PART III
CREDENTIALING PROCEDURES MANUAL AND POLICIES
of the
MEDICAL STAFF
of
CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM
ST. ELIZABETH & ST. MARY
BEAUMONT AND PORT ARTHUR, JEFFERSON COUNTY, TEXAS

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# CREDENTIALING PROCEDURES MANUAL
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PART 1

APPOINTMENT PROCEDURES

1.1 PREAPPLICATION

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

1.2 APPLICATION

The application must be in writing, signed by the applicant, and on such form as designated by the Executive Committee and approved by the Board. 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 its Sections and other clinical units, 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.

1.3 APPLICATION CONTENT

Every applicant must furnish information concerning the following items.

1.3.1 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.

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

1.3.3 A copy of specialty or subspecialty board certification, recertification and eligibility.

The below requirements and conditions regarding board certification shall not apply to Staff Members having clinical privileges at St. Elizabeth or St. Mary as of August 1, 2017 and who continuously remain a Staff Member.

On or after August 1, 2017, every initial applicant to the Staff must be board certified in the specialty and subspecialty for which privileges are requested. An exception shall be granted to new applicants who have successfully completed acceptable residency training prior to the initial application for medical staff at CHRISTUS Southeast Texas St. Elizabeth and St. Mary so long as the applicant is still within the initial period of board eligibility as prescribed by the relevant (sub) specialty board. It is the applicant's responsibility to provide proof that he/she is within the initial period of board eligibility. Acceptable training must be 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.
 Applicants who are granted privileges under this provision must become board certified by the end of the initial board eligible period.

A clinician that has been resigned from the staff due to incomplete medical records in accordance with medical staff rules and regulations #12 is exempt from the above qualifications if reapplication is made within 90 days. (Original on staff date will not change.)

Failure to become Board Certified within the time period stated shall result in automatic termination from the Medical Staff. Clinicians who resign within the time periods stated without achieving specialty board certification, will not be eligible to reapply until board certified. Clinicians who are terminated for failure to obtain board certification within the time periods stated shall not be eligible to reapply to the Medical Staff until they have attained board certification in the specialty and subspecialty area for the clinical privileges requested.

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.

1.3.4 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 institutionalizations 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.

1.3.5 The nature and specifics of any pending or completed action involving denial, revocation, suspension, reduction, limitation, probation, non-renewal 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.

1.3.6 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.

1.3.7 Section assignment, staff category, and specific clinical privileges requested.

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

1.3.9 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

1.3.10 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.

1.4 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.

1.5 EFFECT OF APPLICATION

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

1.5.1 attests to the correctness and completeness of all information furnished;
1.5.2 signifies willingness to appear for interviews in connection with his application;
1.5.3 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;
1.5.4 agrees to maintain an ethical practice and to provide continuous care to his/her patients;
1.5.5 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.
1.5.6 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.
1.5.7 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 designee; 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.

1.6 PROCESSING THE APPLICATION

1.6.1 Applicant's Burden: The applicant has the burden of producing adequate information for a proper evaluation of 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. An application shall be deemed complete if all required information is furnished by the applicant within ninety (90) days following the date noted on the dated application form initially provided to the applicant. During this ninety-(90) day period, the Credentials 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.

1.6.2 Verification of Information: The application is submitted to the Administrator or designee. The Administrator or designee 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 or designee notifies the President of the Staff and the Chairperson of the Credentials Committee of that fact and transmits the application and all supporting materials to the Chairperson of each Section in which the applicant seeks privileges.

1.6.3 Application Misstatements or Omissions: Any significant misstatements in or omissions from an application constitutes cause for denial of appointment or cause for summary dismissal from the medical staff.

1.6.4 Expediting Applications for Initial Appointment and Reappointment

Purpose: To provide for a categorization system for processing applications for Initial Appointment and Reappointment and/or modification of privileges that will facilitate the appointment process in applications meeting defined criteria.

Definitions:

A. Track 1 Initial Application (T1Initial App)

The application meets all of the following criteria:

1. The application has been deemed complete and all required components verified as indicated on the "Appointment Checklist".

2. The applicant has requested privileges consistent with the privileges as defined for that specialty.

3. There are no suggestions or unexplained indications in the verified materials of potential problems and no current or prior disciplinary actions, licensure restrictions, or any type of unresolved investigations or issues with Health Status.

B. Track 2 Initial Application (T2 Initial App)

The application meets any one of the following criteria:

1. The applicant's competency or training is not evident for privileges requested.

2. The NPDB Report contains disciplinary action OR malpractice settlements which are not explained satisfactorily in the appointment application.

3. There is a current challenge or a previously successful challenge to licensure or registration

4. The applicant has received an involuntary termination of medical Staff membership at another organization.

5. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.

6. A Track 1 application in which any of the recommendations of the Section Chairperson, the Credentials Committee Chairperson or the Executive Committee vary or the recommendations are adverse or with limitation.

C. Track 1 Reappointment/Conclusion of Provisional Period Application (T1Reapp)

1. The application has been deemed complete and all required components verified as indicated on the "Appointment Checklist".

