RULES & REGULATIONS

400 West 16th Street
Pueblo, CO 81003

Rules & Regulation Approved:

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MEDICAL STAFF RULES AND REGULATIONS

DEFINITIONS

1. The term “Medical Staff” means all licensed medical practitioners who are privileged to attend patients in the medical center.
2. The term “Governing Body” means the board of Directors of Parkview Medical Center.
3. The term “Medical Executive Committee” (MEC) means the executive committee of the medical staff, unless specific reference is made to the executive committee of the governing body.
4. The term “President/Chief Executive Officer” (President/CEO) means the individual appointed by the governing body to act in its behalf in the overall management of the medical center.
5. The term “Practitioner” means an appropriately licensed medical physician, osteopathic physician, dentist, and podiatrist mandated by state law with a statutory right to be eligible to practice.
6. The term “Medical Staff Year” shall begin in the fall of each year.
7. The term “Allied Health Professional-Advance Practice Nurses/Physician Assistant” (AHP-APN/PA) means a person holding a license, certification, registration, other legal credentials, or are otherwise trained as required by the State of Colorado, who are eligible to provide specified healthcare services at Parkview Medical Center under conditions specified in these bylaws.
8. “PM/PI” means Performance Measurement/Process Improvement
9. The term “in the process of Board Certification” means that a practitioner has successfully completed the requisite education, training and experience to apply to take examination for board certification.
10. The term “Performance Plan” applies to the internal monitoring standards of the Emergency Medicine physician group.
11. The term “FPPE” refers to focused professional practice evaluation.
12. The term “OPPE” refers to ongoing professional practice evaluation.

SECTION 1

ADMISSION AND DISCHARGE OF PATIENTS

1. A patient may be admitted to the medical center only by a physician member of the medical staff. All practitioners shall be governed by the official admitting policies of the medical center. A dentist with clinical privileges may, with the concurrence of an appropriate member of the medical staff, initiate the procedure for admitting the patient. The concurring medical staff member shall assume responsibility for the overall aspects of the patient's care throughout the medical center stay, including the medical history and physical examination.
2. A member of the medical staff shall be responsible for the medical care and treatment of each patient in the medical center, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. It is the transferring physician's responsibility to ensure the receiving physician accepts the transfer either verbally or in writing.
3. Except in an emergency, no patient shall be admitted to the medical center until a provisional diagnosis or valid reason for the admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.
4. Practitioners admitting emergency cases shall be prepared to justify to the executive committee of the medical staff and the administration of the medical center that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted in an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.
5. A patient to be admitted on an emergency basis who does not have a private practitioner may select any practitioner in the applicable department or service to attend to him/her. Where no such selection is made, a member of the active staff on duty in the department will be assigned to the patient. The chairperson of each department shall provide a schedule for such assignments.
6. Each member of the staff who does not reside in the immediate vicinity shall name a member of the staff who is a resident in the area who may be called to attend his/her patients in an emergency or until he/she arrives. In case of failure to name such associate or the chairperson of the department concerned, the chairperson of the executive committee shall have authority to call any member of the active staff in the department concerned, if such an event should occur.

7. Each practitioner must assure timely, adequate professional care for his/her patients in the medical center by being available or having available through his/her office an eligible alternate practitioner that has at least equivalent clinical privileges at the medical center. Failure of an attending practitioner to meet these requirements will result in loss of clinical privileges.
8. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patients might be a source of danger from any cause whatsoever.
9. For the protection of patients, the medical and nursing staffs and the medical center, certain principles are to be met in the care of the potentially suicidal patient:
    a. Any patient known or suspected to be suicidal in intent shall be admitted to the department of psychiatry. If there are not accommodations available in this area, the patient shall be referred, if possible, to another institution where suitable facilities are available.
    b. Any patient known or suspected to be suicidal must have an evaluation by a member of the behavioral health team who consults with a member of the department of psychiatry.
10. The attending practitioner is required to document in the progress notes the need for continued hospitalization after specific periods of stay are identified by the utilization review or the medical care evaluation committee of this medical center and approved by the practitioner clinical department and the executive committee of the medical staff. This documentation must contain:
    a. An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
    b. The estimated period of time the patient will need to remain in the medical center.
    c. Plans for post-hospital care.

    Upon request of the utilization review committee, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient hospitalized, including the estimate of the number of additional days of stay and the reason therefore. This report must be submitted within 24 hours of the receipt of such request. Failure to comply with this policy will be brought to the attention of the executive committee for action.
11. The patient shall be discharged only on a written order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

12. In the event of a medical center death, the deceased shall be pronounced dead by a physician or a registered nurse (RN), at the request of the physician, within six (6) hours. The body shall not be released until an entry has been made and signed in the medical record of the deceased by the member of the medical staff or a registered nurse (RN) at the request of the physician. Policies with respect to release of dead bodies shall conform to local law. It shall be the duty of all staff members to secure meaningful autopsies wherever possible. An autopsy may be performed only with a written consent, signed in accordance with the state law. All autopsies shall be performed by the hospital pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within 48 hours, and the complete report shall be made part of the record within one (1) month.

SECTION 2

GENERAL CONDUCT OF CARE

1. All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated to an RN, graduate nurse, Home Health LPN, Sleep Lab personnel, respiratory therapist, pharmacist, physical therapist, occupational therapist, speech pathologist, radiological technologist, medical technologist, social worker, registered dietitian, and psychologist employed by the medical center functioning within his/her sphere of competence and signed by the responsible practitioner.
2. Other hospital employees, whose job description permits, may accept verbal orders for outpatient tests and evaluations for the purposes of scheduling and obtaining medical necessity.
3. Verbal orders will not be accepted in the acute care setting for patients not assessed during the previous 48 hours by an individual granted clinical privilege to do so in the acute medical/surgical setting.
4. When verbal/telephone orders are taken by the appropriate persons listed above, they will write down and read back to the practitioner with spelling when appropriate and reading of numbers as one single number at a time (such as an order for fifteen, a read back may include “one five”).
    a. The authorized individual receiving a verbal or telephone order shall record in writing the date and time of the verbal order and sign the verbal order with the name of the practitioner issuing the order per his/her own name.
    b. The read-back and verify process shall require that the individual receiving the order immediately read back the order to the physician or responsible individual, who shall immediately verify that the read-back order is correct.
    c. The individual receiving the verbal order shall record in writing that the order was read back and verified as indicated by documenting ‘TORB’ or ‘VORB’.

5. The verbal order shall be authenticated as soon as possible and no later than thirty days after the date of the patient discharge. If the ordering physician is unable to authenticate his/her verbal order it is acceptable for the covering practitioner to authenticate the verbal order of the ordering practitioner.
6. Verbal orders shall be used infrequently. Nothing in this section shall be interpreted to encourage the more frequent use of verbal orders by the medical staff.
7. The practitioner's orders must be written clearly legible and complete. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the appropriate personnel.
8. Patients admitted to critical care units must be assessed by the covering physician within 2 hours of admission. Exceptions are detailed in the "Trauma Team Activation" Policy and patients who are non-critical boarders waiting for an inpatient bed.
9. When an allied health professional-advance practice nurses/physician assistant is providing services to a patient in the hospital, the physician covering must be within 30 minutes of the hospital and available by phone or pager.
10. When a critical laboratory value is called to an AHP-APN/PA, the AHP-APN/PA must notify their supervising physician or the physician who is on call for the supervising physician of the value and plan management.
11. Orders written in critical care areas by an Allied Health Professional with privileges to write orders, must be verified with a physician involved in the care of the patient prior to being carried out and must be countersigned by a physician involved in the care of the patient within 24 hours. Exemption to this rule can only be granted on a case-by-case basis by the Medical Executive Committee and by 1) eligibility criteria listed under "AHP in CRITICAL CARE SETTING" being met, and 2) AHP being a member of the Trauma Service Team.
12. Do Not Resuscitate orders may be suspended when patients go to surgery and for a period of time following the surgery as defined by the surgeon and anesthesiologists after discussion with the patient and family.
13. All previous orders are discontinued when patients go to surgery.
14. Only those qualified practitioners with clinical privileges at Parkview Medical Center can be called for consultation within his/her area of expertise.
15. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling a qualified consultant. He/She will provide written authorization in the patient's medical record to permit another attending practitioner to attend or examine his/her patient, except in an emergency.
16. If a nurse has a reason to doubt or question the care provided to any patient or believes that a consultation is needed and has not been obtained, he/she shall call this to the attention of his/her supervisor, who in turn may refer the matter to the Chief Nursing Officer. If warranted, the Chief Nursing Officer may bring the matter to the attention of the chairperson of the department wherein the practitioner has privileges. Where circumstances are such as to

justify such action, the chairperson of the department may request a consultation.

