TRI-CITY HEALTHCARE DISTRICT
OF THE GOVERNANCE & LEGISLATIVE COMMITTEE
OF THE BOARD OF DIRECTORS
Tuesday, March 7, 2017
12:30 p.m. – Assembly Room 3
Tri-City Medical Center, 4002 Vista Way, Oceanside, CA 92056

The Committee may make recommendations to the Board on any of the items listed below, unless the item is specifically labeled "Informational Only"

	Agenda Item	Time Allotted	Requestor/ Presenter
1.	Call to Order/Opening Remarks/ Welcome New Committee Member	2 min.	Chair
2.	Approval of agenda	2 min.	Chair
3.	Public Comments – Announcement Comments may be made at this time by members of the public on any item on the Agenda before the Committee's consideration of the item or on any matter within the jurisdiction of the Committee. NOTE: During the Committee's consideration of any Agenda item, members of the public also have the right to address the Committee at that time regarding that item		
4.	Ratification of minutes of prior meeting	2 min.	Standard
5.	Old Business – **Discussion/Possible Action** - None	--	--
6.	New Business - **Discussion/Possible Action**		
	a. Medical Staff Rules & Regulations: 1) Division of General & Vascular Surgery 2) Division of Urology 3) Division of Orthopedic Surgery 4) Department of Obstetrics & Gynecology 5) Allied Health Professionals	20 min.	S. Miller
	b Review and discussion of Board Policy 16-037 – Chief Executive Officer and Chief Compliance Officer Succession Planning Policy	15 min.	Director Reno
	c. Review and discussion of Board Policy 15-039 – Comprehensive Code of Conduct	15 min.	Director Reno

Note: Any writings or documents provided to a majority of the members of Tri-City Healthcare District regarding any item on this Agenda will be made available for public inspection in the Administration Department located at 4002 Vista Way, Oceanside, CA 92056 during normal business hours

Note: If you have a disability, please notify us at 760-940-3347 at least 48 hours prior to the meeting so that we may provide reasonable accommodations

	d. Consider recommending Board Educational Workshop	10 min.	Director Reno
	e. Consideration to apply for ACHD Certified District Designation	10 min.	Director Mitchell
7.	Discussion regarding Current Legislation – **Informational Only**	15 min.	Director Reno
8.	Review of Committee FY2017 Work Plan – **Informational Only**	5 min.	Standard
9	Committee Communications	5 min.	Standard
10.	Committee Openings – One	–	Standard
11.	Confirm Date of Next Meeting – April 4, 2017 – 12:30 p.m.	--	Standard
12	Adjournment		
	Total Time Budgeting for Meeting	2 hours	

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Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
February 7, 2017

Members Present: James J. Dagostino, DPT, PT, Chairperson; Director Laura E. Mitchell, Director RoseMarie V. Reno; Dr. Paul Slowik, Community Member; Dr. Cary Mells, Physician Member; Dr. Gene Ma, Chief of Staff ; Dr. Marcus Contardo, Physician Member; Sherry Miller, Manager, Medical Staff Office

Non-Voting Members: Steve Dietlin, CEO; Kapua Conley, COO; Cheryle Bernard-Shaw, Chief Compliance Officer

Others Present: David Bennett, CMO; Wayne Knight, CSO; Teri Donnellan, Executive Assistant; Jane Dunmeyer, League of Women Voters; Robin Iveson, Community Member; Greg Moser, General Counsel

Absent:

	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	The meeting was called to order at 12:30 p.m.in Assembly Room 3 at Tri-City Medical Center by Chairman Dagostino. Chairman Dagostino reported Mr. Eric Burch has resigned from the committee due to a potential relocation.		
2. Approval of Agenda	**It was moved by Director Reno to approve the agenda as presented. Dr. Ma seconded the motion. The motion passed unanimously.**	Agenda approved.	
3. Comments from members of the public	Chairman Dagostino read the Public Comments announcement as listed on today's Agenda.	Information only	
4. Ratification of prior Minutes	**It was moved by Director Reno and seconded by Director Mitchell to ratify the minutes of the January 3, 2017 Governance & Legislative Committee. The motion passed unanimously.**	Minutes ratified.	Ms. Donnellan
5. Old Business a. Review and discussion of Committee Charter	Chairman Dagostino stated the Board referred the Committee's Charter back to the Committee upon a recommendation and advice of the Medical Executive		

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
1) Governance & Legislative Committee	Committee to strike Privilege Cards from the committee's purview. The rationale is that the Privilege Cards are debated through the Medical Staff committees and ultimately brought to the Board. In addition, due to the apparent lack of community member interest on the committee it was recommended the number of community members be changed to a minimum of two and a maximum of three. Discussion was held regarding the advertisement for community members. Chairman Dagostino explained an ad is placed in the Coast News and on our internet. He confirmed that we no longer place ads in the Union Tribune. Director Reno stated community members do not understand what the committee does and therefore feel useless. Discussion was held regarding broadening the search to other areas such as college newspapers and senior centers. Director Reno stated in her opinion it is time for a Board Educational Workshop to discuss items of this nature with a Board Facilitator. Chairman Dagostino noted our last Board Facilitator indicated the Board has too many meetings and suggested the possibility of consolidating committees. **It was moved by Director Reno to recommend approval of the amended Governance & Legislative Committee Charter as presented. Director Mitchell seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve the Governance & Legislative Committee Charter as presented; item to be placed on Board agenda and included in agenda packet.	Ms. Donnellan
6. New Business a. Medical Staff Rules & Regulations: 1) Division of Podiatric Surgery 2) Department of Medicine	Dr. Ma reported the Division of Podiatric Surgery Rules & Regulations were placed on today's agenda following a question at last month's meeting related to Podiatric Surgery. Ms. Sherry Miller explained the core privileges for all of the Rules & Regulations presented today are being removed from the Rules& Regulations and will be a		

4

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
3) Division of Neonatology 4) Department of Emergency Medicine	separate document known as the Privilege Card. Dr. Slowik questioned who has oversight of the Privilege Cards. Dr. Ma stated there is a collaborative process where the needs of the organization are considered. There were no suggested revisions to the Rules & Regulations presented for consideration. **It was moved by Dr. Slowik to recommend approval of the Division of Podiatric Surgery, Department of Medicine, Division of Neonatology and Department of Emergency Medicine Rules & Regulations as presented. Dr. Contardo seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve the Division of Podiatric Surgery, Department of Medicine, Division of Neonatology and Department of Emergency Medicine Rules & Regulations; items to be placed on Board agenda and included in agenda packet.	Ms. Donnellan
b. Review and discussion of Board Policy 17-010 – Board Meeting Agenda Development, Efficiency and Time Limits for Board Meetings	Chairman Dagostino reported Board Policy 17-010 – Board Meeting Agenda Development, Efficiency and Time Limits for Board Meetings was referred by the Board to the Committee. He explained the policy as written allows an individual Board member to request items be placed directly on the Board agenda. Per discussion at the Board meeting it was suggested that action items be referred to the appropriate Board committee for consideration prior to the full Board. Chairman Dagostino stated when a Board agenda item is requested by a Board member the item will be considered at the agenda conference by the Board Chair, CEO and General Counsel and action items will routinely be referred to the appropriate committee. **It was moved by Director Mitchell to recommend approval of Board Policy 17-010 – Board Meeting Agenda Development, Efficiency and Time Limits for Board Meetings. Dr. Mells seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve Board Policy 17-010 – Board Meeting Agenda Development, Efficiency and Time Limits for Board Meetings as written; item to be placed on Board Agenda and appear in agenda packet.	Ms. Donnellan
c Consider development of a new	Chairman Dagostino explained this agenda item was		

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			DRAFT
Board Policy related to the Board's contract approval process	requested by Director Reno and referred by the Board to this committee. Chairman Dagostino stated that although there is not a Board Policy related to the contract approval process there is an Administrative Policy 8610-278 entitled Contract Review. Director Reno expressed concern that it is an Administrative Policy rather than a Board Policy yet the Board is held accountable. Mr. Moser stated there is no distinction between a Board and an Administrative Policy and both are enforceable. Ms. Bernard-Shaw stated the Contract Review Administrative Policy is "tied" into Board Policy 013 – Policies and Procedures Including Bidding Regulations Governing Purchase of Supplies and Equipment, Procurement of Professional Services and Bidding for Public Water Contracts. Mr. Conley stated Policy 8610-278 is a procedural document that was recently revised to adjust the process based on feedback during a CMS visit. Mr. Conley further explained that the policy gives us the flexibility to adjust the process as needed based on CDPH regulations. Mr. Knight recommended Exhibit A be amended to strike Clinical Trial Agreements (device and drug) from the first sentence and move to letter s. Mr. Dietlin suggested the addition of the word "oversight" to Section C. 2. a. to read "The Governing Body is responsible for **oversight** of all services covered under contracts at Tri-City Healthcare District (TCHD)". Ms. Bernard-Shaw recommended the policy be sent back to the AP&P Committee with revisions as described. Mr. Moser noted upon review by AP&P the policy should go through the Audit, Compliance & Ethics Committee as noted on the Department Approval Dates. The committee directed administration to revise the	Administrative Policy 8610-278 will be	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	policy as described and send through the appropriate committees for approval.	revised as described and sent through the appropriate approval process.	
d. Interviews of community candidates for open community seat on Governance & Legislative Committee (1) Robin Iveson	Chairman Dagostino introduced candidate Ms. Robin Iveson to committee members. Ms. Iveson provided a brief summary of her background and experience. She stated that she has served on several hospital committees over the years, most recently the Community Healthcare & Alliance Committee. Ms. Iveson stated she had some concern over the recent resignation of several of the community committee members who expressed they did not feel their input was of much value to the committee. Ms. Iveson stated she believes the community member's input and role is very important and she would be honored to serve on the committee. Committee members commented on Ms. Iveson's commitment to the District and her diligence in attending not only committee meetings but also the regular monthly board meetings. *Ms. Iveson left the meeting at 1:28 p.m. to allow discussion by committee members.* Committee members unanimously agreed that Ms. Iveson has the passion, credentials, experience and dedication to serve on the committee. **It was moved by Director Mitchell to recommend that Ms. Robin Iveson be appointed to a two year term on the Governance & Legislative Committee. Dr. Mells seconded the motion. The motion passed unanimously.** *Ms. Iveson returned to the meeting at 1:35 p.m.* Chairman Dagostino reported the committee unanimously recommended Ms. Robin Iveson be recommended for appointment to the Governance & Legislative Committee.	Recommendation to be sent to the Board of Directors to recommend Robin Iveson be appointed to a two-year term on the committee; item to be placed under New Business on Board agenda and included in agenda packet.	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible
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7. Discussion regarding Current Legislation	The committee had extensive discussion regarding Key State Issues, including the following: ➢ AB 1774 – Would have repealed the laws requiring a clinical laboratory to be licensed and inspected by CDPH including the licensing fee. (Held on Suspense in Assembly Appropriations Committee May 27th and supported by CHA). ➢ SB 1076 – Creates the regulatory structure for hospitals wishing to provide observation services in a dedicated unit. The bill states that observation patients may also be cared for in an inpatient unit or in the ED. (Signed by the Governor September 27. CHA's position is neutral). *It was suggested Mr. Dietlin and Mr. Conley delve deeper into the bill to determine what is different from current procedure.* ➢ AB 533 – Attempted to address "surprise billing" by out-of-network providers. Bill was amended April 15 and would have applied only to non-contracting individual health professionals, not to hospitals. (Placed on Assembly Inactive File August 31. CHA's position is neutral). *Dr. Ma expressed frustration with AB 533 and stated as a healthcare provider you have no leverage and is concerned that CHA has taken a neutral position on this bill.* ➢ AB 1568 - Along with SB 815, implements California's section 1115(a) demonstration waiver, titled "California's Medi-Cal 2020 Demonstration." The waiver renewal effective December 30, 2016 through December 31, 2020 included $6.2 billion of initial federal funding to support the state's Medi-Cal program. (Signed by the Governor July 1 and supported by CHA). *Mr. Dietlin noted both AB 1568 and SP 815 relate to PRIME.* ➢ AB 2024 – Authorizes a critical access hospital to employ physicians, surgeons and doctors of podiatric medicine and charge for professional		

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			DRAFT
	services rendered by those medical professionals if the Medical Staff concurs, by an affirmative vote, that which employment is in the best interest of the communities the hospital serves. (Signed by the Governor September 23 and supported by CHA).*Mr. Moser noted the bill will largely affect the rural areas.* ➢ AB 1300 – Would have specified that trained emergency room physicians and psychiatric professionals in non-designated hospitals, when probable cause exists, have the authority to write/initiate an up to 72-hour involuntary hold. (Referred to Senate Rules Committee and sponsored by CHA.) *Dr. Ma clarified this bill is for non-designated hospitals such as those that do not have an LPS.* ➢ AB 1306 – Would have removed the physician supervision requirement on certified nurse midwives, allowing them greater independence in meeting the health care needs of the millions of individuals added to California's health are system by the Affordable Care act and facilitating timely access to quality care. (Failed passage by full Assembly August 31 and supported by CHA.) ➢ SB 323 – Would have allowed nurse practitioners to practice to the full extent of their education and training to ensure access to healthcare delivery systems for millions of Californian's who now have access to coverage under the Affordable Care Act. (Held in the Assembly Business Professions Committee June 28 and supported by CHA). In addition, Mr. Moser reported on AB 1978 which will require janitors to be trained on sexual harassment by their employers starting July 1, 2018. It was recommended the Key State Issues be included in the Board agenda packet for Chairman Dagostino to lead a discussion with the full Board	Key State Issues to be placed on the Board agenda and included in agenda packet.	Ms. Donnellan

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			DRAFT
	Dr. Ma stated if discussion of the Legislative Issues will be a component of this committee, it would be helpful to know the key positions and what is of concern to the physicians. It was suggested the March agenda include ACHD's proposed bills as well as CMA and CHA. Discussion was held as to whether the Committee should look at federal legislation. Chairman Dagostino stated he, Director Schallock and perhaps other Board members will be attending AHA's Annual Meeting in May in Washington, D.C. which will focus on federal legislation and will share that info with the Committee. Ms. Bernard-Shaw stated President Trump has alluded that the Affordable Care Act will stay in play through 2017 and into 2018. Discussion was held regarding the fact that the District does not have a dedicated Government Relations individual. Chairman Dagostino stated Board members have done a good job of keeping the District abreast and informed of legislative issues affecting the District. Director Reno requested that Mr. Wayne Knight provide the Board with an Affordable Care Act update. Mr. Knight, attending as a community member stated there is no public direction as to where the ACA is going at this point and the new phrase is "amend and repair".	The committee's March agenda will include information on ACHD's key legislative issues as well as CMA and CHA key legislature issues.	Ms. Donnellan
8. Review of FY2017 Board Work Plan	Chairman Dagostino reported a draft Work Plan has been developed based on the Committee's Charter. It was suggested an X be placed for each item in all months to reflect these items may be placed on the agenda whenever the need arises. Director Mitchell suggested Legislative Oversight be discussed every other month or quarterly due to time it takes bills to work its way through the Legislature. Director Reno suggested a Board Educational Session be added to the Work Plan. It was suggested a Board Educational	Revisions will be made to the Work Plan as described. A Board Educational Session will be added to the Board's Work Plan.	Ms. Donnellan Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
	Session be added to the Board's Work Plan rather than the Governance Committee's Work Plan.		
9. Committee Communications	Committee members welcomed Ms. Robin Iveson to the Committee.		
10. Committee Openings – Two	There are currently two openings on the committee		
11. Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, March 7, 2017 at 12:30 p.m.	The next meeting of the Committee is March 7, 2017.	
12. Adjournment	Chairman Dagostino adjourned the meeting at 2:09 p.m.		

I. **MEMBERSHIP**

The Division of General and Vascular Surgery consists of physicians who are Board Certified or in the first thirty-six (36) months of Board Eligibility and actively pursuing certification by the American Board of Surgery, or able to demonstrate comparable ability, training and experience.