2. The applicant has not requested privileges consistent with the privileges as defined for that specialty.

3. There are no suggestions or unexplained indications in the materials (obtained and/or verified) of unresolved potential problems and no current or prior disciplinary actions, licensure restrictions, or any type of investigations or issues with Health Status.
D. Track 2 Reappointment/Conclusion of Provisional Period Application (T2 Reapp)

The application meets any one of the following criteria:

1. The applicant’s competency or training is not evident for privileges requested.
2. The NPDB Report contains disciplinary action not previously reported OR malpractice settlements which are not explained satisfactorily in the reappointment application.
3. The Assessment and Report Form contains information relative to unresolved potential problems, i.e., issues with Health Status, medical records completion, lack of clinical activity, performance improvement activity as compared to aggregate information is significantly outside the norm.
4. There is a current challenge or a previously successful challenge to licensure or registration
5. The applicant has received an involuntary termination of medical Staff membership at another organization.
6. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.
7. A Track 1 reapplication in which any of the recommendations of the Section Chairperson, the Credentials Committee Chairperson or the Executive Committee vary or the recommendations are adverse or with limitation.

Procedure:

1. At such time as the application or reapplication is deemed complete it will be classified as a Track 1 or Track 2 as defined above.

2. Applications classified as Track 1 (Appointment or Reappointment) will proceed as follows:
   a. Section Chairperson/Credentials Chairperson Review – The application will be presented to the applicable Section Chairperson for review. Following a favorable evaluation by the Section Chairperson, by authority of the Credentials Committee, the Chairperson of the Credentials Committee, acting on behalf of the Credentials Committee is empowered to review the application and make a recommendation. If the recommendation is favorable, the application will be forwarded to the Executive Committee Chairperson. An informational report to the Credentials Committee will be made at its next regularly scheduled meeting.
   b. Medical Executive Committee Review – The application will be presented to the Executive Committee Chairperson for review. Following a favorable evaluation by the Executive Committee Chairperson, the application will be forwarded to the Administrator.
   c. Administrator Action – The Administrator, upon favorable recommendations as outlined above, may grant temporary privileges, not to exceed 120 days, pending action by the full Medical Executive Committee and Executive Committee of the CHRISTUS Health SETX Board of Directors or by the full CHRISTUS Health SETX Board of Directors.
   d. Executive Committee of the CHRISTUS Health SETX Board of Directors Action – Upon favorable recommendation by the full Medical Executive Committee, the Executive Committee of the Board, acting on behalf of the board may review the application and, upon favorable evaluation, grant appointment to the Medical Staff and the requested clinical privileges. An informational report will be made to the Board at its next regularly scheduled meeting.

3. Applications classified as Track 2 (Appointment or Reappointment), following evaluation by the Section Chairperson will proceed to the Credentials Committee, Executive Committee and the Board in accordance with provisions in the Credentialing Procedures Manual (i.e., full committee review).

1.6.5. Section Action: The Chairperson of each Section, and/or designee, in which the applicant seeks privileges reviews the application and its supporting documentation and forwards to the Credentials Committee a written report evaluating the evidence of the applicant’s training, experience and demonstrated ability and stating how the applicant’s skills are
expected to contribute to the clinical activities of the Section. This report shall state the Section Chairperson’s recommendation as to approval or denial of, and any special limitations on, Staff appointment, category of Staff membership and prerogatives, Section affiliation, and scope of clinical privileges.

A Section Chairperson may, at his/her discretion, and shall, at the request of the Executive Committee, conduct an interview with the applicant. If a Section Chairperson requires further information about an applicant, he/she may defer transmitting a report but the deferral time must not exceed 30 days. In case of a deferral, the applicable Chairperson must notify the applicant, the President of the Staff and the Administrator in writing of the deferral and the grounds. If the applicant is to provide the additional information required, the notice must contain a specific request to him/her for the same.

1.6.6 Credentials Committee Action: The Credentials Committee reviews the application, the supporting documentation, the reports from the Section Chairperson and any other relevant information available to it, including any submitted by a Staff member. The Credentials Committee may in its discretion, and shall upon request by the Executive Committee, conduct an interview with the applicant. The Credentials Committee then transmits to the Executive Committee its written report and recommendations as to approval or denial of and any special limitations on, Staff appointment, category of Staff membership and prerogatives, Section affiliation, and scope of clinical privileges. If the Credentials Committee requires further information about an applicant, it may defer transmitting its report but for no more than 30 days, and it must notify the applicant, the President of the Staff and the Administrator in writing of the deferral and the grounds. If the applicant is to provide the additional information required, the notice must contain a specific request to him/her for the same.

1.6.7 Executive Committee Action: The Executive Committee, at its next regular meeting, reviews the application, the supporting documentation, the reports and recommendations from the Section Chairpersons and Credentials Committee, 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 limitations on, Staff appointment category of Section/Staff membership and prerogatives, Section affiliation, and scope of clinical privileges.

1.6.8 Effect of Executive Committee Action: Upon receipt of the recommendation of the Credentials Committee, the Executive Committee shall, with respect to each applicant, records its approval, disapproval or modification of the recommendation of the Credentials Committee and, thereupon, forward to the Board each application together with the recommendation of the Credentials Committee and a record of its own action with respect to each application.

1) Adverse Recommendation: See Article 9.2.3 of the Bylaws. When the Executive Committee’s recommendation is adverse to the applicant, the President immediately so informs the applicant by special notice, and he is then entitled to the procedural rights as provided in the Staff Bylaws. An “adverse recommendation” by the Executive Committee is defined as a recommendation to deny appointment, requested Staff category, requested Section assignment, or to deny or restrict requested clinical privileges.

1.6.9 Board Action: The Board shall consider each application together with the recommendation of the Credentials Committee and the action of the Executive Committee. The Board shall, thereupon act upon the application at its next regular meeting and direct the administrator to notify the applicant, the Executive Committee and the Credentials Committee of the action taken.

