CHRISTUS MOTHER FRANCES Hospital

CHRISTUS MOTHER FRANCES HOSPITAL – TYLER ALLIED HEALTH PROFESSIONALS MANUAL

AMENDED MAY 2017

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PREAMBLE

CHRISTUS Mother Frances Hospital recognizes the broad spectrum of patient services necessary to provide quality health care. Such services include those of duly authorized members of the Medical Staff and those of allied health professionals, who are not members of the Medical Staff. To provide quality health care, this Allied Health Professionals Manual (the "Manual") describes the minimum eligibility criteria for appointment and reappointment for allied health professionals, delineates the privileges for Advanced Practice Clinician (APC), defines the authorized scope of service for dependent allied health professionals, addresses corrective action and provides the mechanism for a right to review for all allied health professionals. CHRISTUS Mother Frances Hospital hereby formulates this Manual subject to the approval of its Governing Board.

DEFINITIONS

The words and phrases herein have the following meanings whenever used in this Manual, unless the context requires otherwise.

Administration or *Administrator* refers to the President, the President's designee, Chief Executive Officer (CEO) or the CEO's designee, who is responsible for managing the day-to-day operations of the Hospital.

Advanced Practice Clinician (APC) means a licensed mid-level practitioner who is licensed, registered, certified and/or authorized to provide health care services in the State of Texas by the applicable licensing or accrediting authority and is identified in Appendix A to this Manual. The terms also refer to licensed mid-level practitioners who may or may not be employed by the Hospital or clinic; however, those licensed mid-level practitioners with privileges at the Hospital and its clinics may exercise privileges with a Sponsoring Medical Staff Member with patient co-management responsibilities.

Adverse Action means a professional review activity resulting in the denial of membership, restriction, reduction, suspension or revocation of the Allied Health Professional's ability to exercise scope of practice and/or to act within the authorized scope of service at the Hospital.

Allied Health Professional or *AHP* means an Advanced Practice Clinician (APC) or Dependent Allied Health Professional.

Allied Health Staff means an Allied Health Professional who has been granted the ability to exercise scope of practice or to act within the authorized scope of service at the Hospital.

Appointment and *Reappointment* refer to the process specified herein by which an Allied Health Professional acquires and retains the right to exercise delineated scope of practice or to act within the authorized scope of service.

Bylaws means the Medical Staff Bylaws of CHRISTUS Mother Frances Hospital.

Section Head means the section head leader of a clinical section.

Department Chair means the medical staff leader or the clinical department head of a clinical department.

Scope of practice means the permission granted to an Advanced Practice Clinician (APC) as recommended by the Credentials Committee and Medical Executive Committee and approved by the Governing Board to provide specific professional, diagnostic, therapeutic, medical, or surgical services and procedures at the Hospital.

Day means calendar day.

Sponsoring Medical Staff Member means a member of the Medical Staff of the Hospital who delegates the performance of medical acts, supervises and/or directs the Allied Health Professional by virtue of law, Hospital policy, and/or terms of the AHP's appointment to practice in the Hospital. A Sponsoring Medical Staff Member shall not supervise/delegate any procedure or patient care service that the Sponsoring Medical Staff Member is not duly authorized by the Hospital to perform.

Department or Section means a division of the Medical Staff composed of members who practice a similar specialty.

Dependent Allied Health Professional or *Dependent AHP* is identified in Appendix A to this Manual. The terms also refer to health care professionals other than physicians and APCs who may or may not be employed by the Hospital or clinic and may hold a certificate, license or other authorization under state law. These professionals work under the close supervision of a Sponsoring Medical Staff Member.

Executive Committee means the executive committee of the Medical Staff unless specific reference is made to the executive committee of the Governing Board.

Ex Officio means one who serves as a resource person by virtue of an office or position held, but without voting privileges.

Governing Board means the governing body of the Hospital.

He or His as used in these Bylaws refers to both genders. The use of a masculine pronoun is not intended to express an opinion about the gender of the allied health professionals governed by this Manual.

Hospital means CHRISTUS Mother Frances Hospital located in Tyler, Texas.

Licensed Independent Practitioner or *Professional Member* means any individual who is a graduate of an approved medical, dental or podiatry school and holds a current, unrestricted valid license to practice medicine, podiatry or dentistry in the State of Texas.

Manual means this Allied Health Professionals Manual.

Medical Staff means an organized group of health care professionals who have been granted appointment to the Medical Staff by the Governing Board.

Medical Staff Member means, unless otherwise stated, a Licensed Independent Practitioner or Professional Member, who is appointed by the Governing Board as a member of the Medical Staff of the Hospital.

Peer means a practitioner of like license, similar and/or related experience.

Physician means any Medical Staff Member licensed to practice medicine in the State of Texas by the state licensing authority.

Professional review action pertains to any good faith activity by a professional review body duly authorized by this Manual, in the furtherance of quality health care, which is taken based on the competence or professional conduct of an Allied Health Professional that affects or may affect the Allied Health Professional's delineated scope of practice or authorized scope of service.

Professional review activity means activities undertaken in determining whether an Allied Health Professional may be granted scope of practice in this Hospital, determining the conditions of such scope of practice, or changing or modifying such scope of practice.

Professional or peer review body means this Hospital and the Governing Board or any committee of the Hospital, which conducts professional review activities, and includes any committee of the Medical Staff when assisting the Governing Board in a professional review activity.

Rules and Regulations mean the Medical Staff Rules and Regulations of CHRISTUS Mother Frances Hospital.

Scope of practice means the authorized scope of service granted to a Dependent Allied Health Professional and Advanced Practice Clinician (APC).

Year means twelve (12) consecutive months.

FPPE is defined as Focused Professional Practice Evaluation.

Article I APPOINTMENT AND REAPPOINTMENT

1.1 General

(a) Except as otherwise specified herein, no AHP shall exercise scope of practice in the Hospital or perform a scope of service unless and until the AHP applies for and receives delineated scope of practice and/or authorized scope of service in accordance with this Manual. Appointment to the Allied Health Staff shall confer on the AHP only such scope of practice and/or scope of service as have been granted in accordance with this Manual. Each AHP shall individually be assigned to an appropriate clinical service and carry out his activities subject to services policies and procedures and in conformity with the Medical Staff Bylaws, Rules and Regulations and Hospital policies.

(b) An APC shall function within the parameters set forth in the Medical Staff Bylaws, Rules and Regulations, and Hospital policies. An APC shall operate in the area of specialty of the Sponsoring Medical Staff Member. An APC may not serve as a substitute for the Sponsoring Medical Staff Member.

(c) A Dependent AHP may function only as an aide to a Sponsoring Medical Staff Member in the area of specialty of that Sponsoring Medical Staff Member. A Dependent AHP may not serve as a substitute for the Sponsoring Medical Staff Member under any circumstances. A Dependent AHP may perform duties that do not require the exercise of independent medical judgment as assigned by Sponsoring Medical Staff Member who is responsible for the performance of such tasks and who retains direct control and supervision over them.