17. To ensure “continuity of care” as defined by “Standards for Hospitals”* (Chapter 4, Section 6 Item 6.1) Care by Medical Staff, it shall be the responsibility of the admitting practitioner to retain the obligation of primary physician. The expectations being:
    a. The patient dismissed the admitting physician, and/or
    b. The admitting physician removes him/her self from the case, after providing for continued physician coverage.

SECTION 3

EMERGENCY SERVICES

1. The duties and responsibilities of all personnel serving patients within the emergency area shall be defined in a procedure manual relating specifically to this facility. The contents of such a manual shall be developed by a multi-specialty committee of the medical staff and emergency service committee, including representatives from nursing service and hospital administration. It shall be approved by the medical staff and the governing body.

   EMTALA NOTE: When a patient presents for emergent care, an initial medical screening examination must occur and may be provided by any privileged physician practitioner, (generally an emergency room physician) or in the event of an obstetrical patient, a labor and delivery RN may provide the initial medical screening as the Qualified Medical Person (QMP). Decision to transfer to higher level of care is made only after the initial medical screening has occurred. The contents of the non- physician QMP medical screening examination and process guidelines will be included in approved policy/procedures for the department of OB/GYN consistent with current practice guidelines.

2. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient’s hospital record, if such exists. The record shall include:
    a. Adequate patient identification;
    b. Information concerning the time of the patient’s arrival, means of arrival and by whom transported;
    c. Pertinent history of the injury or illness, including details relative to first aid or emergency care given to the patient prior to arrival at the medical center;
    d. Description of significant clinical, laboratory and roentgen logic findings;
    e. Diagnosis;
    f. Treatment given;
    g. Condition of the patient on discharge or transfer; and
    h. Final disposition, including copy of written instructions given to the patient and/or his/her family relative to necessary follow-up care.

3. Each patient's record shall be signed by the practitioner in attendance that is responsible for its clinical accuracy.
4. There shall be a monthly review of emergency room medical records by the emergency medicine department and by the appropriate clinical departments to evaluate the quality of emergency room medical care. Reports shall be submitted to the executive committee of the medical staff at least every six (6) months.

* Colorado State Department of Public Health (Hospital Services Section)

SECTION 4

DISASTER PLAN

There shall be a plan for the care of mass casualties at the time of any major disaster based upon the hospital's capabilities in conjunction with other emergency facilities in the community. This plan will be developed and updated by the safety committee with input from the medical staff. The Disaster and Safety Manual will be approved as needed and no greater than three years. The medical staff will be kept informed of any changes in the plan and in the plan and their role in the event of a disaster.

SECTION 5

RESIDENTS/FELLOWS IN TRAINING

1. Residents/fellows in training shall be under the supervision of the attending physician on staff at Parkview Medical Center while in a training capacity. The residents and fellows shall have no hospital privileges as such, but shall be able to care for patients in the medical center under the supervision and responsibility of the attending physician. Resident and fellows who are actively training as part of the Parkview Graduate Medical Education (GME) program may have hospital and health system privileges for the sake of moonlighting (where available). Moonlighting opportunities shall only be made available to residents and fellows who possess an active license to practice medicine in the state of Colorado, and have been approved to moonlight by their respective Program Director and the Designated Institutional Official (DIO) and Director of Medical Education (DME) as per GME Policy. When moonlighting, residents and fellows are practicing under their own licenses and are not being supervised. The care they extend will be governed by the general rules and regulations of each clinical department and general bylaws of the medical staff. The practice of care shall be limited by the scope of privileges of their attending physician. Any concerns or problems that arise in the resident's/fellow's performance should be directed to him/her and the Director of Medical Education, as well as the appropriate Program Director, to solve or clarify the problem while in training. All records of the resident/fellow cases must document involvement of the attending physician in the supervision of the patient's care to include co-signature of progress notes, history and physical, operative report and discharge summary.

2. Residents/Fellows may write orders for care of patients under the supervision of the attending physician. When writing orders as a moonlighting physician, their orders stand on their own.
3. All records of resident/fellow cases must document involvement of the attending physician in the supervision of the patient's care to include co-signature of the history and physical, operative report, daily progress notes, and discharge summary while working in a training capacity.
4. All admissions will be co-designated in name and responsibility to include an attending physician.
5. Medical staff members who choose not to participate in the teaching program are not subject to denial or limitation of privileges for this reason alone
6. Visiting residents/fellows from other programs are guests of Parkview Medical Center and are in no way to interfere with patient care or the professional responsibilities of the hospital staff. Employed fellows and residents will conduct themselves as would be expected of any other employed physician.
7. No health care benefits, workers compensation or other benefits are provided by the Parkview Medical Center in the event of illness or injury for visiting housestaff.
8. A completed application form and all additional information requested must be supplied to the Department of Medical Education for consideration and approval prior to working in the hospital.

SECTION 6

MEDICAL RECORDS POLICIES ON COMPLETION OF MEDICAL RECORDS

1. The attending physician, surgeon, and/or consultant which includes osteopaths, medical physicians, podiatrists and dentists, is responsible for completing their respective portions of the medical record in a timely, complete, accurate, meaningful, appropriate and legible manner in a accordance with Parkview Medical Center's medical staff rules and regulations and bylaws on the completion of medical records. The attending physician is responsible for completing the discharge summary/final progress.
2. Health Information Services (HIS) shall use the following definitions to determine the attending physician. Unresolved disputes regarding attending physician assignments shall be referred to URC.
    a. ATTENDING: The physician responsible for the majority of care as identified through documentation in the medical record shall be considered the attending physician and be responsible for the discharge summary. The attending physician shall document a transfer of care order if necessary.
    b. ADMITTING: The physician primarily responsible for the admission of the patient to the medical center shall be considered the admitting physician. In cases where the admitting is not the attending, the

admitting usually writes the first orders and/or completes a history and physical. The admitting is not the emergency room physician.

c. CONSULTING: The physician, whose specialty differs from the attending physician, is asked to participate in the care of the patient along with the attending physician. The consultant is identified by a consultation report. One physician per specialty is identified.
d. OPERATING/PROCEDURE: The physician who performs minor or major surgical, diagnostic or therapeutic procedures including deliveries. For diagnostics or therapeutics, the physician who orders the procedure is identified as the procedure physician.
e. ANESTHETIST/CRNA: The physician, CRNA, or PA administering the anesthetic is identified as the anesthetist for the procedure. The physician supervising the CRNA is identified as the anesthesiologist consultant.

