PART 1
APPOINTMENT PROCEDURES

1.1 PREAPPLICATION

All clinicians desiring initial Staff membership shall complete a pre-application on a form designated by the Executive Committee and approved by the Board. The pre-application form shall contain information indicating whether the clinician satisfies the basic standards for Staff membership. There shall be no processing fee associated with the pre-application.

1.1 APPLICATION

The application must be in writing, signed by the applicant, and on such form as designated by the Texas Department of Insurance. Prior to the application being submitted, the applicant will be provided a copy of, or access to a copy of, the Medical Staff Bylaws and its accompanying manuals, the Rules and Regulations of the Staff, and summaries of other Hospital and Staff policies and resolutions relating to clinical practice in the Hospital. Upon request, the applicant will have access to the article of the Hospital/Bylaws that pertains to the Medical Staff. An application from a clinician who has been in practice following completion of initial residency less than 36 months at the time of application must be accompanied by an application-processing fee of $100. Application from a clinician who has been in practice following completion of initial residency 36 months or more at the time of application must be accompanied by an application processing fee of $300.

1.2 APPLICATION CONTENT

Every applicant must furnish complete information concerning the following items. All certificates of any nature that are in a foreign language and are presented for the credentialing process by Staff members or applicants, must be translated into English by the best expert available, and the transaction must be notarized.

1.2.1 Postgraduate training, including the name of each institution, degrees granted, program(s) completed, dates attended, and names of clinicians responsible for the applicant's performance.

1.2.2 All currently valid medical, dental and other professional licensures or certifications, and Drug Enforcement Administration registration, with the date and number of each.

1.2.3 A copy of Specialty or subspecialty board certification, recertification and eligibility.

Every initial applicant to the Staff must satisfy at least one of the following qualifications:

1) Be Board Certified in the Specialty and Subspeciality for which privileges are requested. OR

2) Successfully completed residency training in a program in the specialty and subspecialty for which privileges are requested, such program being approved by the appropriate association from among the American Board of Medical Specialties, the American Dental Association, the American Osteopathic Association, or the American Podiatric Association.

The requirements of this Section are in addition to, and all Staff members and applicants must also satisfy, all other applicable provisions of the Bylaws concerning Staff membership, delineation of privileges, and reappointment.

"Board Certification" as used herein shall mean that the relevant clinician has been fully and unconditionally certified in the specialty in which he/she conducts the majority of his/her practice (and sub-specialty, if the majority of the practice is
conducted in a sub-specialty) by the appropriate board from among the American Board of Medical Specialties, American Dental Association, American Osteopathic Association, or the American Podiatric Association, as the case may be.

Dentists for whom there are no boards are exempt from this provision.

1.2.4 Health impairments, if any, affecting the applicant's ability in terms of skill, attitude or judgement to perform professional or Medical Staff duties fully; hospitalizations or other institutionalization's for significant health problems during the past five (5) year period; any continuing health problems during the past five (5) year period; any continuing health problems requiring current therapy; statement from personal physician of significant findings on last health examination.

1.2.5 The nature and specifics of any pending or completed action involving denial, revocation, suspension, reduction, limitation, probation, nonrenewal or voluntary or involuntary relinquishment (by resignation or expiration) of a license or certificate to practice any profession in any state or country; Drug Enforcement Administration or other controlled substances registration; membership or fellowship in local, state or national professional organizations; specialty or subspecialty board certification or eligibility; faculty membership at any medical or other professional school; any pending or completed disciplinary action or liability action or claim; staff membership status, prerogatives or clinical privileges at any other hospital, clinic or health care institution.

1.2.6 Location of offices; names and addresses of clinicians with whom the applicant is or was associated and inclusive dates of each such association; names and locations of any hospitals, clinic or health care institution or organization where the applicant provides or provided clinical services with the inclusive dates of each affiliation.

1.2.7 Staff category and specific clinical privileges requested.

1.2.8 Any current felony criminal charges pending against the applicant and any past charges including their resolution.

1.2.9 Statements notifying the applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions of the Medical Staff Bylaws and this Credentialing Procedures Manual.

1.2.10 A recent picture hospital ID card or a valid picture ID issued by a state or federal agency (i.e., driver’s license or passport). The photograph is in no way meant to determine sex or race of applicant.

1.3 REFERENCES

The application must include the names of three (3) individuals, not currently partners with the applicant in professional practice or related to him, who have personal knowledge of the applicant’s current clinical ability, ethical character, and ability to work cooperatively with others and who will provide specific written, substantive comments on these matters upon request from Hospital or Medical Staff authorities. The named individuals must have acquired the requisite knowledge through recent observation of the applicant’s professional performance over a reasonable period of time.

1.4 EFFECT OF APPLICATION

An applicant for appointment, reappointment, or clinical privileges, must sign the application and in so doing:

1.4.1 attests to the correctness and completeness of all information furnished;

1.4.2 signifies his willingness to appear for interviews in connection with his application;
1.4.3 agrees to abide by the terms of the Bylaws, Rules, Regulations, policies and procedure manuals of the Medical Staff and those of the Hospital if granted membership and/or clinical privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not membership and/or privileges are granted;

1.4.4 agrees to maintain an ethical practice and to provide continuous care to his patients; including provisions for the admission of the applicant's patients in his/her absence.

1.4.5 authorizes the Hospital representatives to: 1) consult with individuals who may have information bearing on the applicant's professional or ethical qualifications and competence; 2) obtain from, or provide information concerning the applicant's professional qualifications or competence to the National Practitioner Data Bank or similar information clearing house, and to other entities, as required by law.

1.4.6 Releases from liability all those who, in good faith and without malice, obtain, review, act on or provide information regarding the applicant's competence, professional ethics, character, health status, and other qualifications for Staff appointment and clinical privileges.

1.4.7 Authorizes the Staff and its designees to consult with members of medical staffs of other hospitals with which the applicant has been or is currently associated and with others who may have information bearing on the applicant's professional or ethical qualifications and competence.

For purposes of this Section, the term “hospital representative” includes the Board, its directors and committees; the Administrator or her designees; the Medical Staff members, clinical units and committees which have responsibility for collecting and evaluating the applicant's credentials or acting upon an application; and any authorized representative of any of the foregoing.

1.5 PROCESSING THE APPLICATION

Applicant's Burden: The applicant has the burden of producing adequate information for a proper evaluation of his experience, training, demonstrated ability, and health status, and of resolving any doubts about these or any of the qualifications required for Staff membership, the requested Staff category, the requested clinical privileges, requests for information or clarification (including health examinations) made by appropriate Staff or Board authorities. The applicant is required to furnish all required information within 90 days from the date the application is submitted for processing in order for the application to be deemed complete. During this ninety-(90) day period, the Medical Executive Committee or its designee shall notify the applicant of any difficulties in obtaining information, and it shall then be the applicant's obligation to obtain the required information. Any application which is not deemed complete within the ninety-(90) day period shall be deemed incomplete and invalid and shall be automatically removed from consideration. An application may thereafter be reconsidered only if all information has been resubmitted.

1.5.1 Verification of Information: The application is submitted to the Administrator. The Administrator collects or verifies the references, licensure and other qualification evidence submitted and promptly notifies the applicant of any problems in obtaining the information required to complete the application. Upon such notification, it is the applicant's obligation to obtain the required information. The Medical Staff Office will also obtain a report from the AMA Masterfile, the Educational Commission for Foreign Medical Graduates (ECFMG), National Practitioner Data Bank, a criminal background check, and Medicare/Medicaid Integrity check. When collection and verification is accomplished, the Administrator notifies the Chief of the Staff of that fact and transmits the application and all supporting material to the Executive Committee.

1.5.2 Medical Staff Input: Upon receiving the completed application, the Chief of Staff posts the name of the applicant. Any member of the Staff may submit to the Chief of Staff, in writing and with full details, information relevant to the applicant's qualifications for membership and privileges. Any member who provides such a written statement may also petition or may be requested by the Executive Committee to appear in person before it to discuss the application.

1.5.3 Fast Tracking Initial Applications:
**Purpose:** To provide for a categorization system for initial applicants for Staff appointment and privileges that will facilitate the appointment process in applications meeting defined criteria.

**Definitions:**

1. **Category One (TRACK 1)**
   
   The application meets all of the following criteria:
   
   a. The applicant has consecutively completed all training within three years of submitting the application in a program approved by the Accrediting Council on Graduate Medical Education or the American Osteopathic Association or the American Podiatric Association.
   
   b. The applicant has no more than one other hospital affiliation.
   
   c. The applicant has requested privileges consistent with the core privileges as defined for that specialty.
   
   d. There are no suggestions in the verified materials of potential problems and no prior malpractice or disciplinary actions, licensure restrictions, or any type of investigations.

2. **Category Two (TRACK 2)**
   
   The application meets any one of the following criteria:
   
   a. The applicant’s training was not consecutive or the applicant completed training more than 3 years before receipt of the application.
   
   b. The applicant has more than one other Hospital affiliation;
   
   c. The applicant has requested privileges that vary from those consistent with the core privileges as defined for that specialty;
   
   d. There was difficulty in obtaining information from any of the sources queried during the verification process, such difficulty defined as more than two attempts made to obtain the information.
   
   e. An evaluation not received in the prescribed format or an evaluation that contained any neutral or negative responses.
   
   f. A Category One application in which any of the recommendations of the Executive Committee chairperson vary.

**Procedure:**

1. At such time as the application is deemed complete, the Medical Staff Office and Executive Committee Chair will classify the application. The application will be classified as either Category One or Category Two as defined above.

2. Applications classified as Category One will proceed as follows:
   
   a. The Medical Executive Committee will review the application and make a recommendation to the Board
b. The Executive Committee of the Board, acting on behalf of the board will review the application and, upon favorable evaluation, will grant appointment to the Medical Staff and the requested clinical privileges. An information report will be made to the Board at its next regularly scheduled meeting.

3. Applications classified as Category Two will proceed to the Executive Committee and the Board in accordance with provisions in the Credentialing Procedures Manual.

4. TELEMEDICINE SERVICES: The Board shall approve any services provided via Telemedicine. Pursuant to a written agreement between the distant site hospital or telemedicine entity, the SETX Board may grant privileges based on the medical staff’s recommendations that rely on information provided by the distant site hospital or telemedicine entity. Staff applying for telemedicine privileges shall meet the general qualifications indicated in Part 1, Section 1.2 of the Credentialing Procedures Manual and are credentialled and privileged to do so at the originating site in accordance with the Medical Staff Policy for Telemedicine Services. (added July 2013)

1.5.4 Executive Committee Action: The Executive Committee, at its next regular meeting, reviews the application, the supporting documentation, and any other relevant information available to it, including any submitted by a Staff member. The Executive Committee defers action on the application or prepares a written report with recommendations as to approval or denial of, or any special limitation on, Staff appointment category of Staff membership and prerogatives, and scope of clinical privileges.

1.5.5 Effect of Executive Committee Action:

1) Deferral: Action by the Executive Committee to defer the application for further consideration must be followed up within 30 days with subsequent recommendations as to approval or denial of, or any special limitation on, Staff appointment, category of Staff membership and prerogatives, and scope of clinical privileges. The Chief of Staff must notify the applicant and the Administrator in writing of the deferral and the grounds. If the applicant is to provide additional information, the notice must contain a specific request to him for the same.

