical Center:

Medi-Cal funds cannot be paid at an acute level of care rate when the patient is receiving a lower level of care. There are instances when a patient's level of care is not at the acute level, but they must remain in an acute setting due to:

1. An inability to find nursing facility placement (Acute Administrative Days).
2. Documentation of attempts at placement is required for payment of acute administrative days for nursing facility placement.
3. Patients with tuberculosis (TB) in isolation awaiting negative TB sputum tests following initiation of treatment (TB Administrative Days).
4. Monitoring of an at-risk obstetrical patient (OB Administrative Days).

When a patient no longer meets continued hospitalization but does not have safe facility placement, continued stay is considered as an administrative day as defined under Cal. Admin. Code tit. 22, § 51173, 22 CA ADC § 51173. Placement calls are documented based on the requirements outlined in Cal. Admin. Code tit. 22, § 51173, 22 CA ADC § 51173 for Medi-Cal and some Managed Care Medi-Cal products:

- (A) Documentation of at least one approved acute hospital day prior to initiating Administrative Days.
- (B) Facility placement calls as outlined:
 - i. Ten calls or referrals to approved facilities each day unless there are fewer than ten appropriate facilities potentially available.
 - ii. Call or referral documentation must include:
 - (i) Name of the facility called
 - (ii) Date of the contact
 - (iii) Status of the placement call (accepted or denied)
 - (iv) Name and signature of the placement worker

Arlington Psychiatric Hospital:

For Medi-Cal and certain Managed Medi-Cal plans, if a patient no longer meets criteria for medical necessity but the patient does not have a safe discharge placement, the continued stay may meet criteria for Administrative Days per Cal. Admin. Code tit. 22, § 51173, 22 CA ADC § 51173 guidelines. The attending physician, with the support of the BH QI Coordinator, discharge planner or UR nurse, will indicate when Administrative Days are to begin. Administrative day designation must meet the following requirements:

1. The presence of an Acute Day - documentation must support medical necessity for at least one acute hospital day prior to initiating Administrative Days.
2. There is no appropriate, non-acute residential treatment facility within a reasonable geographic area and there is documentation of **at least five placement calls** to an appropriate, non-acute residential treatment facility **per week** for placement of the beneficiary subject to the following requirements:
 - a. Name of the specific facility called.
 - b. The date of the contact.
 - c. The status of the placement call (patient accepted or denied).
 - d. The signature of the placement worker.
3. The requirement of five contacts per week can be waived if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options.

In no case shall there be less than one placement contact per week

Professional Services Review

The UM Committee will periodically review professional services provided to determine medical necessity and the appropriate utilization of health facilities and services including but not limited to

- a) Availability and use of necessary services - underused, overuse, appropriate use
- b) Timeliness of scheduling of services - operating room, diagnostic
- c) Therapeutic procedures

“Professional Services” include care rendered by Physicians and ancillary services (medications, biologicals, imaging, etc.). UM Committee reviews outlier cases based on extraordinarily excessive costs as outlined in 42 CFR 412.80: The beneficiary's length-of-stay does not exceed criteria established under [paragraph \(a\)\(1\)\(i\)](#) of this section, but the hospital's charges for covered services furnished to the beneficiary, adjusted to operating costs and capital costs by applying cost-to-charge ratios as described in [§ 412.84\(h\)](#), exceed the DRG (Diagnosis Related Group) payment for the case

plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

CONFIDENTIALITY

All members of the UM Committee shall abide by all applicable laws, regulations, policies, and procedures to maintain the confidentiality of the patient's medical information. All UM Committee records, minutes, agenda, reports, physician profiles and data are confidential and protected under Med Staff Committee Manual Evidence Code 1157 – Immunity from discovery and applicable RUHS confidentiality policies.

RECORDS

Meeting minutes and UM committee documents are maintained by the Director of Integrated Case Management or their designee for at least 7 years (*per federal regs* 45 CFR § 164.524). A summary of the number and types of cases reviewed, data, documents and the findings are part of the records. Committee action in extended stay cases, noted outlier practice pattern variances, and other instances of excessive utilization of hospital resources are recorded. Access to the aforementioned information is limited to authorized individuals, government, licensing, or regulatory entities.

ANNUAL REVIEW

The UM Committee performs an annual review of the utilization management program, including the written Utilization Review plan, screening criteria, length of stay norms, readmission data, denial, and appeal activities. The Medical Executive Committee and RUHS Governing body through the Performance Improvement Committee (PIC) present aggregate committee data, reports, and the UR plan annually for approval. The plan is revised as needed based on prior year's utilization management activities and outcomes.

AUTHORITATIVE REFERENCES

Federal

1. 42 CFR §482.30 Condition of Participation: Utilization Review [eCFR :: 42 CFR 482.30 -- Condition of participation: Utilization review.](#)
2. 42 CFR §412.80 Outlier cases: General provisions <https://www.ecfr.gov/current/title-42/section-412.80>
3. 42 CFR §482.12 Governing Body – Standard: Care of Patients [eCFR :: 42 CFR 482.12 -- Condition of participation: Governing body.](#)
4. [42 CFR Subchapter C, part 456, Subchapter D](#)
5. [45 CFR](#) §164.524

State specific

1. California DHCS Superior Waiver Systems [TAR-Free Process \(ca.gov\)](#)
2. CCR Title 22 Acute Administrative Days Cal. Admin. Code tit. 22, § 51173, 22 CA ADC § 51173 [View Document - California Code of Regulations \(westlaw.com\)](#)
3. California DHCS Acute Administrative Days [TAR \(Treatment Authorization Request\)](#) Criteria for Acute Administrative Days (AAD) (tar crit [aad](#)) ([ca.gov](#)) and [Administrative Days \(admin\)](#) ([ca.gov](#))
4. Cal. Admin. Code tit. 9, § 1820.205, 9 CA ADC § 1820.205 [View Document - California Code of Regulations \(westlaw.com\)](#)
5. 9 CCR § 1830.205 § 1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services. [View Document - California Code of Regulations \(westlaw.com\)](#)
6. Section 14680, Welfare, and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code
- 7.

RELATED POLICIES

1. **Med Staff Committee Manual Evidence Code 1157 – Immunity from discovery** Patient Discharge Planning and Patient Discharge Policy 632

2. Discharge Planning – Homeless Patients Policy 632.1
3. Medicare Notifications Policy 148

RELATED PROCEDURES

1. ICM201 Guideline for completion of clinical reviews

ATTACHMENTS

Not Applicable

APPROVALS

Committee approvals as documented on date indicated.

Individual / Committee Name	Date Approved	Notes
RUHS Moreno Valley Utilization Management Committee	6/27/24	Dr Huy Au, Dr Daniel Kim, Dr Shunling Tsang
Medical Executive Committee		
Performance Improvement Committee		