SECTION 7

INPATIENT AND OUTPATIENT RECORDS

1. The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the course and result of treatment accurately. Each clinical event is documented as soon as possible after its occurrence. The medical record shall contain identification data and clinically pertinent documentation which shall include the medical history of the patient, age appropriate psychosocial needs, relevant physical examinations, progress notes, operative/procedure report, diagnostic and therapeutic orders, evidence of informed consent,(consent form appropriately and completely filled out, signed, dated and timed prior to surgery or procedure) clinical observations including the results of therapy, consultations as appropriate and discharge summary or final progress note at the termination of hospitalization or outpatient evaluation or treatment. There shall be a policy on informed consent. The complete unit record is available when a patient is admitted to the hospital, treated in same day surgery, or emergency room.
2. Entries in the medical record by allied health professionals-advance practice nurses/physician assistants or residents as defined in the bylaws under the credentialing of allied health professionals shall be co-signed by the physician.
3. Corrections (at the time you are documenting) to the medical record shall be handled by drawing “one line” through the incorrect data and proceed writing the correct information. Corrections (at a later time) shall be handled by drawing “one line” through the incorrect information and proceed with writing the information, “initial” and “date”.
4. Original reports, legible photocopies, or facsimile copied on to bond paper shall be filed in the medical record. Carbon and NCR copies shall be avoided if possible. Photocopied, facsimile, initials, computer key or electronic signatures are acceptable. Unsigned copies shall be mailed to

attending, referring, operating, or consulting physicians listed on dictated reports.

5. In order for communications to occur in an accurate and timely manner, physicians shall dictate clearly and completely and document handwritten notes and orders legibly, completely and timely.

SECTION 8

RESPITE CARE

Respite care records require an admission progress note stating the reason for admission and plan of care and a discharge note or death summary (if applicable).

SECTION 9

HISTORY AND PHYSICAL

1. For all Inpatient/Observations/Same Day Surgery & Cardiology/Special Procedure patients a medical history and physical (H&P) examination shall be completed no more than 30 days prior to inpatient admission or registration of the patient an update is required within 24 hours after the patient physically arrives for admission/registration, but prior to surgery or a procedure requiring anesthesia services including moderate sedation. A new H&P or update to the H&P is not required when the patient remains continuously hospitalized. An H&P that has been dictated, but not transcribed prior to the procedure does not suffice, and the practitioner performing the procedure is still required to complete an H&P, which may be the Short Form History and Physical if all items have been addressed. (“See dictated H&P is not allowed”).
    a. The Short Form History and Physical must be completed in its entirety, indicating NA for components that are not applicable, and cannot refer to another document in place of completing a specific category. The Short Form History and Physical may be used for same day surgery and cardiology/special procedure patients. If the patient should require admission to inpatient or observation status, a comprehensive History and Physical must be completed. The Short Form H&P can only be updated within 30 days from the original date and only if the patient is returning for a similar procedure. After 30 days, a new H&P must be completed.
    b. An update can be made to an H&P that has been completed within 30 days. The physician shall indicate any history and physical changes in the first progress note or update the H&P using the H&P update stamp. The previous medical center H&P shall be readily available in the unit record. If the H&P is older than 30 days, a new H&P must be completed. An updated H&P can only be updated within 30 days from the original date and only if the patient is returning for a similar procedure.

c. Components of a comprehensive History and Physical include but are not limited to:
    i. Chief Complaint
    ii. History of Present Illness
    iii. Past Medical/Family/Social/Surgical History
    iv. Current Medications
    v. Allergies
    vi. Review of Systems
    vii. Physical Exam
    viii. Diagnostic Studies/Lab
    ix. Assessment/Impression
    x. Plan

2. The medical history and physical examination must be completed and documented by a physician or other qualified licensed individual, credentialed and privileged medical staff member, or allied health professional-advanced practice nurses/physician assistant in accordance with state law and hospital policy.
3. When podiatric surgeons or oral surgeons admit patients for inpatient care or same day surgery with pre-existing medical or psychological conditions that need to be managed, a consultation shall be obtained from an MD or DO upon admission. If a medical condition develops during the hospitalization, a consultation shall be obtained from an MD or DO to manage the medical care.
4. Dental admissions shall have an H&P completed by a doctor of medicine or osteopathy if the dentist is not an oral surgeon.
5. An H&P or consult shall be completed by a medical physician for Psychiatric or Child/Adolescent Services admissions
6. For an emergency situation, the H&P need not be on the chart prior to surgery, but should follow once the patient is out of imminent danger.
7. For elective surgeries and medical admissions, the physician's office H&P is acceptable if it has been completed within the time frames set forth above and is updated within 24 hours after the patient physically arrives for admission/registration but prior to surgery or a procedure requiring anesthesia services including moderate sedation. The office H&P shall include all components set forth above.
8. The prenatal office notes are acceptable, as part of the H&P. The physician shall document any updates in the H&P from the last prenatal visit to admission to the hospital by completing the obstetrical H&P form. This form completed in its entirety is acceptable for patients going to surgery either for cesarean or tubal ligation.
9. The history portion of the H&P shall include the chief complaint; details of present illness, and when appropriate, an assessment of the patient's emotional, behavioral, and social status; relevant past medical/surgical history; allergies; medications; family history; and social history; age appropriate psychosocial assessment (may refer to nursing assessment); and review of symptoms.

10. For pediatric patients, in addition to #8, the H&P shall include an appropriate assessment of the patient's developmental age versus chronological age; immunization status; educational needs and list of daily activities; and patient's family involvement in the treatment plan and continuous care of the patient (may refer to nursing assessment).
11. The physical examination shall be a comprehensive, current examination by the physician with in-depth examination and documentation noted for the specific problem under examination.
12. Pertinent Diagnostic Studies/Lab Results.
13. A statement listing the assessment/impression shall be included.
14. A course of action planned for the patient while hospitalized shall be included. There is a periodic review of the treatment plan and changes to the plan shall be documented in the progress notes.
15. The Invasive Procedure History and Physical is only used for outpatients who are undergoing invasive procedures and for which there is not a significant risk. The Invasive Procedure History and Physical must be completed and on the record after the patient has been registered. The Invasive Procedure History and Physical must contain at a minimum, the reason for procedure, significant medical problems and pertinent past medical history, medications, allergies, vital signs, and examination of the heart, lungs, decision making capacity and exam specific to body system or part where the procedure will be performed, a description of the planned procedure, and the planned disposition. All components must be addressed, indicating NA if not applicable and cannot refer to another document in place of completing a specific category. The Invasive Procedure History and Physical can only be updated within 30 days from the original date and only if the patient is returning for a similar procedure.

SECTION 10

CONSULTATION REPORTS

Consultation reports shall be completed within 24 hours of request or within the time frame specified by the requesting physician and is dependent on the patient's condition. Reason for delay shall be documented. The consultant shall examine the patient and review the medical record prior to completing the consultation examination. Any patient known or suspected to be suicidal shall have a consultation by a behavioral health evaluator who consults with a physician from the department of psychiatry.

SECTION 11

OPERATIVE/PROCEDURE REPORTS

1. Operative reports shall be dictated immediately after the surgical procedure. Procedure notes may be handwritten provided they are legible and complete.
2. There shall be a brief operative note handwritten in the progress notes or Post-Operative Progress Note form immediately after surgery which includes the name of the licensed independent practitioner and assistants, procedure(s) performed and description of the procedure, findings, any

significant estimated blood loss, as appropriate, any specimens removed, and postoperative diagnosis.