1.2 Burden of Producing Information

Any application for appointment or reappointment or change in scope of practice or scope of service shall be deemed complete only when the Hospital, including any committees, received all information required to be produced or otherwise requested from the AHP. The AHP has the burden of timely producing all information supporting the AHP's qualifications and suitability for the scope of practice or scope of service requested and resolving any doubts about these matters. The AHP's failure to sustain this burden within the time frame specified by the Medical Staff services office, Credentials Committee or Medical Executive Committee (MEC) shall result in the immediate withdrawal of the application without further processing or consideration.

Submitting any false information on the application for appointment or reappointment for Allied Health Staff membership and privileges or scope of service may result in the immediate withdrawal of the application without further processing or consideration and may thereafter disqualify the AHP from Allied Health Staff membership or reapplication at any time in the future. Submitting false information includes the omission of material true information or submission of untrue information.

1.3 Appointment Authority

The Governing Board retains the ultimate authority in deciding all Allied Health Staff appointments and reappointments based on the recommendations of the Credentials Committee, MEC, and other committees involved in credentialing and privileging.

1.4 Term of Appointment

Appointment or reappointment to the Allied Health Staff shall be for any period of time up to two (2) years as determined by the Governing Board.

1.5 Application for Initial Appointment

The AHP shall receive an application packet with instructions for completing the application, notification of supporting documents needed, and copies of this Manual, the Bylaws, Rules and Regulations and other applicable policies relating to clinical practice in the Hospital. The AHP shall submit a completed and signed application on the prescribed form (or accompanied by an explanation of why answers are unavailable) with a non-refundable application fee as specified by the Hospital. Initial application fee shall be set at $300.00

1.5-1 Minimum Eligibility Criteria

(a) Each AHP must provide evidence that the AHP meets the minimum eligibility criteria delineated in Appendix A to this Manual, the privilege card and/or authorized scope of service.

(b) Each AHP seeking membership in the Allied Health Staff shall provide written evidence of an agreement to provide services for a Sponsoring Medical Staff Member, and professional medical liability insurance with minimum and aggregate limits determined by the Governing Board. The medical liability insurance may not exclude from coverage any of the procedures for which the AHP is seeking scope of practice and/or scope of service.

1.5-2 Initial Review of Applications

As a preliminary step, the Credentials Committee and/or its designees, which include the Medical Staff services office, shall determine whether the AHP satisfies the minimum eligibility criteria for Allied Health Staff membership. If the AHP fails to meet the minimum eligibility criteria, the AHP shall be notified in writing within 30 days of the determination of ineligibility and the reasons for such ineligibility. The application shall be withdrawn immediately due to ineligibility without further processing or consideration. Failure to meet the minimum eligibility criteria does not entitle an AHP to the right to a review under this Manual.

1.5-3 Additional Criteria

In addition to the minimum eligibility criteria, the AHP shall disclose the following information as part of the application, each of which serves as a basis for determining suitability of the AHP for admission to the Allied Health Staff:

(a) Any voluntary or involuntary restriction, reduction, suspension, relinquishment, lapse, denial or revocation of the AHP's license, registration or certification to provide services in any jurisdiction;

(b) Any restriction, reduction, suspension, relinquishment, lapse, denial or revocation of the AHP's DEA certificate (if applicable);

(c) Any voluntary or involuntary restriction, reduction, suspension, relinquishment, lapse,

denial or revocation by a health care entity of the AHP's (1) Allied Health Staff membership or (2) scope of practice or scope of service at any facility that grants membership and privileges or scope of service;

(d) Any disciplinary action by a health care entity;

(e) Any denied membership application or renewal, or any disciplinary action taken against the AHP, by any medical organization including, but not limited to, Physician-Hospital Organizations (PHOs), Independent Practice Associations (IPAs), etc.;

(f) Any sanctions, exclusions or limitations imposed by the Texas Medical Foundation (TMF) or any other professional review organization;

(g) Any sanctions, exclusions or limitations imposed by any state or federal health care program including Medicare or Medicaid;

(h) Any sanctions, exclusions or limitations based on quality or patient safety reasons and imposed by any private health care program, including, but not limited to, private third-party insurers, health maintenance organizations (HMOs), PHOs, IPAs, etc.;

(i) Any filing of criminal charges against the AHP;

(j) Any professional liability cases filed, currently pending or final judgments or settlements that have been made against, or entered by, the AHP;

(k) Requested scope of practice or scope of service;

(l) Information confirming health status relevant to possible risk to patient health and safety, and to performing the requested scope of practice or scope of service;

(m) List of health care facilities or organizations where the AHP currently holds or has at any time held membership and scope of practice or scope or service;

(n) Three (3) peer references from individuals practicing in the same or similar professional discipline as the AHP and who are familiar with the AHP's current professional competence and ethical character. Such references must come from individuals who are neither related to nor associated in practice with the AHP; and

(o) Any periods of time in excess of 30 days, except for voluntary resignation, that the AHP has not been in continuous active practice.

1.6 Effect of Application

By applying for appointment to the Allied Health Staff, each AHP:

(a) Agrees to appear for interviews as requested;

(b) Agrees to attend an orientation session for new Allied Health Staff if accepted for initial appointment;

(c) Authorizes the Credentials Committee and/or its designees, which includes the Medical Staff services office, to contact and discuss with individuals and organizations who have been associated with the AHP and who may have information bearing on the AHP's current competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information in both oral and written forms;

(d) Consents to inspection by the Credentials Committee and/or its designees, which includes the Medical Staff services office, of records and documents relevant to an evaluation of the AHP's qualifications and ability to perform the requested scope of practice, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

(e) Releases from any liability, to the fullest extent permitted by law, all persons and entities involved in the credentialing process for their acts performed in connection with investigating and evaluating, determining, recommending, and/or deciding on the granting of Allied Health Staff membership and scope of practice or scope of service;

(f) Releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the AHP, including otherwise confidential information;

(g) Agrees to sign the appropriate releases authorizing the applicable licensing or accrediting agencies to disclose the AHP's licensure, registration and/or certification status to the Hospital; and

(h) Consents to the disclosure to other hospitals by the Credentials Committee and/or its designee, which includes the Medical Staff services office, and others involved in the credentialing process at other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the AHP's professional or ethical standing that the Hospital or Medical Staff may have, and releases all those involved in the gathering and release of such information from liability for so doing to the fullest extent permitted by law.

1.7 Procedure for Approval of Application

1.7-1 Review and Verification of Information

The Credentials Committee and/or its designees, which include the Medical Staff services office, shall assess whether the AHP meets all the qualifications for Allied Health Staff membership by verifying, to the best of its ability, the accuracy and veracity of the information submitted by the AHP, as follows:

(a) Current licensure, registration and/or certification. Document and verify from primary sources the AHP's current licensure, registration and/or certification status.