2) Favorable Recommendation: When the Executive Committee’s recommendation is favorable to the applicant in all respects the Administrator promptly forwards it, together with all supporting documentation, to the Board. “All supporting documentation” means the application form and its accompanying information, the reports and recommendations of the Executive Committee, any information submitted by a Staff member, and dissenting views.

3) Adverse Recommendation: When the Executive Committee’s recommendation is adverse to the applicant, the Chief of Staff immediately so informs the applicant by special notice, and he is then entitled to the procedural rights as provided in the Fair Hearing Plan. An “adverse recommendation” by the Executive Committee is defined as a recommendation to deny appointment, requested Staff category, or to deny or restrict requested clinical privileges.

1.5.6 Board Action:

1) On Favorable Executive Committee Recommendation: The Board may adopt or reject, in whole or in part, a favorable recommendation of the Executive Committee or refer the recommendation back to the Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. Favorable action by the Board is effective as its final decision. If, after complying with the requirements of Section 1.5.8, the Board’s action is adverse to the applicant in any respect, the Administrator promptly so informs the applicant by special notice, and he is then entitled to the procedural rights provided in the Fair Hearing Plan.

2) After Procedural Rights: In the case of an adverse Executive Committee recommendation, the Board takes final action in the matter as provided in the Fair Hearing Plan.

3) Without Benefit of Executive Committee Recommendation: If, in its determination, the Board does not receive an Executive Committee recommendation in a timely fashion, it may after notifying the Committee of its intent including a
reasonable period of time for response, take action on its own initiative, employing the same type of information usually considered by the Executive Committee. Any favorable action is effective as the Board’s final decision. If the Board’s action is adverse in any respect, the Administrator promptly so informs the applicant by special notice, and he is then entitled to the procedural rights provided in the Fair Hearing Plan.

4) **Adverse Board Action Defined:** “Adverse action” by the Board means action to deny appointment, requested staff category, requested Section assignment, or to deny or restrict requested clinical privileges.

1.5.7 **Bases for Recommendations and Actions:** The report of each individual or group required to act on an application must state the reasons for each recommendation or action taken, with specific reference to the completed application and all other documentation considered. Any dissenting views at any point in the process must also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

1.5.8 **Conflict Resolution:** Whenever a conflict arises, regional governance and/or Administration and the Medical Staff Leadership should attempt to resolve differences. If informal attempts are unsuccessful the Formal Conflict Resolution process may be invoked as outlined in the Conflict Resolution Process.

1.5.9 **Notice of Final Decision:**

1) Notice of the Board’s final decision is given through the Administrator to the Executive Committee and to the applicant not later than 10 days after the decision of Board.

2) A decision and notice to appoint includes (1) the Staff category to which the applicant is appointed; (2) the Section to which he is assigned; (3) the clinical privileges he may exercise; and (4) any special conditions attached to the appointment.

The applicant shall have 90 days from the date the Board approves the appointment in which to open an office and establish residence in this area. Applicants who are in a training program at the time of Board approval shall have 90 days from the date of completion of the training program in which to open an office and establish residence in this area. Failure without good cause to meet this requirement, or to request an extension of the time allowed, is deemed a voluntary resignation from the staff and results in automatic termination of membership and privileges at the expiration of the 90 days, unless explicitly extended by action of the Executive Committee.

4) New applicants shall complete the New Staff Physician Orientation Program before exercising privileges.

**Customary Time Periods for Processing:** All individuals required to act on an application for Staff appointment must do so in a timely and good faith manner and, except for good cause, each completed application shall be acted upon within 90 days. No other time period specified herein shall be deemed to create any right for the applicant to have his or her application processed within those periods.

1.5.10 **Reapplication After Adverse Credentials Decision:** An applicant who has received a final adverse decision regarding appointment, Staff category, or clinical privileges is not eligible to reapply to the Medical Staff or for the denied category or privileges for a period of twelve (12) months. Any such reapplication is processed as an initial application, and the applicant must submit such additional information as the applicable Staff authorities or the Board may require in demonstration that the basis for the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and will not be further processed.

**PART 2**

**REAPPOINTMENT PROCESS**

2.1 **INFORMATION COLLECTION AND VERIFICATION**
2.1.1 **From Staff Member:** On or before three (3) months prior to the date expiration of a Staff member’s appointment, the Administrator notifies him of the date of expiration. At least sixty (60) days prior to this date, the member furnishes in writing:

(a) complete information to update his file on the items listed in Section 1.2 of this Manual;

(b) specific request for the clinical privileges sought on reappointment, with any basis for changes;

(c) requests for changes in Staff category

Failure to provide this information prior to the due date may result in expiration of appointment and further processing shall be in accordance with Section 1.5.

The Administrator verifies this additional information, and notifies the Staff member of any information inadequacies or verification problems. The Staff member then has the burden of producing adequate information and resolving any doubts about the data.

2.1.2 **From Internal Sources:** The Chairman of the Executive Committee collects for each Staff member’s credentials file all relevant information regarding the individual’s professional and collegial activities, performance and conduct in this Hospital. Such information includes, without limitation: patterns of care as demonstrated in the findings of quality improvement and utilization assessment activities; patient care load maintained at this Hospital; participation in relevant internal teaching and continuing education activities; attendance at required Staff meetings; service as a Staff officer and on Staff and Hospital committees; timely and accurate preparation and completion of medical records; health status; compliance with all applicable bylaws, policies, rules, regulations, and procedures of the Hospital and Staff; cooperativeness in working with other clinicians and Hospital personnel; general attitude toward his patients and the Hospital.

2.1.3 **Insufficient Utilization:** If, during the two year reappointment period, the staff member has not treated any patients in this facility to properly evaluate the staff member’s competence to exercise the clinical privileges requested, staff member shall be moved to affiliate staff category. If, during the two year reappointment period, the staff member has not treated a sufficient number of patients (number determined by each section) in this facility to properly evaluate the staff member’s competence to exercise the clinical privileges requested, the applicant shall have the burden of providing clinical activity (i.e. number of procedures and types of procedures) acceptable to the Credentials Committee from a hospital where active privileges are held. The information must include whether or not the practitioner is in good standing with the hospital. If the staff member is unable to provide clinical activity from another hospital, the Credentials Committee may under special circumstances accept peer recommendations from others familiar with the applicant’s practice attesting to clinical ability and judgment in lieu of clinical activity.

2.2 **EXECUTIVE COMMITTEE ACTION**

The Executive Committee reviews the member’s file and any other relevant information available to it and defers action on the reappointment or prepares a written report with recommendations for reappointment or nonreappointment and for Staff category, Section assignment, and clinical privileges.

2.3 **FINAL PROCESSING AND BOARD ACTION**

Final processing of reappointments follows the procedure set forth in 1.5.5, 1.5.6, 1.5.8, 1.5.9, and 1.5.12. For purposes of reappointment, an “adverse recommendation” by the Executive Committee or “adverse action” by the Board as used in those Sections means a recommendation or action to deny reappointment; to deny a requested Staff category or Section assignment; reduction in Staff category; or, to deny or restrict requested clinical privileges. The terms “applicant” or “appointment” as used in those Sections shall be read respectively as “Staff member” and “reappointment”.
2.4 BASES FOR RECOMMENDATIONS AND ACTION

The report of each individual or group required to act on a reappointment shall state the reasons for each recommendation made or action taken, with specific reference to the Staff member’s credentials file and all other documentation considered. Any dissenting views at any point in the process must also be reduced to writing, supported by reasons and references and transmitted with the majority report.

2.5 TIME PERIOD FOR PROCESSING

All individuals required to act on an application for Staff appointment must do so in a timely and good faith manner and except for good cause, completed applications shall be acted upon within 90 days. No other time period specified herein shall be deemed to create any right for the applicant to have his or her application processed within those periods.

If reappointment processing has not been completed by an appointment expiration date, and if the delay is attributable to the clinician’s failure to provide information required by Section 2.1.1, Staff membership terminates on the expiration date.

2.6 REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

A Staff member may, either in connection with reappointment or at any other time, request modification of his Staff category, Section assignment, or clinical privileges by submitting a written application to the Administrator on the prescribed form. A modification application is processed in the same manner as reappointment.

2.6.1 Leave of Absence: A Staff member may obtain a Leave of Absence from the Staff by submitting written notice to the Executive Committee explaining the reason for this (i.e., military duty, illness, continuing education, pregnancy). A Leave of Absence request should state the period of time, which may not exceed twelve (12) months nor be for less than three (3) months. During the period of leave, the Staff member’s privileges and prerogatives shall be suspended. The Executive Committee shall make a recommendation to the Board for final action.

2.6.2 Termination of Leave: At least 45 days prior to the termination of the leave, or at any earlier time, the Staff member may request reinstatement of his privileges and prerogatives by submitting a written notice to that effect to the Executive Committee. The Staff member shall submit a written summary of his relevant activities during the leave. The Executive Committee shall make a recommendation to the Board concerning the reinstatement of the member’s privileges. Thereafter, the request for reinstatement shall be processed in the same manner as a request for reappointment. A clinician is entitled to the procedural rights provided in the Fair Hearing Plan in the event the clinician’s timely request for reinstatement, following an approved leave of absence, is denied.

Failure, without good cause, to request reinstatement or to provide a requested summary of activities as provided, shall result in automatic termination of Staff membership and privileges with right of Fair Hearing for the sole purpose of determining the issue of good cause. A request for Staff membership subsequently received from a Staff member so terminated shall be submitted and processed in the manner specified for application for initial appointment.

PART 3

CONCLUSION AND EXTENSION OF PROVISIONAL PERIOD

3.1 SUCCESSFUL CONCLUSION

3.1.1 Statements Required: One year after initial appointment to the Staff, a provisional Staff Member is assessed/evaluated to determine eligibility for continued Staff membership in the initially appointed category and for exercising the clinical privileges initially granted. This assessment/evaluation must include statements from the Chief of Staff or designee attesting to the physical and mental health of the Provisional Staff Member, satisfactory performance according to accepted medical practices
and the ethical conduct standards, and demonstrated ability to exercise the privileges provisionally granted. These statements are evidenced by the Chief of Staff or designee’s signature on the Evaluation/Assessment Report.

3.1.2 Action Required: The Executive Committee considers the requests and statement(s) furnished to it and either defers action on the request, but for no more than 30 days, or prepares a written report with recommendations and supporting documentation for transmittal to the Board. Final processing follows the procedures set forth in Part 1 of this Manual. For purposes of concluding the provisional period, and “adverse recommendation” by the Executive Committee or an “adverse action” by the Board as used in the appointment process means a recommendation or action to deny a requested Staff category or Section assignment; to reduce privileges. The terms “applicant” and “appointment” as used in those Sections shall be read, respectively as “Staff member” and “conclusion of the provisional period”.

3.2 EXTENSION

If during the review process, it is determined additional data or monitoring is necessary to determine eligibility for continued Staff membership, the provisional period may be extended for one (1) six (6) month period.