II. **FUNCTIONS OF THE DIVISION**

The general functions of the Division of General and Vascular Surgery shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care.

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital.

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice.

D. Review and evaluate Division member adherence to:
   1. Medical Staff policies and procedures
   2. Sound principles of clinical practice

E. Submit written minutes to the ~~QA/PI~~Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Division review and evaluation of activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring.

G. Take appropriate action when important problems in patient care, patient safety, and clinical performance or opportunities to improve patient care are identified

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509).

I. Approve On-Going Professional Practice Evaluation Indicators, and

J. Formulate recommendations for Division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DIVISION MEETINGS**

The Division of General and Vascular Surgery shall meet at the discretion of the Chief, but at least quarterly. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the ~~QA/PI~~Medical Quality Peer Review Committee, and then to the Medical Executive Committee.

Twenty-five percent (25%) of the Active Division members, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. **DIVISION OFFICERS**

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Division.

The Division Chief shall be elected every year by the Active Staff members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of members of the Division.

The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in that Division. Division officers shall be eligible to succeed themselves.

V. DUTIES OF THE DIVISION CHIEF

The Division Chief shall assume the following responsibilities:

A. Accountability for all professional and administrative activities of the Division.
B. Ongoing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division.
C. Ensuring practitioners practice only within the scope of the privileges defined within their delineated privilege form.
D. Recommendations to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division.
E. Recommendations of clinical privileges for each member of the Division.
F. Ensuring that the quality, safety, and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended by the Department of Surgery or the Medical Executive Committee.

VI. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff ~~Office~~Department.
B. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.
C. **Physician Assistants** – Refer to the Allied Health Professionals Rules and Regulations for basic credentialing requirements. ~~In accordance with Department of Surgery rules and regulations~~.
~~D.~~ **Registered Nurse First Assist (RNFA)** – Refer to the Allied Health Professionals Rules and Regulations for basic credentialing requirements. ~~In accordance with Department of Surgery rules and regulations.~~
~~E~~ D. ~~Forensic~~ **Progressive Care Outpatient Site-Specific Privileges** – Privileges annotated with an (F) indicates privileges that may be performed at either Tri-City Medical Center or the ~~Forensic~~ Progressive Care Outpatient Clinic.

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit Patients Consultation, including via telemedicine (F) Perform Medical History & Physical Examination, including via telemedicine (F)	Board certification, or in the first 36 months of Board eligibility and actively pursuing certification by the American Board of Surgery, or demonstrated comparable ability, training or experience.	Completion of General Surgery proctoring satisfies proctoring for these privileges	N/A
BASIC GENERAL SURGERY PRIVILEGES			
• Anal canal biopsy (F) • Anoscopy (F) • Arterial catheterization for monitoring • Basic advancement flaps: rotational and myocutaneous (excluding TRAM and micro-vascular) • Biopsy / excision skin & soft tissue lesions (F) • Central venous catheter placement • Chemical destruction of anal warts (F) • Cricothyroidotomy • Debridement of wound, soft tissue infection • Excision of neuroma, neurofibroma, neurilemoma • Excision of skin, soft tissue neoplasm • I&D abscess (F) • Intraoperative Endoscopy, concomitant to surgical procedure • Minor laceration repair • Neurorrhaphy – Suture of Nerve • Paracentesis • Parathyroidectomy • Radical neck dissection, modified • Right heart catheterization for monitoring • Rigid proctoscopy (F) • Rubber band ligation of internal	• Board certification, or in the first 36 months of Board eligibility and actively pursuing certification by the American Board of Surgery, or demonstrated comparable ability, training or experience. • One hundred (100) general surgery procedures, reflective of the scope of privileges requested, during the previous twenty-four (24) months or demonstrate successful completion of an ACGME/AOA accredited residency or clinical fellowship within the previous (24) months.	Ten (10) cases	Sixty (60) cases from this category

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
hemorrhoids (F) • Sentinel lymph node biopsy • Sigmoidoscopy, includes rigid or flexible • Thoracentesis • Thyroidectomy • Tracheostomy • Tube thoracostomy **Abdomen and Perineum Surgery:** • Abdominal perineal resection • Abdominal wall repair, inguinal or femoral hernia, laparoscopic • Adrenalectomy, open • Anal sphincterotomy • Anti-reflux procedures, open • Appendectomy, open or laparoscopic • Cholecystectomy, open or laparoscopic • Choledochoenteric anastamosis • Colostomy, closure • Colostomy, creation, open or laparoscopic • Common bile duct exploration, transcystic, open or laparoscopic • Diagnostic laparoscopy with or without biopsy • Drainage of anorectal abscess • Drainage of intra-abdominal abscess • Drainage of pseudocyst • Enterolysis • Esophageal diverticulectomy, open • Esophagogastrectomy • Exploratory laparotomy • Fasciotomy • Gastrectomy, partial or total • Hemorrhoidectomy • Hernia, abdominal wall, to include: femoral, inguinal, incisional, lumbar, spigelian, ventral, open or laparoscopic • Hernia, repair of diaphragmatic or hiatal, open • Ileostomy creation or closure • Intestine resection (small or			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
larger intestine), open or laparoscopic • Liver biopsy, open or laparoscopic • Lymphadenectomy • Lysis of adhesions, open or laparoscopic • Pilonidal cystectomy • Repair of anorectal fistula • Repair of rectal prolapse • Splenectomy, open • Ulcer surgery, (Omental patch, V&A, V&O, V&GJ, HSV, etc), open • Vagus transection, for peptic ulcer disease **Breast Surgery:** • Axillary dissection • Biopsy, incisional or excisional • Breast abscess, drainage of • Intraoperative needle localization • Intraoperative ultrasound • Mastectomy, partial • Mastectomy, total • Mastopexy **Urogenital Surgery:** • Bladder repair, incidental • Hydrocelectomy, incidental • Hysterectomy, incidental • Nephrectomy, incidental • Orchiectomy, incidental • Partial cystectomy, incidental • Salpingo-oophorectomy, incidental or in an acute abdominal emergency • Ureteral repair, incidental • Skin grafting			
BASIC PERIPHERAL VASCULAR SURGERY PRIVILEGES			
• Amputation, digital • Amputation, foot • Amputation, knee, above • Amputation, knee, below • Ligation of perforating veins (open or minimally invasive using laser or ablation using radiofrequency) • Operations for venous	Board certification by the American Board of Surgery, or in the first 36 months of Board eligibility, or can demonstrate comparable ability, training and experience. Ten (10) cases within the previous twenty-four (24) months.	One (1) case	Five (5) cases

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
ulceration/split thickness skin grafting (STSG) • Sympathectomy - (Including vascular ischemia) • Vein ligation or stripping of varicose veins/phlebectomy • Portal Decompression: • Mesocaval shunt • Portocaval shunt • Splenorenal shunt			
ADVANCED GENERAL SURGERY PRIVILEGES:			
Advanced Breast Surgery: Oncoplastic repair	• Basic General Surgery privileges which effectively covers the need for board certification. • For Oncoplastic Repair privileges: Documentation of ten (10) CME credits relating to oncoplastic repair within the previous twenty-four (24) months, OR current oncoplastic repair privileges at another institution, OR completion of a Breast fellowship, OR ten (10) cases performed during residency training or within the previous twenty-four (24) months.	Three (3) cases	Ten (10) cases
Advanced Laparoscopic:: • Adrenalectomy , laparoscopic • Antireflux/fundoplication procedures (e.g. laparoscopic Nissen/Toupet), laparoscopic • Cholecystenteric anastomosis, laparoscopic • Choledochoenteric anastomosis, laparoscopic • Colostomy closure, laparoscopic • Esophageal procedures, laparoscopic • Gastric resection , laparoscopic • Hepatic resection , laparoscopic • Hernia repair, diaphragmatic or	• Basic General Surgery privileges which effectively covers the need for board certification. • Forty (40) advanced general and abdominal procedures during the previous twenty-four (24) months.	Three (3) cases from this category	Twenty-four (24) cases from this category

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
hiatal, laparoscopic • Pancreatic procedures, laparoscopicSplenectomy, laparoscopic • Ulcer surgery (Omental patch, V&A, V&O, V&GJ, HSV, etc), laparoscopic			
Advanced Abdominal:			
• Esophagectomy, including thoracoabdominal approach • Hepatic lobectomy, open • Hepaticoenterostomy • Pancreatic procedures, open or laparoscopic	• Basic General Surgery privileges which effectively covers the need for board certification. • Two (2) advanced abdominal procedures during the previous twenty four (24) months.	One (1) case from this category	Two (2) cases from this category

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Advanced Head & Neck Surgery: • Parotid gland • Salivary glands & ducts • Thymectomy	• Basic General Surgery privileges which effectively covers the need for board certification. • Twenty (20) advanced head and neck procedures during the previous twenty-four (24) months.	Two (2) cases from this category	Ten (10) cases from this category
ADVANCED PERIPHERAL VASCULAR SURGERY:			
• Aortic, aorto-iliac, aorto-femoral bypass • Axillary-femoral bypass • Bypass of upper extremity vessel • Carotid – Subclavian bypass • Celiac/superior mesenteric axis endarterectomy, repair or bypass • Embolectomy or thrombectomy • Endarterectomy, carotid • Endarterectomy or bypass, vertebral • Endarterectomy, repair or bypass, renal artery • Exploration, repair, thrombectomy, or embolectomy of abdominal aorta, iliac, femoral or infrageniculate artery • Femoral to femoral bypass • Femoral to infrageniculate bypass • Femoral to popliteal bypass • Repair of aortic branches • Repair of iliac, femoral, popliteal, or mesenteric aneurysm • Repair of infra or suprarenal aortic aneurysm • Repair of upper extremity vessel • Retroperitoneal exposure for spine vertebral body procedures, includes incidental vascular procedures* • Upper and lower extremity deep or superficial vein procedures • Upper or lower extremity fistula, autogenous or artificial	• Basic General Peripheral Vascular Surgery privileges which effectively covers the need for board certification. • Forty (40) vascular cases within the previous twenty-four (24) months (With application, submit list of major procedures done in two (2) years preceding application. Include indications, results, morbidity and mortality data and operative reports.) • *If only Retroperitoneal exposure for spine vertebral body procedures privilege is requested, documentation of five (5) cases within the previous twenty-four (24) months and documentation of current privileges in vascular or trauma surgery at a healthcare facility. All other privileges in the category must be crossed out.	• Five (5) cases from this category • * If only Retroperitoneal exposure for spine vertebral body procedures privilege is requested, two (2) cases	• Twenty (20) vascular cases from this category • *If only Retroperitoneal exposure for spine vertebral body procedures granted, five (5) cases and documentation of current privileges in vascular or trauma surgery at a healthcare facility. All other privileges in the category must be crossed out.

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
placement of central venous catheter placement			
SPECIAL PRIVILEGES:			
Bariatric Surgery: • Roux en Y gastric bypass, open and laparoscopic • Sleeve gastrectomy, open and laparoscopic • Adjustable gastric banding, open and laparoscopic • Revisional metabolic and bariatric surgery, open and laparoscopic • Biliopancreatic diversion, with or without duodenal switch, open and laparoscopic • Bariatric Endoscopy	• Completion of General Surgery residency program. • Privileges to perform Basic and Advanced Abdominal surgery and advanced laparoscopy. • Completion of a Bariatric and Metabolic Surgery fellowship, or Minimally Invasive fellowship with documentation of rotation in Bariatrics and the performance of a minimum of five (5) cases within the previous twenty-four (24) months, or case logs documenting the performance of a minimum of fifteen (15) bariatric cases and (10) Bariatric Endoscopy cases within the previous twenty-four (24) months. • Documentation to indicate malpractice coverage includes bariatric surgery.	Three (3) Bariatric cases and Three (3) Bariatric EGD Cases	• Fifteen (15) cases within the previous twenty-four (24) months •
Colonoscopy	Completion of an ACGME accredited training program in General Surgery or Colon and Rectal surgery within the previous twenty four (24) months. If training was completed greater than twenty four (24) months ago, documentation of a refresher training course in lower endoscopy or documentation of fifty (50) cases within the previous twenty-four (24) months is required.	Two (2) cases if training was completed within the previous twenty-four (24) months prior to granting of privileges or if training was completed more than twenty-four months prior	Ten (10) cases

~~Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
		~~to granting privileges and documentation of fifty (50) cases was provided.~~ ~~Seven (7) cases if training was completed greater than twenty-four (24) months prior to granting of privileges and documentation of a refresher course was provided.~~	
~~Upper endoscopy (EGD) – intraoperative/as integral part of operation (i.e., Heller myotomy, gastric bypass), or as preoperative evaluation or as follow-up for specific operative procedures~~	~~Initial: Completion of an ACGME-accredited training program in General Surgery or Colon and Rectal Surgery within the previous twenty-four (24) months. If training was completed greater than twenty-four (24) months ago, documentation of a refresher training course in upper endoscopy or documentation of fifty (50) cases within the previous twenty-four (24) months is required.~~	~~Two (2) cases if training was completed within the previous twenty-four (24) months prior to granting of privileges or if training was completed more than twenty-four months prior to granting privileges and documentation of fifty (50) cases was provided.~~ ~~Seven (7) cases if training was~~	~~Seven (7) cases within the previous twenty-four (24) months~~

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
		completed greater than twenty-four (24) months prior to granting of privileges and documentation of refresher course was provided.	
Endovenous Ablative Therapy	Documentation of completion of product-sponsored training, which included the performance/interpretation of twenty (20) endovenous ablative therapy procedures	Three (3) cases	Five (5) cases
Endovascular Repair of Aortic Aneurysms	Per policy 8710-503	Per policy 8710-503	Per policy 8710-503
Fluoroscopy	Per policies 8710-528 and 8710-528A	Per policies 8710-528 and 8710-528A	Per policies 8710-528 and 8710-528A
KTP Laser	Documentation of completion of training for specific energy source(s) to be used. Or, if training completed greater than two years prior to privilege request, submit case logs from previous 24 months identifying specific energy source used.	Two (2) cases	Two (2) cases
Moderate Sedation	Per policy 8710-517	Per policy 8710-517	Per policy 8710-517
Robotic Surgery (da Vinci) • Multiple Port • Single Port • Assist in robotic surgery	Per policy 8710-563	Per policy 8710-563	Per policy 8710-563
Transoral Esophagogastric Fundoplication (TIF)	1. Completion of ACGME accredited residency program and possess board certification or board eligibility in Surgery; and 2. 1. Documentation of completion of product-sponsored training course, or have	Three (3) cases	Six (6) cases

~~Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
	~~performed at least five (5) TIF procedures in the previous twelve (12) months~~		
~~Placement of Vagal Nerve Stimulator~~	~~1. Basic General Surgery privileges which effectively covers the need for board certification.~~ ~~2. Documentation of performing five (5) vagal nerve stimulator cases in the previous twenty-four (24) months~~ ~~3.1. Must have Carotid Endarterectomy privileges.~~	~~Two (2) cases~~	~~Five (5) cases~~

VII. **REQUIREMENTS FOR REAPPOINTMENT**

A. Active certification by the Division of General and Vascular Surgery or demonstration of comparable ability, training and experience shall satisfy the requirements for receiving cognitive privileges for all categories as well as for admitting privileges to Tri-City Medical Center.

B. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCHD to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. The physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. **PROCTORING OF PRIVILEGES**

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated, until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Division will act as proctors. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative b) operative, c) surgical technique and/or, d) postoperative care.

C. ~~THE MONITOR MUST BE PRESENT IN THE OPERATING ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE APPLICANT MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E. H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE SURGEON'S COMPETENCE.~~ Supervision of the member by the proctor will include concurrent review for invasive cases or retrospective chart review of cognitive processes for noninvasive cases and direct observation of

procedural techniques. The monitor must be present in the Operating Room for a sufficient period of time to assure himself/herself of the member's competence

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).