(b) Relevant education, training and experience. Document and verify from primary sources whenever feasible the veracity of the AHP's disclosures regarding relevant education, training and experience; and query the National Practitioner Data Bank.

(c) Continuing professional competence. Review of at least three (3) written references from individuals in the same or similar professional discipline as the AHP and who are knowledgeable about the AHP's professional performance within the past two (2) years to attest to and confirm the AHP's continuing professional competence and ability to perform the scope of practice or scope of service requested. Additional references may include peers who are neither related to nor associated in practice with the AHP, but who are personally acquainted with the AHP's professional qualifications and current professional competence.

(d) Health status. Confirm absence of any substance abuse or health conditions that may adversely affect the AHP's ability to perform the privileges or scope of service requested from the chief of service or staff at another hospital where the AHP has privileges or scope of service, or by a currently licensed physician designated by the Credentials Committee. Such confirmation may include a physical and/or mental health examination conducted by a health care professional of the Credentials Committee's choosing.

(e) Litigation history. Verification of the existence of any prior or current lawsuits, settlements, or judgments, including malpractice claims.

Following receipt and verification of the foregoing information, the Section Head in which the AHP is requesting scope of practice or scope of service, or his designee, acting on behalf of the Credentials Committee shall review the completed application and supporting documentation as described in 1.7-3 below. The Credentials Committee shall have up to four (4) months following receipt of an application to complete the verification and review functions described herein in order to determine whether or not the application is complete. If after four (4) months all necessary information has not been received from the AHP or other sources, and all questions regarding the AHP or other sources have not been satisfactorily answered, the application shall be deemed incomplete and immediately withdrawn without further processing or consideration. In such event, the AHP shall not be entitled to the right to review under this Manual.

1.7-2 Hospital Department Needs and Resources

The Hospital may decline to offer particular scope of practice or scope of service in connection with appointment, reappointment or otherwise on the basis of:

(a) The Hospital's present inability to provide adequate facilities or support services for the AHP and such AHP's patients or requirements or limitations in the Hospital's medical staff development plan; or

(b) The existence of a contractual or other arrangement for the provision by AHPs of professional services of the type being requested.

A decline to offer scope of practice under this Section shall not constitute a denial of scope of practice or scope of service and shall not entitle the AHP to the right to review under this Manual.

1.7-3 Advanced Practice Clinician (APC) Department Review

Upon a determination that an application is complete, the application and all supporting documentation will be forwarded to the appropriate Section Head, acting on behalf of the Credentials Committee, for the purpose of reviewing the application. The appropriate Section Head may personally or through a designee conduct a personal or telephone interview with the AHP. The Section Head shall evaluate all matters relevant to arriving at a recommendation regarding scope of practice or scope of service. The Section Head may contact other individuals with personal knowledge of the AHP's qualifications. After reviewing all pertinent information (but in no event later than 30 days after receiving the completed application), the Section Head shall make a written report to the Credentials Committee regarding department appointment and scope of practice of scope of service to be granted, if any, along with any special conditions.

1.7-4 Credentials Committee Recommendation

Not later than 90 days after receiving a completed application with report from the Section Head, the Credentials Committee or its designee shall review and investigate the application, the supporting documentation, and any other relevant information available. The Credentials Committee or its designee may consult with the applicable Department Chair. The Credentials Committee may also interview the applicant.

If the Credentials Committee, or its designee requires further information it may request additional information from the AHP and specify the deadline for response. Failure to respond in a timely manner by the AHP shall terminate further processing of the application and is deemed a withdrawal of the application without a right to review under this Manual.

If the Credentials Committee or its designee requires no additional information, it shall approve and specify the AHP's appointment or reappointment, delineated scope of practice and/or authorized scope of service, level of the Sponsoring Medical Staff Member's supervision, department assignment, and any conditions on the AHP's practice; or 2) deny the appointment or reappointment to practice as an AHP.

1.7-5 MEC Recommendation

Not later than 30 days after receiving the recommendation from the Credentials Committee, the MEC shall make a recommendation to the Governing Board on whether the AHP's appointment or reappointment should be approved and, if so, the approved scope of practice and/or authorized scope of service, level of Sponsoring Medical Staff Member's supervision, department assignment, and any conditions on the AHP's practice. If the MEC requires further information from the AHP, it may defer action for up to 30 days, and the AHP and the Chair of the Credentials Committee shall be notified of the deferral and the reason. The MEC may request additional information from the AHP and specify the deadline for response. Failure to respond in a timely manner by the AHP shall terminate further processing of the application and is deemed a withdrawal of the application without a right to review under this Manual.

1.7-6 Governing Board Action

The Governing Board shall approve or deny the application not later than 30 days after receiving the recommendation from the MEC. The Governing Board shall issue a final decision on the AHP's application. The Hospital shall notify the AHP and any designated Sponsoring Medical Staff Member in writing within 20 days of the Board's decision. If the decision is adverse as defined in the definition section and Article III this Manual, the notice shall also advise the AHP of the right to review as outlined in Article IV of this Manual.

1.7-7 Dependent Allied Health Practitioners Department Review

Upon a determination that an application is complete, the application and all supporting documentation will be reviewed by Medical Staff Services Personnel and presented to the Vice President of Medical Affairs (VPMA) or designee for the purpose of reviewing the application. The VPMA may personally or through a designee conduct a personal or telephone interview with the AHP. The VPMA shall evaluate all matters relevant to arriving at a recommendation regarding scope of practice. The VPMA may contact other individuals with personal knowledge of the AHP's qualifications. After reviewing all pertinent information, the VPMA or designee

shall grant or decline request for scope of practice, if any, along with any special conditions.

1.8 Special Provisions

1.8-1 Contracted Services

AHPs applying for Allied Health Staff membership by virtue of a contractual relationship to provide clinical services in the Hospital are not entitled to the automatic granting of Allied Health Staff membership or scope of practice or scope of service by virtue of the contractual relationship. Such AHPs shall follow the same procedures for requesting membership and scope of practice or scope of service as outlined in this Manual. Unless the contractual relationship between the AHP and the Hospital, or the AHP's group and the Hospital, states otherwise, the AHP's membership on the Allied Health Staff and any associated scope of practice or scope of service shall be deemed automatically terminated if the contractual relationship is terminated (either by termination of the contract, or termination of the AHP's association with the contracted group). In such event, the AHP shall have no right to review under this Manual.