3. The surgeon shall dictate a complete operative note that includes a pre-operative diagnosis (may be in H&P), post-operative diagnosis, name of procedure, name of surgeon, name of assistant surgeon, indications for surgery (may be in H&P), evidence of informed consent noting risks and alternatives discussed with the patient (may sign consent or note in H&P), description of findings, technical procedures used, and specimens removed.

SECTION 12

PROGRESS NOTES

1. Progress notes shall be dated and signed at the time the note is written.
2. An admission progress note by the admitting medical staff member or covering member that documents a brief initial assessment must be written within 24 hours of admission (may be covered in the H&P). A medical staff member must assess the patient within 24 hours of admission regardless of whether the patient has already been seen by an AHP-APN/PA.
3. Each physician's patient in the acute care setting will be assessed and a progress note shall be written daily. Progress notes shall be written at least every three days for patients in non-acute care inpatient areas of the hospital campus and at least once every 30 days or whenever the patient condition changes in the Skilled Nursing Facility.
4. Progress notes shall reflect changes in the treatment plan.
5. Progress notes shall assess abnormal test results or other diagnostic or therapeutic treatment. Progress notes shall specify the reason for high- risk drugs or seclusion/restraint orders as noted in the nursing documentation.
6. When appropriate, progress notes shall indicate discussion of Living Will, Do Not Resuscitate Orders, donor/recipient options for potential transplant cases, and discharge AMA.
7. Progress notes shall be comprehensive and clinical, avoiding subjective one or two word brief statements, such as "improved" or "doing well".
8. Hospital ancillary personnel may document in the progress notes only as indicated under the General Conduct of Care as specified in the medical staff rules and regulations of PMC.
9. If death occurs, there shall be a note with the date and time of death written by the physician who pronounces the patient dead or by a registered nurse (RN) at the request of the physician. This shall occur no later than six hours after death.

ORDERS

1. There shall be admitting orders of which one of the orders specifies whether a patient is in an observation bed, same day surgery, or inpatient admission type according to IS/SI criteria. Subsequent orders shall specify any change in admission type. Patients cannot be admitted to ICU or NICO as an observation patient type.

2. There shall be diagnostic and/or therapeutic orders for all same day surgery patients to include an admission order.
3. Orders for oxygen in newborn patients shall be written in a percent.
4. An order is required by the attending physician when transferring care of a patient to another physician.
5. Standing order forms shall be dated and blanks filled in. The physician shall sign standing order forms as promptly as possible. Standing order forms shall be reviewed and updated by patient services.
6. A discharge or transfer order shall be written and signed as promptly as possible.
7. Physician orders should not contain any of the prohibited abbreviations.
8. Orders for outpatient diagnostic and rehabilitative services to patients from non- privileged/non-member providers may be accepted provided that such order received for services is within the scope of licensure of that practitioner. If any receiving department is unsure of the identity or licensure status of the ordering practitioner, a call shall be made to the Department of Medical Staff Services to verify the license/identity of the referring practitioner and legal scope of practice. (See MSS. Policy MSS.320 Outpatient Diagnostic and Rehabilitative Services)
    a. Criteria that ordering provider must meet:
        1. Responsible for the care of the Patient – provider/patient relationship established – under the care of (i) A doctor of medicine or osteopathy (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under State law or a State's regulatory mechanism – including Physician Assistants and Nurse Practitioners, but only with respect to functions which he or she is legally authorized by the State to perform.); (ii) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license; (iii) A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform; (iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices; (v) A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist; or(vi) A clinical psychologist, but only with respect to functions which he or she is legally authorized by the State to perform (vii) Nurse practitioners practicing independently, but only with respect to functions which he or she is legally authorized by the State to perform.
        2. Licensed in the state of practice under state law
        3. Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order applicable outpatient services.

SECTION 13

DISCHARGE SUMMARY / FINAL PROGRESS NOTE

1. A dictated discharge summary is required for all inpatient stays over 48 hours, all inpatient surgical cases, and for all deaths regardless of length of stay. A final progress note is acceptable for: 1) inpatient stays under 48 hours; 2) observation; 3) outpatient surgery who rollover to observation; 4) normal newborn; and 5) uncomplicated obstetric cases. The final progress note shall be completed and signed by the attending physician within 72 hours of discharge. The final progress note shall include the principal diagnosis (which is the reason after the study the patient sought hospital care) and complications and co-morbidities (CCs), the clinical condition of the patient on discharge (not in terms of "improved" or "doing well") and other secondary procedures when indicated. The newborn discharge examination may serve as the final progress note. Discharge instructions may be included in the final progress note or may refer to nursing discharge instruction sheet. Provided the operative note for SDS patients documents the diagnoses and procedures, the final progress note need not be completed.
2. All inpatient stays greater than 48 hours, inpatient surgical cases and deaths require a complete discharge summary. The attending physician shall complete the discharge summary within 72 hours of discharge. The discharge summary shall include the reason for admission, hospital course (or course leading to death), significant findings, procedures performed and treatments rendered, principal diagnosis, co-morbid conditions other than secondary diagnoses along with the principal procedure and all secondary procedures, clinical condition of the patient on discharge (not in terms of "improved" or "doing well"), discharge instructions to include medications, diet, physical activity, and follow-up (may refer to nursing discharge instruction sheet).
3. When an autopsy is performed, the provisional results shall be completed within two days and the final report shall be completed within thirty (30) days unless there are exceptions for special studies. Autopsy consents shall be signed according to law.
4. The entire medical record for each inpatient, same day surgery, or observation record shall be completed and ready for permanent filing within thirty (30) days post-discharge.

SECTION 14

DIAGNOSTIC REPORTS

The record shall include all diagnostic imaging and therapeutic test results.

SECTION 15

EMERGENCY ROOM RECORD

The emergency room physician or physician called-in shall document in the emergency room record the history of illness/injury, admit time and admit mode (refer to nursing), physical findings, vital signs (refer to nursing), emergency care given prior to arrival (refer to ambulance record), diagnostic and therapeutic orders, and assessment of medications that may affect the patient status. The physician shall document all results of treatment given, and note suspect for rape, child abuse, or physical assault, and indicate that the physician provided follow up and referral for suicide cases. The diagnostic impression shall be listed along with the patient's condition in clinical terms on discharge along with the discharge instructions (see nursing for discharge instructions). Any referral shall be documented to indicate when the patient left against medical advice (AMA). The ER record shall be completed within fourteen (14) days of the ER visit.

SECTION 16

MEDICAL RECORD REVIEW

1. The PMC medical staff shall support medical record review and approve criteria set forth in this section to be reviewed by HIS in conjunction with the utilization review committee (URC) and the medical staff. The criteria shall include the clinical pertinence of the documentation in the medical record, which is defined as timely, complete, accurate, meaningful, appropriate, and legible documentation.
2. Colorado Foundation for Medical Care (CFMC) and PMC utilization review program requirements shall be complied with according to regulations and time frames specified. Changes and revisions shall be reviewed and approved by the Medical Staff.
3. Physicians who have failed to complete their peer review assignments may be considered delinquent and the current suspension mechanism would apply. No physician should be required to perform a peer review outside of his/her clinical expertise.
4. Violations of the above will result in suspension of admitting privileges, and the privilege of treating any new patient not admitted under the physician's name as of the date of the suspension, until such time that records are complete.

SECTION 17

RETIRE INCOMPLETE RECORDS

The URC medical staff chairperson/committee shall have the authority to declare an incomplete record to be filed in the permanent file if the physician has expired, retired, resigned, or is permanently unavailable.