3.3 INSUFFICIENT UTILIZATION

If, at the end of the provisional period, the Staff Member has not treated a sufficient number of patients to properly evaluate the Staff Member’s competence to exercise the clinical privileges granted, the Staff Member shall be deemed to have voluntarily relinquished his/her reappointment and clinical privileges or moved to an appropriate staff category.

3.4 PROCEDURAL RIGHTS WHEN PERIOD EXPires

Whenever a provisional period including any period of extension expires without favorable conclusion for the clinician or whenever an extension is denied, the Chief of Staff will provide him with special notice of the adverse result and of his entitlement to the procedural rights provided in the Staff Bylaws.

PART 4

HEALTH PROFESSIONAL STAFF

The policies and procedures for the Health Professional Staff are outlined in the Health Professional Staff Policy and Procedure Manual which is attached and incorporated herein as part of the Credentials Procedures.

Part 5

DISCIPLINARY AND CORRECTIVE ACTION PROCEDURES

The procedures for Disciplinary and Corrective Action are found in the Staff Bylaws.

PART 6

ADOPTION AND AMENDMENT

6.1 ADOPTION
6.1.1 Staff: This Credentialing Procedures Manual was adopted and recommended to the Executive Committee in accordance with the Medical Staff Bylaws on April 30, 2003.

6.1.2 Local Governing Board: This Credentialing Procedures Manual was approved and adopted by resolution of the after considering the Executive Committee’s recommendation and in accordance with the Hospital Corporate Bylaws on July 31, 2003.

6.2 AMENDMENT

This Credentialing Procedures Manual may be amended and repealed, in whole or in part, by a resolution of the Executive Committee recommended to and adopted by the Board;

CREDENTIALING MANUAL HISTORY FOLLOWS:

CREDENTIALING PROCEDURES MANUAL HISTORY

2003: Revision and Readoption of the Credentialing Procedures Manual in entirety on May 5, 2003 by the Medical Staff and on July 31, 2003 by the Local Governing Body.

2006: Revision and Readoption of the Credentialing Procedures Manual in entirety on September 26, 2006 by the Medical Staff and on November 2006 by the Local Governing Body.


October 2012: Revision and Readoption of the Credentialing Procedures Manual in entirety on September 26, 2012 by the Medical Staff and on October 25, 2012 by the Local Governing Body.

July 25, 2013: Revision and Readoption of the Credentialing Procedures Manual in entirety in February 2013 by the Medical Staff and on July 25, 2013 by the Local Governing Body.

October 29, 2014: Reviewed by the Medical Executive Committee – no changes.

October 26, 2016: Reviewed and revised to clarify sections regarding use of pre-application, application fee, insufficient utilization, customary processing period, and extension of provisional period.

July 27, 2017: Reviewed and revised to add Conflict Resolution Policy

January 25, 2018: Reviewed and revised FPPE Policy
PURPOSE:

To improve the facility emergency response plan for credentialing during a large-scale disaster.

POLICY:

In a true, large-scale disaster in which the hospital needs every available clinician to treat patients in an emergency situation, assistance from volunteer clinicians may be required. Disaster privileges are granted by the Administrator, or designee upon the recommendation of either the applicable clinical section chairperson or the President of the Medical Staff only when the following two conditions are present:

- The emergency management plan has been activated
- The organization is unable to meet immediate patient needs

These privileges will be in effect at maximum only for the duration of the event and will automatically terminate when the Administrator declares the emergency to be over. The volunteer shall be granted core privileges on an emergency basis for his or her specialties. The Administrator, or designee, shall assign tasks consistent with the hospital’s immediate needs.

PROCEDURE:

1. The clinician will be directed to the Medical Staff Office (or other designated area) to provide a copy of photo identification and state licensure card, and to complete an application for disaster privileges. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer clinician presents to the organization.

2. To assist the volunteer with unfamiliar surroundings and procedures, the volunteer clinician will be paired with a Medical Staff member or nurse from the hospital. A volunteer armband will be worn to allow staff to readily identify the volunteer.

3. Professional performance evaluation of volunteer clinicians will be ongoing by oversight and personal observations of the President of the Medical Staff and input provided to the President of the Medical Staff by medical staff members and hospital staff associated with the volunteer clinicians. A decision is made (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

4. A log will be kept and reported to the Credentials and Executive Committees indicating which clinicians were granted disaster privileges.

5. Volunteer clinicians will be provided a copy of the Medical Staff Bylaws and Rules & Regs upon request.

Source: JCAHO Medical Staff Standard MS.4.110
CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM JASPER MEMORIAL HOSPITAL
Disaster Plan Responsibilities of Volunteer Medical Staff

Purpose:
To clarify the role of volunteer clinicians and to facilitate clinician involvement and collaboration when implementing the hospital disaster plan.

Responsibilities:
Clinicians volunteering their services during a disaster situation agree to the following:

1. Assist in notifying Medical Staff Leadership of “Code Black” (Disaster).
2. Inventory the number and types of clinicians and other staff present.
3. Organize, prioritize and assign clinicians to areas where medical care is being delivered. Assist in maintaining a log of medical staff assignments.
4. When necessary, assist with clinician orientation to in-patient and treatment areas.
5. Meet with Incident Command Center to assist in coordinating staffing needs and issues.
6. Assist and facilitate transfer of patients to other facilities as necessary.
7. Provide support for patient priority assessment to designate patients for early discharge.
8. Establish a medical staff message center and emergency incident information board.
9. Assist in developing a medical staff rotation schedule.
10. Develop a medical staff rest and nutritional area.
CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM JASPER MEMORIAL HOSPITAL
DISASTER PRIVILEGING VERIFICATION FORM

NAME OF CLINICIAN: __________________________ DATE: __________________________

Specialty: _______________________________________________

Address: ________________________________________________

City, State, Zip Code: _______________________________________

Telephone #: __________________________ SS #: __________________________

Date of Birth: __________________________ Birthplace: __________________________ Sex: ______

Name of professional liability insurance coverage company: (verified by phone) □
____________________________________________________________________________________________________

Hospital(s) where you are employed and/or hold staff membership and privileges: (verified by phone) □
____________________________________________________________________________________________________

Forms of Verification: Obtain a copy of #1 & 2 below and attach to this form if the situation allows use of a copier.
1. _____ A current picture ID card.

2. _____ A current license to practice _______________ License Number _______ State (verified) □

3. ______ Volunteer Armband issued

4. _____ Volunteer paired with _______________ (Medical Staff member or Nurse)

I certify that the above information is true and correct to the best of my knowledge, information, and belief. I hereby agree to abide by the medical staff bylaws, rules and regulations, as well as any hospital policies and directives. I understand a decision is made (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted. I understand that this termination is automatic and does not entitle me to a hearing or other due process.

Signature of Clinician: __________________________ Date: __________________________

Verifications completed by: __________________________ Date: __________________________

I have reviewed the available information and recommend the granting of disaster privileging as requested until the disaster plan is discontinued.

Signature of CEO/AOC: __________________________ Date: __________________________

I have reviewed the available information and recommend the granting of disaster privileging as requested until the disaster plan is discontinued.

Signature of President of Staff/Designee: ______________ Date: ______________
Jasper Memorial Hospital Medical Staff
POLICY ON PROCTORING OR FOCUSED REVIEW

A. Section Assignment

1. Each member of the Staff will be assigned to one section.

2. The Chief of Staff shall provide continuing surveillance of the professional performance of all individuals who have delineated clinical privileges.

B. Purpose

To define the method of determining competency of an individual practitioner when the organization either has no first hand data or the data it does have suggests a potential issue.

This policy shall apply to all applicants for initial medical staff membership and clinical privileges, current members requesting additional privileges not held, or when a question arises about a currently privileged practitioner’s ability to provide safe, high quality patient care during the course of ongoing professional practice evaluation.

C. Duration of Monitoring Period

The duration of the monitoring period shall be applicant specific and tailored to the individual based on training and experience and available data on competency and risk of privileges to be utilized. The monitoring period may be extended for two (2) additional 90-day periods if during the review process it is determined additional data or monitoring is necessary to further assess current competence, practice behavior, and ability to perform the privileges requested or there is low utilization and insufficient information to evaluate the staff member’s competence to exercise the privileges granted.

D. Patient Admission/Treatment Requirements

1. Each applicant for active, courtesy, or consulting medical staff membership and privileges shall:

   a. Be proctored for five cases as determined by the Medical Executive Committee. The requirement for proctoring begins immediately in any CHRISTUS Southeast Texas facility with the first patient seen and continues with each subsequent patient until requirements are met within two (2) months. At the discretion of the Medical Executive Committee, the assigned number of proctored cases may be lower for certain specialties i.e. dentistry or ophthalmology.
b. Identify the names of Medical Staff members who will serve as proctors or as identified by the Chief of Staff. Proctors should be Active staff members qualified and credentialed to perform the procedures for which she/he is reviewing. Members of the same group may proctor each other.

c. Have the proctor provide a written report on each case proctored. Performance Evaluation Forms (proctoring forms) will be provided to monitoring members.

d. Maintain responsibility to assure that the proctoring forms are completed and submitted to the Medical Executive Committee by way of the Medical Staff Office in a timely manner.

2. Each current medical staff member requesting additional privileges shall:

a. Complete proctoring requirements as set forth in credentialing criteria for additional privileges requested or as determined by the Medical Executive Committee.

b. Have the proctor provide a written report on each case proctored. Performance Evaluation Forms (proctoring forms) will be provided to monitoring members.

c. Maintain responsibility to assure that the proctoring forms are completed and submitted to the Medical Executive Committee by way of the Medical Staff Office in a timely manner.

3. If, at the end of the monitoring period, the physician has not met the admission/treatment requirements, the Medical Executive Committee may:

a. Recommend an additional monitoring period of not longer than 6 months;

b. Acknowledge the physician’s voluntary relinquishment of appointment or clinical privileges;

c. Moved to an appropriate staff category (Credentialing Procedures Manual 3.1).

4. If, at the end of any additional monitoring period, the physician has still not treated a sufficient number of patients to properly evaluate the physician’s competence to exercise the clinical privileges granted at CHRISTUS Southeast Texas Health System, the physician shall be deemed to have voluntarily relinquished his or her appointment or clinical privileges.

(Credentialing Procedures Manual 3.3)

E. The method of evaluation shall be determined by the Medical Executive Committee and shall consist of at least one of the following:

a. Review of medical records of patients admitted or treated by the physician. The requirement for retrospective evaluation begins with the first patient seen and continues with each subsequent patient until the requirements are met. The review shall evaluate the following: (1) Diagnostic Workup; (2) Patient Management; (3) Patient Discharge; (4) Relationship with Patients & Hospital Employees; and (5) a basic assessment of the treatment of the patient.

b. Direct Observation;

c. Discussions with other individuals involved in the care of each patient including, where
appropriate: consulting physicians, assistants at surgery, anesthetists, pharmacists and nurses, if indicated;

d. Discussion with appointee about each of the cases, if indicated.

A written report of the evaluation shall be made to the Medical Executive Committee utilizing the Performance Evaluation Report Forms.