1.8-2 Temporary Approval for Advanced Practice Clinician (APC)

(a) There is one circumstance in which Temporary Approval may be granted. This circumstance is:

- When an applicant for new scope of practice with a complete application that raises no concerns is awaiting review and approval by the Medical Executive Committee and the Governing Board. Examples would include an individual applying for scope of practice at the hospital for the first time; an individual currently holding scope of practice who is requesting an additional procedure(s); and an individual who is in the reappointment/recredentialing process and is requesting one or more additional procedures.
    - Scope of Practice may be granted for a period of up to 120 days in 30 day increments
    - Scope of Practice may be granted by the organized medical staff upon verification of the following:
        - Current Licensure
        - Relevant training or experience
        - Current competence
        - Ability to perform the privileges requested
        - Other criteria required by the medical staff bylaws
        - A query and evaluation of the NPDB information
        - A complete application
        - No current or previously successful challenge to licensure or registration
        - No subjection to involuntary termination of medical staff membership at another organization
        - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges

The Department Chairperson responsible for supervision may impose special requirements of consultation and reporting. Except in unusual circumstances, temporary scope of practice will not be granted unless the practitioner has agreed in writing to abide by this Manual, as well as guidelines and requirements of the Hospital and its Medical Staff in all matters relating to temporary scope of practice. Whether or not such written agreement is obtained, this Manual and the bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital and/or its Medical Staff control all matters relating to the exercise of scope of practice.

(b) Termination. The Chief of Staff or the CEO, after consultation with the appropriate Department Chairman and/or Section Head, may on the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's professional qualifications or ability to exercise any or all of the scope of practice, may at any time terminate any or all of a practitioner's temporary scope of practice, provided that the life or well-being of a patient is determined to be endangered. The termination may be effected by any person entitled to impose summary suspension as outlined in this Manual.

(c) Rights of the Practitioner. A practitioner is not entitled to the procedural rights outlined in this Manual because his request for temporary scope of practice is refused or because all or any part of his temporary scope of practice are terminated, limited or suspended.

1.9 Procedure for Reappointment

1.9-1 Application

At least six (6) months prior to the expiration date of a AHP's current Allied Health Staff appointment, a reapplication form shall be sent to the AHP. Each AHP must submit to the Medical Staff services office a completed application at least 90 days prior to such expiration date. An application shall not be considered complete until all requested information has been received.

1.9-2 Department Review

The Medical Staff services office shall forward the application and all pertinent information to the appropriate Section Head. The completed application for reappointment submitted by the AHP must include all information necessary to update and evaluate the AHP's qualifications, including but not limited to, the items set forth in Sections 1.5, 1.6 and 1.7 of this Manual. The Section Head shall review the application and may consider any additional information available including, but not limited to the following:

(a) Citations from applicable Hospital and Medical Staff committees;

(b) Results of quality assurance/performance improvement activities, including drug utilization review, relating to the member's clinical and/or technical competence using relevant AHP-specific data compared to aggregate data, when available, and Performance Measurement Data including morbidity and mortality data, when available;

(c) Peer recommendations as to the AHP's current continuing clinical competence and suitability for continued Allied Health Staff membership;

(d) Fulfillment of Allied Health Staff responsibilities relating to the AHP's scope of practice and scope of service; and

(e) National Practitioner Data Bank query.

The Section Head shall follow the process described in Section 1.7-3 of this Manual.

1.9-3 Credentials Committee Recommendation

The Credentials Committee shall follow the process described in Section 1.7-4 of this Manual.

1.9-4 MEC Recommendation

The MEC shall follow the process described in Section 1.7-5 of this Manual.

1.9-5 Governing Board Action

The Governing Board shall follow the process described in Section 1.7-6 of this Manual.

1.10 Failure to Submit a Completed Reappointment Application

If the AHP does not submit a completed application by 90 days prior to the reappointment expiration date, the application will be deemed incomplete and the AHP's scope of practice or scope of service will expire at the end of the current Allied Health Staff appointment. If an Allied Health Staff appointment expires because of an incomplete reappointment application, the AHP is not entitled to a right to review under this Manual. Any application submitted after the expiration date shall be processed as a request for an initial appointment.

1.11 Leave of Absence

1.11-1 Leave Status

An AHP may apply for a voluntary leave of absence (not to exceed the earlier of one (1) year or the last day of the AHP's current term of appointment) from the Allied Health Staff by submitting a written request to the Section Head and Credentials Committee specifying the reasons and the approximate period of leave. During a leave of absence, the AHP shall not exercise scope of practice or perform a scope of service at the Hospital, and membership rights and responsibilities shall be inactive. In exceptional circumstances and upon demonstrating good cause, a leave of absence may be extended beyond one (1) year upon approval of the MEC, based upon the recommendation from the Section Head and Credentials Committee.

1.11-2 Reinstatement

(a) If the leave of absence is for any reason other than the AHP's illness, incapacity or impairment or other cause that could affect the AHP's ability to fully and competently exercise the scope of practice or scope of service granted to such AHP (e.g. to attend to an ailing family member; when called to active military duty), the leave of absence may be terminated prior to its expiration at the written request of the AHP and the AHP will be reinstated by the Chairman of the Credentials Committee or its designee. To be reinstated, the AHP must submit a written request prior to expiration of the period specified in the AHP's request for leave.

(b) In circumstances when the leave of absence is due to illness, incapacity, or impairment or other causes that could affect the AHP's ability to fully and competently exercise the scope of practice or scope of service granted to such AHP, reinstatement is conditioned upon a showing that:

(1) The AHP has submitted to the Credentials Committee a written request for reinstatement at least 30 days prior to the expiration of the leave, and demonstrated that the reasons for the leave will no longer exist by the expiration of the leave or by the requested date for reinstatement;

(2) In case of impairment, the AHP must present a letter of release from the AHP's physician, and, as may be required by the Medical Executive Committee, an agreement for ongoing treatment or therapy, a treatment plan from a treating physician, and the AHP's agreement for random testing, if applicable;

(3) The AHP currently meets all of the qualifications for membership set forth in this Manual; and

(4) The AHP has submitted such other information as requested by the Credentials Committee, the MEC, or the Governing Board.

No reinstatement of a leave granted under (b) above shall be effective until approved by the Governing Board upon the recommendation of the MEC.

1.11-3 Failure to Request Reinstatement

Failure to request reinstatement from a leave of absence in any event shall be deemed a voluntary resignation from the Allied Health Staff and shall result in automatic revocation of Allied Health Staff membership and clinical privilege or scope of service. A request for Allied Health Staff membership subsequently received from an AHP who fails to request timely reinstatement shall be submitted and processed in the manner specified for applications for initial appointments.

1.12 Continuing Duties after Appointment

By accepting an appointment to the Allied Health Staff and scope of practice and/or scope of service at the Hospital, the AHP affirmatively agrees to the following duties:

(a) Abide by this Manual, the Medical Staff Bylaws, Rules and Regulations, and related documents, as applicable, and all other applicable standards, policies and rules of the Medical Staff and Hospital;

(b) Notify the Medical Staff services office in writing within five (5) business days upon actual or constructive knowledge of any of the following:

(1) Any material change to information submitted as part of an initial or renewal application for Allied Health Staff membership including that information required by Sections 1.5, 1.6, and 1.7-1 of this Manual;

(2) Taking any requested or mandatory leave of absence by the AHP at any health care facility;

(3) The cessation of clinical practice by the AHP at any health care facility for

any reason (except for a voluntary resignation) for a period exceeding 30 days; and

(4) The reduction of the AHP's professional liability insurance coverage below the minimum limits set forth in this Manual, or exclusion from coverage for any procedures for which the AHP has or is seeking scope of practice or scope of service.