SECTION 18

SUSPENSION

1. Suspension is defined as the temporary suspension of admitting privileges from the date the suspension list is created the day following the last Wednesday of the current month. The physician shall not admit new patients to inpatient or observation status under his/her name or any other physician name. The physician shall not schedule inpatient, outpatient or observation status under his/her name or any other physician name. The physician shall not schedule inpatient or same day surgery if he/she is on the suspension list. Previously scheduled surgeries remain scheduled.
2. The Health Information Services (HIS) shall send bi-weekly notices to all physicians informing them of their incomplete medical records (records less than 14 days old) and delinquent records (records 14 days old and older). Physicians will be suspended for having 10 or more delinquent records that are 14 days old or older. Physicians will be suspended for one or more delinquent records 60 days old or older.
3. When a physician is placed on suspension, HIS will notify: 1) physician; 2) physician's credentials file; 3) Chief of Staff; 4) medical department chairperson; 5) URC chairperson; 6) administration; 7) surgery; 8) staffing; 9) emergency room and 10) admissions. Upon completion of all the incomplete medical records by the physician, HIS will notify the above areas to remove him/her from the suspension list. This immediately reinstates the physician to the medical staff and full admitting or surgery scheduling privileges are granted to the physician.
4. The physician or his/her office shall notify HIS if the physician is on vacation, sick, or if any other extenuating circumstances exist that may prevent him/her from completing their medical records in a timely manner. If not already on suspension, the physician will have one week to complete the records upon his/her return. If the physician is already on suspension at the time of their absence, the physician remains on suspension.

SECTION 19

COMMITTEES

1. Utilization Review
    a. <u>Composition</u>

    The utilization review committee shall consist of medical staff representatives from each of the following departments: surgery, medicine, OB/GYN, family practice, radiology, emergency medicine, anesthesia, psychiatry, and pediatrics. Each representative shall be appointed by the chairperson of his/her respective department. Each position shall be for a three (3) year staggered term. The committee shall be chaired by the Chief Medical Officer. Each medical staff department shall appoint a designated representative to serve on this committee. Ex-officio, non-voting members shall be the

president/chief executive officer or his/her designee and the chief nursing officer.

b. Meetings

The quality and utilization review committee shall meet at least quarterly and report in writing to the executive committee.

c. Duties

The duties in evaluating the quality of patient care and utilization of the medical center's resources are:

1. Review and act upon findings from the PM/PI activities:
    i. process review
    ii. risk management
    iii. generic occurrence screens
    iv. utilization management
    v. operative and other procedures
    vi. medical assessment and treatment of patients
2. Performs the medical record review functions
3. Adopt specific programs and procedures for the identification and resolution of problems that impact the quality of patient care in order to maintain the desired quality, efficiency, and effectiveness of patient care within the medical center.
4. Forwards any educational needs to medical staff committees.

d. Committee Chairperson Responsibilities

1. Serve as a member of the medical executive committee, the quality committee of the board, and the Senior Leadership Team.
2. Gives medical staff quality reports to the medical executive committee at least quarterly and to the SLT and quality committee of the board on an annual basis.
3. Responsible for leading the implementing the quality improvement process tools in all of the medical staff clinical quality process.
4. Supports Parkview Medical Center's "quality" philosophy.

e. Committee Member Responsibility

1. Each member represents his or her clinical department.
2. Feedback from the clinical departments shall be reported by the committee members to the Utilization Review Meeting.
3. Committee members shall support the "quality" philosophy of Parkview Medical Center.
4. Shall function as team members and utilize the quality improvement process tools in all of the medical staff clinical quality processes.

2. Critical Care Committee (ICU, NICU)

a. Composition

The Critical Care committee shall consist of at least one (1) member of the department of surgery, two (2) members of the department of medicine, one (1) pulmonary/critical care disease specialist, and one (1) emergency medicine physician, one (1) of the members must be a

neurosurgeon or neurologist, one must be a cardiologist or a cardiac surgeon. All members shall be appointed by the Chief of Staff. Ex-officio, non-voting members shall be the president/chief executive officer or his/her designee, the nursing director for critical care services, the nurse managers for MICU, CVICU and NICU, and the director of Respiratory Therapy services. The chairperson shall be appointed by the Chief of Staff.

b. Meetings

The special care committee shall meet no less than quarterly or as needed as combined units. They will report their findings to the executive committee.

c. Duties

1. Formulate and evaluate the medical center patient care procedures and monitor medical conduct of the special care units.
2. Review and evaluate the quality, safety, and appropriateness of care rendered in the unit and report such findings to the executive committee.

3. Medical Education Committee

a. Composition

The medical education committee may consist of medical staff representatives of the following departments appointed by the respective chairperson: medicine, surgery, psychiatry, OB/GYN, pediatrics, emergency, family practice, the trauma coordinator and the Director of Graduate Medical Education. The Chief Medical Officer shall be an ex-officio, non-voting member.

b. Meetings

The medical education committee shall meet at least two (2) times a year or as needed and report its findings to the Governing Body.

c. Duties

1. Coordination of medical staff and medical center continuing education activities.
2. Upon the recommendations of the quality utilization review committee, clinical departments, medical center administration, the medical staff, and the medical center PM/PI programs, identify and meet education needs.
3. Analyze the changing needs of the medical center library service for hospital management.

d. Purpose

To improve the general level of patient care in Parkview Medical Center by providing ongoing educational opportunities for the physicians on staff in order to increase their knowledge and skills

e. Goals

To provide an ongoing program of continuing education for physicians, or both topics of general interest and those on sub-specialty conferences at regularly scheduled intervals. The program

will be offered to all members of the medical staff and to all physicians in Pueblo and outlying rural areas.

f. Organization

The medical education committee consists of representatives from the major departments of the medical staff. The chairperson is the director of medical education and is appointed by the chief of staff. The needs of the medical staff are evaluated by the committee who made recommendations for programs. The director of medical education or his/her designee is responsible for arranging such programs as will meet the needs of the staff.

Funding for the programs is provided through grants from Parkview Medical Center, fees for individual conferences, and donations from other organizations.

4. Infection Control Committee
    a. The Infection Control Committee shall be a multidisciplinary committee consisting of the director of med/surg, representative from respiratory therapy, operating room educator, director of cardiopulmonary, supervisor of microbiology, pharmacy director and clinical pharmacist, director of surgical services, director of environmental services, employee health nurse, homecare director, representative from sterile processing, director of plant operations, the Chief Medical Officer, the director of infection control and three representatives for the medical staff appointed by the Chief of Staff. The chairperson shall be appointed by the Chief of Staff for a two (2) year term and may be reappointed for additional terms.
    b. All members shall have voting privileges.
    c. The committee shall meet quarterly or as needed as determined by the chairperson.
    d. The committee will report to the medical executive committee.
    e. The duties of the infection control committee shall be to:
        - Provide standard criteria for the identification and classification of infections;
        - Determine the type of surveillance and reporting system to be used;
        - Recommend corrective action based on records, reports, and reviews of infections and infection potential among patients and hospital employees;
        - Review results of any antimicrobial susceptibility/resistance trend studies; monitor all findings from any patient care quality assessment activity that relates to infection control;
        - Make and review policies and procedures with review of policies at least every two (2) years;
        - Provide guidelines for isolation precautions/barrier protection for the protection of patients and staff;

- Institute appropriate control measures or studies where there is reasonably considered to be a danger to any patient or staff in collaboration with physician staff and hospital staff.