F. External Review

Performance monitoring can be conducted by an external source when expertise on the medical staff is not available for a new procedure, additional expertise is needed after all internal resources have been exhausted, interpersonal conflict, disagreement as to the appropriate action to be taken.

G. Executive Committee’s Report

1. If, at any time during the monitoring period, the proctoring physician determines that the physician is not competent to perform specific clinical privileges and his or her continued exercise of those privileges jeopardizes patient safety, he or she shall report his or her findings and assessment to the Medical Executive Committee. If necessary, the physician’s clinical privileges may be summarily suspended in the manner outlined in Medical Staff Bylaws and Credentialing Procedures Manual. The Executive Committee’s recommendation is forwarded to the Board.

2. At the end of the monitoring period, the Medical Executive Committee shall determine:

   a. whether sufficient treatment of patients occurred to properly evaluate the clinical privileges being exercised;
      a. If not, whether the monitoring period should be extended.

   c. If sufficient treatment of patients has occurred to properly evaluate the clinical privileges being exercised, the Medical Executive Committee’s recommendation is then forwarded to the Board.

H. Failure to meet Patient Admission or Attendance Requirements

Whenever a monitoring period including any period of extension expires without favorable conclusion for the clinician or whenever an extension is denied, the Staff President will provide him with special notice of the adverse result and of entitlement to the procedural rights provided in the Fair Hearing Plan.

(Credentialing Procedures Manual 3.3)

1/08
Reviewed & Revised 1/2013; 10/13; 4/2016; 1/18
JASPER MEMORIAL HOSPITAL
PROCTOR IDENTIFICATION FORM

Clinician Name (Please Print): ____________________________________________

In accordance with the Medical Staff Bylaws and the Medical Staff Policy on Proctoring or Focused Review, this policy shall apply:

1) to all new applicants for initial medical staff membership and clinical privileges,
2) current members requesting additional privileges not held,
3) when a question arises about a currently privileged practitioner’s ability to provide safe, high quality patient care during the course of ongoing professional practice evaluation.

Active, Consulting, and Courtesy (Jasper only) category appointments must be proctored in any CHRISTUS Southeast Texas facility for the number of cases, procedures, admissions, or consultations as required by the Section or Medical Executive Committee. Call coverage staff only provides call coverage for designated physicians and does not perform elective cases nor take ER call; therefore, for the first 10 patient contacts a retrospective chart review will be performed by the designated proctor.

• Proctor(s) must be Active staff members qualified and credentialed to perform the procedures for which she/he is reviewed.
• Members of the same group may proctor each other.

In consideration of the above listed requirements, I have made arrangements for the Medical Staff member(s) listed below who has agreed to serve as my proctor(s).

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Clinician Signature __________________________ Date __________________________

1/08
10/2013; 4/2016; 1/18

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CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM
JASPER MEMORIAL

Medical Staff Ongoing Professional Practice Evaluation Process (OPPE)

Purpose:
To assure that CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM through the activities of the Medical Staff, assess the ongoing professional practice and competence of each member of the medical staff, conducts professional practice evaluations, and uses the results of such assessment and evaluation to improve professional competence, practice and care.

I. Complimentary to the Peer Review Policy:
This policy is complimentary to the Peer Review Policy. This policy refers to the records and proceedings of the medical staff, which has the responsibility of evaluation and improvement of quality of care rendered in the hospital.

II. Criteria:
Criteria utilized for the OPPE may include, but not limited to:
- Review of operative and other clinical procedures and their outcomes;
- Pattern of blood and pharmaceutical usage;
- Requests for tests and procedures;
- Length of stay/utilization patterns;
- Mortality data;
- Section and Committee specific data;
- Sentinel events and/or events required by regulatory agencies to be reported.
- Core measures
- Antibiotic selection
- Infection Control Data
- Patient Satisfaction

III. Methods:
Methods utilized to identify information may include:
- Chart review;
- Proctoring (retrospective, prospective, and concurrent);
- Direct observation;
- Routine monitoring of indicators as well as complaints or concerns from patients, employees, or administrative personnel.

IV. Rationale:
It is the policy of CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM and the Medical Staff at CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM to comply with statutory and regulatory requirements regarding OPPE and FPPE. Ongoing data review and findings about practitioner practice and performance are evaluated by the Multidisciplinary Peer Review Committee and Section Chairman and/or the Medical Executive Committee every eight months and utilized to assess the quality of each practitioner at the time of their biennial reappointment.

V. Procedure:
Ongoing data review and findings about practitioner practice and performance will be evaluated by the Medical Executive Committee every 8 months and will be utilized to assess the quality of care of each practitioner at time of reappointment or any time additional privileges are requested. Patterns, trends or issues identified will be addressed for further review, correction action and/or additional monitoring, as necessary.

Practitioner-specific OPPE reports will be mailed to individual practitioners every 8 months.

In accordance with Section 2.1.3 of the Credentials Manual, practitioners who do not admit and/or utilize the hospital with adequate frequency for assessment or are in a specialty that does not provide inpatient care shall be responsible for providing alternate information for review to allow an informed decision regarding professional practice evaluation.

DEFINITION: “Staff Member” is defined to be a member of the Medical Staff or the Health Professional Staff.

I. POLICY STATEMENT

1. CHRISTUS Medical Center and its medical staff are committed to providing its patients with quality care. The delivery of quality care can be compromised if a member of the medical staff is suffering from an impairment. Impairment may result from a physical, psychiatric, or emotional condition.

2. Education of the medical staff and other hospital staff about illness and impairment recognition issues specific to a Staff Member is paramount and this policy provides overall guidance and direction on how to proceed when confronted with a potentially impaired Staff Member (1).

3. To promote reporting of impairment issues, self-referral by the affected Staff Member and referral by other organization staff is encouraged. The hospital and medical staff leadership shall assist the Staff Member in locating a suitable rehabilitation program. Confidentiality of the Staff Member seeking referral or referred for assistance will be maintained, as well as the identity of any person who reports a Staff Member who may be possibly impaired, unless otherwise required for legal reasons, ethical obligation, or when patient safety is threatened(4). The purpose of this process is assistance and rehabilitation rather than discipline. A report will be made to the medical staff leadership of instances in which a Staff Member is providing unsafe treatment.(7)

II. MECHANISM FOR REPORTING AND REVIEWING POTENTIAL IMPAIRMENT

1. If any individual has a concern that a member of the medical staff may be impaired in any way that may affect his or her practice at the hospital, a written report shall be given to the Chief Executive Officer or the VPMA or the President of the Staff. The report shall include a factual description of the incident(s) that led to the concern.

2. If, after discussing the incident(s) with the individual who filed the report, the Chief Executive Officer, the VPMA and/or the President of the Staff believe there is enough information to warrant a review, the matter shall be referred to the Physician Health Committee. Other Staff Members may be asked to serve in an advisory capacity when deemed appropriate by committee members.

3. The Physician Health Committee shall act expeditiously in reviewing concerns of potential impairment that are brought to its attention.

4. As part of its review, the Physician Health Committee may meet with the individual(s) who prepared the report.

5. If the Physician Health Committee has reason to believe that there is enough credible information to warrant further review, it shall meet with the Staff Member. At this meeting, the Staff Member should be told that there is a concern that he or she might be suffering from an impairment that affects his or her practice. The Staff Member should not be told who filed the initial report, but should be advised of the nature of the concern.
6. As part of its review, the Physician Health Committee may request that the Staff Member be evaluated by an outside organization and have the results of the evaluation provided to it. A consent for the release of information to the Physician Health Committee is attached as Appendix A.

7. Depending upon the severity of the problem and the nature of the impairment, the Physician Health Committee has the following options available to it:
   a. recommend that the Staff Member voluntarily take a leave of absence, during which time he or she would participate in a rehabilitation or treatment program to address and resolve the impairment;
   b. recommend that appropriate conditions or limitations be placed on the Staff Member’s practice;
   c. recommend that the Staff Member voluntarily agree to refrain from exercising some or all privileges in the hospital until rehabilitation or treatment has been completed or an accommodation has been made to ensure that the Staff Member is able to practice safely and competently;
   d. recommend that some or all of the Staff Member’s privileges be suspended if the Staff Member does not voluntarily agree to refrain from practicing in the hospital.

8. If the Physician Health Committee recommends that the Staff Member participate in a rehabilitation or treatment program, it should assist the Staff Member in referring the affected Staff Member to an appropriate professional internal or external resource for diagnosis and treatment of the condition or concern;

4. If the Staff Member agrees to abide by the recommendation of the Physician Health Committee, a confidential report will be made to the Chief Executive Officer, the VPMA and the President of the Staff. In the event there is concern by the Chief Executive Officer, the VPMA, and/or the Chief of Staff that the action of the Physician Health Committee is not sufficient to protect patients, the matter will be referred back to the Physician Health Committee with specific recommendations on how to revise the action or it will be referred to the Credentials Committee for an investigation.

III. REINSTATEMENT

1. Upon sufficient proof that a Staff Member who has an impairment has successfully completed a rehabilitation or treatment program, the Physician Health Committee may recommend that the Staff Member’s clinical privileges be reinstated. In making a recommendation that an impaired Staff Member be reinstated, the Physician Health Committee must consider patient care interests as paramount.

2. Prior to recommending reinstatement, the Physician Health Committee must obtain a letter from the clinician overseeing the rehabilitation or treatment program. (A copy of a release from the clinician authorizing this letter is attached as Appendix B.) The letter must address the following:
   a. the nature of the Staff Member’s condition;
   b. whether the Staff Member is participating in a rehabilitation or treatment program and a description of the program;
   c. whether the Staff Member is in compliance with all of the terms of the program;
   d. to what extent the Staff Member’s behavior and conduct need to be monitored;
   e. whether the Staff Member is rehabilitated;
   f. whether an after-care program has been recommended to the Staff Member and, if so, a
description of the after-care program; and

g. whether the Staff Member is capable of resuming medical practice and providing continuous, competent care to patients.

3. Before recommending reinstatement, the Physician Health Committee may request a second opinion on the above issues from a Staff Member of its choice.

4. Assuming that all of the information received indicates that the Staff Member is capable of resuming care of patients, the following additional precautions shall be taken before the Staff Member’s clinical privileges are reinstated:

a. the Staff Member must identify at least one practitioner who is willing to assume responsibility for the care of his or her patients in the event of the Staff Member’s inability or unavailability; and

b. the Staff Member shall be required to provide periodic reports to the Physician Health Committee from his or her attending physician, for a period of time specified by the Committee, stating that the Staff Member is continuing rehabilitation or treatment, as appropriate, and that his or her ability to treat and care for patients in the hospital is not impaired. Additional conditions may also be recommended for the Staff Member’s reinstatement.

5. The final decision to reinstate a Staff Member’s clinical privileges must be approved by the Chief Executive Officer in consultation with the VPMA, the Chief of Staff and/or the Chairperson of the Credentials Committee.

6. There will be monitoring of the affected Staff Member’s exercise of clinical privileges in the hospital and of the safety of patients by the Section Chairperson or by a Staff Member appointed by the Section Chairperson until the rehabilitation or any disciplinary process is complete. The nature of that monitoring shall be recommended by the Physician Health Committee in consultation with the Chief of Staff and the Chairperson of the Credentials Committee.