1) Adverse Board Action: See Article 9.2.3 of the Bylaws. “Adverse action” by the Board means action to deny appointment, requested staff category, requested Section assignment, or to deny or restrict requested clinical privileges.

1.6.10 Notice of Final Decision:

1) Notice of the Board’s final decision is given through the Administrator to the applicant within 10 business days of the Board’s action.
2) A decision and notice to appoint includes (1) the Staff category to which the applicant is appointed; (2) the Section to which the applicant is assigned; (3) the clinical privileges the applicant may exercise; and (4) any special conditions attached to the appointment.

3) 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.

1.6.11 Customary Processing Time: 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.

1.6.12 Reappplication After Adverse Decision: An applicant who has received a final adverse decision regarding appointment, Staff category, Section assignment or clinical privileges or whose privileges were terminated in accordance with Article 8.4 of the Bylaws is not eligible to reapply to the Medical Staff or for the denied category, Section or privileges for a period of twelve (12) months. Any such reappplication 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 reappplication will be considered incomplete and will not be further processed.

1.6.13 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 of expiration of a Staff Member's appointment, the Administrator or designee notifies him/her of impending expiration. The member furnishes in writing:

(a) complete information to update his/her file on the items listed in Section 1.3 of this Manual;
(b) specific request for the clinical privileges sought on reapppointment, with any basis for changes;
(c) requests for changes in Staff category and Section assignments.

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 1.6.

The Administrator or designee 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 Chairperson of the Credentials Committee collects for each Staff Member's credentials file all relevant information regarding the individual's professional performance and conduct in this Hospital. Such information includes, but is not limited to: patterns of care as demonstrated in the findings of quality improvement and utilization assessment activities; patient care load maintained at this Hospital; service as a Staff officer and on Staff, Section, 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/her 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 SECTION ACTION

Each Chairperson of the Section and/or designee in which the Staff Member requests or has exercised privileges reviews the member’s file and forwards to the Credentials Committee a written report, including a statement as to whether or not he/she knows of, or has observed or been informed of any conduct which indicates significant present or potential health problems affecting the clinician’s ability to perform professional and Medical Staff duties appropriately and with recommendations for reappointment or non-reappointment and for Staff category, Section assignment, and clinical privileges.

2.3 CREDENTIALS COMMITTEE ACTION

The Credentials Committee reviews the member’s file, the Section Chairperson’s report, and all other relevant information available to it and forwards to the Executive Committee, a written report with recommendations for reappointment or non-reappointment and for Staff category, Section assignment, and clinical privileges.

2.4 EXECUTIVE COMMITTEE ACTION

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

2.5 FINAL PROCESSING AND BOARD ACTION

Final processing of reappointments follows the procedure set forth in Sections 1.6. 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".

2.6 BASIS 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.

2.7 CUSTOMARY PROCESSING TIME

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.
2.8 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 Staff category, Section assignment, or clinical privileges by submitting a written application to the Administrator or designee on the prescribed form. A modification application is processed in a manner similar to that provided in Section 1.

2.8.1 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. Additional Leave of Absence requests may be granted at the discretion of the Executive Committee and the Board.

2.8.2 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 privileges and prerogatives by submitting a written notice to that effect to the Executive Committee. The Staff Member shall submit a written summary of relevant activities during the leave. The Medical Staff Office shall provide the Staff member with an application and the request shall be processed in the same manner as a request for reappointment. The Executive Committee shall make a recommendation to the Board concerning the reinstatement of the member's privileges. A clinician is entitled to the procedural rights provided in the Staff Bylaws 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
PROVISIONAL PERIOD

3.1 CONCLUSION OF PROVISIONAL PERIOD

3.1.1 Evaluation/Assessment: 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 Section Chairperson 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 Section Chairperson’s signature on the Evaluation/Assessment Report.

3.1.2 Extension of Provisional Period: 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.

3.1.3 Action Required: The Credentials 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 Executive Committee. Final processing follows the procedures set forth in Part 1 of this Manual. For purposes of concluding the provisional period, an "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 Staff category assignments without the clinician's consent; or to deny or restrict requested clinical 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 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.

3.3 PROCEDURAL RIGHTS WHEN PERIOD EXPIRES

Whenever a provisional period expires without favorable conclusion for the clinician the Staff President will provide him/her with special notice of the adverse result and of 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 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 CHRISTUS Health SETX Board by the Executive Committee in accordance with the Medical Staff Bylaws on February 24, 2005.

6.1.2 CHRISTUS Health SETX Board: This Credentialing Procedures Manual was approved and adopted by resolution of the CHRISTUS Health SETX Board after considering the Executive Committee’s recommendation and in accordance with the Hospital Corporate Bylaws on April 14, 2005.

6.2 AMENDMENT

This Credentialing Procedures Manual may be amended and repealed by a resolution of the Executive Committee recommended to and adopted by the Board.
CREDENTIALING PROCEDURES MANUAL HISTORY

2007
1.3.10 Application Content. Revised to require picture hospital ID or state or federal agency issued ID. Approved January 18, 2007.
2.8.1 Leave of Absence. Additional LOA time beyond the maximum of twelve months are at the discretion of MEC and Board of Directors. Approved January 18, 2007.

2008
1.3.3 Board Certification Requirements. Amended to create an exception in the requirement for a medical staff member who has been resigned from the staff due to incomplete medical records (Medical Staff Rule & Reg 12) if reapplication is made within 90 days and to allow the Medical Staff member to retain the original on staff date. Approved April 24, 2008.
2.1.3 Insufficient Utilization. Amended to all the Credentials Committee on a case by case basis to accept a recommendation from the section chair and one other peer familiar with the applicant’s practice to attest to clinical ability and judgment in lieu of clinical activity. Approved July 24, 2008.