5. Pharmacy and Therapeutics Committee
    a. The Pharmacy and Therapeutics Committee (P&T Committee) shall be a multidisciplinary committee consisting of the Chief Nursing Officer, (preferably) two (2) lead clinical nurses, a representative from Microbiology, a representative from Nutritional Support, the Pharmacy Director, Pharmacy Manager, Pharmacy Administrative Coordinator or Clinical Pharmacist, Chief Medical Officer, Chief Clinical Officer the Infection Control Nurse and three (3) representatives from the medical staff appointed by the Chief Medical Officer. The chairperson shall be appointed by the Chief of Staff and shall serve for at least two (2) years. It will not be necessary to establish a quorum in order to vote on pertinent issues.
        - Computerized Physician Order Entry (CPOE) Governance Committee shall be a sub-committee of the P&T Committee consisting of Pharmacy Staff, Nursing Staff, Information Systems staff, Chief Medical Officer or the Chief Clinical Officer.
            - Duties shall include review and approval of predefined order sets that contain medication orders in an effort to facilitate utilization of the CPOE system.
            - All order set requests from individual members/ departments of the Medical Staff will be reviewed and approved through this Committee.
            - CPOE Governance Committee will report to P&T Committee
    b. All members shall have voting privileges.
    c. The Committee shall meet at least quarterly.
    d. The Committee will report to the Medical Executive Committee.
    e. The duties of the Pharmacy and Therapeutics Committee shall be to:
        - Develop and approve policies and procedures relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials;
        - Drug Therapy Management protocols (see Colorado State Board of Pharmacy Rules and Regulations);
            - Review and approve clinical protocols (vancomycin and aminoglycoside kinetics, warfarin dosing and monitoring, parenteral nutrition (TPN), renal dosing, and Lipid Clinic)
        - Review and approve all standing orders containing medications;
        - Develop and maintain the drug formulary (See Pharmacy P&P 150-15)
            - The formulary policy includes a position regarding herbs and supplements (See Pharmacy P&P 060- 128);

- Review all significant adverse drug reactions (See Pharmacy P&P 150-10)
    - Summaries of adverse drug reactions are analyzed for trends and opportunities for correction and improvement;
- Monitor and evaluate the use of drugs, based on objective criteria, that reflect current knowledge, clinical experience and relevant literature
    - Report, as appropriate to the Medical Staff, the conclusions, recommendations and actions regarding medication use review; and
- Maintain written minutes of conclusions, recommendations, actions taken, and results of actions taken.
    - Report these findings by the most expeditious means including Email, "***Physician's Resource"***, etc.

6. Code Blue and Rapid Response Committee
    a. The Code Blue and Rapid Response committee shall be a multidisciplinary committee consisting of the medical director of critical care services, the nursing director of critical care services, the nursing managers of CVICU, NTICU, MICU and the director of Respiratory services, clinical pharmacist, supervisor of sterile processing, director of emergency services, Chief Nursing Officer, Vice President of Medical Affairs, and three (3) representatives from the medical staff appointed by the Chief of Staff. The chairperson shall be appointed by the Chief of Staff and shall serve for two (2) years.
    b. All members shall have voting privileges.
    c. The committee shall meet at least quarterly or as needed as determined by the chairperson.
    d. The committee will report to the Medical Executive Committee
    e. The duties of the Code Blue and Rapid Response committee shall be to provide for an organized mechanism for providing resuscitation services. This mechanism includes:
        - Appropriate policies, procedures, processes or protocols governing the provision of resuscitation services;
        - Appropriate equipment placed strategically throughout the hospital close to areas where patients are likely to require resuscitation services;
        - Appropriate staff trained and competent to recognize the need for and use of designated equipment in resuscitation efforts.
        - Appropriate data collection related to the processes and outcomes of resuscitation; and
        - Ongoing review of outcomes related to resuscitation in the aggregate to identify opportunities for improvement of resuscitation efforts.
        - Maintain written reports of conclusions, recommendations, actions taken, results of actions taken and report quarterly or as appropriate to the medical staff clinical departments.

7. Trauma QA Committee
    a. The Trauma QA Committee is a subcommittee of the Medical Executive Committee and is the governing medical staff team for trauma care and reports directly to the Medical Executive Committee as needed. The committee consists of at least one emergency department physician, one orthopedic surgeon, one general/trauma surgeon, one neurosurgeon, one anesthesiologist, one radiologist, one pathologist, and surgical department chair. Ex-officio members include: administrative representatives,
    nursing directors from surgical services, emergency service, critical care and the trauma nurse coordinator. Members are appointed by the chairperson (Medical Director of Trauma Services) for two-year terms. They may be reappointed.
    b. Voting shall be determined by the committee chair.
    c. Fifty percent (50%) attendance is required for each member.
    d. The committee shall meet quarterly or as needed as determined by the chairperson.
    e. The duties of the trauma QA committee shall be to:
        - Set policy related to trauma care;
        - Review trauma care, the performance of the trauma program;
        - Develop educational programs;
        - Perform chart review on cases that meet pre-determined criteria and to use that information for performance improvement;
        - Maintain written reports of conclusions, recommendations, actions taken, results of actions taken and report quarterly or as appropriate, to the medical staff clinical departments.

8. Transfusion Committee
    a. The transfusion committee shall be a multidisciplinary committee consisting of the director of laboratory services, blood bank supervisor, director of maternal child services, director of ICU, oncology clinical nurse, director of accreditation/medical staff services, director of pharmacy, director of surgical services, director NICU and med/surg, lead clinical nurse for NICU, director of emergency services, Chief Nursing Officer, Vice President of Medical Affairs and five (5) representatives from the medical staff (to include at least one representative from surgery, emergency department, and anesthesia and two at-large appointees) appointed by the Chief of Staff. The chairperson shall be appointed by the Chief of Staff for a two (2) year term and may be reappointed.
    b. All members shall have voting privileges.
    c. The committee shall meet quarterly or as needed determined by the chairperson.
    d. The committee will report to the Medical Executive Committee.
    e. The duties of the transfusion committee shall be to:

- Monitor and evaluate the appropriateness and effectiveness with which blood and blood components are used, as determined by the use of medical staff approved screening criteria;
- Develop and/or approve policies and procedures for ordering, preparation and handling, distribution and administration of blood and blood products;
- Evaluate all confirmed transfusion reactions;
- Review the adequacy of transfusion services to meet the needs of patients;
- Review ordering practice for blood and blood components;
- Maintain written reports of conclusions, recommendations, actions taken, results of actions taken and report quarterly or as appropriate to the medical staff clinical departments.

9. Ethics Committee
    a. The Ethics Committee is a unique committee to Pueblo, Colorado. It is a multidisciplinary countywide committee consisting of 29 members from the Pueblo community, Parkview Medical Center, Colorado Mental Health Institute, and St. Mary Corwin. Parkview Medical Center membership shall include seven members who are employees of Parkview Medical Center and at least five physician members from all three hospitals. Membership may change from time to time.
    b. All members shall have voting privileges.
    c. The committee shall meet twice a year or as needed.
    d. The duties of the Ethics Committee shall be:
        - Educational programs and policy setting for the community with results reported to URC and the SLT.
        - Consultation requests for ethical issues in patient care.
10. Cardiovascular Conference Committee
    a. The cardiovascular conference committee is a subcommittee of the medical cardiovascular care. It reports directly to the Medical Executive Committee. The committee consists of all staff cardiologist and cardiovascular surgeons. Administrative members include: administrative representatives, cardiopulmonary services director, ICU director, CEO, VP/CNO, and VP/MA. Term of membership is ongoing.
    b. Voting shall be determined by the Cardiology Medical Director.
    c. There is no attendance requirement.
    d. The committee shall meet monthly or as needed determined by the Cardiology Medical Director.
    e. The duties of the cardiovascular conference committee shall be to:
        - Set policy related to cardiovascular care;
        - Review cardiovascular care, the performance of cardiovascular program;
        - Review cases who have had interventional procedures and review need for surgical interventions;

- Perform peer review on cases that meet pre-determined criteria and to use that information for performance improvement;
- Develop periodic reports of statistics, outcomes and results of peer review to the appropriate medical staff clinical departments.