7. If the Staff Member has an impairment relating to substance abuse, the Staff Member must, as a condition of reinstatement, agree to submit to random alcohol or drug screening tests at the request of the Chief Executive Officer, the VPMA, the President of the Staff, or any member of the Physician Health Committee.

8. In the event of any apparent or actual conflict between this policy and the bylaws, rules and regulations, or other policies of the hospital or its medical staff, including the investigation, hearing and appeal Sections of those bylaws and policies, the provisions of this policy shall control.

IV. COMMENCEMENT OF AN INVESTIGATION

1. The hospital and the medical staff believe that issues of impairment can best be dealt with by the above policy and the Physician Health Committee to the extent possible. If, however, the Physician Health Committee makes a recommendation, including a recommendation for an evaluation or a restriction or limitation on privileges, and the Staff Member refuses to abide by the recommendation, the matter shall be referred to the Credentials Committee for an investigation to be conducted pursuant to the Bylaws/Credentialing Policy.

V. DOCUMENTATION AND CONFIDENTIALITY

1. The original report and a description of any recommendations made by the Physician Health Committee should be included in the Staff Member’s credentials file. If, however, the review reveals that there was no merit to the report, the report should be destroyed. If the review reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in the Staff Member’s
credentials file and the Staff Member’s activities and practice shall be monitored until it can be established whether there is an impairment that might affect the Staff Member’s practice or the safety of patients. The Staff Member shall have an opportunity to provide a written response to the concern about the potential impairment and this shall also be included in his or her credentials file.

2. The Chief Executive Officer or the President of the Staff shall inform the individual who filed the report that follow-up action was taken.

3. Throughout this process, all parties should avoid speculation, conclusions, gossip, and any discussions of this matter with anyone other than those described in this policy.

4. If at any time it becomes apparent that the matter cannot be handled internally, or jeopardizes the safety of the Staff Member, Health Professional, or others, the Chief Executive Officer, the VPMA, and/or the President of the Staff, may contact law enforcement authorities or other governmental agencies.

5. All requests for information concerning the impaired Staff Member shall be forwarded to the Chief Executive Officer for response.

Recommended by the Credentials Committee this 26th day of June, 2001

Recommended by the Executive Committee this 28th day of June, 2001

Approved by the Board this 11th day of July, 2001

Policy Revision History
2003: Quality Committee named as Physician Health Committee. Approved by MEC 12/2002, CHRISTUS Health SETX Board on 1/16/03.
Reviewed: 7/08

REFERENCE: MEDICAL STAFF LEADER HANDBOOK, HORTY, SPRINGER & MATTERN
APPENDIX A
CONSENT FOR RELEASE OF INFORMATION PERTAINING TO EVALUATION

I hereby request that ____________________ [the Facility/Clinician Evaluator] provide CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM (“the Hospital”) and its Medical Executive Committee with all information relevant to your evaluation of my ability to care for patients safely, to competently fulfill the responsibilities of medical staff appointment and to relate cooperatively to others in the Hospital.

I also request that the Hospital and Executive Committee provide ____________________ [the Facility/Clinician Evaluator] with a copy of any information which it believes supports the need for the evaluation and any other information that ____________________ [the Facility/Clinician Evaluator] might request.

I release from liability and grant absolute immunity to, and agree not to sue, ____________________ [the Facility/Clinician Evaluator] and the Hospital and its Medical Executive Committee (and any Staff Member on the Hospital’s medical staff who is involved in reviewing my practice) for providing the information set forth above.

__________________________________
Date
Signature of Staff Member

APPENDIX B
CONSENT FOR RELEASE OF INFORMATION

I hereby request that Dr. ____________________ [clinician overseeing treatment] provide CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM (“the Hospital”) and its Medical Executive Committee with information pertaining to my rehabilitation or treatment program. Specifically, this information should include:

(a) the nature of my condition;
(b) whether I am participating in a rehabilitation or treatment program;
(c) whether I am in compliance with all of the terms of the program;
(d) to what extent my behavior and/or conduct needs to be monitored;
(e) whether I am rehabilitated;
(f) whether an after-care program has been recommended for me and, if so, a description of the after-care program; and
(g) whether I am capable of resuming medical practice and providing continuous, competent care to patients.

I also request that Dr. ____________________ provide the Hospital and its Medical Executive Committee with periodic reports relating to my ongoing rehabilitation or treatment and my ability to treat and care for patients in the Hospital.

I release from liability, grant absolute immunity to and agree not to sue Dr. ____________________ for providing the information set forth above.

__________________________________
Date
Signature of Staff Member
POLICY STATEMENT:

It is the policy of CHRISTUS Health that all individuals within its facilities be treated with respect, courtesy and dignity. CHRISTUS promotes a work environment consistent with the CHRISTUS Mission, Core Values and Associate Covenant - a workplace filled with hope, dignity and mutual respect. CHRISTUS values its relationships with physicians and has adopted a “Physician Compact” that details mutual commitments to be demonstrated through organizational and personal behavior. In particular, CHRISTUS and physicians commit to behaviors that exhibit respect and honor the dignity of all Associates and health care partners, patients and their families.

CHRISTUS Core Values

- Dignity: Respect for the worth of every person with special concern for the poor and underserved.
- Integrity: Honesty, justice, and consistency in all relationships.
- Compassion: Service in a spirit of empathy, love, and concern.
- Stewardship: Wise and just use of talents and resources in a collaborative manner

To this end, CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM and the Medical Staff are committed to promoting a safe, cooperative, and professional health care environment. Therefore, the CHRISTUS Health Southeast Texas Board (the “Board”), requires that all individuals, associates, physicians, and other independent practitioners conduct themselves in a professional, cooperative, and respectful manner in the hospital. In dealing with all incidents of behaviors that undermine a culture of safety, the protection of patients, associates, physicians, and others in the Hospital and the orderly operation of the Medical Staff and Hospital are paramount concerns. This policy shall be enforced in a firm, fair, and equitable manner. This policy is applicable to unprofessional behaviors that undermine a culture of safety, which may adversely affect patient care, and is therefore a concern of both the CHRISTUS Health Southeast Texas Board and the CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM Medical Staff. To ensure an appropriate environment in which quality patient care is the primary goal, the clinical privileges of the practitioner whose behavior is at issue may be suspended on a temporary or permanent basis as the circumstances may require.

I) DEFINITIONS and APPLICABILITY

Issues of associate conduct will be dealt with in accordance with Human Resource Policies. Issues of conduct by members of the Medical Staff, or Health Professional, will be addressed in accordance with this Policy.

A) For purposes of this policy all members of the Medical Staff (licensed physicians, dentists, and podiatrists), Health Professional Staff are required to abide by the guidelines of professional behaviors outlined in this policy. Any of the corrective actions outlined in section IV may be applied to all Medical Staff and Health Professional members, however those members who are considered Health Professional are not entitled to the Due Process procedures described herein, but rather may be entitled to the Due Process procedures described in the Health Professional/ Policy.

B) CHRISTUS Health Southeast Texas Board shall mean those persons selected to act within delegated limits as the governing body of the Hospital (and shall include any committee of the Region Board whose members are exercising the powers of the Region Board) who, acting as a group, exercise the ultimate authority with respect to all public affairs, administrative affairs and oversight of the medical affairs of the Hospital.

C) The term “adversely affecting” includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.

D) Professional review action means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician.
E) Review Committee means the Panel of individuals selected to participate in the review of the adverse recommendation.

II) GUIDELINES
Medical Staff members should conduct themselves in a reasonable and professional manner, by way of example Medical Staff members should:

- Comply consistently with practice standards for professionalism
- Communicate with colleagues clearly and directly, displaying respect for their dignity
- Support policies promoting cooperation and efficient teamwork
- Use conflict resolution and mediation skills to manage disagreements
- Address concerns about clinical judgments with team members directly and in private
- Address dissatisfaction with practice policies through appropriate grievance channels
- Routinely offer and accept constructive feedback.

COMMON BEHAVIORS WHICH ARE UNPROFESSIONAL AND/OR UNDERMINE A CULTURE OF SAFETY

Inappropriate anger or resentments
- intimidation
- abusive language
- blames or shames others for possible adverse outcomes
- unnecessary sarcasm or cynicism
- threats of violence, retribution, or litigation

Inappropriate words or actions directed toward another person
- sexual comments or innuendoes
- sexual harassment
- seductive, aggressive, or assaultive behavior
- racial, ethnic, or socioeconomic slurs
- lack of regard for personal comfort and dignity of others

Inappropriate response to patient needs or staff requests
- late or unsuitable replies to pages or calls
- unprofessional demeanor or conduct
- verbal or physical attacks leveled at other members of the staff or members of the hospital community
- uncooperative, defiant approach to problems
- rigid, inflexible responses to requests for assistance or cooperation
- impertinent and inappropriate comments or illustrations made in the patient medical record or other official facility documents impugning the quality of care, staff and/or associates or facility polices

III) INVESTIGATION and DOCUMENTATION
Complete and accurate investigation and documentation of behaviors that undermines a culture of safety is critical. Ordinarily it is not one incident that leads to disciplinary action, but rather a pattern of inappropriate conduct. However, a single egregious incident may result in the imposition of any one or more corrective action(s) as outlined below.

1. Staff Members, associates, patients, family members or visitors who observe behavior by a Medical Staff Member which disrupts the smooth operation of the Hospital, or adversely impacts patient care, shall document and report the incident. The report and/or subsequent documentation should include as much information as possible:

   a) Date, time, location and description of the behavior, limited to factual objective language;

   b) If the behavior was in the presence of the patient, or affected or involved a patient in any way, the name of the patient;
c) Circumstances which precipitated the situation;

d) Consequences, if any, of the behavior that undermines a culture of safety as it relates to patient care, or personnel, or Hospital operations and any action taken, if any; including date, time, place, action and name(s) of those intervening; and

e) List of witnesses to the incident.

2). The Report should be submitted to Administration who will then route it to the Vice President of Medical Staff Affairs (“VPMA”). The VPMA, in consultation with the president of the medical staff, will investigate the report. The investigation should include interviewing the person submitting the complaint and other witnesses or patients involved. The VPMA or the president of the medical staff will then inform the Staff Member of the report and advise him/her of the allegations and require the Staff Member responds to the allegation. The Staff Member has the right to submit a written rebuttal to the allegation. Such rebuttal will be maintained as a permanent part of the record. The Staff Member will be informed that any attempt to confront, intimidate, or otherwise retaliate against the individual(s) who reported the behavior in question or who participated in the investigation is a violation of this policy and grounds for further disciplinary action. Reports determined to be unsubstantiated or insignificant may be dismissed although a record of the investigation will be maintained in the member’s peer review file.