(c) Provide and/or secure continuous care of the AHP's patients and communicate with other health care professionals whenever necessary or appropriate, but does not have the authority to request consultation without the knowledge and consent of the sponsoring physician or refuse consultation on behalf of the sponsoring physician;

(d) Complete a medical history and physical examination in accordance with the requirements set forth in the Bylaws, Rules and Regulations, and hospital policies;

(e) Write orders in accordance with the requirements set forth in the Bylaws, Rules and Regulations, and hospital policies;

(f) Maintain an ethical practice, including refraining from the following: offering, soliciting, providing or accepting illegal inducements for patient referrals;

(g) Perform services only within the scope of practice and/or authorized scope of service and with the appropriate level of supervision by the Sponsoring Medical Staff Member; and

(h) Communicate with and inform patients and their families that the AHP is not a physician and refrain from any conduct or discussion that could lead patients and their families to believe that the AHP is a physician.

Article II ALLIED HEALTH STAFF MEMBERSHIP

2.1 Prerogatives of Allied Health Professionals

The prerogatives of an AHP are to:

(a) Perform such health care services as the AHP has been educated and trained to perform and as have been specifically delineated in scope of practice or authorized scope of service pursuant to this Manual, privilege card, or any other applicable Medical Staff or Hospital policies, procedures, rules or regulations;

(b) Serve on committees, if so appointed, and with a vote if so specified by the appointing authority;

(c) Attend, when invited, clinical meetings of the Medical Staff, a department or other clinical units;

(d) Attend educational meetings of the Medical Staff, a department, or the Hospital; and

(e) Exercise such other prerogatives as the Credentials Committee, MEC, or Governing Board may accord to the AHP.

2.2 Delineated Scope of practice or Authorized Scope of Service

Scope of practice and/or a written description of the authorized scope of service shall be developed by the Credentials Committee and approved by the MEC and by the Governing Board. Input shall be obtained, as applicable, from the Sponsoring Medical Staff Member and Administration. For each AHP, the scope of service shall contain at the least the following:

(a) Any additional minimum qualifications or eligibility criteria for the scope of practice or scope of service requested;

(b) Specification of the classes of patients that may (or may not) be seen;

(c) Description of the services to be provided and procedures to be performed, including any special equipment, procedures of protocols that specific tasks may involve, and responsibility (if any) for charting services provided in the patient's medical record;

(d) Definition of the degree of assistance that may be provided to a Medical Staff member in treating patients and any conditions thereon; and

(e) The degree of supervision by the Sponsoring Medical Staff Member.

Notwithstanding the delineated scope of practice or authorized scope of service permitted under law, conditions may be placed on an AHP's delineated scope of practice or authorized scope of service as deemed necessary by the Hospital.

2.3 Emergency Exercise of Scope of Practice and/or Scope of Service

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to that danger, an AHP on the Allied Health Staff is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree authorized by the AHP's licensure, registration or certification regardless of the delineated scope of practice or authorized scope of services. In such an emergency, the AHP shall summon all consultative assistance available and relinquish care of the patient to a Medical Staff member or other appropriate professional as soon as possible.

2.4 Disaster Privileges

Disaster privileges shall be granted on a case-by-case basis to volunteer AHPs when the Hospital's emergency management plan has been activated or if the Hospital is unable to meet immediate patient needs (e.g., community disaster/national disaster). Any APC shall be permitted and assisted to do everything possible in the care of the patients within the scope of his licensure, registration, or certification. The granting of disaster privileges shall be authorized by the President of the Medical Staff, the Medical Director, or an authorized designee. The specific volunteer AHP shall present to the Medical Staff office or Command Center and present to the chief administrative officer or President of the Medical Staff or their designee(s) current licensure or a valid government-issued photo identification such as a driver's license or passport. In addition, the volunteer AHP must provide at least one of the following: a current hospital picture identification card that clearly identifies the individual's professional designation; a current license to practice; primary source verification of licensure; identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals

(ESAR-VHP), or other recognized state or federal organization or group(s); identification indicating that the AHP has been granted authority to render patient care, treatment, or services in disaster circumstances (such as authority having been granted by a federal, state, or municipal entity); identification by a current member(s) of the organization who possesses personal knowledge regarding the volunteer AHP's qualifications. Volunteer AHPs shall be assigned to work with an employee/peer within their scope of practice for organization oversight. Once the immediate situation is under control, the Medical Staff office shall obtain primary source verification of the volunteer AHP's license. Primary source verification shall be completed within 72 hours from the time the volunteer AHP presented to the organization. In extraordinary circumstances (e.g. no means of communication or a lack of resources), verification may exceed 72 hours, but shall be completed as soon as possible.

Proof of professional liability insurance coverage shall also be provided or verified as soon as practically possible. Disaster privileges shall be terminated once the disaster no longer exists.

2.5 Request for Modification of Scope of Practice

An AHP may request modification of the scope of practice and/or scope of service by submitting a written request to the Medical Staff services office. The request must contain all requested information supporting of the request and is processed according to the procedures outlined in this Manual, including verification with primary sources external to the Hospital and compilation of internal data as necessary to evaluate properly the request.

2.6 Quality Review of ~~Allied Health Professionals~~ Advanced Practice Clinicians (APCs)

An ~~AHP~~ **APC** is subject to evaluation, formal periodic reviews and disciplinary procedures as set forth in this Manual. Each ~~AHP~~ **APC** shall be assigned by the Credentials Committee to the clinical department and/or Hospital service appropriate to the ~~AHP's~~ **APC's** professional training and delineated scope of practice or authorized scope of service. An ~~AHP's~~ **APC's** provision of specified services within any department or Hospital service is subject to the rules and regulations of that department/service and to the authority of its chair/director. The quality and efficiency of the care provided by an ~~AHP~~ **APC** within any department/service may be monitored and reviewed as part of the Hospital's quality management program.

Each APC will maintain a Clinical Log with a minimum of 10 charts listed for review and have monthly face to face meetings with their supervising physician or their delegate. See section 2.8 (h)

2.7 Supervision by Sponsoring Medical Staff Member

The level and nature of supervision required from the Sponsoring Medical Staff Member for the AHP's performance of a service shall be within the delineated scope of practice and/or authorized scope of service as follows:

Level 1: Sponsoring Medical Staff Member is physically present to observe performance of service or task by the AHP.

Level 2: Sponsoring Medical Staff member is physically present in the Hospital and immediately available while the service or task is being performed by the AHP.