E. The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon.

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

G. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available at the front desk in the O.R. ~~from the Operating Room Supervisor and/~~or at the Medical Staff ~~Office~~Department and provided to the proctor for completion.

H. Forms will be made available to the member scheduling the case for surgery and immediately forwarded to the proctor for completion. It is the responsibility of the new member to notify the Operating Room Supervisor of the proctor for each case.

I. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff ~~Office~~Department.

J. The proctor shall have current unrestricted privileges to perform the procedures s/he is proctoring.

IX. **EMERGENCY DEPARTMENT CALL:**

A. Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.

B. It is the policy of the Emergency Department that when a patient indicates that a staff member has previously treated him or her, that member will be given the opportunity to provide further care.

C. The member of the Division will then determine whether to provide further care to an emergency room patient based upon the circumstances of the case. If a member declines, the on-call physician will provide any necessary emergency special care.

D. The care provided by an on-call physician should be completed with regard to the particular problem that the physician was called to treat. The care provided by an on-call physician will not create an obligation to provide further care.

E. Provisional or Courtesy staff may participate in the Emergency Call panel at the discretion of the Division Chief or Department Chair.

APPROVALS:
General & Vascular Surgery Division: 9/10/2015
Surgery Department: 10/01/2015
Medical Executive Committee: 10/26/2015
Governance Committee: 10/6/2015
Board of Directors: 10/29/2015

I. **MEMBERSHIP**

The Division of Urology consists of physicians who are Board Certified or actively pursuing certification by the American Board of Urology, or able to demonstrate comparable ability, training, and experience.

II. **FUNCTIONS OF THE DIVISION**

The general functions of the Division of Urology shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice;

D. Review and evaluate Division member adherence to:
   1. Medical Staff Policies and Procedures
   2. Sound principles of clinical practice

E. Submit written minutes to the ~~QA/PI/PS~~Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Division review and evaluation of activities, actions taken thereon, the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified.

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509)

I. Approve On-Going Professional Practice Evaluation Indicators; and

J. Formulate recommendations for Division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DIVISION MEETINGS**

The Division of Urology shall meet at the discretion of the Chief, but at least annually. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the, ~~QA/PI/PS~~Medical Quality Peer Review Committee, and then to the Medical Executive Committee.

Twenty-five percent (25%) of the Active Division members, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. **DIVISION OFFICERS**

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in the clinical area covered by the Division.

The Division Chief shall be elected every year by the Active members of the Division who are eligible to vote. If there is a vacancy in the office for any reason, the Department Chairman shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of the members of the Division.

The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. **DUTIES OF THE DIVISION CHIEF**

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Division;
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
D. Recommend to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommend clinical privileges for each member of the Division;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended from the Department of Surgery or the Medical Executive Committee.

VI. **PRIVILEGES**

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the ~~Medical Staff Office~~Medical Staff Department.
~~B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.~~
~~C.~~B. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.
~~D.~~C. Sites:
1. All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056
2. Privileges annotated with (F) may be performed at the Outpatient ~~Forensic~~ Progressive Care Clinic(s).

~~Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~Admit Patients~~ ~~Consultation, including via telemedicine (F)~~ ~~Perform history and physical examination, including via telemedicine (F)~~	~~Successful completion of an ACGME or AOA accredited residency or fellowship program in urology.~~	~~Successful completion of procedure-specific proctoring satisfies proctoring for these privileges~~	~~N/A~~
~~Basic Urology Privileges~~			
~~Abdominal procedure(s), incidental~~ ~~Anterior Exenteration~~ ~~Colporrhaphy~~ ~~Incisional Hernia, incidental~~	~~1. Successful completion of an ACGME or AOA accredited residency or fellowship program in urology.~~	~~Five (5) cases from the Basic Urology Privileges category~~	~~Fifty (50) representative blend of cases~~

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Inguinal Hernia, incidental Lithotripsy Surgery of the lymphatic system, including lymph node dissection (inguinal, retroperitoneal, or pelvic) Male Genital System – all procedures for: • Scrotum • Testis • Vas Deferens • Penis • Retroperitoneal Surgery Radical Cystectomy Urinary System – all procedures for: • Kidney • Ureter • Bladder • Prostate • Urethra Urodynamics - Foley catheter placement (F)	2. Documentation of at least of fifty (50) cases within the previous twenty four (24) months.		
Special Urology Privileges			
Laser Privileges: • CO_2 Laser • Diode (Greenlight) Laser • Holmium Laser	1. Documentation of completion of training for specific energy source(s) to be used; or 2.1. If training completed greater than two years prior to privilege request, submit case logs from previous twenty four (24) months identifying specific energy source used.	One (1) case for each energy source	One (1) case for each energy source
Moderate Sedation	Per policy 8710-541	Per policy 8710-541	Per policy 8710-541

~~Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~Renal Laparoscopy and/or Laparoscopic Nephrectomy~~	~~1. Successful completion of an ACGME or AOA-accredited residency or fellowship program in urology that included training in laparoscopy; or~~ ~~2. Successful completion of a hands-on training course for renal laparoscopic and/or laparoscopic nephrectomy procedures; or~~ ~~3.~~1. ~~Documentation of at least three (3) renal laparoscopic and/or laparoscopic nephrectomy procedures within the previous twenty-four (24) months (required if training was completed more than two years prior to application).~~	~~Three (3) renal laparoscopy and/or laparoscopic nephrectomy procedures~~	~~Three (3) renal laparoscopy and/or laparoscopic nephrectomy procedures~~
~~Robotic Surgery – da Vinci~~ ~~Robotic Surgery, assist – da Vinci~~	~~Per policy 8710-563~~	~~Per policy 8710-563~~	~~Per policy 8710-563~~

~~Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~Sacral Nerve Stimulation~~	~~1. Successful completion of an ACGME or AOA-accredited residency program and board certified or actively pursuing board certification in Urology; or successful completion of a urogynecology fellowship program; AND~~ ~~2. Documentation of successful completion of a training course in sacral neuromodulation therapy; or documentation of performing at least six (6) sacral neuromodulation therapy stimulator tests and implant procedures within the previous twelve (12) months (required if training was completed more than two years prior to application)~~	~~One (1) case~~	~~Two (2) cases~~

VI. **REAPPOINTMENT OF CLINICAL PRIVILEGES:**

Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

IX. **PROCTORING OF PRIVILEGES**

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Division will act as proctors. An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique and/or, d) postoperative care.

C. ~~THE MONITOR MUST BE PRESENT IN THE OPERATING ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE,~~

~~OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE SURGEON'S COMPETENCE.~~Supervision of the member by the proctor will include concurrent review for invasive cases or retrospective chart review of cognitive processes for noninvasive cases and direct observation of procedural techniques. The monitor must be present in the Operating Room for a sufficient period of time to assure himself/herself of the member's competence

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).

E. The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon.

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

G. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available at the front desk in the O.R. ~~from the Operating Room Supervisor and/~~or the ~~Medical Staff Office~~Medical Staff Department and provided to the proctor for completion.

H. Forms will be made available to the member scheduling the case for surgery and immediately forwarded to the proctor for completion. It is the responsibility of the new member to notify the Operating Room Supervisor of the proctor for each case.

I. The proctor's report shall be confidential and shall be completed and returned to the ~~Medical Staff Office~~Medical Staff Department.

J. The proctor shall have current unrestricted privileges to perform the procedures s/he is proctoring.

X. EMERGENCY DEPARTMENT CALL

Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the medical staff. Please refer to Medical Staff Policy and Procedure #8710-520.

Provisional staff members may be assigned to the Emergency Department Call Roster at the discretion of the Chief of the Division. The care provided by an on-call physician will not create an obligation to provide further care.

APPROVALS:

Division of Urology:	06/15/2015
Department of Surgery:	06/18/2015
Medical Executive Committee:	07/27/2015
Governance Committee:	08/04/2015
Board of Directors:	08/27/2015

I. **MEMBERSHIP** (5/15)

A. The Division of Orthopedic Surgery consists of physicians who are board certified or in the first thirty-six (36) months of board eligibility and are actively progressing towards certification by the American Board of Orthopedic Surgery, or able to demonstrate comparable ability, training and experience. (5/15)

II. **FUNCTIONS OF THE DIVISION** (5/15)

A. The general functions of the Division of Orthopedic Surgery shall include:

1. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients within the Division and develop criteria for use in the evaluation of patient care;
2. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;
3. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice;
4. Review and evaluate Division member adherence to:
   - i Medical Staff policies and procedures
   - ii Sound principles of clinical practice
5. Submit written minutes to the Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   - i Division review and evaluation of activities, actions taken thereon, and the results of such actions; and
   - ii Recommendations for maintaining and improving the quality and safety of care provided in the hospital.
6. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;
7. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;
8. Recommend/request Focused Professional Practice Evaluation (FPPE) as indicated (pursuant to Medical Staff Policy 8710-509);
9. Approve On-Going Professional Practice Evaluation (OPPE) indicators;
10. Formulate recommendations for Division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DIVISION MEETINGS** (5/15)

A. The Division of Orthopedic Surgery shall meet at the discretion of the Chief, but at least annually. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients.

B. Minutes shall be transmitted to the Department of Surgery, Medical Peer Review Committee, and to the Medical Executive Committee.

C. Twenty-five percent (25%) of the Active Division members, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. **DIVISION OFFICERS** (5/15)

A. The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Division.

B. The Division Chief shall be elected every year by the Active members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of the members of the Division.

C. The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses Medical Staff membership or clinical privileges in the Division. The Division Chief shall be eligible to succeed him/herself if elected. (5/15)

V. DUTIES OF THE DIVISION CHIEF (5/15)

A. The Division Chief shall assume the following responsibilities:

1. Accountable for all professional and administrative activities of the Division;
2. Ongoing monitoring of the professional performance of all individuals who have delineated clinical privileges in the Division;
3. Assure practitioners practice only within the scope of their privileges as defined within the delineated privilege form;
4. Recommend to the Department of Surgery and the Medical Executive Committee criteria for clinical privileges in the Division;
5. Recommend clinical privileges for each member of the Division;
6. Assure the quality, safety, and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
7. Other duties as recommended by the Department of Surgery or the Medical Executive Committee. (5/15)

VI. REAPPOINTMENT AND RENEWAL OF CLINICAL PRIVILEGES (~~5/15~~)(1/17)

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff ~~Office~~Department.

B. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified. (5/15)

C. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VII. CLASSIFICATIONS (5/15)

A. Members of Division of Orthopedics are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training, such as in the broad field of internal medicine although not necessarily at the level of sub-specialist. Such physicians may act as consultants to others and may, in turn, be expected to request consultation when:

1. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness.
2. Unexpected complications arise which are outside this level of competence.
3. Specialized treatment or procedures are contemplated with which they are not familiar.

VIII. PRIVILEGES (~~5/15~~) See Orthopedic Surgery Privilege Card (1/17)

Orthopedic Surgeon Privileges (5/15)			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
Admit patients	As required for Basic Orthopedic Surgery Category privileges		
BASIC ORTHOPEDIC SURGERY CATEGORY			
Amputations: • Elective • Traumatic	1. Successful completion of an ACGME- or AOA-accredited residency in orthopedic surgery. Documentation of one hundred (100) cases from the previous twenty-four (24) months representative of the privileges requested.	Six (6) cases from this category	Fifty (50) cases from this category reflective of the privileges requested
Arthrodesis of Extremities			
Arthroscopy surgery for knee, shoulder, elbow, hand, ankle, wrist & hip joints			
Biopsy (bone/soft tissue)			
Bone Grafting, with or without allografts			
Dislocation: • External Fixation • Internal Fixation			
Fasciotomy and fasciectomy			
Foreign body removal			
Fractures: • External Fracture Fixation (includes Taylor Spatial Frame) • Fracture treatment of hand* • Internal Fracture Fixation • Pelvic Fracture Care (open/closed) • Hip hemiarthroplasty*			
Ligament Reconstruction			
Management of infections and inflammations of bones, joints, and tendon sheaths			
Manipulation of joints			
Minor total joint Arthroplasty: • Fingers • Toes			
Nerve repair of hand*			
Osteotomy			
Reconstruction of non-spinal			

~~Orthopedic Surgeon Privileges~~ (5/15)			
~~Privileges~~	**~~Initial Appointment~~**	**~~Proctoring~~**	**~~Reappointment (every 2 years)~~**
~~congenital musculoskeletal anomalies~~			
~~Repair lacerations~~			
~~**Skin grafts:**~~ • ~~Muscle and tendon release, repair, and fixation (flexor & extensor tendon repair of hand)*~~ • ~~Tendon transfer~~ • ~~Tendon reconstruction (free graft, staged)~~ • ~~Treatment of infections~~			
~~Soft tissue/bony mass management (debridement, flaps (non-microvascular))~~			
~~Treatment of cartilage injuries (i.e. autologous chondrocyte implantation (ACI) and osteoarticular transfer system (OATS)/osteochondral allograft)~~			
~~**Total Joint Arthroplasty:**~~ • ~~Ankle~~ • ~~Hip (includes resurfacing)~~ • ~~Knee~~ • ~~Shoulder~~ • ~~Wrist~~			
~~Treatment of trauma~~			
~~**ADVANCED ORTHOPEDIC SURGERY PRIVILEGES**~~ (5/15)			
~~**Hand Surgery:**~~ • ~~Fracture treatment of hand~~ • ~~Microsurgical nerve repair and graft of hand~~ • ~~Microvascular replantation~~ • ~~Microvascular/tissue transfer~~ • ~~Neurorrhaphy~~ • ~~Removal of soft tissue mass, ganglion on the palm or wrist, flexor sheath or similar mass~~ • ~~Repair of rheumatoid arthritis deformity~~ • ~~Vascular lesion repair of extremities~~ • ~~Vein graft to vascular lesion in extremities~~	~~1. Successful completion of a fellowship in hand surgery, or successful completion of an ACGME- or AOA-accredited residency in orthopedic surgery and demonstrate significant clinical experience in hand surgery through documentation of twenty-five (25) hand cases within the previous twenty-four (24) months;~~ ~~2. If hand fellowship was completed more than~~	~~Two (2) cases from this category~~	~~Ten (10) cases from this category~~

Orthopedic Surgeon Privileges (5/15)			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
	twenty-four (24) months prior to application, documentation of twenty-five (25) hand cases from the previous twenty-four (24) months is required.		
Spine Surgery: • Assessment of the neurologic function of the spinal cord and nerve roots • Cervical Discectomy • Closed reduction of fractures and dislocations of the spine • Interpretation of imaging studies of the spine • Laminectomy • Management of traumatic, congenital, developmental, infectious, metabolic, degenerative, and rheumatologic disorders of the spine • Open reduction of internal/external fixation of fractures and dislocations of the spine (includes pedicle screws, plating, cages) **Spinal Arthrodesis:** • Cervical • Lumbar • Thoracic	1. Successful completion of spine fellowship; or successful completion of an ACGME- or AOA-accredited residency in orthopedic surgery and demonstrate significant clinical experience in spine surgery through documentation of twenty-five (25) spine cases within the previous twenty-four (24) months; 2.1. If spine fellowship was completed more than twenty-four (24) months prior to application, documentation of twenty-five (25) spine cases from the previous twenty-four (24) months is required.	Two (2) cases from this category	Ten (10) cases from this category
Peripheral nerve surgery	1. Basic Orthopedic Surgery Privileges 2.1. Documentation of ten (10) cases in the previous twenty-four (24) months.	Two (2) cases	Ten (10) cases
Vertebral Augmentation	Per Medical Staff Policy 8710-534		
Blue Belt Navio PFS (BBN) guided knee arthroplasty	The surgeon must be currently privileged to perform underlying procedure without BBN guidance, AND have one of the following:		Four (4) cases