IV) REPORTS THAT WARRANT FURTHER INVESTIGATION and/or ACTION

Unless deemed to be insignificant or not credible a follow up discussion with the physician is warranted, either through referral to the appropriate committee or through an individual meeting with the physician. The decision for referral and handling will be at the discretion of the VPMA and the president of the medical staff. After investigation of the incident and input from the involved Staff Member the VPMA, the President of the Medical Staff or the appropriate committee (whichever handled the investigation) may recommend to the MEC any of the following actions*, including but not limited to:

a) No action.

b) A follow-up meeting with the VPMA and/or other Department/Section Chief or Medical Director.

c) The practitioner to meet with the full Medical Executive Committee.

d) The practitioner to meet with the Governing Board Chair

e) Letter of reprimand from the VPMA, the President of the Medical Staff, or the investigating committee, warning that such behavior is not acceptable and must cease. The letter should emphasize that if the behavior that undermines a culture of safety recurs, the Medical Staff and/or the Board will take more formal action.

f) Letter of reprimand and final warning. This letter is not a request for further discussion, but rather constitutes the physician’s final warning.

g) Recommendation for counseling, psychiatric counseling or other appropriate behavior modification course.

h) Impose a “personal” code of conduct on the practitioner and make continued appointment and clinical privileges contingent on the practitioner’s adherence to it.

*The imposition of any of the above actions does not entitle the practitioner to a due process hearing

V. PATTERN of BEHAVIOR

In the case of a pattern of behavior the VPMA, President of the Medical Staff and/or the facility CEO may hold a series of meetings with the Medical Staff Member or the appropriate committee may schedule follow up meetings. The intervention involved in each meeting will progressively increase in severity until the behavior in question ceases. However at any point in the discussions, at the sole discretion of the VPMA, the President of the Medical
Staff and the facility CEO, the physician will be informed that such conduct is intolerable and will inform the individual that a single recurrence of the offending behavior shall result in a recommendation of termination of medical staff membership and privileges. This meeting is not a discussion, but rather constitutes the physician's final warning. The physician will also receive a follow-up letter that reiterates the final warning.

VI) ADMINISTRATIVE COOLING OFF PERIOD

In the case of egregious behavior, or behavior that undermines a culture of safety that has had a serious impact on an associate or other person within the facility the President of the Medical Staff, the VPMA, the Chief Executive Officer of the Hospital or the Chairperson of the Regional Governing Board may impose a “Cooling off Period” for a period of less than fourteen (14) days during which time the Staff Member may not engage in clinical management of patients nor perform any administrative duties at the Hospital. The Staff Member will be given an opportunity to arrange for his/her patients currently in the Hospital to be cared for by another qualified Staff Member or to be discharged if appropriate. During this time period the Staff Member will not be permitted to schedule or perform any elective admissions, surgeries or procedures. The imposition of such an action shall be based on the reasonable belief that the action was necessary in the furtherance of quality care. This cooling off period is intended to serve as a process to ensure the integrity of patient care and the safety and concern for associates while further investigation is conducted; or in the alternative to serve as a final warning prior to or in lieu of a formal recommendation to suspend or terminate the Staff Member privileges and membership. The imposition of a cooling off period does not trigger the provisions of the appeals process of the Staff Bylaws.

VII) DUE PROCESS PROCEEDING SPECIFIC to this POLICY

Other than the actions described above, any professional review action that is considered adverse as defined in section 9.2.3 of the Medical Staff Bylaws will proceed as outlined in Section 9.4, Mediation, or in accordance with the procedures and safeguards set forth in the Staff Bylaws.

VIII) PROMOTING AWARENESS OF CODE OF CONDUCT

The medical staff shall, in cooperation with the hospital, promote continuing awareness of this Code of Conduct among the medical staff and the hospital community, by:

1. Sponsoring or supporting educational programs on behaviors that undermine a culture of safety to be offered to staff members and hospital employees;
2. Disseminating this Code of Conduct to all current medical staff members upon its adoption and applicants for membership to the medical staff.
3. Encouraging the Physician Health Committee to assist members of the medical staff exhibiting behaviors that undermine a culture of safety to obtain education, behavior modification, or other treatment to prevent further infractions.
4. Informing the members and the hospital staff of the procedures the medical staff and hospital have put into place for effective communication to hospital administration of any medical staff member’s concerns, complaints and suggestions regarding hospital personnel, equipment, and systems.

Approved: Medical Staff Executive Committee, October 16, 2008
SETX Board of Directors, January 22, 2009

Revised: 7/2009
Reviewed: 3/2010
Reviewed: 1/2011
Reviewed: 7/2012; 4/2013
Reviewed & Revised: 4/2015; 10/2016; 1/2018
CONFLICT RESOLUTION POLICY

OBJECTIVE: To provide a process for governance leaders, governing boards, administration and medical staff leadership to resolve differences when a conflict arises on policy decisions affecting the organization.

DIRECTIVE: CHRISTUS Health SETX region will maintain processes to periodically review the effectiveness of its governance, administrative and medical staff relationships to provide a forum for all stakeholders to give input should a conflict arise between regional governing boards, local leadership, the CHRISTUS Health Board of Directors, the Medical Staff leadership, or members of the Medical Staff.

ONGOING OPPORTUNITIES FOR INTERACTION:

1. Leadership Involvement: Quarterly meetings of the CHRISTUS Health Senior Leadership Team (SLT) and the Regions Leadership Team (CLT) to discuss issues generated from the Regions. The CHRISTUS Health President has the final decision-making authority over the management of CHRISTUS Health, pursuant to those authorities in the CHRISTUS Health and Region Bylaws.

2. Governance Information Sharing: Policy decisions adopted by the CHRISTUS Health Board of Directors are communicated through the CHRISTUS Health President. Governance decisions at the Regions are communicated through minutes and memos; as well a representative of the CHRISTUS Health SLT is assigned to each regional board as a resource for information and to enhance communications. In addition, periodic meetings of the Chair Council provide a forum for chairpersons of the Region Boards to give input and report on regional issues and to enhance communications and align system and regional strategies. The Region's Bylaws provide for the periodic review of its Bylaws for relevancy and completeness. The Region Board reviews the Bylaws on issues relating to the governance structure; the authorities and processes for making decisions; and reports its findings and recommendations to the CHRISTUS Health President or the CHRISTUS Health Board Chairperson.

3. Medical Staff leadership representation: The medical staff has representation on the CHRISTUS Health Board and the regional Boards and committees as determined by the Board member selection process.

4. Vice President of Medical Affairs: The Vice President of Medical Affairs is also instrumental in resolving conflicts through direct interaction at the facility level.

Resolution of Conflicts: When a conflict arises, regional governance and/or Administration and the Medical Staff Leadership should first use one of above processes to attempt to resolve the issue. The Value Based Decision Making Process (Attachment A) should also be considered as a tool for conflict management.

If informal attempts are unsuccessful the Formal Conflict Resolution process may be invoked by either the:
   a) Board Chair;
   b) President of the Medical Staff;
   c) Administrator or CEO;
   d) Request by Majority of Department Chairs;
e) Petition signed by at least 51% of the medical staff members who are entitled to vote as per the bylaws.

The list below can give rise to conflict in the healthcare environment:

**Medical staff/governing body/administration potential conflict issues:**

- Conflicts between physicians
- Conflicts between physicians and non-physicians (e.g., nursing staff, allied health professionals)
- Impaired and disruptive practitioners
- Election and selection of medical staff officers
- Contractual arrangements with physicians (independent contracts; exclusive contracts)
- On-call issues (selection of personnel and payment issues)
- EMTALA issues
- Charity care, uninsured, or underinsured patient issues
- Requirements of professional malpractice insurance coverage to obtain and maintain medical staff privileges
- Ethical issues/challenges related to the mission and goals of the organization
- Requirements for medical staff membership
- Unilateral adoption and amendment of medical staff bylaws
- Licensing and accreditations requirements, which may impact medical staff bylaws
- Mergers and acquisitions of hospitals and combining medical staff members requiring revision of medical staff bylaws
- Impact on patient safety of decreased number of primary care providers and nursing staff;
- Use of hospitalists
- Allied health practitioners privileging and supervision
- Budget constraints adversely affecting existing and future medical programs
- New technology, resulting in need for expenditure on sophisticated equipment
- Electronic medical records in the hospital and in private practices, interoperability issues, and requests for hospital financial assistance
- Outsourcing of medical care (e.g., telemedicine, teleradiology)
- Employee/employer conflicts (N.B. This must be done in consideration with other human resources policies.)
- Labor union issues
- Hospital/physician arrangements and Stark and fraud and abuse implications
- Conflicts of interest within the governing body and medical staff
- Vendor relationships with medical staff
- Role of research and hospital/medical staff financial support
- Department/department conflicts relating to resource allocation

**Patient Care Issues:**

- Treatment issues, including timing and location
- Adverse outcomes and sentinel events: discussing the issues with patients and resolving questions patients may have, including monetary issues
- End-of-life decisions, including dealing with intra-familial differences
- Health insurance coverage issues
- Coverage of "experimental" procedures and treatments
- Drug treatment coverage disputes
- Billing disputes
- Transfer of patients from a higher level of care to a lower level of care
- Patient competency issues
- Conflicts between the organization’s mission and values and the patient’s values and
religious beliefs
Cultural issues and their impact on patient safety and care
Need for interpreters or other accommodations for special needs patients
Emancipated or “mature” minors issues related to consent, confidentiality and payment
Experimental trials and institutional review board issues
Ethics committee issues
Consent issues related to religious reservations (e.g., Jehovah’s Witnesses)
Ethical issues related to institutional policies or mandates related to care, e.g., related to religious directives or practitioner “conscience provisions”
Human rights complaints

Formal Conflict Resolution Process:

If informal methods of conflict management have failed to resolve the dispute or reduce the disruptions flowing from the conflict, then legal/compliance/risk management issues or threats to patient safety and quality of care may require more formal dispute resolution methods. The formal resolution process shall be followed:

1) If the conflict involves the medical staff, the facilitator will be appointed by the Chief of Staff in consultation with the CEO. If the conflict involves administrative or governance issues, the CEO in consultation with the Board Chairman shall appoint the facilitator; The facilitator is neutral as to the process, will guide the discussion, balance the participation of all the participants, model mutual respect and integrity for the participants, and help the participants work through resolution of the conflict;
2) The facilitator will identify who the participants will be in the conflict management process. Participants necessary to the management of the conflict may include not only the individuals engaged in the conflict, but also their supervisors or others who may be affected by the conflict of its consequences.
3) The facilitator will schedule the place, date, and time and duration of the conflict management session; explain the ground rules of the session, provide participants with either an oral or written summary of what was accomplished including additional facts, definition or clarification of issues, agreement on options for resolution, agreement o meet again, or the barriers to reaching resolution, obtain responses to the summary from the participants, and assist with implementation of the outcome as appropriate.
4) The participants will demonstrate mutual respect during the process, cooperate in good faith with the facilitator, will focus on facts and advocate in a reasoned and civil manner, will attempt to define and narrow issues, and will try to view issues with an open mind or from a different perspective.
5) If the conflict involves the medical staff, the recommendation resulting from the conflict resolution process will be forwarded to the Medical Executive Committee and the Board for disposition. If the conflict involves administration or governance, the recommendation resulting from the formal resolution process will be forwarded to the Board for disposition.

NOTE: For conflicts between the CHRISTUS Board and regional governance, the Management Directive No. 0046, “Conflict Resolution for Governance in Policy Decisions” will be followed.