Level 3: Sponsoring Medical Staff Member is available by telephone immediately while the service or task is being performed by the AHP.

2.8 Responsibilities of Sponsoring Medical Staff Member

Unless otherwise provided by Hospital policy or scope of practice, the Sponsoring Medical Staff Member shall:

(a) Abide by this Manual, the Bylaws, Rules and Regulations, policies and procedures governing the service of AHPs in this Hospital and utilize the AHP in accordance with the AHP's delineated scope of practice and/or authorized scope of service in the Hospital;

(b) Be specifically privileged by the Credentials Committee to supervise AHPs;

(c) Accept full responsibility for the proper conduct of the AHP within the Hospital, for the AHP's observance of this Manual, the Bylaws, Rules and Regulations, policies and procedures of the Hospital and Medical Staff, and for the correction and resolution of any problems that may arise;

(d) Maintain ultimate responsibility for directing the course of the patient's medical treatment and provide active and continuous overview of the AHP's activities in the Hospital to ensure that directions and advice are being implemented;

(e) Ensure that the AHP maintains the necessary qualifications and competency to provide services as required in this Manual;

(f) Delegate the performance of any medical acts in accord with applicable law and within the AHP's delineated scope of practice and authorized scope of service; and

(g) Notify immediately the Credentials Committee or Medical Staff services office in the event any of the following occurs:

(1) Termination of an agreement to serve as a Sponsoring Medical Staff Member or employment of the AHP;

(2) The Sponsoring Medical Staff Member's approval to supervise the AHP is revoked, limited, or otherwise altered by action of the applicable state licensing board; or

(3) The Sponsoring Medical Staff Member is notified of investigation of the AHP or of the member's supervision of the AHP by the applicable state licensing board or any other accrediting body.

(h) perform 10 chart reviews per month monthly, face-to-face meetings with the collaboration/supervising physician with date and signatures of both parties documented on the logs provided. The logs are to be kept by the AHP.

(i) be available for appropriate supervision of the AHP per Section 2.7 and upon request of AHP

(j) Physicians utilizing APC's must see their non-ICU patients within twenty-four (24)

hours of admission or consultation. ICU admission and consults must be seen within 12 hours by the attending physician. This does not negate the need for the APC to see the patient within a timely manner. All consultations should be made physician to physician or with knowledge and consent of the sponsoring physician.

(k) Attending Physicians may delegate initial ICU assessment to an APC with appropriate documentation reflecting collaboration. APCs are responsible for reviewing the case with the Attending Physician immediately following their initial assessment and documenting time and date in the medical record.

(l) If the patient remains unstable or becomes unstable after being initially evaluated by the APC, then it is the responsibility of the Attending Physician to do a bedside assessment within 60 minutes of initial admission or transfer to the ICU.

Failure to follow these responsibilities may result in restriction or loss of privileges for AHPs.

AHPs may not be a substitute for physician call responsibilities.

Article III CORRECTIVE ACTION

3.1 Actions Other Than Summary Restriction or Suspension

(a) Basis for Corrective Action. An investigation of an AHP my be requested when information indicates that the AHP may have exhibited acts, demeanor, or conduct reasonably likely to (1) be detrimental to patient safety or the delivery of quality patient care within the Hospital; (2) be unethical; (3) be contrary to this Manual, the Bylaws, Rules and Regulations, or any Hospital or Department policies or procedures; (4) be below applicable professional standards; or (5) indicate impairment due to substance abuse or other medical ailment. The appropriate Section Head, Department Chairman Credentials Committee, MEC, Hospital President or Governing Board may request an investigation of the AHP. The request shall identify areas of concern and be submitted to the Credentials Committee.

(b) Investigation. If the Credentials Committee determines that an investigation is warranted, the Credentials Committee shall conduct the investigation or assign the investigation to an appropriate Medical Staff committee or an ad hoc committee appointed to conduct such investigation. If such investigation is assigned by the Credentials Committee, the investigating body shall submit a written report of the investigation to the Credentials Committee that may include recommendations on corrective action, if any. The investigation shall not constitute an Adverse Action and the AHP shall not be entitled to a right to review under this Manual.

(c) Credentials Committee Recommendation. Upon the conclusion of the investigation, the Credentials Committee may in its discretion recommend to the MEC any of the following:

(1) Removal of any adverse information from the AHP's file if no corrective action is warranted by the investigation;

(2) Deferral of action;

(3) Issuance of letters of admonition, censure, reprimand, or warning. The affected AHP may respond to such letters and warnings, and any written responses shall be placed in the AHP's file;

(4) Imposition of special conditions that may include elements of FPPE, including case review, continuing medical education, counseling or probation, which do not involve a restriction, reduction, suspension or revocation of the AHP's scope of service or ability to exercise scope of practice at the Hospital;

(5) Probation, restriction, reduction, suspension or revocation of scope of practice; or

(6) Other actions deemed reasonable and appropriate under the circumstances.

(d) MEC Action. Upon receipt of a recommendation from the Credentials Committee, any MEC action that does not involve the denial of appointment or reappointment or restriction, reduction, suspension or revocation of the AHP's delineated scope of practice and/or authorized scope of service or the AHP's ability to exercise scope of practice and/or scope of service may be implemented by the MEC without further review and shall be effective when notice is delivered to the AHP.

Upon receipt of a recommendation from the Credentials Committee, the MEC shall promptly submit to the Governing Board and notify the affected AHP of any recommendation for corrective action that involves the denial of appointment or reappointment or the restriction, reduction, suspension, or revocation of the AHP's scope of practice and/or scope of service or ability to exercise scope of practice and/or scope of service. Any MEC recommendation that is an Adverse Action (meaning that it involves denial of appointment or reappointment, restriction, reduction, suspension or revocation of the AHP's delineated scope of practice or authorized scope of service or ability to exercise scope of practice or scope of service) shall entitle the AHP to a right to review under this Manual effective as of the date of the MEC recommendation unless otherwise indicated in this Manual.

If the MEC recommendation is supported by credible evidence, the Governing Board shall approve the MEC recommendation and shall notify the affected AHP.

(e) Initiation by Governing Board. If the MEC fails to take corrective action, the Governing Board in its discretion may direct the MEC to initiate an investigation or to consider corrective action. If the MEC fails to act, the Governing Board may initiate corrective action consistent with this Manual.

3.2 Summary Restriction or Suspension

(a) Criteria for Initiation. A summary restriction or suspension of an AHP's scope of practice or scope of service may be made by the appropriate Department Chair, Chairman of the Credentials Committee or Chairman of the MEC when an AHP's conduct appears to require immediate action to be taken to protect the well-being of any person including patients, visitors and Hospital personnel, or to reduce a substantial and imminent likelihood of injury or impairment to the life, health, or safety of any such persons. Unless otherwise stated, such summary restriction or suspension shall be effective immediately upon imposition, and the responsible

person or body shall deliver written notice to the AHP, MEC, Hospital President, and Governing Board. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if not stated, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the AHP's patients shall be assigned to the sponsoring physician in accordance with this Manual, Bylaws, Rules and Regulations and Hospital and Department policies and procedures.