Orthopedic Surgeon Privileges (5/15)			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
	a. Documentation of training in residency/fellowship and log of ten (10) cases; OR b. Certificate of completion of BBN or comparable hands-on training program and documentation of ten (10) cases beyond proctoring from another institution; OR c. Certificate of completion of BBN or comparable hands-on training program.	a. One (1) case concurrently proctored by a BBN credentialed/ experienced/ faculty physician. b. One (1) cases concurrently proctored by a BBN credentialed/ experienced/ faculty physician. c. Three (3) cases concurrently proctored by BBN credentialed/ experienced/ faculty physician.	
Assisting at Blue Belt Navio PFS (BBN) guided knee arthroplasty	One of the following: a. Currently privileged to perform BBN guided knee arthroplasty; OR b. Currently privileged to assist in surgery AND documentation of completion of BBN or comparable hands-on training program.	One (1) case concurrently proctored by a BBN credentialed/ experienced/ faculty physician. If the assistant is privileged to perform BBN guided knee arthroplasty and has been released from proctoring in the surgeon role, no additional	Four (4) cases

~~Orthopedic Surgeon Privileges~~ (5/15)			
~~Privileges~~	**~~Initial Appointment~~**	**~~Proctoring~~**	**~~Reappointment (every 2 years)~~**
		~~proctoring is required in the assistant role.~~	
~~Laser privileges:~~ • ~~CO2~~ • ~~KTP~~ • ~~Argon~~	~~Documentation of completion of training for specific energy source(s) to be used. Or, if training completed greater than two years prior to privilege request, submit case logs from previous twenty-four (24) months identifying specific energy source used.~~	~~One (1) case for each energy source~~	~~Two (2) cases~~
~~Mazor Surgery:~~ • ~~Mazor Robotic Surgery~~ • ~~Assist in Mazor robotic surgery~~	~~Per Medical Staff Credentialing Policy 8710-566~~		
~~Moderate Sedation~~	~~Per Medical Staff Policy 8710-517~~		
~~Pain Management~~	~~Per Medical Staff Policy 8710-541~~		
~~Procedures Outpatient Forensic Clinic:~~ (5/15)			
• ~~Aspiration of joints~~ • ~~Casting and splinting~~ • ~~Closed reduction of fractures using local anesthesia~~ • ~~Foreign Body Removal~~ • ~~Implant removal, small (i.e. K-wires)~~ • ~~Injections into joints or tendon sheaths~~ • ~~Minor I&D abscess or hematoma~~ • ~~Repair lacerations~~ • ~~Soft Tissue Management (Debridement)~~	~~As required for Basic Orthopedic Surgery Category privileges~~	~~Proctoring complete when released from specialty-specific proctoring~~	~~N/A~~

~~* Indicates privileges required for participation on the Orthopedic ED Call Schedule.~~ (5/15)

IX. **ALLIED HEALTH PROFESSIONALS** See Allied Health Professionals Rules & Regulations ~~(5/15)~~1/17)

A. Physician Supervisor for Physician Assistants

1. A Physician Assistant may only provide those medical services, which he/she is competent to perform and which are consistent with the physician assistant's education, training and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant.
2. A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

3. A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physicians specialty or usual customary practice and with the patient's health and condition.
4. A physician assistant may not admit or discharge patients.

~~Physician Assistant Privileges (5/15)~~			
~~**Privileges**~~	~~**Initial Appointment**~~	~~**Proctoring**~~	~~**Reappointment (every 2 years)**~~
~~A physician assistant may also act as first or second assistant in surgery, under supervision of an approved supervising physician.~~	~~Per AHP Rules and Regulations~~	~~Per AHP Rules and Regulations~~	~~Fifty (50) cases~~
~~Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans, record and present pertinent data in a manner meaningful to the physician.~~			
~~Order or transmit an order for x-ray, other studies, therapeutic diets, physical/rehab therapy, occupational/speech therapy, respiratory therapy, and nursing services.~~			
~~Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.~~			
~~Recognize and evaluate situations that call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.~~			
~~Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases.~~			
~~Initiate arrangements for admissions, complete forms and~~			

~~Physician Assistant Privileges (5/15)~~			
~~**Privileges**~~	~~**Initial Appointment**~~	~~**Proctoring**~~	~~**Reappointment (every 2 years)**~~
~~charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home.~~			
~~Initiate and facilitate the referral of patients to the appropriate health facilities, agencies and resources of the community.~~			
~~Order and administer medications. A physician assistant may not administer, provide or transmit a prescription for controlled substances in schedules II through V without patient-specific authority by a supervising physician. A physician assistant may not order chemotherapy agents.~~			
~~Assist in Mazor robotic surgery~~	~~Per Medical Staff Credentialing Policy 8710-566~~		

B. Orthopedic Surgery Technician – ~~As outlined in the privilege table below. (5/15)~~See Orthopedic Surgery Technician privilege card. ~~(1/17)~~

~~Orthopedic Surgery Technician Privileges (5/15)~~			
~~**Privileges**~~	~~**Initial Appointment**~~	~~**Proctoring**~~	~~**Reappointment (every 2 years)**~~
~~Intraoperative Retractions: • Retract Tissue or organs by use of hand • Place or hold surgical retractors • Pack sponges into body cavity to hold tissues or organs out of the operative field • Manage all instruments in the operative field~~	~~Per AHP Rules and Regulations~~	~~Per AHP Rules and Regulations~~	~~Fifty (50) cases~~

~~Intraoperative Homeostasis:~~ • ~~Aspiration of blood and other fluids from the operative site~~ • ~~Sponge wounds or other areas of dissection~~ • ~~Clamp bleeding tissues or vessels~~ • ~~Cauterize and approximate tissue~~ • ~~Place hemoclip or ligating sutures on vessels or tissue~~ • ~~Connect drainage~~			
~~Intraoperative Wound Closure:~~ • ~~Apply surgical dressing~~ • ~~Care and removal of drains~~			
~~Other:~~ • ~~Assist with applying casts, braces, or plaster splints~~			

X. **PROCTORING OF PRIVILEGES** ~~(5/15)~~1/17)

A. Each new Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor with current unrestricted privileges as indicated until his or her privilege status is established by a recommendation from the Division Chief to Credentials Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. The member is responsible for arranging a proctor.

C. All Active members of the Division will act as proctors. ~~An associate~~ One or all of the associates of the physician being proctored may monitor up to a total of 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique and/or, d) postoperative care.

~~D.~~ Supervision of the member by the proctor will include concurrent review for invasive cases and direct observation of procedural techniques. The monitor must be present in the Operating Room for a sufficient period of time to assure himself/herself of the member's competence. ~~THE MONITOR MUST BE PRESENT IN THE OPERATING ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE SURGEON'S COMPETENCE.~~

In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).

The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon.

When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

~~H.~~G. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall, impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available at the front desk in the O.R. or at the Medical Staff Department and provided to the proctor for completion~~from the Operating Room Supervisor and/or the Medical Staff Office~~.

~~I.~~H. Forms will be made available to the member scheduling the case for surgery and immediately forwarded to the proctor for completion. It is the responsibility of the member to notify the Operating Room ~~Supervisor~~ personnel of the proctor for each case.

~~J.~~I. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff ~~Office~~Department.

XI. EMERGENCY DEPARTMENT CALL (5/15)

A. Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy #8710-520.

B. The care provided by an on-call physician should be completed with regard to the particular problem that the physician was called to treat. For future different orthopedic problems, there is no obligation on the part of the physician to provide care.

C. Provisional staff members may participate on the Emergency Department Call Roster at the discretion of the Chief of the Division.

APPROVALS:

Division of Orthopedic Surgery:	3/2/15
Department of Surgery:	4/15/15
Medical Executive Committee:	4/27/15
Governance Committee:	5/05/15
Board of Directors:	5/28/15

I. **MEMBERSHIP**

A. The Department of Obstetrics and Gynecology consists of physicians who are board certified or actively progressing towards certification by the American Board of Obstetrics and Gynecology and have successfully completed an ACGME/AOA-accredited residency training program in Obstetrics and Gynecology.

B. Any member of the Department of Obstetrics and Gynecology who was Board Eligible when initially granted surgical privileges, and who was granted such privileges on or after June 1, 1991, shall be expected to obtain Board Certification within thirty-six (36) months of his/her appointment to the Medical Staff.

II. **GENERAL FUNCTION**

The general functions of the Department of Obstetrics and Gynecology shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Department and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practice;

D. Review and evaluate Department member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice.

E. Submit written minutes to the QA/PI Committee and Medical Executive Committee concerning:
   1. Department review and evaluation activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified.

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

I. Approve of On-Going Professional Practice Evaluation Indicators; and

J. Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DEPARTMENT MEETINGS**

A. The Department of Obstetrics and Gynecology shall meet at the discretion of the Chair, but at least quarterly. The Department will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the QA/PI Committee, and then to the Medical Executive Committee.

B. Twenty-five percent (25%) of the Active Department members, but not less than two (2) members shall constitute a quorum at any meeting.

IV. **DEPARTMENT OFFICERS**

A. The Department shall have a Chair and Vice-Chair who shall be members of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Department.

B. The Department Chair and Vice-Chair shall be elected every year by the Active members of the Department who are eligible to vote. The Chair and Vice-Chair shall be elected by a simple majority of the members of the Department. Vacancies of any officer for any reason shall be filled for the un-expired term through a special election.

C. The Department Chair and Vice-Chair shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Department. Department officers shall be eligible to succeed themselves.

V. DUTIES OF THE DEPARTMENT CHAIR

A. The Department Chair, and the Vice-Chair, in the absence of the Chair, shall assume the following responsibilities:

1. Be accountable for all professional and administrative activities of the Department;
2. Continue surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department.
3. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form.
4. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department.
5. Recommend clinical privileges for each member of the Department.
6. Assure that the quality, safety, and appropriateness of patient care provided by members of the Department are monitored and evaluated; and
7. Assume other duties as recommended from the Medical Executive Committee.

VI. CLASSIFICATIONS

A. PHYSICIAN

1. Members of Department of Obstetrics and Gynecology are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training. Such physicians may act as consultants to others and may, in turn, be expected to request consultation when:
   a. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness.
   b. Unexpected complications arise which are outside this level of competence.
   c. Specialized treatment or procedures are contemplated with which they are not familiar.

B. PHYSICIAN ASSISTANT (PA)

1. Physician Assistants may only provide those medical services for which he/she is competent to perform and which are consistent with the physician assistant's education, training and experience, which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant, and as privileges granted.
   a. A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

b. A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physicians specialty or usual customary practice and with the patient's health and condition, (e.g., surgical assisting).
c. A supervising physician shall observe or review evidence of the physician assistant performance of all tasks and procedures as delegated to the physician assistant until assured of competency.
d. A physician assistant may initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care.
e. Refer to the AHP rules and regulations for further delineation of sponsoring physician's supervision requirements.
f. A physician assistant may not admit or discharge patients.

2. The Department of Obstetrics and Gynecology requires a physician co-signature as delineated in the AHPs Rules and Regulations.

C. **REGISTERED NURSE FIRST ASSISTANT (RNFA)**

1. A registered nurse first assistant is a healthcare provider who, under the supervision of a physician, performs a variety of pre, intra, and postoperative services for patients undergoing a surgical procedure in the surgical suites. The RN first assistant directly assists the surgeon by controlling bleeding, providing wound exposure, suturing and other surgical tasks in accordance with privileges granted. The RN first assistant practices under the supervision of the surgeon during the intraoperative phase of the perioperative experience. The RN first assistant functions under standardized procedures and must adhere to the AHP's rules and regulations.

D. **CERTIFIED NURSE MIDWIFE (CNM)**

1. The midwife (CNM), a dependent allied health professional (AHP), functions under standardized procedures and must adhere to the AHPs rules and regulations. Refer to CNM standardized procedures for specific criteria.

VII. **PRIVILEGES**

A. The Department of Obstetrics and Gynecology will define privilege criteria requirements on the privilege card. Recommendations for privileges are made to the Department, Credentials Committee, Medical Executive Committee, and Governing Board.
B. All privilege cards are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.
C. By virtue of their training and experience all practitioners with Obstetrical privileges are considered competent and able to perform FERN testing and other associated testing within their scope of practice, or for any emergency procedure, which, in the physician's judgment, is deemed indicated.
D. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.
E. The categories and applicable privileges are as follows:
   1. Obstetrical
   2. Gynecological
   3. Maternal-Fetal Medicine
   4. Gynecological-Oncology

F. Members of Department of Obstetrics and Gynecology are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training. Such physicians may act as consultants to others and may, in turn, be expected to request consultation when:

d. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness.

e. Unexpected complications arise which are outside this level of competence.

f. Specialized treatment or procedures are contemplated with which they are not familiar.

VIII. **REAPPOINTMENT OF CLINICAL PRIVILEGES**

Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

IX. **PROCTORING**

A. Each new Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Department to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Department will act as proctors. An associate may proctor 50% of the required proctoring. Additional cases may be proctored as recommended by the Department Chair. It is the responsibility of the Department Chair to inform the proctored member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique and/or, d) postoperative care.

C. For invasive cases, proctor must be present for the procedure for a sufficient period of time to assure himself/herself of the member's competence. For noninvasive cases the proctor may review case documentation (i.e. H&P) entirely to assure himself/herself of the practitioner's competence.

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).

E. The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon.

F. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

G. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Operating Room Supervisor and/or the Medical Staff Office.

H. Forms will be made available to the member scheduling the case for surgery and immediately forwarded to the proctor for completion. It is the responsibility of the new member to notify the Operating Room Supervisor of the proctor for each case.

I. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

X. **DEPARTMENT QUALITY REVIEW AND MANAGEMENT**

A. The Department of OB/GYN will have a Quality Review Committee (Q.R.C.) compromised of no less than four (4) department members. The committee Chairman is the department's representative to the Medical Staff QA/PI Committee. The Department Chairperson shall appoint the remaining members for a two (2)-year term. Committee members are able to succeed themselves. At least one (1) member from each OB/GYN "group" will be on the Q.R.C. if possible. The Q.R.C. will meet at least four (4) times per year.

B. General Function:

1. The Q.R.C. provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the department members to OB/GYN patients in the hospital.

C. Specific Functions. The Q.R.C. is established to:
1. Identify important elements of OB/GYN care in all areas in which it is provided.
2. Establish performance monitoring indicators and standards that are related to these elements of care.
3. Select and approve their performance monitoring indicators.
4. Integrate relevant information for these indicators and review them quarterly.
5. Formulate thresholds for evaluation related to these performance monitoring indicators.
6. Review and evaluate physician practice when specific thresholds are triggered.
7. Identify areas of concern and opportunities to improve care and safety, and provide education to department members based on these reviews.
8. Highlight significant clinical issues and present the specific information regarding quality of care to the appropriate department member in accordance with Medical Staff Bylaws.
9. If needed, request Focused Professional Practice Evaluation when/if questions arise regarding a physician's practice.
10. Monitor and review the effectiveness of any intervention and document any change.

D. Other functions:
1. Assist in the reappointment process through retrospective review of charts.
2. Review any issues related to OB/GYN that are forwarded for review by other departments.
3. Assist in the collection, organization, review, and presentation of data related to OB/GYN care, safety, and department clinical pathways.
4. Review cases involving any OB/GYN deaths in the hospital.

E. Reports:
1. Minutes are submitted to the Medical Staff QA/PI Committee and the M.E.C. The Q.R.C. will provide minutes and, as needed, verbal or written communication regarding any general educational information gleaned through chart review or the Performance Improvement process to the department members and to QA/PI Committee.

XI. EMERGENCY ROOM CALL

A. Medical Staff Department members within the Department of OB/GYN may participate in the Emergency Department call roster or consultation panel as determined by the medical staff or Department Chair or their designee who:
1. Have been successfully removed from proctoring for Obstetrical Category Privileges, and
2. Have had one (1) Laparoscopic case and one (1) Abdominal Hysterectomy case proctored. This does not preclude complying with proctoring requirements as outlined above.

B. Refer to Medical Staff Policy, #8710-520 Emergency Room Call: Duties of the On-Call Physician.

C. When a patient indicates that she has been previously treated by a staff member, that member will be given the opportunity to provide further care.