APPROVED: Medical Executive Committee, May, 2017
SETX Board, July 27, 2017
Reviewed: 1/2018

SOURCE: CHRISTUS Management Directive #0046
Conflict Management Toolkit, American Health Lawyers Association
Non-Staff Care Givers/Ordering of Outpatient Tests: The following non-staff caregivers are permitted to order non-invasive outpatient lab tests, imaging services, and therapies, i.e. PT, OT, respiratory therapy):

- **Physicians, Dentists, and Podiatrists** – Must be responsible for the care of the patient, currently licensed in the jurisdiction where he/she sees the patient and acting within his/her scope of practice under State law, and not be excluded from participation in Medicare/Medicaid.

- **Nurse Practitioners and Physician Assistants** – Licensed Advanced Nurse Practitioners and Physician Assistants may order outpatient lab tests, imaging services, and therapies on outpatients without requiring physician co-signature. Must be currently licensed and not be excluded from participation in Medicare/Medicaid. *(MEC 7/06)*

- **Chiropractors are not eligible to order and refer. (CMS 8/23/11)*

The Hospital will verify current licensure and perform sanction checks on those non-staff practitioners as requested.

Orders for outpatient chemotherapy will not be accepted from a non-staff caregiver unless there is agreement from a local physician to assume the care of the patient in the case of admission. Orders for invasive imaging studies which may require admission may be accepted from non-staff caregivers at the discretion of the performing radiologist.

Source: CMS Ref: S&C-12-17-Hospitals

APPROVED: Medical Executive Committee, 3/29/12
- SETX Board, 4/26/12; 4/2013; 4/2015; 10/2016; 1/2018
Telemedicine is the practice of healthcare delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications. Neither a telephone conversation nor an electronic mail message between a healthcare provider and patient constitutes “telemedicine” for purposes of this policy.

Distant site is the site where the practitioner providing professional services is located.

Originating site is the site where the patient is located.

Distant-site telemedicine entity is not a Medicare participating hospital and provides telemedicine services in a manner that enables the hospital to meet all applicable Conditions of Participation (CoPs), particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of the hospital.

POLICY:

The medical staff of CHRISTUS Jasper Memorial Hospital shall provide safe and effective telemedicine services.

CHRISTUS Jasper Memorial Hospital shall credential any licensed independent practitioner (LIP) providing services to patients via telemedicine. Pursuant to a written agreement between the distant site hospital or telemedicine entity, the SETX Board may grant privileges based on the medical staff’s recommendations that rely on information provided by the distant site hospital or telemedicine entity.

Telemedicine services shall be provided under a written agreement that describes the nature and scope of services between the hospital and Distant-site telemedicine entities.

The written agreement must contain the following provisions:

The distant-site hospital or telemedicine entity must use a credentialing and privileging process that, at a minimum, meets the Medicare standards that hospitals have traditionally been required to use (found at 42 CFR 482.12(a) and 42 CFR 482.22(a)).

The distant-site hospital or telemedicine entity must provide a list of telemedicine physicians and practitioners who are privileged there and their current privileges at the distant-site hospital or entity to the hospital.
In the case of an agreement with a distant-site telemedicine entity, the agreement must also state that the entity is a contractor of services to the hospital which furnishes contracted telemedicine services in a manner that permits the hospital to comply with all applicable Medicare CoPs.

The hospital, under the terms of the agreement, must review the services provided to its patients by telemedicine physicians and practitioners covered by the agreement and provide written feedback to the distant-site hospital or telemedicine entity, addressing, at a minimum, all adverse events or complaints related to the telemedicine services provided at the hospital.

PROCEDURE:

Each medical staff section will determine which services commonly provided by the specific section can be provided via telemedicine.

Each section will recommend to the medical staff specific criteria for clinical privileges that are relevant to the practice of telemedicine within the section.

All licensed independent practitioners who are responsible for the patient's care, treatment and services via a telemedicine link are credentialed and privileged to do so at the originating site, according to Joint Commission standards MS.06.01.03 through MS.06.01.13 and CMS regulations.

CHRISTUS Jasper Memorial Hospital shall use a copy of the distant site hospital or telemedicine entity's credentialing packet for privileging. This packet includes a list of all privileges granted to the licensed independent practitioner by the distant site hospital or telemedicine entity, pertinent licensure information, and an attestation signed by the distant site hospital or telemedicine entity indicating that the packet is complete, accurate and up-to-date.

PERFORMANCE IMPROVEMENT:

Leaders will monitor contracted services by evaluating those services in relation to the hospital's expectations to include review of quality data, patient complaints, and adverse events. Information will be provided to the distant site hospital or telemedicine entity on all adverse events that result from the provision of telemedicine services and on all complaints received regarding a telemedicine physician.

Leaders will take steps to improve contracted services that do not meet expectations. These steps may include:

Increase monitoring of the contracted services
Providing consultation or training to the contractor
Renegotiating the contract terms
Terminating the contract

When contractual agreements are renegotiated or terminated, this hospital maintains the continuity of patient care.

References: TJC Standards LD.04.03.09, EP 23 and MS.13.01.01 EP 1 42 CFR. Part 482 and Part 485, Subpart F
Name of Policy  Co-Signature on Allied Health Provider Charts  JASPER MEMORIAL HOSPITAL

Implementation Date:  July 31, 2013  
Reviewed Date:  October 29, 2014; October 2016  
Policy #:  857101-30

POLICY:
The supervising physician shall review and co-sign every Mid-level inpatient chart within 72 hours.

PROCEDURE:
A Mid-level provider may admit patients to the hospital after consultation with the physician. To insure quality of care, the Physician responsible for the mid-level provider must review each inpatient chart and co-sign the chart within 72 hours.
Credentialing Criteria for Moderate or Deep Sedation JASPER MEMORIAL HOSPITAL

Implementation Date:  September 20, 2011
Reviewed Date:  March, 2012
October 29, 2014
October, 2016

POLICY:
Sedation to anesthesia is a continuum and it is not always possible to predict how an individual patient receiving medication will respond. For the purposes of credentialing, the continuum of sedation and the privilege criteria are defined below. Clinicians, apart from credentialed anesthesiologists, who wish to provide deep or moderate sedation must be specifically credentialed for these privileges.

Moderate sedation/analgesia (“conscious sedation”) – A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Practitioners granted moderate sedation privileges are deemed qualified to rescue patients from deep sedation and are competent to manage a compromised airway and to provide adequate oxygenation and ventilation.

Deep sedation/analgesia – A drug-induced depression of consciousness during which patient cannot be easily aroused, but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Clinicians granted deep sedation privileges are deemed qualified to rescue patients from general anesthesia and are competent to manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation.

PROCEDURE:
For specialties for whom moderate, i.e., conscious, sedation is a routine part of their training, documentation of training in an accredited program or certification in the clinician’s appropriate board, will be considered adequate to determine competency.

For those clinicians who have not had routine training in moderate, i.e., conscious, sedation during residency or fellowship; documentation of attendance at a course or inservice in moderate, i.e., conscious, sedation, and successful performance of five (5) procedures under moderate sedation without complications of the sedation and with demonstration of adherence to hospital procedure for administration of moderate sedation will be considered adequate.

For clinicians without specific residency or fellowship training but with experience otherwise obtained in performance of procedures under moderate sedation: documentation of previous experience and documentation of successful performance of five (5) procedures under moderate sedation without complication of the sedation and with demonstration of adherence to hospital procedure for administration of moderate sedation will be considered adequate.

Credentialing Criteria for Deep Sedation

For clinicians other than Anesthesiologists or CRNA’s; Advanced Cardiovascular Life Support (ACLS) certification, and successful performance of five (5) procedures under deep sedation without complications of the sedation and with demonstration of adherence to hospital procedure for administration of deep sedation will be considered adequate.

For clinicians who obtain certification in Advanced Cardiovascular Life Support to meet the requirements for administration of deep sedation, this certification must be maintained during the course of these privileges.
POLICY: The ordering and cancellation of procedures are to be determined only by a physician.

PROCEDURE: The need for a procedure for a patient shall be made by a physician. The procedure is to be ordered only by a physician or through the physician’s proxy, under the direction of the physician. Additionally, the decision to cancel a procedure may only be made by the physician who is to perform the procedure or through the physician’s proxy, under the direction of the physician.

Concerns surrounding the need to cancel a procedure should be addressed directly with the physician. The final determination is to be made by the physician.
1. General

The Board permits certain types of Specified Professional Personnel to provide patient care services at Jasper Memorial Hospital without appointment to the Medical and Dental Staff. Such Specified Professional Personnel must be qualified by academic and clinical or other training to provide services at Jasper Memorial Hospital. All individuals providing services shall be responsible to a member of the Active or Courtesy Medical and Dental Staff, either through an employment agreement or a sponsorship arrangement. No Specified Professional Personnel shall be considered as a licensed independent practitioner at Jasper Memorial Hospital. These Specified Professional Personnel may provide services only as permitted in Jasper Memorial Hospital and in keeping with all applicable rules, policies, and procedures of Jasper Memorial Hospital and the Jasper Memorial Hospital Medical and Dental Staff.

2. Specified Professional Personnel

2.1 Categories of Specified Professional Personnel. The following types of Specified Professional Personnel may be granted permission to provide services at Jasper Memorial Hospital. These categories include, but are not limited to, the following:

(A) Nurse Practitioners
(B) Physician Assistants
(C) Nurse Anesthetists
(D) Prosthetics
(E) Registered Nurses
(F) Licensed Practical Nurses/Licensed Vocational Nurses
(G) Scrub/OR Techs
(H) Others as indicated

2.2 Status of Specified Professional Personnel. All Specified Professional Personnel are considered dependent practitioners by the Medical and Dental Staff and the Board. Each Specified Professional Personnel must be responsible to an Active or Courtesy Staff member of the Medical and Dental Staff, either through an employment agreement or a sponsorship arrangement, or contracted by Hospital and responsible to an Active or Courtesy Staff member of the Medical and Dental Staff. All clinicians utilizing the services of Specified Professional Personnel must sign the Specified Professional Personnel Application and Scope of Duties Forms.