2010
Reviewed with no changes made.

2011
Reviewed with references to the Fair Hearing Plan deleted.

2012
Section 1.6.11. Changed from 20 days to 10 days to be in compliance with URAC requirements. Added new applicants shall complete the on-line physician orientation.
Section 2.1.3 Insufficient Utilization. Revised to state if staff member has not treated any patients during the two year reappointment period, staff member shall be moved to affiliate staff category

2013
Revised Section 1.3.3, Section 2B, Board Certification, removing requirement that members must complete the certifying exam after two consecutive times it is offered.

2015
Revised Professional Behavior Guidelines replacing any references to “disruptive behavior” to “behavior that undermines the culture of safety”.

2017
Revised Section 1.6.2 to remove Federation of State Medical Boards and Section 1.6.3 as names of applicants are no longer posted.
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.
Excellence: High standards of service and performance.
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 ST. ELIZABETH & ST. MARY 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 ST. ELIZABETH & ST. MARY 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 policies

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; 4/2017
HOSPITAL POLICY REGARDING CLINICAL PRIVILEGES IN LIGHT OF ILLNESS OR LIMITATION

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

1. Statement of Purpose
It is the policy of the Medical Staff and Hospital to be sensitive to a Staff Member’s health or condition that may adversely affect that Staff Member’s ability to provide safe, competent care to patients. It is further the policy of the Medical Staff and Hospital to structure the clinical privileges of Staff Members whose abilities are diminished due to illness or other limitation in the least restrictive way possible, with the primary concern being quality patient care.

2. Effect of the Policy
To effectuate that Policy, the Hospital hereby recognizes the Medical Staff’s formation of a Physician Health Committee, organized in accordance with the Bylaws (which may be an ad hoc committee) and approved by the Board, to address concerns that Staff Member’s health or limitations may affect patient care and to work with any Staff Member whose abilities are diminished due to illness or other limitation, and to structure his or her clinical privileges appropriately. The President of the Staff or the Chief Executive Officer will refer matters of concern to the Quality Council who will act as the Physician Health Committee according to procedures detailed hereunder and, further, will publicize the existence of the Physician Health Committee and the advisory nature of its work.

3. Patient Care is Dominant
Patient care concerns are paramount. In the event that a Staff Member’s condition is such that safe, competent practice is no longer possible, the Physician Health Committee will facilitate the work of the appropriate committees to limit, suspend or terminate the practitioner’s clinical privileges. The Hospital will make timely reports in those circumstances in which reporting is required by law.

4. Referrals to the Physician Health Committee
The Credentials Committee, Hospital management, the Board, or any individual who has a concern that a Staff Member’s health or condition may be affecting or could affect his or her ability to safely and competently practice in the Hospital shall refer the matter to the Physician Health Committee. Any referral should be in writing and outline the nature of the concerns and the specific incidents which gave rise to them. To encourage reporting, the identity of any person who reports a Staff Member who may be possibly impaired will be kept confidential, unless otherwise required for legal reasons, including the Staff Member’s receipt of a hearing and appeal.

5. Reports to State Agencies
As required by law, the Hospital will report the following:
   a. Any action that adversely affects a Staff Member’s clinical privileges for a period exceeding 30 days;
   b. If the Hospital accepts the surrender of a Staff Member’s clinical privileges while the Staff Member is under investigation by a Medical Peer Review Committee relating to possible incompetence or improper professional conduct; or
   c. If the Hospital accepts the surrender of Staff Member’s clinical privileges in return for not conducting such an investigation or proceeding.

6. Patient Notification
Staff Members who perform exposure-prone procedures should know their HIV status and if not immunity to Hepatitis B, their HbsAg status. Staff Members who are infected with HIV or HBV may perform an exposure prone procedure only if they have sought counsel and direction from an Expert Review Panel as outlined in Texas Health & Safety Code 85:201-206. Proceedings and communications will be confidential and comply with chapter 81. Expert review panel may be accessed through the President of the Staff or Chairperson of the Clinical Services Committee. In compliance with the laws of Texas, the Hospital will not disclose
the identity of the Staff Member, or any information that could lead to the discovery of the Staff Member’s identity, should the Expert Review Panel conclude that a Staff Member with HIV seropositive status, active Hepatitis B infection, or other potential blood born virus performed an exposure-prone procedure, as defined by state and federal law, on a patient. The patient notification letter will inform the patient that she or he may have been exposed to the particular communicable disease by a health care worker during a Hospital procedure or stay and recommend that they be tested for whichever infectious agent to which they may have been exposed.

Approved by: Medical Executive Committee: 10/29/97    Local Governing Body: 12/97  Reviewed: 7/03 Revised 7/04;
Reviewed: 7/08
Reviewed: 3/2010
Reviewed: 1/2011
CHRISTUS SOUTHEAST TEXAS ST. ELIZABETH & ST. MARY
HOSPITAL POLICY REGARDING SEXUAL HARASSMENT BY STAFF MEMBERS

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

WHEREAS, it has been and is a policy of the Board, that sexual harassment of or by employees, patients, members of the Medical Staff, and others has no place, and will not be tolerated in this Hospital; and

WHEREAS, the Federal Equal Employment Opportunity Commission has declared that habitual harassment constitutes illegal discrimination under Title VIII of the Civil Rights Act of 1964 for which the employee may be held responsible even if the harassment is committed by a person who is not an employee of the Hospital;

NOW, THEREFORE, the Board restates it's policy that sexual harassment by a Staff Member will not be tolerated and hereby directs the Chief Executive Officer to see that appropriate steps are taken to communicate the Boards' intent, as expressed in this Policy, to the Hospital's Medical Staff. Specifically, the Chief Executive Officer shall insure that members of the Medical Staff are aware of the Hospital's Policy against sexual harassment, that adequate procedures are in effect to facilitate prompt reporting of specific acts of sexual harassment that may occur in the Hospital and that prompt action is taken on all complaints that are made.