D. When a patient presents to the Emergency Department and advises that they are under the care of a community clinic. The community clinic OB physician on call must see any patient, including obstetrical patients, who is under 13 weeks pregnant and who has been seen within the past two years by a primary care provider of that clinic, with the exception of vaccination clinics. Any obstetrical patients greater than 13 weeks with the above-referenced criteria are unassigned patients and will be cared for by the on-call OB/GYN for unassigned patients.

E. The members of the Department of OB/GYN will then determine whether to provide further care to an emergency room patient based upon the circumstances of the case. If a member declines, any necessary emergency special care will be provided by the on-call physician.

F. The care provided by an on-call physician will not create an obligation to provide further care.

~~G. The exception to the aforementioned Emergency Department On-Call requirements is North County Health Services call panel.~~

Approvals:

Department of Ob/Gyn:	10/6/14; 10/16
Medical Executive Committee:	11/16
Board of Directors:	12/16

I. **DEFINITIONS:**

A. Allied Health Practitioner (AHP) means a health care professional, other than a physician, dentist or podiatrist, who holds a license or other legal credential, as required by California law, to provide certain professional services and who, pursuant to the terms of the Medical Staff Bylaws, are not eligible for Medical Staff membership, but have been granted clinical privileges to provide certain clinical services.

B. Clinical Privileges (or Privileges) means the permission granted to an AHP to provide specified patient care services within his or her qualifications and scope of practice.

II. **QUALIFICATIONS:**

A. An AHP ~~,~~ is eligible for clinical privileges at Tri-City Medical Center (TCMC) if he or she:

1. Holds a license, certificate, or other legal credential in a category of AHPs which the Board of Directors has identified as eligible to apply for clinical privileges; and
2. Meets the qualifications described in these Rules and Regulations; and
~~2.~~ 3. Documents his or her education, experience, background, training, current competence, judgment, and ability with sufficient adequacy to demonstrate that any patient treated by the practitioner will receive care of the generally recognized professional level of quality established by the Medical Staff; and
~~3.~~ 4. Is determined, on the basis of documented references to adhere strictly to the lawful ethics of his or her profession, to work cooperatively with others in the hospital setting so as not to affect adversely patient care, and to be willing to commit to and regularly assist the Medical Staff in fulfilling its obligations related to patient care, within the areas of the practitioner's professional competence and credentials; and
~~4.~~ 5. Agrees to comply with all Medical Staff and Department and Division bylaws, rules and regulations, policies and procedures, and protocols to the extent applicable to the AHP; and
~~5.~~ 6. Maintains professional liability insurance, or is covered by the terms of their employer's insurance, with an insurer meeting the requirements specified in Medical Staff Policy 8710-558 (Liability Insurance Requirements), with minimum limits in the amount of $1 million per occurrence and $3 million per aggregate.

~~6.~~ B. More specific qualifications may be established by Departments and/or Divisions as stated in their respective rules and regulations and/or other privileging documents.

III. **CATEGORIES OF AHPs ELIGIBLE TO APPLY FOR CLINICAL PRIVILEGES:**

A. The following categories of Allied Health Professionals have been approved by the Board of Directors:

1. Audiologist
~~2. Behavioral Optometrist~~
~~3.~~ 2 Certified Nurse Midwife
~~4.~~ 3. Clinical Psychologist
~~5.~~ 4. ~~Clinical Research Coordinator,~~
~~6.~~ 5. Marriage and Family Therapist Intern
~~7.~~ 6. Medical Physicist/Radiation Physicist

~~8.7.~~ ~~Neurophysiologist (Evoked Potential)~~
~~9.~~8. Nurse Practitioner
~~10.~~9. Orthopedic Surgery Technician
~~11.~~10. Physician Assistant
~~12.~~11. Registered Nurse First Assist

B. The Board of Directors shall review the designation of categories at least annually and at other times~~,~~ within its discretion or upon the recommendation of the Medical Executive Committee (MEC).

IV. **PROCEDURE FOR GRANTING CLINICAL PRIVILEGES:**

A. An AHP whose scope of practice allows independent practice must apply and qualify for clinical privileges and, at the time patient care services are rendered, must designate a physician member of the active medical staff who is responsible, to the extent necessary, for the general medical condition of the patient for whom the AHP proposes to render services in the hospital. This provision currently only applies to clinical psychologists. Each AHP who practices independently must maintain communication with the relevant physician in order to enable the physician to assume responsibility, to the extent it is indicated, for the general medical condition of the patient.

B. An AHP whose scope of practice does not allow independent practice must apply and qualify for clinical privileges and must provide services under the supervision of an active Medical Staff member. An AHP under this subsection may apply to work under the supervision of one active Medical Staff member or a group of medical staff members. Such supervision must be in strict accordance with any hospital-developed standardized procedures and with any rules and regulations or other policies developed by the appropriate department/division and approved by the MEC, and does not replace any supervision requirements mandated under state law.

C. All AHP applications for initial granting and renewal of clinical privileges shall be submitted to the Interdisciplinary Practice Committee (IDPC). All such applications shall be processed in a parallel manner to that provided in Articles IV (Membership and Membership Renewal) and V (Clinical Privileges) of the Medical Staff Bylaws, except that the Interdisciplinary Practice Committee shall review all AHP applications prior to the Credentials Committee ~~and the MEC~~review, and except that any reference in the Bylaws to hearing rights shall not apply to any AHP except clinical psychologists.

D. AHPs shall not practice within the hospital until requested privileges have been granted. Temporary privileges may be granted. Granting of temporary privileges shall follow a similar process as prescribed by the Medical Staff Bylaws, Section 5.5 and in Medical Staff Policy 8710-515 (Temporary Privileges).

E. Except as is provided below, ~~under Section VIII.A.4.a., a~~an AHP who (a) has received a final adverse decision regarding his or her application for clinical privileges, ~~or~~ (b) withdrew his or her application for clinical privileges following an adverse recommendation by the IDPC or MEC, ~~or~~ (c) after having been granted clinical privileges, has received a final adverse decision resulting in termination of clinical privileges or (d) has relinquished his or her clinical privileges following the issuance of a ~~Medical Staff~~IDPC, MEC, or Board of Directors recommendation adverse to his or her clinical privileges, shall not be eligible to reapply for clinical

privileges affected by such decision or recommendation for a period of at least ~~six (6)~~18 months from the date the adverse decision became final, the application was withdrawn, or the AHP relinquished his or her clinical privileges. An AHP who reapplies after the waiting period must provide evidence demonstrating to the Medical Staff's satisfaction that the factors that led to the adverse recommendations or actions have been resolved. The waiting period described in this Section shall not apply to an AHP whose application was deemed withdrawn as incomplete, whose application was denied for failing to meet the Specific Credentialing Criteria found in Section XIV, or whose privileges were automatically terminated under Section IX.

F. AHP categories identified as eligible for clinical privileges are identified above. Practitioners who are not in one of those categories ~~All other categories~~ may not apply for clinical privileges, but may submit a written request to the IDPC, requesting that the Medical Staff and the Board of Directors ~~to~~ consider adding an additional category of AHPs eligible to apply for clinical privileges.

1. Upon receipt of such a request, the IDPC shall obtain the recommendation of any affected department or division in order to determine if there is a need for an additional category of AHP and shall forward the recommendation from the respective department or division to the Credentials Committee. The recommendation of the Credentials Committee is then forwarded on to the MEC.
2. The MEC makes the final recommendation to the Board of Directors. The Board of Directors shall consider the recommendation of the MEC, as well as the recommendation of any affected department or division, either before or at the time of its annual review of the categories of AHPs. If the requested category of AHP fulfills a patient service need as identified by the Board of Directors, the category will be added to the recognized categories of AHP.
3. Once added, the appropriate department/division, IDPC and Credentials Committee (as appropriate), and MEC shall establish clinical privilege requirements, scope of service, and monitoring mechanisms. After approval by the Board of Directors of these requirements, the AHP may apply for clinical privileges.

G. Each AHP who is granted clinical privileges shall be assigned to the department/division appropriate to his or her occupational or professional training. Although AHPs may not be Medical Staff members, they shall, ~~and,~~ unless otherwise specified in these rules and regulations, ~~shall~~ be subject to the ~~terms and conditions~~Basic Responsibilities of Medical Staff Membership and the prohibition against harassment ~~that parallel those~~ specified in Article II (Membership) of the Medical Staff Bylaws, as they may logically apply to AHPs and may be appropriately tailored to the particular category of AHPs. In addition, each AHP must adhere to the terms and conditions as delineated in their delegation of services agreement, standardized procedures, protocols, job description, and clinical privileges.

H. If a service provided by a category ~~(ies)~~ of AHP is no longer a service that is being provided by TCMC, the category ~~(ies)~~ may be eliminated without affording the process described in section VIII.A of these rules and regulations ~~by~~ to those ~~categories~~ AHPs affected.

V. **PREROGATIVES:**

A. The prerogatives which may be extended to a member of a particular category of AHP shall be defined in the applicable privilege/prerogatives cards reviewed by the Department/Division Chief and the IDPC, and approved by the Medical Executive Committee ~~Medical Staff or applicable Department/Division rules and regulations~~. Such prerogatives may include:

1. Provision of specified patient care services consistent with clinical privileges granted to the AHP and within the scope of the AHP's licensure or certification.
2. Service on Medical Staff and hospital committees except as otherwise expressly provided in the Medical Staff bylaws, rules and regulations. An AHP may not serve as chair of Medical Staff committees.
3. Attendance at meetings of the Department/Division to which he or she is assigned, as permitted by the department/division rules and regulations, and attendance at Medical Staff educational programs in his or her field of practice. An AHP may not vote at department/division meetings.

B. AHPs may not:

1. Admit or discharge patients from the hospital ~~without consultation with physician~~.
2. Give orders, verbal or written, unless they are authorized by the Medical Staff and unless it is within the AHP's scope of licensure.
3. Give telephone orders.
4. Act as a first assistant at any surgical, diagnostic or therapeutic procedure for which the Medical Staff requires the presence of an assisting physician.
5. Inhibit or in any way interfere with the responsibilities of employees of the hospital.

VI. **RESPONSIBILITIES:**

A. Each AHP shall:

1. Meet those responsibilities required by the Medical Staff bylaws, rules and regulations, policies and procedures and TCMC policies and procedures.
2. Retain appropriate responsibility within his/her area of professional competence for the care of each patient in the hospital for whom he/she is providing services.
3. Participate, when requested, in patient care audit and other quality review, evaluation, and monitoring activities required of AHPs, in evaluating AHP applicants, in supervising initial AHP appointees of his/her same occupation or profession or of an occupation or profession ~~which is governed by~~which has a more limited scope of practice ~~statute~~, and in discharging such other functions as may be required by the Medical Staff from time to time.
4. Prepare and complete, in a timely manner, any documentation relevant to patient care provided.
5. Abide by the ethical and moral principles of their respective profession.

VII. **DEFINITION OF PHYSICIAN SUPERVISION:**

A. Level of Physician Supervision - ~~As defined by the individual category of AHP's scope of practice.~~

1. Each AHP shall be supervised by their supervising physician(s) in a manner consistent with the requirements of the California scope of practice statutes and regulations, as well as in a manner consistent with these Rules and Regulations, the Medical Staff Bylaws, and the applicable privileging forms, standardized procedures, delegation agreements, and policy and procedures.
2. Each supervising physician must sign a medical staff-developed form acknowledging his or her responsibilities as a supervising physician.
3. Available: Each supervising ~~Physician~~ physician must be available ~~within thirty (30) minutes travel time~~ in the manner detailed by the applicable privileging forms, standardized procedures, delegation agreements, and policy and procedures.
~~1.~~ 4. The supervising physician shall ~~and~~ always be available by electronic communication whenever the AHP he or she is supervising is practicing at the hospital.
5. The following additional supervision requirements apply to the following units and situations:
~~2.~~ i. Medical/Surgical Units: Documentation of an examination of the patient by the supervising physician(s) every third day if care is given by the AHP.
~~3.~~ ICU/Telemetry Units: Examination of the patient by the supervising physician(s) the same day as care is given by the AHP.
~~4.~~ ii. ~~ED & Imaging: The supervision of AHPs by their supervising physician(s) is delineated in the "Delegation of Service Agreement" incorporated in each credential file of the AHP.~~
~~5.~~ iii. Non-Scheduled Admission(s): Examination of the patient by the supervising physician(s) the same day as care is given by the AHP.

B. Podiatrists may not supervise physician assistants unless the ~~Podiatrist~~ podiatrist also holds a M.D. or a D.O. license.

C. Physician Co-signature:
1. Order(s) ~~and telephone order(s)~~, verbal or written, may be immediately implemented. ~~and p~~Physician co-signature is required within ~~24~~ 48 hours of AHP's order. excluding those covered under an already approved standardized procedure.
2. Any medical record of any patient cared for by an AHP for whom the physician's prescription has been transmitted or carried out shall be reviewed and countersigned and dated by the supervising physician within ~~24~~ 48 hours.
3. The H&P must be co-signed by the supervising physician(s) within ~~24~~ 48 hours.
4. The supervising physician must review and authenticate any progress note within the medical record of any patient(s) documented by an AHP within ~~24~~ 48 hours.

D. Each time an AHP provides care for a patient and enters his/her name, signature, initials, or computer code on a patient's record, chart, or order, the AHP must also enter the name of his/her supervising physician who is responsible for the patient. When a physician assistant transmits an oral order, he/she must also

state the name of the supervising physician responsible for the patient (16 C.C.R. §1399.546.)

VIII. **TERMINATION, SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES:**

A. ~~**GENERAL**~~ **PROCEDURES FOR AHPS WHO ARE NOT NURSE PRACTITIONERS, CERTIFIED NURSE MIDWIVES, REGISTERED NURSE FIRST ASSISTS, OR PHYSICIAN ASSISTANT**

~~1.~~

1. For the purposes of Section VIII.A. only, the term "AHP" applies only to those professionals who are not nurse practitioners, certified nurse midwives, registered nurse first assists, or physician assistant.

2. At any time, the Chief of Staff or Chair/Chief of the Department/Division to which the AHP has been assigned may recommend to the MEC that an AHP's clinical privileges be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Interdisciplinary Practice Committee), if the MEC agrees that corrective action is appropriate, the MEC shall recommend specific corrective action to the Board of Directors. A Notification Letter regarding the recommendation shall be sent by certified mail to the subject AHP. The Notification Letter shall inform the AHP of the recommendation and the circumstances giving rise to the recommendation.

3. Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an AHP, other than a clinical psychologist, to the hearing rights set forth in Bylaws Articles VI and VII. However, an AHP shall have the right to challenge any recommendation which would constitute grounds for a hearing under Section 7.2 of the Bylaws (to the extent that such grounds are applicable by analogy to the AHP) by filing a written ~~grievance~~ objection (i.e., a letter objecting to the recommended action and requesting an interview) with the MEC within fifteen (15) days of receipt of the Notification Letter. Upon receipt of an ~~grievance~~objection, the MEC or its designee shall afford the AHP an opportunity for an interview concerning the ~~grievance~~objection. Although such interview shall not constitute a "hearing" as established by Article VII of the Bylaws, and need not be conducted according to the procedural rules applicable to such hearings, the purpose of the interview is to allow both the AHP and the party recommending the action the opportunity to discuss the situation and to produce evidence in support of their respective positions. The MEC shall have sole discretion in determining what evidence may be permitted and how it may be presented. Minutes of the interview shall be retained.

4. Within fifteen (15) days following the interview, the MEC, based on the interview and all other aspects of the investigation, shall make a final recommendation to the Board of Directors, which shall be communicated in writing, sent by certified mail, to the subject AHP. The final recommendation shall discuss the circumstances giving rise to the recommendation and any pertinent information from the interview. Prior to acting on the matter, the Board of Directors may, in its discretion, offer the affected practitioner the right to ~~appeal to the Board or a subcommittee thereof~~discuss the recommendation with the Board or with a

subcommittee of the Board, in a manner and at a time determined by the Board. The Board of Directors shall adopt the MEC's recommendation, so long as it is reasonable and, appropriate under the circumstances. The final decision by the Board of Directors shall become effective upon the date of its adoption. The AHP shall be promptly provided with notice of the final action, sent by certified mail.