2.3 Need for Additional Categories of Specified Professional Personnel. The Board may approve other types of Specified Professional Personnel services on the basis of need, considering the:

(A) Availability of equipment and supplies,
(B) Availability of trained staff,
(C) Excess or stressed capacity,
(D) Patient convenience,
(E) Quality of care issues,
(F) Ability to appropriately supervise the performance of non-physicians,
(G) Efficiency of scheduling, organizing, supervising and providing support services,
(H) Development of key services, and the
(I) The legitimate business and patient care objectives of the organization.
3. Qualifications

To be permitted to perform services, a Specified Professional Personnel applicant must:

(A) be responsible to an Active Staff or Courtesy member of the Medical and Dental Staff;
(B) hold a current license, certificate or other legal credential if required by State law or otherwise document adequate training for the requested scope of service;
(C) document his or her training, experience, demonstrated ability and current clinical competency, and current physical and mental health status;
(D) meet the specific qualifications and requirements established by Jasper Memorial Hospital;
(E) maintain and provide evidence of professional liability insurance in such amounts as the Board shall specify from time to time. Failure to provide evidence of insurance in the required amounts and coverage shall result in ineligibility of an applicant for SPP staff membership or immediate termination of a SPP staff member, without recourse to any procedural rights;
(F) agree to abide by the Bylaws, Rules & Regulations, polices and procedures of Jasper Memorial Hospital and the Jasper Memorial Hospital Medical and Dental Staff.
(G) Shall be required to submit to drug testing upon initial application and randomly thereafter. Failure or refusal to cooperate with any aspect of this, but not limited to, refusal to sign forms consent to drug testing or the refusal to submit to urine or blood sampling for testing to determine use of, or impairment by, a controlled substance or intoxicant will result in disciplinary action up to and including discharge and the reporting of failure to follow protocol.
(H) Shall be required to submit to a criminal background check upon initial application and at reappointment. This will include a criminal search (10 years or up to 3 criminal searches), certified Texas statewide DPS criminal search (if applicable), Federal Criminal District Court Search National, social security number verification, sexual offender registry/predator registry, national wants and warrants submission, U.S. Government Terrorist list search, consumer credit report (if applicable), maiden/aka name search, and sanctioned, excluder individuals report (by the NHDB).

Specific qualifications may apply to certain classes of Specified Professional Personnel and will be stated on the Job Duties/Scope of Practice form.

4. Application

4.1 Application Content. Each applicant must complete the application supplied by Jasper Memorial Hospital and shall contain a request for the particular scope of practice desired by the applicant. The completed application shall include a current copy of the applicant's license/certificate to practice (if applicable), Drug Enforcement Administration Certification (if applicable), and certificates from all graduate and post-graduate training programs completed. The application shall be completed by both the individual seeking privileges and the physician(s) responsible for him or her.

4.2 Required Information. The application form shall require information about the applicant's professional qualifications, including: the names and addresses of at least three (3) individuals who have had recent experience in observing and working with the applicant, at least one of whom is similarly licensed or certified when applicable; the former employers and/or hospitals with whom the applicant has been affiliated; information as to whether the applicant's right to practice has ever been voluntarily or involuntarily relinquished, denied, revoked, suspended, reduced, or not renewed at any other hospital or health care facility; information as to whether the applicant has ever withdrawn his or her application to practice or resigned such practice before a final decision by the hospital's or health care facilities Board; information as to whether the applicant's license to practice any profession in any state and if these licenses have ever been voluntarily or involuntarily suspended, modified, terminated, restricted, or is currently being challenged; information as to the applicant's professional liability insurance coverage, the name of the insurance company, the amount and classification of such coverage, whether said insurance policy covers the scope of practice the applicant seeks to exercise in the hospital, and a consent to the release of information from present and past professional liability insurance carriers; information concerning the applicant's malpractice litigation experience and/or any professional misconduct, proceedings involving the applicant, in this state or
any other state, information concerning the suspension or termination for any period of time of the right or
privilege to participate in Medicare, Medicaid; current information regarding the applicant's ability to function;
information as to whether the applicant has ever been a defendant in a criminal action or convicted of a
crime, information on the citizenship and/or visa status of the applicant; the applicant's signature; and such
other information as the hospital may require.

4.3 Required Statements. Specified Professional Personnel must submit a statement from the responsible
Active or Courtesy Staff member of the Medical and Dental Staff concurrent with the request for permission
to provide services. The conditions of responsibility of the Medical and Dental Staff member(s) for the
Specified Professional Personnel will be outlined in the application/.scope of service form. The Medical and
Dental Staff member(s) will agree, in writing, to these conditions.

4.4 Burden of Proof. The applicant shall have the burden of producing information deemed adequate by the
hospital for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving
any doubts about such qualifications.

The applicant shall have the burden of proving that all the statements made and information given on the
application are true and correct.

4.5 Application Processing

Each application form shall be delivered to an agent of Jasper Memorial Hospital (the Medical Staff
Coordinator or Administrator). This agent will seek to verify information contained within the application
(when applicable) and will seek to collect such additional information as is deemed necessary to permit an
adequate and complete evaluation of the individual's request for permission to provide services.

Once the application is determined to be complete and all additional information has been obtained, the
application will be submitted to the appropriate Medical and Dental Staff medical director who shall examine
the application and all supporting information and documentation, evaluate the applicant's education,
training, and experience, and make a recommendation to the Chief Executive Officer regarding the
applicant's qualifications for the requested scope of practice.

The Chief Executive Officer may use the expertise of any individual on the Medical and Dental Staff, or an
outside consultant, if additional information is required regarding the applicant's qualifications. In evaluating
the application, the Chief Executive Officer or his/her designee may also meet with the applicant and/or the
responsible Medical Staff Member.

The Chief Executive Officer, upon authority granted by the Board and, upon the recommendation of the
designated representative of the Jasper Memorial Hospital Medical and Dental Staff, may permit Specified
Professional Personnel to practice in the Hospital under the supervision and guidelines as outlined in this
Policy, the Medical and Dental Staff Bylaws, Rules & Regulations and Credentialing Procedures Manual.

Quarterly, a report will be submitted to the Medical Executive Committee and the Board concerning the
number and type of individuals who have been reviewed and approved pursuant to this policy. The Board
expressly reserves the right to reverse or otherwise alter the action taken by their agent.

4.6 Time Periods for Processing: All individuals required to act on an application for Specified Professional
Personnel appointment must do so in a timely and good faith manner and, except for good cause, each
completed application should be processed within the following time periods:

<table>
<thead>
<tr>
<th>INDIVIDUAL/GROUP</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) Chief Executive Officer</td>
<td>60 days</td>
</tr>
<tr>
<td>(B) Board</td>
<td></td>
</tr>
</tbody>
</table>

Quarterly a report will be submitted to the Executive Committee and CHRISTUS Health SETX Board of Directors
concerning the number & type of individuals who have been reviewed.
and approved pursuant to this policy.

These time periods are to be deemed guidelines and are not directives such as to create any rights for a clinician to have an application processed within these precise periods.

Applicants will receive written notification of any final action on the application, including any reason for denial or restriction of the scope of duties requested.

5. Term of Appointment/Reappointment

5.1 Term. An appointment to the SPP staff shall be for a maximum of two (2) years and may be terminated by the Administrator at any time with or without cause.

5.2 Application for Reappointment. An individual may apply for reappointment and shall follow the procedure set forth in #4 above. All appointments and reappointments confer absolutely no vested rights, nor any right to reappointment. In no event shall a SPP staff member or applicant to the SPP staff have recourse to any procedural rights set forth in the Medical and Dental Staff Bylaws.

5.3 Reappointment Review. The reappointment review will include a review of all aspects of performance including clinical care and interpersonal relations with patients, staff and physicians. These reviews will be considered by the appropriate Medical Director, and reported to the Chief Executive Officer, the Executive Committee and the Board. The Board will have the authority to extend the individual's privileges for another two years based on a favorable review.

6. Obligations.

A SPP staff member must:

1) abide by the Bylaws, and the Hospital Bylaws and policies
2) prepare and promptly complete medical records in accord with applicable rules
3) conform to the ethical standards of his or her profession and in accordance with the mission and philosophy of Jasper Memorial Hospital.
4) provide care to medically indigent patients at the Administrator's request, and
5) participate in quality assessment activities.
6) will introduce themselves to patients as an assistant to the clinician.

7. Disciplinary Action: Suspension, Modification, or Termination of Permission to Provide Services.

7.1 Appointment Not a Right. SPP appointment and scopes of service are not a right. To that end, any individual who provides services beyond the scope of his/her duties or conducts him or herself in a manner that is contrary to hospital policy, ethical behavior or compromises patient care in any manner can have his or her privileges revoked.

7.2 Reporting SPPs. An infraction which would cause concern shall be documented and reported on the appropriate form and submitted to the administrative director of the area in which the individual serves. This Report will be forwarded by the administrative director to the Chief Executive Officer of the hospital for action. Additionally, this information will be provided to the Medical Director and the Chief of Staff so the individual's responsible physician can be notified or counseled, as deemed appropriate by the Chief of Staff. The Chief Executive Officer will take such action as deemed appropriate up to and including permanent revocation of appointment and services.

7.3 Subject to Discipline. Each Specified Professional Personnel may be subject to discipline and corrective action, and his or her permission to provide services may be suspended, modified, or terminated. (Note: in such cases, a conference will generally be conducted with the employing/responsible clinician).
7.4 **Suspension/Termination of Employing/Contracting Clinician.** If the appointment or privileges of the employing/responsible clinician are suspended or terminated, the Specified Professional Personnel’s permission to provide services will also be suspended or terminated. If the appointment or privileges of the employing/responsible clinician are suspended or terminated, the Specified Professional Personnel’s permission to provide services will also be suspended or terminated and the Specified Professional Personnel will be so notified.

If the employment/sponsoring relationship between the responsible clinician and the Specified Professional Personnel is terminated, the Specified Professional Personnel and the physician will provide written notice to the hospital that the relationship no longer exists. Once this notification is received, the Specified Professional Personnel will be notified, in writing that the Specified Professional Personnel membership and scope of duties no longer exists.

7.5.1 **Procedural Rights.** When a Specified Professional Personnel receives written notification that his/her application has been denied or restricted, or that his/her scope of duties has been suspended, modified, or terminated for reasons other than those specified in 8.4 above, the Specified Professional Personnel and the employing/responsible clinician will be offered an opportunity to appeal the action by conferencing with the Credentials Committee.

8. **Hospital Employees**

8.1 **Function as SPP Outside Regular Work Hours.** It is recognized that some employees may function as SPPs outside of their regular work hours. These individuals must follow the guidelines set forth in this policy and be credentialed in the usual manner to function in this capacity.

8.2 **Function as Employee During Regular Work Hours.** Individuals, during their regular hours of employment by Jasper Memorial Hospital, shall be governed by such hospital policies, manuals, and descriptions as may be established from time to time by the Chief Executive Officer or other appropriate designees.

8.3.1 **Involuntary Termination of Jasper Memorial Employee who also Functions as SPP Outside Regular Work Hours.** In the event an employee is involuntarily terminated from Jasper Memorial Hospital for cause, the appointment and scope of services afforded the individual as an SPP shall also be terminated, recognizing that termination of employment indicates significant concerns over the individual’s technical skills or personal interactions. There will be no right of appeal if the Specified Professional Personnel’s appointment and scope of service are terminated due to involuntary termination as a Jasper Memorial Employee.

9. **Amendments**

This Policy may be amended by the Board based on the recommendation of the Medical and Dental Staff. Proposed amendments shall be submitted to the Medical Staff Executive Committee for comment prior to the Board meeting and any member of the Medical and Dental Staff shall have the right to submit written comments to the Board regarding the same.

The Medical and Dental Staff Credentials Committee will review written requests for additional categories of professionals at least annually.

For the further implementation of this Board policy, policies and procedures may be created by Administration, upon recommendation of the Medical Executive Committee.

Approved:

07/31/03 – Approved by the board.
04/16/04 – Revised & approved by the board.
07/29/04 – Revised & approved by the board.
2/29/12 - Reviewed by MEC