(b) Initiation of Summary Restriction or Suspension. A summary suspension may be initiated by the appropriate Department Chair, Chairman of the Credentials Committee or Chairman of the MEC. If none of these individuals is available, the Hospital President or Governing Board may summarily restrict or suspend an AHP's scope of practice or scope of service or scope of practice, provided that the Hospital President or Governing Board first made reasonable attempts to contact the individuals identified above.

(c) MEC Action. Within 31 days after a summary restriction or suspension, the MEC shall conduct a meeting to review and consider the action. The affected AHP may request to attend and present a statement to the MEC and to be accompanied by the AHP's Sponsoring Medical Staff Member; however, the AHP may not be represented by a lawyer at the meeting and the AHP shall not be entitled to a right to review under this Manual. The MEC shall recommend to the Governing Board to modify, continue, or terminate the summary restriction or suspension, and shall deliver notice of its recommendation to the affected AHP.

If the MEC does not ratify the restriction or suspension, it shall terminate upon the earlier of (a) the 31st day after imposition or (b) the date the MEC votes not to ratify the action. Notice of any action taken under this Section shall be delivered to the affected AHP.

If the summary restriction or suspension is not terminated within 31st days, the affected AHP shall be entitled to a right to review under this Manual.

3.3 Administrative Suspension and Revocation

An administrative suspension of the AHP's scope of practice or scope of service may be made by the MEC based on an AHP's conduct as described in this Section 3.3. Unless otherwise stated, such administrative suspension shall be effective immediately upon imposition, and the MEC shall deliver written notice to the affected AHP, appropriate Department Chair, Credentials Committee, Hospital President and Governing Board. The administrative suspension shall be limited in duration and shall remain in effect for the period stated or, if not stated, until resolved as set forth herein.

Administrative suspension may be applied by failure to abide by continuing duties after appointment as described in Section 1.12

3.3-1 Licensure

If an AHP's license, certification or registration to practice in Texas lapses, the AHP's scope of practice or scope of service shall be suspended until the deficiency is corrected. If, within 90

days following the lapse, the AHP does not demonstrate that the AHP's license, certification or registration has been renewed, the AHP's scope of practice or scope of service shall be automatically revoked.

3.3-2 DEA Certificate

If an AHP's DEA certificate lapses, if applicable to clinical practice, the AHP's scope of practice or scope of practice may be suspended unless the AHP provides documentation from the DEA demonstrating that the expiration date of the DEA certificate has been extended. If, within 90 days following the lapse, the AHP does not demonstrate that the AHP's DEA certificate has been renewed, the AHP's scope of practice shall be automatically revoked.

3.3-3 Professional Liability Insurance

If an AHP fails to maintain professional liability insurance as set forth in this Manual, the AHP's scope of practice may be suspended until the deficiency is corrected. If within 90 days following the deficiency, the AHP does not provide evidence of required professional liability insurance, the AHP's scope of practice may be automatically revoked.

3.3-4 Disruptive Behavior

An AHP is expected and required to adhere to the ethics of the profession, to work cooperatively with others, and to discharge properly the responsibilities of the AHP. If an AHP fails to do so, or if an AHP's behavior is disruptive to the reasonably expected functioning of the Hospital, the AHP's scope of practice may be suspended for a period of up to 10 days.

3.3-5 Repetitious Infractions

If an AHP has been subject to at least three (3) administrative suspensions under this Section 3.3 within any consecutive twenty-four (24) month period, the AHP's scope of practice may be revoked by the MEC.

3.3-6 Procedural Rights

Any revocation under 3.3-5 shall entitle the affected AHP to a right to review under this Manual.

3.4 Professional Health

Whenever the AHP's actions, demeanor, conduct, or physical or mental condition reasonably appears to be impaired, the AHP may be asked by the appropriate Section Head, Credentials Committee, MEC, Hospital President or Governing Board to provide evidence of current health status through a physical or mental examination, and will be referred to the committee on professional health. An impairment due to substance abuse is deemed reasonably likely to be detrimental to patient safety or to the delivery of quality patient care within the Hospital and shall be grounds for immediate summary suspension of the AHP's scope of practice or scope of service as provided in this Manual. An AHP has a duty to self-report to the appropriate Section Head, Credentials Committee, MEC, or Governing Board any professional health matter that may adversely affect the AHP's ability to exercise safely scope of practice and may seek assistance from the committee on professional health. Management and resolution of professional health matters shall be the responsibility of the MEC. Any physical or mental

examination shall be at the expense of the affected AHP, shall be provided by a practitioner selected by the committee on professional health and may include an appropriate drug screen testing program for an individual suspected of impairment due to substance abuse.

3.5 Automatic Adverse Action

In the following instances, an AHP's scope of practice shall be subject to automatic adverse action as stated below, without a right to review under this Manual.

3.5-1 Licensure, Certification or Registration

If an AHP's license, certification or registration to practice in Texas is placed on probation, restricted, reduced, suspended or revoked, the AHP's scope of practice or scope of service shall be subject to the same action under the same terms and conditions as of the date of such action becomes effective and throughout its term.

3.5-2 DEA Certificate

If an AHP's DEA certificate, if applicable to clinical practice, is placed on probation, restricted, reduced, suspended or revoked, the AHP's scope of practice or scope of service shall be subject to the same action under the same terms and conditions as of the date of such action becomes effective and throughout its term.

3.5-3 Felony

If an AHP is convicted of a felony, the AHP's scope of practice or scope of service shall be automatically revoked upon the Hospital receiving actual notice of the conviction.

3.5-4 Professional Health Program

If an AHP violates the terms of a return to work agreement signed as part of the Hospital's professional health program, the AHP's scope of practice or scope of service shall be automatically revoked.

3.5-5 False Information

If an AHP has falsified an application for appointment or reappointment, the AHP's scope of practice or scope of service may be suspended. If upon investigation such falsification is confirmed, the MEC may declare an automatic revocation and the AHP shall not be entitled to a right to review under this Manual.

3.6 Corrective Action against Sponsoring Medical Staff Member

If the AHP's Sponsoring Medical Staff Member fails to comply with the obligations described in this Manual, corrective action may be taken against the Sponsoring Medical Staff Member pursuant to the Medical Staff Bylaws.

Article IV RIGHT TO REVIEW

4.1 Scope

The AHP shall not be entitled to any procedural rights, including the right to a hearing, as set forth in the Medical Staff Bylaws, or to those rights afforded to employees pursuant to Hospital policy. The right of an AHP to a review or appeal of any Adverse Action is specifically limited to the rights set forth in this Manual.