~~5.~~

~~6.~~ B. **~~GENERAL~~ PROCEDURES FOR AHPS WHO ARE NURSE PRACTITIONERS, CERTIFIED NURSE MIDWIVES, REGISTERED NURSE FIRST ASSISTS, OR PHYSICIAN ASSISTANTS:**

~~7.~~

1. AHPs who are nurse practitioners, certified nurse midwives, registered nurse first assists, or physician assistants shall be entitled to the AHP limited-hearing procedures detailed below:

Purpose

This Appendix A to the Allied Health Practitioner Rules and Regulations provides the process by which certain Allied Health Practitioners subject to the Allied Health Practitioner Rules and Regulations of the Tri-City Medical Center Medical Staff can challenge adverse actions or adverse recommendations against their practice privileges.

Scope/Coverage

This policy applies only to nurse practitioners (NP), certified nurse midwifes (CNM), certified registered nurse anesthetists (CRNA), registered nurse first assists (RNFA), and physician assistants (PA).

Definitions

1. **Adverse Action and Adverse Recommendation** mean actions and recommendations, respectively, that constitute grounds for a hearing, as described in the AHP Rules and Regulations.

2. **Allied Health Practitioner (AHP)** for the purposes of this Appendix, means only NPs, CNMs, RNFAs, CRNAs, and PAs.

3. **Limited Hearing** means the process by which AHPs may challenge an adverse action or an adverse recommendation, and is not a hearing that is described in the Medical Staff Bylaws.

Policy

Nothing contained in the Medical Staff Bylaws or this Appendix shall be interpreted to entitle an AHP covered by the scope of this Appendix to the hearing rights set forth in Bylaws Articles VI and VII. However, an AHP covered by the scope of this Appendix shall have the right to challenge any recommendation which would

constitute grounds for a hearing under Section 7.2 of the Bylaws (to the extent that such grounds are applicable by analogy to the AHP) as set forth here.

Procedure

1. At any time, the Chief of Staff or Chair/Chief of the Department/Division to which the AHP has been assigned may recommend to the Medical Executive Committee (MEC) that an AHP's clinical privileges be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Interdisciplinary Practice Committee), if the MEC agrees that corrective action is appropriate, the MEC shall recommend corrective action and send a Notification Letter to the AHP. The Notification Letter shall inform the AHP of the recommendation and the circumstances giving rise to the recommendation.

2. An AHP may request a limited hearing by filing a written objection (i.e., a letter objecting to the recommended action and requesting review) MEC no later than 15 days after receipt of a Notification Letter. Failure to submit a letter within 15 days shall result in a waiver of the right to a limited hearing.

3. Upon receiving the request, the MEC shall make arrangements to convene a limited hearing. The limited hearing shall not constitute a Medical Staff hearing as established in the Hearings and Appellate Review Article of the Bylaws and need not be conducted according to the procedural rules applicable to such hearings.

4. The parties to the limited hearing shall be the MEC and the AHP subject to the adverse recommendation or action. The MEC may select an individual to serve as its representative at the limited hearing; however, that person shall not be an attorney.

5. The Chief of Staff shall appoint at least three unbiased Medical Staff members or AHPs, or a combination of the two, who are in good standing and of good ethics, along with the appointment of at least one member to serve as an alternate, to serve on a review committee. Such appointment shall include designation of the chair. When feasible, at least one member shall hold the same type of license as the AHP party. The review committee members shall gain no direct financial benefit from the outcome of the limited hearing, and shall not have acted as accusers, investigators, fact finders, initial decision makers or otherwise actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude an individual from serving as a member of the review committee. Employers, supervisors, or co-workers of the AHP are not eligible to serve on the review committee.

6. The Chief of Staff may appoint a hearing officer, who shall have the same qualifications described for hearing officers in the Medical Staff Bylaws.

7. The chair of the review committee or hearing officer, if any, shall schedule the limited hearing, with the goal to for the limited hearing to occur no sooner than 30 days, and no later than 60 days, of the request for limited hearing.

8. No later than 20 days prior to the limited hearing, each party shall submit to the review committee a written statement of the party's own position. The written statement should be supported by proposed evidence, which may include, but is not limited to, declarations from witnesses and relevant portions of medical records. Each party must supply a copy of its written statement and the proposed supporting evidence to the other party. No later than 10 days before the limited hearing, each party may submit a rebuttal to the other party's written statement, with proposed supporting evidence. Each party must supply a copy of its rebuttal and proposed supporting evidence to the other party. The hearing officer, or if none is appointed, the review committee, may impose limits as to the length of the written submissions, and decides whether proposed evidence shall be included in the record of the limited hearing proceedings. An AHP applicant shall not be permitted to introduce information requested by the Medical Staff, but not produced during the application process, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

9. At the limited hearing, each party may make an oral argument addressing the issues raised by the adverse action or recommendation; however, neither party shall present evidence during the limited hearing that had not been presented with the written statement or rebuttal or that had been rejected by the hearing officer or review committee. The Hearing Officer or, if none appointed, the chair may impose appropriate time limits to the oral statements and to the limited hearing as a whole. The review committee may interview or question either party and may invite witnesses to attend the limited hearing in order to be questioned by the committee. No party may question a witness directly, though the parties may submit questions to the chair, which the chair, in his or her discretion, may ask the witness. Neither party may be represented by an attorney at the limited hearing. Minutes of the limited hearing shall be retained.

10. At the conclusion of the limited hearing, the review committee shall meet and deliberate. If a preponderance of the evidence supports the adverse action or recommendation, then the review committee shall recommend to the MEC that it be upheld. An AHP applicant shall bear the burden of persuading the review committee, by a preponderance of the evidence, of his/her qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for membership and privileges.

11. Within seven days of the review committee's deliberations, the committee shall submit a written decision to the parties and to the MEC regarding its

recommendation, including facts and conclusions supporting the recommendation.

12. Within 14 days following receipt of the decision, the MEC will consider the review committee's decision and make a final recommendation to the Board of Directors. The MEC, in its discretion, may adopt the review committee's decision as its own, or may modify or reject the recommendation. The MEC shall deliver to each party a copy of its recommendation.

13. AHP shall have the right to appeal the MEC's recommendation to the Board of Directors.

14. The affected AHP shall be informed in writing of his or her right to appeal the final recommendation. The affected AHP shall have ten (10) days after being informed of his or her right to appeal to request an appeal review. The request for appeal shall state with specificity the basis for the appeal.

15. The appeal review shall be conducted within thirty (30) days of the request. The parties to the appeal shall be the MEC and the AHP.

16. Each party shall have the right to present a written statement in support of his, her or its position on appeal. The Board of Directors Chair shall appoint an Appeal Board of up to three people, including at least one Board member. Each party may submit a written statement in support of its position to the Appeal Board within thirty (30) days of the Board's acceptance of the appeal. No party has the right to personally appear and make oral argument, though the Appeal Board, in its discretion, may allow oral argument by both parties. In such cases, neither party shall have the right to representation by counsel at oral argument. The Appeal Board may then, at a time convenient to itself, deliberate outside the presence of the parties.

8.1 The Appeal Board shall issue written recommendations to the Board of Directors within fifteen (15) days of the conclusion of the appellate review. The Board of Directors shall issue a final decision at its next regular meeting, which shall be delivered to the parties by hand delivery, courier delivery service with confirmed delivery (such as Federal Express or UPS), or certified mail.

~~9.~~

10.C **SUMMARY SUSPENSION:**

i1. Notwithstanding any other provision in Section VIII.~~A.1~~, an AHP's clinical privileges may be immediately suspended or restricted where the failure to take such action may result in an imminent danger to the health of any individual. Such summary suspension or restriction may be imposed by the Chief of Staff, the MEC, or the Chair/Chief of the Department/Division to which the AHP has been assigned (or

his/her designee). Unless otherwise stated, the summary action shall become effective immediately upon imposition and the person responsible for taking such action shall promptly give written notice of the action to the Board of Directors, the MEC, and the Chief Executive Officer. The notice shall also inform the practitioner of his or her right to file an ~~grievance~~objection if the suspension is imposed for more than 14 days. The practitioner's right to file an ~~grievance~~objection and subsequent interview procedures shall be in accordance with Section VIII.A and B, except that all reasonable efforts shall be made to ensure that the practitioner is given an interview or limited-hearing as expeditiously as possible and that final action is taken within (15) days or as promptly thereafter as practicable.

ii2. Within three (3) working days of the summary action, the affected practitioner shall be provided with written notice of the action. The notice shall include the reason(s) for the action and that such action was necessary because of a reasonable probability that failure to take the action could result in imminent danger to the health of an individual.

iii3. Within five (5) working days following the action, the Interdisciplinary Practice Committee shall meet to consider the matter and make a recommendation to the MEC as to whether the summary suspension should be vacated or continued pending the outcome of any interview with the affected practitioner. Within eight (8) days following the imposition of the action, the MEC shall meet and consider the matter in light of any recommendation forwarded from the Interdisciplinary Practice Committee. Within two (2) working days following the MEC's meeting, the MEC shall provide written notice to the affected practitioner regarding its determination on whether the summary action should be vacated or continued pending the outcome of any interview proceeding.

IX. AUTOMATIC SUSPENSION, TERMINATION OR RESTRICTION:

A. Notwithstanding subsection VIII.A, above, an AHP's clinical privileges may be subject to automatic suspension or termination as set forth in this Section IX.

B. ~~Notwithstanding subsection VIII.A, above,~~ aAn AHP's clinical privileges shall be subject to automatic suspension in the event that:

1. the AHP's license or other legal credential expires. The automatic suspension will continue until proof of renewal is received.
2. With respect to an AHP who must have a physician supervisor:
   - i The medical staff membership or privileges of the supervising physician is terminated, whether such termination is voluntary or involuntary; or
   - ii The supervising physician no longer agrees to act in such capacity, or
   - iii The relationship between the AHP and the supervising physician is otherwise terminated, regardless of the reason.

   ~~A.~~ In any of these cases, the automatic suspension will be lifted if the AHP finds a supervising physician within 30 days of the suspension being imposed.
3. The AHP fails maintain professional liability insurance, if any is required.
4. The AHP fails to complete medical records as required by policy and procedure.
5. The AHP fails to provide documentation of Tuberculin testing in accordance with applicable medical staff policy.

6. If the AHP's DEA certificate is revoked, limited or suspended, the AHP shall automatically and correspondingly be suspended of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
7. The AHP fails, without good cause, to appear at a meeting called by the AHP's department chair or section chief or a medical staff committee or officer to discuss a suspected deviation from standard clinical practice, if the AHP has been given at least seven days' written notice of such meeting.

B.C. Notwithstanding subsection VIII.A, above, an AHP's clinical privileges shall automatically terminate in the event that:

1. The AHP's privileges have been automatically suspended for more than 30 continuous days.
2. The AHP's certification, license, or other legal credential is not renewed, is revoked, or is suspended.

~~1.~~

~~2. With respect to an AHP who must practice under physician supervision:~~

~~i The medical staff membership or privileges of the supervising physician is terminated, whether such termination is voluntary or involuntary; or~~

~~ii The supervising physician no longer agrees to act in such capacity for any reason, or the relationship between the AHP and the supervising physician is otherwise terminated, regardless of the reason therefore;~~

~~3. When the AHP's clinical privileges are automatically terminated for reasons specified in (2.a) or (2.b) above, the AHP may apply for reinstatement as soon as the AHP has found another physician member of the active medical staff who agrees to supervise the AHP.~~

C.D. ~~Notwithstanding subsection IX above, i~~In the event that the AHP's certification, ~~or~~ license, or DEA certification is restricted or made the subject of an order of probation, the AHP's corresponding clinical privileges shall automatically be subject to the same restrictions or conditions of probation.

E. Where the AHP's privileges are automatically terminated, suspended, or restricted pursuant to this subsection, the notice and interview procedures under subsection VIII.~~A~~ shall not apply and the AHP shall have no right to an interview. The MEC, within its discretion, may, upon the AHP's request, invite the AHP to a meeting to discuss ~~except, within the discretion of the MEC, regarding~~ any factual dispute over whether or not the circumstances giving rise to the automatic termination, suspension, or restriction actually exist. Such a meeting shall not be a hearing under the Medical Staff Bylaws or an interview or AHP limited-hearing under Section VIII, above.

~~D.~~

X. **APPLICABILITY OF SECTION VIII:**

A. The rights afforded by Section VIII shall not apply to any decision regarding whether a category of AHP shall be eligible for clinical privileges ~~and~~ or the terms or conditions of such decision.

XI. **REAPPLICATION:**

A. Initial and renewal of clinical privileges shall be for a period of up to two years. Each AHP must reapply for renewed clinical privileges in accordance with Section IV.

XII. **ON-GOING PROFESSIONAL PRACTICE EVALUATION (OPPE):**

A. AHPs are subject to the provisions of the Medical Staff's OPPE process outlined in Medical Staff Policy 8710-509.

XIII. **FOCUS PROFESSIONAL PRACTICE EVALUATION (FPPE)/PROCTORING:**

A. AHPs are subject to the provisions of the Medical Staff's FPPE process outlined in Medical Staff Policy 8710-542 and the applicable Department/Division Rules and Regulations.

B. ~~Unless otherwise~~In addition to what is specified in the applicable Department/Division Rules and Regulations, all AHPs shall be proctored (i.e., initial FPPE) for a minimum of six (6) cases of patient contact.

XIV. **SPECIFIC CREDENTIALING CRITERIA** (in addition to documentation of current competence in scope of privileges and other documentation as requested in accordance with Medical Staff Bylaws and applicable Department/Division requirements):

A. Audiologist:
   1. Current, valid Audiologist license issued by the California Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.
   2. Masters or doctorate degree in audiology (AuD)
   3. Documentation of participation in relevant continuing education activities.

~~B. Behavioral Optometrist:~~
   ~~1. Current, valid Optometrist license issued by the California State Board of Optometry~~
   ~~2. Doctorate of Optometry (OD)~~
   ~~3. Documentation of participation in relevant continuing education activities.~~
   4. ~~BLS, CPR, or ACLS~~

~~C~~B. Certified Nurse Midwife (CNM)
   1. Current, valid RN license issued by the California Board of Registered Nursing
   2. Current, valid NM certificate issued by the California Board of Registered Nursing
   3. Current Furnishing Number issued by the California Board of Registered Nursing
   4. Current certification (or actively pursuing certification; must be certified within one year of initial appointment) by the American Midwifery Certification Board (formerly the ACNM Certification Council, Inc.) College of Nurse Midwives
   5. Current, valid NRP certificate
   6. Current, valid DEA registration
   7. Documentation of participation in relevant continuing education activities.

~~D~~C Clinical Psychologist
   1. PhD or PsyD degree

2. Current, valid Clinical Psychologist license issued by the California Board of Psychology
3. Documentation of participation in relevant continuing education activities.

E-D. Clinical Research Coordinator:
1. Current, valid certification by the Association of Clinical Research Professionals (ARCP) or the National Institutes of Health (NIH)
2. Documentation of participation in relevant continuing education activities.
3. BLS or ACLS
4. In order to administer medications, the individual must have a current, valid RN license issued by the California Board of Registered Nursing

F-E. Marriage and Family Therapist Intern
1. Masters or doctorate in counseling psychology
2. Registered with the California Board of Behavioral Sciences as an MFT Intern
3. BLS or ACLS
4. Documentation of participation in relevant continuing education activities.

G-F. Medical Physicist/Radiation Physicist
1. Masters of Science in medical physics or physics; or PhD in related field
2. Certified by the American Board of Medical Physics, the American Board of Radiology, or in the process of obtaining certification.
3. Documentation of participation in relevant continuing education activities.

H-G. Neurophysiologist (Evoked Potential)
1. Certified by the American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRET)
2. Documentation of participation in relevant continuing education activities.