It is also a violation of Policy for any person to retaliate against any employee, patient, Medical Staff member or other independent practitioner making a complaint about such harassment. Any person found to have violated the Hospital's Policy on harassment will be subject to appropriate disciplinary action such as reprimand, suspension or termination. The type of disciplinary action imposed will depend on the nature and severity of the offense and the surrounding circumstances.

I. General Definition of Sexual Harassment

Although this Policy covers all forms of harassment, Medical Staff Members should be aware of the several forms of sexual harassment to which this Policy is specifically addressed. Sexual harassment includes unwelcome sexual advances, request for sexual attention, and other verbal or physical conduct of a sexual nature where such contact has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile, or offensive work environment.

II. Procedure to Investigate a Complaint of Sexual Harassment by a Staff Member

If any individual working in the Hospital has observed or been the victim of Staff Member conduct that constitutes sexual harassment, the following steps should be taken:

a) A written variance report, co-signed by the individual's Supervisor, shall be filed with the Risk Management Department who will then forward the complaint to the Medical Director with a copy to the Chief Executive Officer and the President of the Medical Staff. The report shall include a factual description of the incident including any offensive language used. A Staff Member may file a written report about another Staff Member.

b) If, after a discussion with the individual(s) who filed the report by the President of the Staff, the Chief Executive Officer and the Medical Director, or their designee, it is found to constitute a credible report of conduct that constitutes sexual harassment, the Staff Member involved shall be required to meet with the Medical Director and the President of the Staff. The Staff Member shall be advised of the complaint(s) and be given an opportunity to respond. If, at the conclusion of that discussion, Hospital and Medical Staff leadership find that the reported act(s) did occur, the Staff Member shall be advised that such conduct is intolerable and in violation of federal and Hospital Policy.

c) The Staff Member, if deemed appropriate, should be given an opportunity to voluntarily cease the conduct which gave rise to the complaint.

d) If the Staff Member agrees to cease such conduct, the meeting shall be followed by a report to the appropriate Clinical Lead Team for review and to the Staff Member's confidential peer review file.
e) Any further complaint(s) of sexual harassment, after the Staff Member has agreed to cease the harassing conduct, shall result in a formal investigation by the Chief Executive Officer, President of the Staff, and Medical Director, or their designee. If the investigation results in a finding that the further sexual harassment took place, the President of the Staff may recommend to the Medical Executive Committee that the Staff Member be suspended for a given term or that his or her appointment be terminated, depending on the circumstance. However, prior to any formal action on the recommendation, the Staff Member shall be given formal notice of the charges and of his or her right to request a hearing pursuant to the Medical Staff Bylaws.

f) After good faith efforts by the Chief Executive Officer and the President of the Staff, the Staff Member refuses voluntarily to cease the conduct which gave rise to the complaint(s), the Staff Member may be formally suspended by the Chief Executive Officer, acting for the Board, for a defined period of time pursuant to the Medical Staff Bylaws. The Staff Member will be given formal notice of his or her rights to a hearing following such suspension in accordance with the Medical Staff Bylaws.

g) The matter shall be reported to the Medical Executive Committee along with a brief explanation of the circumstances.

Recommended and approved by:

Medical Executive Committee: 10/29/97
Local Governing Body: 12/97

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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 (2). 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 ST. ELIZABETH & ST. MARY (“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
I hereby request that Dr. ____________________ (clinician overseeing treatment) provide CHRISTUS SOUTHEAST TEXAS ST. ELIZABETH & ST. MARY ("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 FOR EMERGENCY CREDENTIALING CLINICIANS WHO ARE NOT MEMBERS OF THE HOSPITAL’S MEDICAL STAFF OR PRIVILEGED AT THIS FACILITY


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 ST. ELIZABETH & ST. MARY
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 ST. ELIZABETH & ST. MARY
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: ________________
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 to 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: October 28, 2010
Board: January 27, 2011

SOURCE: CHRISTUS Management Directive #0046
Conflict Management Toolkit, American Health Lawyers Association
MEDICAL STAFF
POLICY ON PROCTORING OR FOCUSED REVIEW

A. Section Assignment (MS Bylaws Article 11)

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

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

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 or consulting medical staff membership and privileges shall:

   a. Be proctored for the number of cases as determined by the respective section or 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 Credentials Committee or 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 Section Chair or 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 Credentials Committee or Medical Executive Committee by way of the Medical Staff Office in a timely manner.

2. Applicants for call coverage staff membership and privileges:

This practitioner’s primary practice site is at another facility where the practitioner is a member of the Active Staff in good standing. The practitioner only provides call coverage for designated physicians and does not perform elective cases nor take ER call. For the first 10 patient contacts a retrospective chart review will be performed.

3. 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 Credentials Committee or 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 Credentials Committee or 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 Credentials Committee or Medical Executive Committee may, after reviewing a recommendation from the Chairperson of the Section or Chief of Staff to which the physician was assigned:

   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 ST. ELIZABETH & ST. MARY, the physician shall be deemed to have voluntarily relinquished his or her appointment or clinical privileges.