SECTION 20

CONFLICT RESOLUTION

Any conflict between the organized medical staff and the MEC will be resolved using the mechanisms noted below:

1. Submission of written notification to the Chief of Staff of the challenge and the basis for the challenge including any recommended changes to the rule or policy.
2. At the meeting of the MEC that follows such notification, the MEC shall discuss the challenge and determine if any changes will be made to the rule or policy.
3. If changes are adopted, they will be communicated to the medical staff, at such time each medical staff member in the organized medical staff may submit written notification of any further challenge(s) to the rule or policy to the Chief of Staff.
4. In response to a written challenge to a rule or policy, the MEC may, but is not required to, appoint a task force to review the challenge and recommend potential changes to address concerns raised by the challenge.
5. If a task force is appointed, following the recommendations of such task force, the MEC will take final action on the rule or policy.
6. Once the MEC has taken final action in response to the challenge, with or without recommendations from a task force, any medical staff member may submit a petition signed by fifty percent (50%) of the organized medical staff requesting review and possible change of a rule, regulation, policy or procedure. Upon presentation of such a petition, the amendments and adoption procedure outlined in Articles XVII-XVIII will be followed.

If the organized medical staff votes to recommend directly to the Board an amendment to the bylaws or rules and regulations or a policy that is different from what has been recommended by the MEC, the following conflict resolution process shall be followed:

1. The MEC shall have the option of appointing a task force to review the differing recommendations of the MEC and the organized medical staff, and recommend language to the bylaws, rules and regulations, or policy that is agreeable to both the organized medical staff and the MEC.
2. Whether or not the MEC adopts modified language, the organized medical staff shall still have the opportunity to recommend directly to the Board alternative language. If the Board receives differing recommendations for bylaws, rules and regulations, or a policy from the MEC and the organized medical staff, the board shall also have the option of appointing a task force of the Board to study the basis of the differing recommendations and to recommend appropriate Board action. Whether or not the Board appoints

such a task force, the Board shall have final authority to resolve the differences between the medical staff and the MEC.

At any point in the process of addressing a disagreement between the medical staff and MEC regarding the bylaws, rules and regulations, or policies, the OMS, MEC, or governing board shall each have the right to recommend utilization of an outside resource to assist in addressing the disagreement. The final decision regarding whether or not to utilize an outside resource, and the process that will be followed in so doing, is the responsibility of the Board.

DEPARTMENT RULES AND REGULATIONS AND CLINICAL DELINEATION OF PRIVILEGES

DEPARTMENT OF ANESTHESIA

SECTION 1

RULES AND REGULATIONS

The department of anesthesia shall have the responsibility to:

1. Provide anesthesia services in the form of anesthetic agents and techniques as appropriate for the patient, the surgical procedure, and the capabilities of the anesthetist concerned.
    a. Anesthesia care will be provided 24 hours a day, seven days a week for all surgical and operative/complicated obstetrical cases. When not physically present in the hospital, the on-call CRNA or PA and anesthesiologist will inform the hospital operator and nursing supervisor of his/her location and/or telephone pager number.
        i. Anesthesia call is from 0700 to 0700.
        ii. Any call case started by an individual or group will be completed by that individual group.
        iii. Add-on cases scheduled throughout the day shall be distributed at the discretion of the front desk. Cases started after 15:00 will be the responsibility of the on-call anesthesia provider.
    b. The anesthesia department shall provide both the personnel component in the knowledge and proper application of anesthetic agents and the availability of equipment necessary for the conduct of anesthesia.
    c. When an anesthesiologist is directly supervising a CRNA or PA in the administration of an anesthetic, he/she is to be physically present or immediately available to the operating suite. The anesthesiologist is responsible for the professional medical and anesthetic care of the patient. When a CRNA or PA administers the anesthetic without the direct supervision of an anesthesiologist, all parties must understand that the professional medical care of the patient during such administration is delegated to the surgeon or other physician present. When the operating surgeon/anesthesia provider team consists entirely of non-physicians, there must be a physician immediately available in case of a medical emergency.
    d. Anesthesia call shall be formulated so that on any given day a “back-up” or “second call” status shall be maintained. The call list shall be established in such a way that the on-call CRNA or PA always has an anesthesiologist as second call. CRNA and PAs are instructed to consult the anesthesiologist liberally regarding emergencies. In such situations, if disagreement persists after consultation, the staff anesthesiologist shall be obliged to assume the responsibility for conduct of the anesthetic. Should the clinical situation not permit the delay involved in summoning the anesthesiologist, the responsibility and, likewise, the authority of anesthetic care is delegated to a

surgeon, and his/her decision shall be binding. The chairperson of the department of anesthesia is subject to consultation at any time by either party if the situation cannot be resolved at the primary level.

2. Determine, in collaboration with the operating surgeon, the type of anesthetic to be employed.
    a. All surgical and obstetrical patients will be evaluated pre-anesthetically by the responsible anesthesia provider. In order to promote continuity of care and to promote the experience and in-depth training of CRNAs or PAs, at the discretion of the chairman of the anesthesia department, the CRNA or PA may perform the pre-anesthetic evaluation of their assigned patients and plan the anesthetic management. Both of these functions will be critically reviewed by an anesthesiologist, prior to implementation of any part of the CRNAs or PAs proposed course of action, and alterations made as appropriate. All pre-anesthesia evaluations, plans for anesthetic management, anesthesia records and orders by the CRNA and PA shall be reviewed and countersigned by the supervising anesthesiologist or other delegated anesthesiologist.
    b. Evaluation will include review of the chart and interview with the patient to discuss medical, anesthetic, and drug history, establish NPO status, and to perform any examination or investigations that would provide information that should assist in decisions regarding anesthetic risk management (see Department of Anesthesia Routine Guidelines for Pre-Operative Testing). An anesthesia questionnaire must be completed for the patient in all but extreme emergencies when he/she is admitted to the nursing unit.
    c. Consultations shall be obtained as believed necessary. Request of consultations initiated by CRNAs and PAs will be routed via the chairperson of the department or his/her designee. The department of anesthesia desires notifications of preoperative patients who present conditions, which, in the surgeon's opinion, merit pre-operative non-anesthesia consultation, especially those in the realm of internal medicine. Thus, even in the absence of a formal consultation directed to the anesthesia department, early evaluation by an anesthesiologist is possible, permitting better opportunity to plan effectively and concurrently with other specialists. Certainly advance notice of any factor likely to affect the anesthetic management, or to render the surgical procedure itself non-routine, is encouraged and welcome.
    d. Diagnostic impressions, assessment of risk via classification of ASA physical status 1-5 and choice of anesthetic technique shall be recorded on the patient's chart.
    e. Ultimate choice of anesthetic technique is the prerogative of the medical department of anesthesia, unless the case is scheduled as a "local". In this instance, no anesthesia services are rendered. If "MAC" (Monitored Anesthesia Care) or "standby" services are requested, the usual evaluation and services are provided.
    f. <u>Informed Consent.</u> The individual responsible for anesthetic care (anesthesiologist, CRNA, PA) shall discuss the anesthesia plan with

the patient and/or responsible adult, including potential risks and benefits involved. Informed consents shall be documented (see obstetrical anesthesia and surgical anesthesia consent forms).