I-H. Nurse Practitioner (NP) (Non-surgical)
1. Current, valid RN license issued by the California Board of Registered Nursing
2. Current, valid NP certificate issued by the California Board of Registered Nursing
3. Current, valid Furnishing Number issued by the California Board of Registered Nursing
4. Current, valid DEA registration issued by the United States Drug Enforcement Administration.
5. Documentation of participation in relevant continuing education activities.
6. BLS or ACLS

J-I. Nurse Practitioner (NP) (Surgical)
1. Current, valid RN license issued by the California Board of Registered Nursing
2. Current, valid NP certificate issued by the California Board of Registered Nursing
3. Current, valid Furnishing Number issued by the California Board of Registered Nursing
4. Current, valid DEA registration issued by the United States Drug Enforcement Administration.
5. Documentation of participation in relevant continuing education activities.
6. BLS or ACLS

7. Documented completion of a formal Registered Nurse First Assistant training program.

~~K.~~J Orthopedic Surgery Technician
1. Certified by the National Board for Certification of Orthopedic Technologists
2. Documentation of participation in relevant continuing education activities.
3. BLS or ACLS

~~L.~~K Physician Assistant (PA)
1. Graduate of an accredited physician assistant education program
2. Current, valid PA license issued by the California Physician Assistant ~~Committee~~ Board ~~of the Medical Board of California~~.
3. Certified by the National Commission on Certification of Physician Assistants
4. Current, valid DEA registration issued by the United States Drug Enforcement Administration.
5. Documentation of participation in relevant continuing education activities.
6. BLS or ACLS

~~M.~~L Registered Nurse First Assist (RNFA)
1. Current, valid license issued by the California Board of Registered Nursing
2. Current CNOR certification
3. Documentation of successful completion an AORN-approved RNFA course
4. Documentation of participation in relevant continuing education activities.
5. ACLS

APPROVALS:

Interdisciplinary Practice Committee:	~~06/13/13~~
Credentials Committee:	~~06/12/13~~
Medical Executive Committee:	~~06/24/13~~
Board of Directors:	~~06/27/13~~

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #16-037

POLICY TITLE: Chief Executive Officer and Chief Compliance Officer Succession Planning Policy

I. PURPOSE:

A. The Board of Directors of Tri-City Health Care District ("TCHD" or "District") believes that the continued proper functioning of the District, the maintenance of the highest quality of patient care and the preservation of the District's financial integrity require that the District have a pre-established and orderly process for succession of the Chief Executive Officer ("CEO") and the Chief Compliance Officer ("CCO"). Therefore, it has adopted the following policy to assist the Board in the event of a vacancy in either position ("Vacancy"), as follows:

1. An immediate Vacancy, unanticipated short-term or long-term caused by the death or extended disability or incapacitation of the Chief Executive Officer or the Chief Compliance Officer.

2. An anticipated Vacancy from a long-term notice by the Chief Executive Officer or the Chief Compliance Officer.

3. An impending Vacancy that will occur within several months caused by a notice of resignation.

B. The intent of this policy is to provide clarity for the transition process, upon a Vacancy, with minimal disturbance to the performance and effectiveness of the Health Care District, subsidiaries and related organizations.

II. PRACTICE

A. It is the responsibility of the Board of Directors in consultation with the Chief Executive Officer of the District to develop and maintain this plan, and to review the plan on an annual basis.

B. In the event of incapacitation of the Chief Executive Officer or the Chief Compliance Officer, the situation will be evaluated by the Board in consultation with the Chief of Staff of Tri-City Medical Staff to determine the need for the immediate appointment of an interim Chief Executive Officer or interim Chief Compliance Officer. For purposes of this policy, "incapacitation" means physical or mental incapacitation due to disease, illness or accident where there is reasonable cause to believe that the incumbent will not be able to perform the duties of his or her office for a period of three consecutive months or more. For purposes of this policy "temporary" incapacitation shall mean less than three

consecutive months. Nothing in this policy shall be construed to abridge any rights an employee may have under his or her contract or any insurance coverage or workers compensation laws.

C. Appropriate arrangements will be made through the District's legal counsel and Chief Financial Officer for the interim Chief Executive Officer or Interim Compliance Officer to have the necessary signing authority where required.

D. After the Board Chair, in consultation with the Vice President of Human Resources, has been made aware of whether the incapacitation or disability is temporary or permanent, the following will occur:

1. In the event of temporary incapacitation, the interim Chief Executive Officer or interim Chief Compliance Officer will continue in that role until the determination is made by the Board that the Chief Executive Officer or Chief Compliance Officer, respectively, can resume the position.

   a. In the event of temporary incapacitation of the Chief Executive Officer, the following list identifies the positions that will be considered by the Board to fill the role for the period of the Chief Executive Officer's incapacitation.

      - Chief Operating Officer;
      - Chief Nurse Executive;
      - Chief Financial Officer;
      - Other qualified members of the senior leadership team.

   b. In the event of temporary incapacitation of the Chief Compliance Officer, the following list identifies the positions that will be considered by the Board to fill the role for the period of the Chief Compliance Officer's incapacitation.

      - The District's legal counsel;
      - Other qualified members of the senior leadership team.

2. In the event of permanent incapacitation, the members of the Board will confer on the process to select and appoint a Search Committee to initiate the search for a new Chief Executive Officer or Chief Compliance Officer.

E. Communications

1. Once a determination has been made, it will be the responsibility of the Board Chair to communicate the plan of action with the District leadership, medical staffs, Auxiliary, Foundation, and employees, as appropriate, the plan of action to be initiated in search of the new Chief Executive Officer or Chief Compliance Officer. This may take the form of special newsletters, e-mails, telephone calls, etc.

2. External audiences to be notified of the plan of action will include, as appropriate, community and business leaders in the district, members of the press, affiliates and partners of TCHD and social service agencies associated with the District.

3. During this period the Board will select the Public Information Officer, the Chair, or other authorized person, to serve as the spokesperson for the District. All requests for information will be directed through the Public Information Officer.

F. Impending Vacancy Caused By Resignation or Termination

1. In the event of an impending Vacancy in the Chief Executive Officer position or the Chief Compliance Officer position, the Board shall meet as soon as practicable and initiate the following plan:

   a. In order to ensure stability at the time of an immediate Vacancy (within 60 days) an interim Chief Executive Officer or Chief Compliance Officer will be named.

   b. The Board, in consultation with the leadership of the medical staff, shall determine whether the use of an outside management firm is appropriate or whether there is adequate internal leadership to assume responsibilities for the Chief Executive Officer or Chief Compliance Officer.

2. The Chair of the Board after consultation with the Vice-Chair and the Vice President of Human Resources will determine and recommend to the Board of Directors the level and extent of compensation (including any incentives and/or benefits) to be paid to the individual assuming the interim Chief Executive Officer's role or the interim Chief Compliance Officer's role during the period in question.

3. Within 60 days of notification by the Chief Executive Officer or Chief Compliance Officer of his or her impending resignation or retirement or in the event of termination, the Board of Directors may form a Search Committee with the Chair to be named by the Chair of the Board of TCHD.

4. Representation on the Search Committee for the Chief Executive Officer may include, but is not limited to:

   a. Members of the TCHD Board;

   b. Representation from the Medical Staff Leadership of Tri-City Medical Center;

5. Representation on the Search Committee for the Chief Compliance Officer may include, but is not limited to:

   a. The Chief Executive Officer;

   b. Staff Members of Tri-City Medical Center.

6. The role of the Search Committee will be:

   a. Manage the search process, including initiation of request for proposals (RFPs) for selection of a search firm;

   b. Interview and recommendation of a search firm, if appropriate;

   c. Review and approve the Success Profile (job description/ requirements) for the Chief Executive Officer or Chief Compliance Officer position;

   d. Interview candidates and screen references;

   e. Recommend the top candidates to the TCHD Board for final interview.

7. The Search Committee will meet within two weeks of their appointment to begin the selection process. The Vice President of Human Resources will serve as staff to the committee.

8. Should the Vacancy date be later than one (1) year or longer, a Search Committee will be formed within six (6) months of the Chief Executive Officer or Chief Compliance Officer leaving the position to allow time for adequate selection of the incumbent's replacement and an effective transition to occur.

9. The Chair of the Search Committee will make regular and timely reports to the Board on the progress of the search.

10. The Search Committee must comply with the public notice and open meeting requirements of the Ralph M. Brown Act, as applicable.

Reviewed by the Gov/Leg Committee: 09/10/08 & 10/15/08 & 05/13/09
Approved by the Board of Directors: 05/28/09
Reviewed by the Gov/Leg Committee: 04/01/14
Approved by the Board of Directors: 04/24/14
Reviewed by the Gov/Leg Committee: 04/05/2016
Approved by the Board of Directors: 04/28/16

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #15-039

POLICY TITLE: Comprehensive Code of Conduct

The following is the Board-approved Code of Conduct for District Board Meetings:

I. PURPOSES AND GOALS OF CODE OF CONDUCT.

Effective leadership requires the Board to foster effective communication throughout the organization. Effective communication is necessary to encourage the delivery of safe, high quality care, as well as compliance with ethical and legal imperatives. Effective communication occurs best in an atmosphere of mutual respect, in which patients, physicians, hospital staff and members of the public, as well as members of the Board, feel valued and free to express themselves. Effective communication requires thorough preparation for meetings, adherence to approved procedures for the conduct of meetings, including compliance with time limits and courteous conduct during debate and discussion. Effective communication requires an atmosphere free from threats, intimidation, abusive behavior, violence, harassment, and other dangerous or disorderly conduct.

The Board believes that at a minimum, its members must behave as if they are fiduciaries who are expected to honor the same duties of loyalty and care expected of their peers who serve on the boards of non-profit hospitals. Board members should act professionally at all times.

This Code of Conduct is intended to describe: (1) minimum expectations for conduct at, and surrounding Board meetings; (2) how Board members are provided the resources needed for effective, informed governance; (3) rules for ensuring the fairness of proceedings; and to (4) prescribe consequences for misconduct which does not contribute to effective leadership of TCMC, including making Board members ineligible for receipt of discretionary perquisites of office within the jurisdiction of the Board.

II. MINIMUM EXPECTATIONS FOR CONDUCT OF BOARD MEETINGS

1. Once the Board has a quorum, the meeting should immediately commence. Time periods announced by the Chair for recesses shall be strictly observed.

2. For each agenda item on which there is anticipated action, at the discretion of the Chair or upon request by any Board member, consideration may commence with a staff presentation or other report or public comments, or with a motion and a second. Board discussion shall be permitted following any presentation or public comments, except that:

a. any Board member who must abstain from participation in a matter because of a legal conflict of interest shall ask the Chair for permission to announce the conflict prior to consideration of the item; and

b. any Board member who has had any discussions or received information prior to the meeting with respect to an agenda item which will affect substantial legal rights of a party appearing before the Board such as regarding credentialing of a health care provider, proposed imposition of sanctions on a Board member, or another quasi-judicial matter, shall, prior to consideration of the item, ask the Chair for permission to describe the nature of those contacts. Disclosing such information helps ensure fairness of Board decisions by ensuring that, to the extent possible, all involved have the same information regarding the matter. In case of doubt, a Board member shall err on the side of disclosing relevant information obtained outside of the meeting, including who provided the information and in what circumstances.

c. If the requestor for an item is listed as "Standard," any member may make the first motion. If the anticipated action is based on a recommendation from a Board committee, the first motion should normally be made by the Chair of that committee. If a particular member is listed as the requestor for the item, the first motion on the item should normally be made by that member.

3. If there is no motion on an action item, or if a motion is made and there is no second, the Chair should move to the next agenda item without further comment from the Board members.

4. For each agenda item that has received a motion and a second, the Chair should ask each member in turn as to whether that member wishes to address the motion, starting with the maker of the motion.

5. Each member will be recognized by the Chair and shall be allotted up to 3 minutes to speak to the motion, once recognized. Time for questions and answers addressed by a member to staff or to other Board members is included in the three minutes, unless the Chair grants an exception. Members who anticipate that this time will be insufficient shall, whenever feasible: (1) submit written statements at any time; (2) submit written questions to the Chair and CEO at least 48 hours in advance of a regular meeting when feasible (see II, B, above); or (3) request additional time. Only the member who has been recognized may speak on the motion during that time. Once a member is recognized, a timekeeper selected by the Chair will start the three-minute clock upon the direction of the Chair. A person other than the Chair shall operate the time clock under the direction of the Chair. Upon expiration of the allotted time, the

timekeeper shall notify the Chair by word or sign. Time limits are to be consistently and strictly enforced.

6. When the member's three-minute time allotment has concluded, the Chair should immediately recognize the next member in turn to determine if he/she wishes to speak. When recognized, the member should start speaking and the prior speaker shall promptly yield the floor.

7. Once the Chair has offered each member the opportunity to be heard, the Chair may offer a second round of comments. The Chair should again offer each member a three-minute opportunity to speak.

8. Unless recognized by the Chair, Board members shall not address members of the public who come forward to speak, and should not enter into a dialogue or debate. Members of the public shall be recognized to speak in accordance with Board Policy No. 10-018.

9. Agenda materials are intended to provide answers to as many questions as possible regarding agenda items, prior to the Board meetings. Board members are expected to review the agenda materials thoroughly, prior to the Board meetings, and to timely request additional information or clarification in advance whenever feasible—generally prior to any regular meeting. Questions from Board members at the meetings should be for the purposes of seeking clarification and/or additional information regarding particular agenda items and/or agenda materials.

10. Board members should be courteous and respectful of all meeting participants, including the Chair. Board members shall comply with the legitimate orders of the Chair regarding the orderly conduct of the business before the Board.

11. Conduct while attending Board meetings and other meetings and events related to the Board and Board committees, and while engaged in other Board-related business, which is unsafe, disruptive or which constitutes threats, intimidation, abusive behavior, violence, harassment, and other dangerous or disorderly conduct, willful disturbance of the meeting or which otherwise violates Penal Code section 403 is prohibited. Board members shall comply with, and are subject to the District Harassment policy, which is set forth in Exhibit "A" to this Policy.

12. Board members and other persons shall comply with all applicable Board Policies pertaining to the conduct of board meetings, including but not limited to Board Policy #07-010 (Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings) #07-22 (Maintenance of Confidentiality) and Board Policy 10-018 (Public Comments at the Tri-City Healthcare District Board of Directors Meetings/Committee Meetings).

13. Board Members should attend every Board Meeting and remain for the entirety of each meeting, including returning to the meeting after exclusion from closed session or any portion thereof. The Board Chair shall make an oral announcement of any departure from the meeting and the reason, if available.

III. BREACHES OF ORDER AT MEETINGS; SANCTIONS.

The Board has a right to make and enforce rules to ensure the conduct of the public's business in an efficient and orderly manner, and without disruption by members of the public or members of the Board. At the same time, the public and Board members shall be free to criticize the policies, procedures, programs and services of the organization, and the acts and omissions of the Board.

Notwithstanding any other policy of the Board, violations of this policy during a Board meeting may be enforced, as follows:

1. The Chair shall call to order, by name, any person who is in violation of any of the rules of conduct established under this policy, and Board Policy No. 10-018, which is committed in the immediate view and presence of the Board. The Chair shall request that person refrain from any further violation, warn that a repetition may violate Penal Code section 403 and result in removal from the meeting, and may specifically state that any further violation may constitute contempt of the Board.

2. If the person repeats the violation or proceeds to violate any other provision of this policy in the immediate view and presence of the Board (such as by refusing to yield the floor or otherwise disrupting proceedings), the Chair may call a recess of the meeting, stating that the reason for the delay is due to the misconduct of the Board member or other person. If following such recess, the Board member or other person persists in willfully interrupting the meeting such that order cannot be restored, the Chair, with the concurrence of the Board, shall order the disruptive Board member or other person removed from the meeting room by District security personnel, or, as to Board members, may request a motion under paragraph 3. If removal of a Board member is ordered, the Board member shall be entitled to adjourn to attend the balance of the meeting by telephone at the meeting location or other location consistent with the Brown Act, notwithstanding the provisions of any other Board policy.