   (Credentialing Procedures Manual 3.3)

E. Retrospective Evaluation (Medicine to include all medical specialties except Gastroenterology and Cardiology), Family Practice, Pediatrics, Pathology)

Retrospective evaluations shall consist of at least the following:

   a. Review of medical records of patients admitted or treated by the physician (number of records to be determined by the respective section. 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. 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;
c. Discussion with appointee about each of the cases, if indicated;
d. A written report of the evaluation shall be made to the Chairperson of the Section or Chief of Staff to which the appointee has been assigned, utilizing the Performance Evaluation Report Forms.

F. Prospective Evaluation (ED, Radiology)

Prospective evaluations shall consist of at least the following:

a. Evaluation of the care of patients that is to be delivered before the fact. (Number of records to be determined by the respective section. The requirement for retrospective evaluation begins immediately 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. 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;
c. Discussion with appointee about each of the cases, if indicated;
d. A written report of the evaluation shall be made to the Chairperson of the Section or Chief of Staff to which the appointee has been assigned, utilizing the Performance Evaluation Report Forms.

G. Concurrent Evaluation of Surgical or Other Invasive Procedures and of Diagnostic or Non-invasive Procedures (General Surgery to include all surgical subspecialties) Cardiology/Interventional Radiology/OB/GYN, Dental, Gastroenterology, Neonatology, Anesthesiology, Pathology/5 frozen Sections, Pain Management)

1. The concurrent evaluator is at all times acting on behalf of, and with the authority of, the hospital.

2. The concurrent evaluation of surgical or other invasive procedures shall consist of at least the following:
   a. Direct observation of the surgical or other invasive procedure being performed (number of procedures to be determined by the respective section. The requirement for concurrent evaluation begins immediately with the first patient seen and continues with each subsequent patient until the requirements are met.
   b. Discussion with the appointee about the procedure to be done and the indications for it, if indicated.
   c. A written report of the evaluation shall be made to the Chairperson of the Section or Chief of Staff to which the appointee has been assigned. The physician evaluator may visit the monitoring appointee’s patients in the hospital, review the physician’s orders and progress notes and discuss the patient’s course with the physician.

H. 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.

I. Section Chief’s, Credentials and Executive Committee’s Reports and Recommendations

1. If, at any time during the monitoring period, the Chairperson of the Section or Chief of Staff to which the physician
has been assigned determines that the physician is not competent to perform specific clinical privileges and his or her continued exercise of those privileges jeopardizes patient safety, the Section Chairperson or Chief of Staff shall report his or her findings and assessment to the Credentials Committee or Medical Executive Committee. The Credentials Committee or Chief of Staff shall then review the evaluator's reports and the medical records of the patient treated by the physician and shall make a recommendation regarding the appointee's continued appointment and clinical privileges. If necessary, the physician’s clinical privileges may be summarily suspended in the manner outlined in Medical Staff Bylaws and Credentialing Procedures Manual. The Credentials Committee or Chief of Staff’s recommendations shall be forwarded to the Executive Committee. The Executive Committee shall either adopt the Credentials Committee or Chief of Staff’s recommendation, or if it determines to make a recommendation different than the Credentials Committee or Chief of Staff’s, outline specific reasons for its disagreement. The Executive Committee’s recommendation is forwarded to the Board.

2. At the end of the monitoring period, the Chairperson of the Section or Chief of Staff shall report to the Credentials Committee or Medical Executive Committee:
   
   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.
   
   e. If sufficient treatment of patients has occurred to properly evaluate the clinical privileges being exercised, the Section Chairperson or Chief of Staff shall make a report to the Credentials Committee or Medical Executive Committee concerning the appointee’s qualifications and fitness for these clinical privileges. The Credentials Committee or Chief of Staff shall then make a recommendation to the Executive Committee. The Medical Executive Committee shall either adopt the Credentials Committee or Chief of Staff’s recommendation or, if it determines to make a recommendation different than the Credentials Committee or Chief of Staff, outline specific reasons for its disagreement. The Medical Executive Committee’s recommendation is forwarded to the Board.

J. 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
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

Purpose:
To assure that CHRISTUS SOUTHEAST TEXAS ST. ELIZABETH & ST. MARY 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 ST. ELIZABETH & ST. MARY and the Medical Staff at CHRISTUS SOUTHEAST TEXAS ST. ELIZABETH & ST. MARY 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 Multidisciplinary Peer Review Committee every 8 months and forwarded to the Credentials and/or Executive Committees 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 shared with 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.

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; 4/2017
DEFINITIONS:

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 SOUTHEAST TEXAS ST. ELIZABETH & ST. MARY shall provide safe and effective telemedicine services.

CHRISTUS SOUTHEAST TEXAS ST. ELIZABETH & ST. MARY 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 have granted privileges to the individual telemedicine physicians and practitioners providing telemedicine services to hospital patients, and the distant-site telemedicine physicians or practitioners must hold a license issued or recognized by the State where the hospital located.
  
  - 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 SOUTHEAST TEXAS ST. ELIZABETH & ST. MARY's medical staff shall use a copy of the distant site hospital or telemedicine entity’s credentialing packet for privileging purposes.