4.2 Review

An AHP, who has been notified of an Adverse Action, must deliver a written request for review to the Medical Staff services office within ten (10) days of delivery of the notice. Failure to timely request a review shall be deemed a waiver of all rights to review under this Manual and acceptance of the action or recommended action, as applicable. The Credentials Committee will meet with the AHP within thirty (30) days after receipt of the request for review. The AHP may be accompanied by the AHP's Sponsoring Medical Staff Member and one (1) other representative. Following the meeting, the Credentials Committee shall submit a report of the review along with its recommendation to the MEC. The MEC is not bound by the recommendation of the Credentials Committee, so it may affirm, modify or reverse the same.

4.3 Appeal

An AHP, who has been notified of an Adverse Action pursuant to Section 4.2 above, may appeal that action by delivering a written request for appeal to the Medical Staff services office within ten (10) days of delivery of the notice. Failure to timely request an appeal shall be deemed a waiver of all rights to appeal under this Manual and acceptance of the action or recommended action, as applicable. The MEC will meet with the AHP within thirty (30) days after receipt of the request for appeal. The AHP may be accompanied by the AHP's Sponsoring Medical Staff Member and one (1) other representative. Following the meeting, the MEC shall submit a report of the appeal along with its recommendation to the Governing Board. The Governing Board is not bound by the recommendation of the MEC, so it may affirm, modify or reverse the same.

4.4 Reapplication after Adverse Action

An AHP who has received a final Adverse Action based on clinical competency or professional conduct is not eligible to reapply for services for a one (1) year period commencing on the date of final resolution of the AHP's status (i.e., either the date of notice from the Governing Board, if no review is requested, or the date of resolution of a review). Any reapplication after one (1) year shall be processed as a request for initial appointment.

Article V ADOPTION AND AMENDMENT OF MANUAL

5.1 Annual Review and Amendment

The Manual shall be reviewed at least annually and may be amended in the following manner:

(a) Amendments shall be presented first to the Credentials Committee and approved by two-thirds (2/3) of the eligible voting members of the Credentials Committee.

(b) If approved by the Credentials Committee, amendments shall be presented to the MEC at the next regularly scheduled MEC meeting for review and adoption by two-thirds (2/3) of the eligible voting members of the MEC.

(c) The amendments will then be presented to the Governing Board for final review and approval.

5.2 Savings Clause

The provisions set forth in this Manual supersede all prior versions thereof contained in the Bylaws, Rules and Regulations, and other applicable Hospital and Department policies and procedures. Except as expressly superseded herein, the provisions of the existing Bylaws, Rules and Regulations and other applicable Hospital and Department policies and procedures shall remain in full force and effect unless and until replaced by a subsequently written document. To the extent the existing Bylaws, Rules and Regulations or other applicable Hospital and Department policies and procedures conflict with the provisions set forth herein, the provisions of this Manual shall control.

APPENDIX A
SPECIFIC CATEGORIES AND QUALIFICATIONS OF ALLIED HEALTH PROFESSIONALS

A. Advanced Practice Clinician (APC)

1. Advanced Practice Nurse. Current and unrestricted Texas license issued by the Board of Nurse Examiners (BNE) and approved by the BNE to practice as an Advanced Practice Nurse on the basis of completion of an advanced educational program. The practice area of the Advanced Practice Nurse shall be appropriate to his/her clinical authority derived from policies and protocols developed jointly by the Advanced Practice Nurse and the appropriate Medical Staff members. Categories of Advanced Practice Nurses include, but are not limited to, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Clinical Nurse Specialist, and Nurse Practitioner.

   Applicants must hold national certifications in the advanced role and specialty for which they are applying.

   a. Certified Registered Nurse Anesthetist. Current and unrestricted Texas license issued by the BNE and approved by the BNE to practice as an Advanced Practice Nurse on the basis of completion of an advanced educational program.

   b. Clinical Nurse Specialist. Current and unrestricted Texas license issued by the BNE and approved by the BNE to practice as an Advanced Practice Nurse on the basis of completion of an advanced educational program.

   c. Nurse Practitioner. Current and unrestricted Texas license issued by the BNE and approved by the BNE to practice as Nurse Practitioner on the basis of completion of an advanced educational program.

   d. Neonatal Nurse Practitioner. Current and unrestricted Texas license issued by the BNE and approved by the BNE to practice as an Advanced Practice Nurse on the basis of completion of an advanced educational program.

2. Physician Assistant. Current and unrestricted Texas license issued by the Texas Physician Assistant Board. Graduate of a Physician's Assistant training program approved by the Council on Medical Education of the American Medical Association and/or successful completion of examination administered by the National Commission on the Certification of Physician Assistants.

3. Doctor of Pharmacy (PharmD). Current and unrestricted Texas License issued by the Texas State Board of Pharmacy and approved to perform Drug Therapy Management based on The Texas Administrative Code (Title 22, Part 15, Chapter 295, Rule 295.13) and the Medical Practice Act (Chapter 157). The practice area shall be appropriate to his/her clinical expertise/practice derived from policies and approved protocols.

B. Dependent Allied Health Professionals

1. Audiologist. Current and unrestricted Texas license issued by the State Board of Examiners for Speech-Language Pathology and Audiology to practice as an audiologist.

2. Chemical Dependency Counselor. Current and unrestricted Texas license issued by the Texas Commission on Alcohol and Drug Abuse to practice as a chemical dependency counselor.

3. Dental Assistant. Current registration with the State Board of Dental Examiners.

4. Licensed Clinical Psychologist. Current and unrestricted Texas license issued by the Texas State Board of Examiners of Psychologists to practice as a Licensed Psychologist and successful completion of a program in clinical psychology and achievement of a doctoral degree (PhD).

5. Licensed Professional Counselor. Current and unrestricted Texas license issued by the Texas State Board of Examiners of Professional Counselors to practice as a licensed professional counselor.

6. Licensed Vocational Nurse. Current and unrestricted Texas license issued by the BNE.

7. Registered Nurse. Current and unrestricted Texas license issued by the BNE.

8. Registered Nurse First Assistant. Current and unrestricted Texas license issued by the BNE and appropriate documentation for First Assistant designation.

9. Social Worker.

   (a) Licensed Baccalaureate Social Worker. Current and unrestricted Texas baccalaureate social worker license issued by the Texas State Board of Social Workers (TSBSW) to practice as a baccalaureate social worker.

   (b) Licensed Clinical Social Worker. Current and unrestricted Texas clinical social worker license issued by the TSBSW to practice as a clinical social worker.

   (c) Licensed Master Social Worker. Current and unrestricted Texas master social worker license issued by the TSBSW to practice as a master social worker.

   (d) Licensed Social Worker. Current and unrestricted Texas social worker license issued by the TSBSW to practice as a social worker.

10. Surgical Technologist. If credentialed prior to September 1, 2009, does not have to become certified. If credentialed after September 1, 2009, must have graduated from an accredited program and be certified by approved agency.