3. In the alternative, if a Board member repeats the violation or proceeds to violate any other provision of this policy in the immediate view and presence of the Board, or, following a return from recess of the meeting if called, the Chair may call for a motion holding the Board member in contempt. Such a motion shall take precedence over any other motion, and shall describe the action or actions constituting the violation of this

policy. If such a motion is made and seconded, each board member shall have an opportunity to discuss the motion in accordance with this policy. If the motion is passed, the Board member shall be advised by the Chair that he or she has been held in contempt. A second motion may then be made to prescribe the sanction or sanctions to be imposed. which may include, but shall not be limited to, one or more of the following:

a. A statement of censure, identifying the misconduct;

b. Removal of the offending Board member from membership on one or more Board committees, or, if chair of any committee, removal from that position, for a specified period, or if no period is specified, until the annual election of Board officers;

c. Removal of the offending Board member from holding any Board office currently held;

d. Removal of the offending Board member from the meeting room and offering the member the right to adjourn to attend the balance of the meeting by telephone at the meeting location or another location consistent with the Brown Act (notwithstanding the provisions of any other Board policy) ; provided that the offending Board member may also be required to attend one or more future meetings by teleconference;

e. A determination that no compensation shall be earned by the offending Board member for attendance at the meeting at which the contempt occurred;

f. A determination that the offending Board member shall not be provided any defense or indemnity in any civil actions or proceedings arising out of or related to the member's misconduct or the agenda items whose consideration was wilfully disrupted or prejudicially delayed by the misconduct, based upon the Board member's actual malice;

g. Rendering the offending Board member ineligible to receive any advances or reimbursement of expenses to attend future conferences or meetings otherwise permitted under Board Policy #07-020 (except those previously-approved for which expenses have been incurred prior to the time of the finding of contempt), for a period of time or subject to conditions specified in the motion;

h. Referral of the matter to the County Criminal Grand Jury pursuant to Government Code section 3060.

i. Referral of the matter to the Fair Political Practices Commission or other prosecuting authority with jurisdiction over the matter.

4. Following the outcome of a motion for sanctions, the Chair shall direct that the order of the Board be carried out by security, the Chief Executive Officer, and/or General Counsel, as appropriate.

5. In the event violations of this Policy occur in a closed session, the Chair may suspend the closed session and return to open session for the purpose of commencing the enforcement process contemplated by this section. All proceedings under this section III shall occur in open session.

IV. VIOLATIONS OF BOARD POLICIES OUTSIDE OF BOARD MEETINGS.

1. Board members shall not act on behalf of, nor represent themselves as speaking on behalf of, the Board without the Board's express authorization.

2. When a violation of a Board policy by a member of the Board is alleged to have occurred outside of a Board meeting, the Chair or any member of the Board may request that an item be placed on the agenda to consider what sanctions may be appropriate, if any. In such instances, evidence of the misconduct shall be presented by the requesting member. The Board member accused of misconduct shall have an opportunity to present evidence and respond to the allegations made. Formal rules of evidence shall not apply.

3. After consideration of the evidence presented, the Board may take such actions as it may deem appropriate, including but not limited to those described in section III of this policy, other than paragraph III(e).

V. AUTHORITY OF ADMINISTRATION TO PROVIDE FOR SECURITY.

1. The District Administration is authorized and directed to develop and implement policies and procedures designed, engage employees or contractors to provide security, consistent with applicable law, to promote a secure and orderly environment for Directors, employees, staff, and members of the public. These policies and procedures will include a process for notifying the District Administration in the event that any person feels that he or she has been subjected to conduct which violates this Policy.

2. The District Administration is authorized and directed to take lawful and appropriate action and to pursue lawful and appropriate remedies against any person found to have violated this Policy.

VI. BOARD ORIENTATION AND TRAINING

1. Every Board member shall participate in an orientation and training to be offered by Tri-City Healthcare District within 60 days of election, re-election to office, or assuming office, as a condition to receiving compensation or allowance of expenses.

2. The required orientation and training shall be offered at times and places convenient to the Board member.

3. The orientation and training shall include:

    a. A tour of the facilities owned or operated by Tri-City Healthcare District

    b. An explanation of Board policies, procedures, committee structure and bylaws, and delivery of a copy of the current Board policies, procedures and bylaws

    c. Briefings delivered by members of the management team regarding:

        i. Health care finance

        ii. District financial management and budgeting practices

        iii. Compliance laws and regulations, including conflict of interest rules under State and Federal law and the accreditation process

        iv. Areas of health care and specialties offered

        v. Medical staff organizations and relationship with the hospital

        vi. Nursing policies, staffing and practices

        vii. The roles and responsibilities of each department

        viii. Legal responsibilities of Board members

4. This orientation and training shall supplement the training required by law under AB 1234.

Reviewed by the Gov/Leg Committee: 1/13/10
Approved by the Board of Directors: 1/28/10
Reviewed by Gov/Leg Committee: 4/13/11
Approved by the Board of Directors: 4/28/11
Reviewed by Gov/Leg Committee: 9/14/11

Approved by the Board of Directors: 9/29/11
Reviewed by Gov/Leg Committee: 4/11/12
Approved by the Board of Directors: 4/26/12
Approved by the Board of Directors: 5/31/12
Reviewed by the Gov/Leg Committee: 6/04/13
Approved by the Board of Directors: 6/27/13
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Reviewed by the Gov/Leg Committee: 10/6/15
Approved by the Board of Directors: 10/29/15

ACHD Certified Healthcare Districts

(http://www.achd.org/wp-content/uploads/sites/6/2015/06/certified-logo.png)

As Public Entities, Healthcare Districts have well defined obligations for conducting business in a manner that is open and transparent. To assist ACHD Members in demonstrating compliance with these obligations, the ACHD Governance Committee has developed a core set of standards referred to as Best Practices in Governance. Healthcare Districts that demonstrate compliance with these practices will receive the designation of ACHD Certified Healthcare District.

Antelope Valley Healthcare District
November, 2014

Beach Cities Health District
October, 2014

Eden Township Healthcare District
November, 2015

Fallbrook Healthcare District
November, 2016

Grossmont Healthcare District
May, 2016

John C. Fremont Healthcare District
March, 2015

Los Medanos Community Healthcare District
April, 2016

Marin Healthcare District
August, 2016

Mark Twain Healthcare District
April, 2016

Palomar Health District
August, 2014

Peninsula Health Care District
November, 2015

Petaluma Health District
May, 2015

Pioneers Memorial Healthcare District
February, 2017

Sequoia Healthcare District
August, 2014

Sonoma Valley Healthcare District
April, 2016

Tahoe Forest Health System
May, 2016

To request application materials to begin the Certification process please contact Ken Cohen (mailto:ken.cohen@achd.org).

CONTACT US

(916) 266-5200
Email Us (mailto:info@achd.org)

RECENT NEWS

Kaweah Delta earns top quality rating among local hospitals (http://www.achd.org/2017/02/24/kaweah-delta-earns-top-quality-rating-among-local-hospitals/)

Pioneers Memorial Healthcare District Receives District Certification (http://www.achd.org/2017/02/17/pioneers-memorial-healthcare-district-receives-district-certification/)

Department of Health Care Services (http://www.achd.org/2017/02/14/department-health-care-services/)

Flexing Muscles: 70 Strong (http://www.achd.org/2017/02/13/flexing-muscles-70-strong/)

Antelope Valley Hospital Blood Donor Center Exchanges "Pies for Pints" Feb. 14-16 (http://www.achd.org/2017/02/07/antelope-valley-hospital-blood-donor-center-exchanges-pies-pints-feb-14-16/)

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(https://twitter.com/ACHDnews)

Key State Issues

Latest News on Key Bills in the State Legislature

CALIFORNIA HOSPITAL ASSOCIATION

February 17, 2017

Today marks the deadline for legislators to introduce bills. So far, 1,643 bills have been introduced. Some bills are in spot bill form, meaning that they include the Legislature's intent but provide few details. These bills will be amended prior to their hearing in policy committees. Details on high-priority health care-related bills CHA is tracking this legislative session are provided below. CHA's Health Policy Legislative Day, March 14-15 in Sacramento, offers members an opportunity to meet with state legislators about the potential impact of proposed legislation. To register, visit www.calhospital.org/legislative-day. For an online version of this report that can be filtered by topic and is updated daily, visit www.calhospital.org/key-state-issues.

Bill No.	Author		Location/Action	CHA Position	Staff Contact
Civil Actions					
SB 33	Dodd (D-Napa)	Would prohibit a business from requiring, as a condition of entering into a contract for the provision of goods or services, that a customer waive any legal right — including right to a jury trial or to bring a class action lawsuit — that arises as a result of fraud, identity theft or other act related to the wrongful use of personal identifying information.	To be heard in Senate Judiciary and Appropriations Committees.	Oppose, Unless Amended	Lois Richardson/ Connie Delgado
Emergency Services					
AB 259	Gipson (D-Carson)	Co-sponsored by CHA, this spot bill will be amended to address emergency services, specifically emergency department (ED) overcrowding. CHA and the Regional Associations have been engaged in numerous activities to alleviate this escalating issue, and recently formed the Emergency Care Systems Initiative to convene a consortium, gather data, find solutions and take action.	In the Assembly.	Cosponsor	BJ Bartleson/ Connie Delgado
Labor					
AB 5	Gonzalez Fletcher (D-San Diego)	Would require an employer to offer additional hours of work to an existing employee who, in the employer's reasonable judgment, has the skills and experience to perform the work before hiring any additional employees or subcontractors, including hiring an additional employee or subcontractor through the use of a temporary employment agency, staffing agency, or similar entity. The bill would not apply where it would result in payment of overtime, and would also require the employer to use a transparent and nondiscriminatory process to distribute the additional hours of work among existing employees.	To be heard in Assembly Labor and Employment Committee.	Pending Review	Gail Blanchard-Saiger/Kathryn Scott

California Hospital Association Key State Issues

Bill No.	Author		Location/Action	CHA Position	Staff Contact
Labor (continued)					
AB 387	Thurmond (D-Richmond)	Would expand the definition of "employee" to include any individual, other than doctors or nurses, engaged in supervised work experience to satisfy requirements for licensure, registration or certification as an allied health professional. Would treat hospitals and other facilities that offer clinical experience to allied health professionals — including pharmacists, therapists, clinical lab scientists, technicians and technologists — as their employers, and would require them to pay those individuals minimum wage. This change could extend to other aspects of the employment relationship.	In the Assembly.	Oppose	Gail Blanchard-Saiger/Kathryn Scott
AB 402	Thurmond (D-Richmond)	Would require Cal/OSHA to convene, by June 1, 2018, an advisory committee to develop regulations requiring hospitals to evacuate or remove plume — noxious airborne contaminants generated as byproducts from specific devices used during surgical, diagnostic and therapeutic procedures. The proposed regulations must be submitted to the Cal/OSHA Standards Board by June 1, 2019, and the board must adopt regulations by July 1, 2020.	In the Assembly.	Under Review	Gail Blanchard-Saiger/Kathryn Scott
Medi-Cal					
AB 205	Wood (D-Healdsburg)	Would implement a provision of recently enacted Medicaid managed care rules that allows Medi-Cal beneficiaries to file an appeal up to 120 days after the date of notice, instead of 90 days in existing state law. AB 205 also states the Legislature's intent to implement newly revised federal regulations governing Medi-Cal managed care. AB 205 is an identical companion bill to SB 171 (Hernandez, D-Azusa).	To be heard in Assembly Health Committee.	Follow, Hot	Amber Kemp/ Barbara Glaser
SB 171	Hernandez (D-Azusa)	Would implement a provision of recently enacted Medicaid managed care rules that allows Medi-Cal beneficiaries to file an appeal up to 120 days after the date of notice, instead of 90 days in existing state law. SB 171 also states the Legislature's intent to implement newly revised federal regulations governing Medi-Cal managed care. SB 171 is an identical companion bill to AB 205 (Wood, D-Healdsburg).	To be heard in Senate Health and Appropriations Committees.	Follow, Hot	Amber Kemp/ Barbara Glaser
Medical Records					
SB 241	Monning (D-Carmel)	Would harmonize state law with the federal health information privacy regulations adopted under the Health Insurance Portability and Accountability Act (HIPPA) of 1996.	In the Senate.	Support	Lois Richardson/ Connie Delgado

California Hospital Association Key State Issues

Bill No.	Author		Location/Action	CHA Position	Staff Contact
Medical Staff					
AB 148	Mathis (R-Porterville)	Would lower the eligibility threshold for rural practice settings participating in the Steven M. Thompson Physician Corps Loan Repayment Program. The program provides financial incentives, including repayment of educational loans, to a physician or surgeon who practices in a medically underserved area. Currently, eligible practice settings include community clinics, a clinic owned or operated by a public hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role to serve its indigent population. These settings must be located in a medically underserved area and at least 50 percent of patients must be from medically underserved populations. This bill would lower the eligibility threshold for serving the above described populations to 30 percent for practice settings located in rural areas.	To be heard in Assembly Health Committee.	Support	Peggy Wheeler/ Connie Delgado
Mental Health					
AB 191	Wood (D-Healdsburg)	Would amend current law to authorize a licensed marriage and family therapist or a licensed professional clinical counselor to certify an individual for an extended involuntary hold. This bill would require that the signatory have participated in an evaluation of the individual, and stipulates that he or she must be the second signature. This authority would only pertain to involuntary holds exceeding 72 hours that require an additional period of intensive treatment not to exceed 14 days, or 30 days under specified conditions.	To be heard in Assembly Health Committee.	Support	Sheree Lowe/ Alex Hawthorne
Public Health					
SB 43	Hill (D-San Mateo)	Would establish a statewide public health surveillance system for tracking antibiotic resistant infections and deaths. Specifically, the bill would require doctors to list an antibiotic resistant infection as a cause of death if, in the attending physician's professional judgment, the resistant infection was a factor in a patient's death. It would also require hospitals and clinical labs, beginning July 1, 2018, to conduct and submit to the California Department of Public Health (CDPH) an annual antibiogram (a summary of all the antibiotic resistant infections in the previous year). However, hospitals are already creating antibiograms as part of their antibiotic stewardship programs. CDPH would be required to publish an annual report on the occurrence of antibiotic resistant infections and deaths, based on death certificate information. This report would break down the data by facility type, type of resistant infection and geography; facility names would not be included. CHA is currently reviewing the bill and working closely with the Senator's office and other stakeholders.	To be heard in Senate Health Committee.	Follow, Hot	Debby Rogers/ Alex Hawthorne

California Hospital Association Key State Issues

Bill No.	Author		Location/Action	CHA Position	Staff Contact
Skilled-Nursing Facilities					
SB 481	Pan (D-Sacramento)	Co-sponsored by CHA, this spot bill will be amended to address CANHR v. Chapman, which, if upheld on appeal, would render current law for treating unrepresented patients in skilled-nursing facilities unconstitutional.	In the Senate.	Co-sponsor	Patricia Blaisdell/ Lois Richardson/ Alex Hawthorne

Governance & Legislative Committee Work Plan
FY 2017

	July	Aug	Sept	Oct	Nov	Dec	Jan 2017	Feb	Mar	Apr	May	June	Date(s) Reviewed
Review proposed Medical Staff Rules & Regulations as needed	X	X	X	X	X	X	X	X	X	X	X	X	2/7/17
Review Board Policies as needed	X	X	X	X	X	X	X	X	X	X	X	X	2/7/17
Review Board Bylaws	X	X	X	X	X	X	X	X	X	X	X	X	
Review Committee Charter (every 3 years)	X	X	X	X	X	X	X	X	X	X	X	X	2/7/17
Review all Board Committee Charters (every 3 years)	X	X	X	X	X	X	X	X	X	X	X	X	
Monitor Legislative Affairs and make recommendations to Board	X	X	X	X	X	X	X	X	X	X	X	X	2/7/17