  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

APPROVAL: Credentials Committee, 8/27/2012
Medical Executive Committee, 8/30/2012
SETX Board, 10/25/2012
REVIEWED: 4/2015; 4/2017
1. Allied Health Professionals - General

The Board permits certain types of Allied Health Professional Staff (AHP) to provide patient care services at CHRISTUS Southeast Texas Health System - St. Elizabeth and St. Mary ("the Hospitals") without appointment to the Medical Staff. Such personnel must be qualified by academic and clinical or other training to provide services at the Hospitals. All individuals providing services shall be responsible to an Active Staff member of the Medical Staff, either through an employment agreement or a sponsorship arrangement. Allied Health Professional Staff personnel shall not be considered as licensed independent practitioners at the Hospitals. Allied Health Professional Staff personnel may provide services only as permitted in the Hospitals and in keeping with all applicable bylaws, rules, policies, and procedures of the Hospitals.

2. Allied Health Professionals

2.1 Special Qualifications. Allied Health Professionals must be individuals who:

(1) are directly supervised by, and affiliated with, an Active Staff member of the Medical Staff;
(2) hold a license, certificate or other legal credential if required by state law, or can otherwise document adequate training for the professional activity;
(3) maintain professional liability insurance coverage in the amounts of $100,000/$300,000;
(4) document their experience, background, training, demonstrated ability, and physical and mental health status with sufficient adequacy to demonstrate that they can perform the duties and prerogatives they request at a generally recognized professional level of quality; and
(5) are determined, on the basis of documented references and their own declarations, to adhere strictly to the ethics of their respective professions, as applicable, and to work cooperatively with others.

2.2 Categories. Allied Health Professionals shall be divided into two categories. They are as follows:

(1) Privileged Allied Health Advanced Professionals shall consist of Physician Assistants, Advanced Practice Registered Nurses, and Residents.

(2) Non-Privileged Health Professionals shall consist of Registered Nurses, Licensed Vocational Nurses, Medical Assistants, Certified Podiatric Assistants, Dental Assistants, Surgical Assistants, Surgical Technicians, Ophthalmic Assistants, Audiologists, Prosthetists, Orthotists, and neurological monitoring technicians.

2.3 Duties and Prerogatives. Allied Health Professionals provide specified patient care services under the supervision or direction of an Active Staff physician member of the Staff, consistent with the limitations stated in the specification of services. Scope of practice determinations for all categories will be developed by the Credentials Committee and approved by the Medical Executive Committee and the Board.

2.4 Responsibilities. Each Allied Health Professional shall retain appropriate responsibility within his or her area of professional competence for each patient in the Hospital for whom he or she is providing services, or arrange a suitable alternative for such care and supervision, which arrangements for alternate coverage must be made by or through the supervising physician member of the Medical Staff who has ultimate responsibility for the patient's medical care. Allied Health Professionals shall conform to appropriate standards of conduct within the Hospital, and abide by
such directives as may be from time to time issued by the Board.

2.5 Status. The Medical Staff and Board consider all Allied Health Professional Staff as dependent staff regardless of the scope of duties or privileges granted. Each Allied Health Professional must be responsible to a member of the Medical Staff, either through an employment agreement or a sponsorship arrangement.

2.6 Need for Additional Categories of Allied Health Professional Staff. The Board may approve other types of categories on the basis of hospital need considering the availability of equipment, supplies, and providing support services, availability of trained staff, quality of care issues, patient convenience, and the legitimate business and patient care objectives of the organization.

3. Procedure for Appointment

3.1 Application. A person desiring membership on the Allied Health Professional Staff, or a medical staff member who desires to utilize an Allied Health Professional, shall submit an application in writing, on a form or forms provided by the Hospital.

3.2 Required Information. It is the applicant’s responsibility to provide all documentation necessary to complete an application. No application will be deemed completed without the following:
  • A completed and signed application form;
  • A request to provide services;
  • A copy of a current state license (if applicable);
  • A copy of a photo identification card (i.e. driver’s license);
  • A certificate of insurance providing evidence of professional liability insurance that covers them while working in the hospital in amounts of $100,000/$300,000.
  • Copies of certificates or letters confirming completion of training programs (if applicable) or other educational curricula; and
  • Payment of a non-refundable application fee of $100.

3.3 Completed Applications. Only completed applications shall be processed or considered. Any submitted application not deemed complete within 90 days shall be automatically deemed expired and inactive. The submission of false or inaccurate information shall be sufficient grounds for immediate rejection of an application.

3.4 Application Processing. Information will be collected as is deemed necessary to permit an adequate and complete evaluation of the individual’s request for permission to provide services and will seek to verify the following information contained within the application: education, license, work history for the prior 7 years, and criminal background history. In addition, three peer references will be requested (at least two of which are to be from individuals qualified in the same licensed field, if applicable). Applicants to the Allied Health Staff must complete health screening requirements per hospital policy for contract personnel and orientation prior to starting work. In order to accommodate out of area applicants, we will accept drug screens and TB from any facility if resulted recently from a JCAHO certified lab. Once the application is complete and verified, specified patient care services may be approved. In relation to Category 1 (privileged providers):

a. Advanced Practice Registered Nurses

   Once the application is complete and verified, privileges may be granted upon recommendation of the Chief Nurse Executive, the Credentials Committee, the Medical Executive Committee, and the Board.

b. Physician Assistants and Residents

   Once the application is complete and verified, privileges may be granted upon recommendation of the Credentials Committee, the Medical Executive Committee, and the Board.
4. **Burden of Proof.**

The applicant shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of training, experience, 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 information given and statements made on the application are true and correct.

5. **Burden of Updating Information.**

The applicant shall be required to inform the Hospital of any changes in the information provided in order to assure that all information in the application continues to be true and correct.

6. **Maintenance of Appointment**

   **Category (1)**

6.1 **Focused Professional Practice Evaluation (FPPE)** means a process whereby the privilege/procedure-specific competence of a AHP who does not have sufficient documented evidence of competently performing the requested privilege at the facility is evaluated. This process may also be used when a question arises regarding a currently privileged AHP’s ability to provide safe, quality patient care for which he or she possesses current privileges. FPPE is a time-limited period during which an organization evaluates and determines the AHP’s professional performance. This process shall apply to all initial applicants or existing members requesting additional privileges and shall be completed by the designated sponsor within six months. This review will be forwarded to the Credentials Committee, the Medical Executive Committee and the Board.

6.2 **Ongoing Professional Practice Evaluation (OPPE)** is the continuous evaluation of the AHP’s professional performance, rather than an episodic evaluation. It is intended to identify and resolve potential performance issues as soon as possible, as well as foster a more efficient, evidence-based privilege renewal process. Ongoing professional practice evaluation results will be shared with the AHP on a regular basis. The sponsoring physician will complete an evaluation every 6 months to include a review of charts and clinical activity if applicable. Results of the reviews will be forwarded to the Peer Review Committee. Any further action will be forwarded to the Credentials Committee, the Medical Executive Committee and the Board.

6.3 **Provisional Period.**

   **Applicability and Duration.** All new appointments to the Allied Health Professional Staff and all grants of initial clinical privileges to new appointees are provisional for a minimum period of six (6) months.

   **No Effect on Membership or Exercise of Privileges.** During a provisional period, a Staff Member must demonstrate all of the qualifications, may exercise all of the prerogatives, and must fulfill all of the obligations of the Staff category; and the Staff Member may exercise all of the privileges granted.

   **Purpose.** During the six month provisional period, the supervising physician will be responsible for overseeing a Staff Member’s performance and co-signing required medical record entries. Once the provisional period is satisfactorily completed, the supervising physician may petition for removal of the co-signature requirements. An extension of a provisional period does not entitle the Staff Member to any procedural due process rights.

6.4 **Biennial review (Category 1).** The biennial 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 conducted by the supervising physician and the Section Chairperson with input from peers, and approved by the Credentials Committee, Medical Executive Committee and the Board.
6.5 Annual review (Category 2). The annual 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 conducted by the supervising physician with input from peers, and approved by the Chief Executive Officer or designee.

**Burden of Updating Information**

6.6 Licenses / Insurance / Certifications. It shall be the responsibility of the Allied Health Professional to assure that the Hospital has a current copy of all license(s), certification(s) and certificates of insurance with appropriate coverage limits. Failure to provide these documents shall constitute cause for suspension of the Allied Health Professional’s permission to provide services.

The Allied Health Professional shall be required to inform the Hospital immediately of any changes in the information he or she has provided in order to assure that all information in the credentials file continues to be true and correct.

7. **Disciplinary Action**

7.1 Suspension/Termination of Employing/Contracting Clinician. If the appointment or privileges of the employing/responsible Staff member are suspended or terminated, or if the employment/sponsoring relationship between the Staff member and the Allied Health Professional Staff member is terminated, the Allied Health Professional personnel’s privileges or permission to provide services will also be suspended or terminated.

7.2 Enforcement. Any Allied Health Professional violating these rules and regulations will be subject to suspension or revocation of granted privileges or the permission to provide services. Any active Medical Staff member violating these rules and regulations will be subject to withdrawal of his or her privilege to sponsor or utilize an Allied Health Professional and to suspension or revocation of his or her hospital privileges.

7.3 Due Process. In no event shall an Allied Health Professional have recourse to any procedural rights set forth in the Medical Staff Bylaws. If, however, privileges or the permission to provide services are terminated with cause owing to the Allied Health Professional staff member (a) providing services beyond the granted scope of services, duties, or privileges or (b) conducting himself or herself in a manner that is contrary to hospital policy or ethical behavior or (c) compromising patient care in any manner, the Allied Health Professional may request a conference with the sponsoring physician and the CEO or designee.

8. **Amendments.**

This policy may be amended by the Board based on the recommendation of the Medical 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 Staff shall have the right to submit written comments to the Board regarding same.

APPROVAL: CHRISTUS Health SETX Board of Directors 4/14/05

**History of Allied Health Professional Policy**

2005: CHRISTUS Hospital Allied Health Professional Policy approved by the CHRISTUS Health SETX Board of Directors on April 14, 2005.

Addition to 3.4: Applicants to the Allied Health Staff must complete health screening requirements per hospital policy.
for contract personnel and orientation prior to starting work.
Revision to 3.4 a and b allows a representative of the Medical Executive Committee not on the Credentials Committee to act upon applications of an Advanced Practice Nurses and Physician Assistants. Approved by the CHRISTUS Health SETX Board of Directors on July 21, 2005.

2006: Revision to Section 6 (Maintenance of Appointment). 6.1 from biennial review to annual review. Approved by the CHRISTUS Health SETX Board of Directors on July 20, 2006.

2007: Revised to add Section 8 – Scientific Staff

2010: Revision to Section 2.2 and 3.4d to include residents

2011: Revisions to Section 2.2 (2); Section 2.3; Section 2.6; Section 3.4.a-d; and Section 6.2-6.4. Approved by the CHRISTUS Health SETX Board of Directors on October 27, 2011.

2013: Revision to add Section 6.3 – Provisional Period

2014: Revision to remove Scientific Staff category

2016: Revision to Section 3.4 to include: We will accept drug screens and TB from any facility if resulted recently from a JCAHO certified lab. Updated sections referring to Human Resources processes.

Added new hospital logo.