g. Anesthetic Administration
    i. Each patient shall be re-evaluated immediately prior to induction of anesthesia including but not limited to the following:
        - Confirmation that ordered laboratory and diagnostic examinations have been recorded on the chart and are within acceptable limits
        - Determination that the effect of pre-medication has not been adverse
        - Determination that no conditions have arisen since the pre-anesthetic visit, which might affect the choice or conduct of the planned anesthetic.
    ii. Prior to induction, a careful and thorough check of anesthetic and monitoring equipment and gas supplies, drugs, and fluids shall be performed as a routine safeguard against equipment failures.
    iii. Each patient will be appropriately monitored (see basic standards for intra-operative monitoring).
    iv. Anesthesia will share responsibility for patient positioning and its complications with the OR staff and surgeon. Anesthesia will accept sole responsibility for eye care while under anesthesia.
    v. At the conclusion of anesthesia, the responsible anesthesia provider shall accompany the patient to the post-anesthesia care unit (PACU).
h. Post Anesthesia Care
    i. The responsible anesthesia provider shall give an appropriate report to PACU personnel and remain with the patient until such time as the requirements for patient care are within the capabilities of PACU personnel.
    ii. The anesthesia department shall remain responsible for the care of the patient in conjunction with the primary surgeon while the patient remains in PACU. (The anesthesia department will have primary responsibility for anesthetic related problems, while the surgeon will have the responsibility for surgically related problems).
    iii. Discharge from the PACU shall be according to criteria established by the anesthesia department and nursing service administration.
    iv. Whenever possible a post-anesthetic visit preferably within 48 hours, shall be performed by a member of the anesthesia department. Anesthesia-related problems shall be noted, the operating surgeon notified, and management outlined.

3. Render consultative advice to the responsible surgeon in the event of any post-anesthetic complications.

a. Post-anesthetic visits shall be performed in order to detect any unfavorable results of the anesthetic procedures, including, but not limited to: positional injury to peripheral nerves or other tissues, thermal injury, backache, headache, pulmonary disorders, significant hepatic or renal sequelae and peripheral phlebitis. If further therapy is believed to be warranted, it shall be with cognizance and consent of the responsible surgeon.
b. A further aim of post-anesthetic visits is to alleviate any misunderstanding or adverse psychological sequelae related to the anesthetic procedure.

4. Maintain a complete written record of each anesthetic administered. Documentation is a factor in the provision of quality care, and is a responsibility of the individual(s) providing the anesthetic care. While anesthesia is a continuum, it is usually viewed consisting of pre- anesthesia, peri-anesthesia, and post-anesthesia components. Anesthesia care should be documented to reflect these components and to facilitate review. The record should include documentation of:
    a. Pre-Anesthesia Evaluation
        i. Patient interview to review:
            - Medical history
            - Anesthesia history
            - Medication history
        ii. Appropriate physical examination
        iii. Review of objective diagnostic data (e.g., laboratory, ECG, x-ray)
        iv. Assignment of ASA physical status
        v. Formulation and discussion of an anesthesia plan with the patient and/or responsible adult
        vi. Informed consent
    b. Pre-Anesthesia (time-based record of events)
        i. Immediate review prior to initiation of anesthetic procedures
            - Patient re-evaluation
            - Check of equipment, drugs, and gas supply
        ii. Monitoring the patient (e.g., recording of vital signs, see basic standards for intra-operative monitoring)
        iii. Amounts of all drugs and agents used and times given
        iv. The type and amounts of all intravenous fluids used including blood and blood products
        v. The anesthetic technique(s) used
        vi. Unusual events during the anesthesia period
        vii. The status of the patient at the conclusion of anesthesia
    c. Post-Anesthesia (see standards for post-anesthesia care)
        i. Patient evaluation on admission and discharge from the PACU
        ii. A time-based record of vital signs and level of consciousness
        iii. All drugs administered, dosages, and times given
        iv. Type and amounts of intravenous fluids administered including blood and blood products

v. Any unusual events including post-anesthesia or post-procedural complications
vi. Post-anesthesia visits

5. Render consultative services to the physician in charge of patients with problems of airway patency, respiratory depression, and other cardiopulmonary disorders. Continual, integral involvement and practice in the techniques, theory, and clinical dynamics of cardiopulmonary support are inherent in the administration of anesthesia. The staff of the anesthesia department shall provide an around the clock source of expertise in airway management and therapy of physiological depression regardless of etiology. This assistance may consist simply of consultative advice, or extended if requested, to actual management in cases requiring intermittent or continuous ventilatory support, interpretation of blood gas studies, and assessment of pulmonary function.
6. Established policies relative to anesthetic safety.
    a. Flammability
        i. Flammable anesthetics are not to be used or be physically present in the department. All solvents or cleaning agents must be non-flammable.
        ii. Anesthesia staff members shall have access to and be familiar with NFPA Bulletin 56.
    b. Electronic
        i. All electronic equipment used during anesthesia or resuscitation by the anesthesia staff shall be inspected at regular intervals, both for proper function and for absence of electrical hazard to patients or personnel. Written record of such inspections will be kept in a departmental equipment log by the chief of anesthesiology service.
        ii. Service contracts for electronic equipment, with manufacturer representatives, shall be maintained to manufacturer specifications.
        iii. Electronic techniques shall perform regular testing of all cardiac defibrillators in the hospital, including that under the jurisdiction of the anesthesiology service.
        iv. Malfunction of any electronic equipment in the operating suite shall be reported to the chief of anesthesiology service or his/her designee to ensure prompt removal from the area of possible electrical hazard to patients or other personnel. This includes monitoring devices, electrosurgical apparatus, electric powered implements, and defibrillators.
    c. Chemical
        i. The chief of anesthesiology service shall cause to be investigated any adverse drug reaction or evidence of unanticipated chemical toxicity occurring in relation to administration of anesthesia.
        ii. Appropriate precautions and inspections will be carried out for loss of potency and/or degradation of anesthetic and adjunctive drugs.

iii. Non-narcotic anesthesia drugs shall be stored in the anesthesia drug room. Ordering, restocking, and checking for outdated drugs shall be the responsibility of the anesthesia technical and pharmacy department.

iv. Controlled substances needed by anesthesia will be checked out from the OR Satellite Pharmacist as described in Pharmacy Policy 060-110. Narcotics will be requested on an Anesthesia Pharmacy Narcotic Dispensing Form. The form should include the patient name, billing number, date, the drugs requested and the signatures of the dispensing pharmacist and the anesthesia personnel requesting the narcotics. The drugs will be dispensed in a plastic box with the white copy of the form. (OR Pharmacist will keep the yellow copy of the form). Anesthesia personnel are responsible for returning the form along with any unused drug to the OR Pharmacist. Drugs used and unused must be documented on the form.

If narcotics are needed at a time when the OR Pharmacist is not on duty, a limited supply of narcotics is kept in the night box in the Anesthesia Workroom. Access to the night box key is by a code assigned by the Department of Security.

Anesthesia personnel are responsible for documenting on the record any narcotics used from the night box, including the patient name, billing number, drug, and amount used and wasted. Drug to be wasted will either be left in the locked night box drawer or deposited in the designed container.

Controlled substances for anesthesia are also kept on 5SW LDRP in a locked cabinet. Access to the cabinet is by code assigned by security. Anesthesia personnel are responsible for documentation of drug used and wasted as described above. Unused drug is either returned to the OR Pharmacist, left in the locked night box drawer in the OR, or deposited in the designated container in the OR.

d. Anesthetic Apparatus

i. Written records shall be kept of regular inspections of anesthesia machines and ventilators. Maintenance contracts for periodic preventative maintenance and minor repair of such equipment shall be entered in the record of that machine.

ii. Standard departmental procedures will be defined in manuals for cleansing and decontaminating reusable equipment. Adequacy of these measures will be tested by periodic bacteriologic samplings.

iii. In accordance with hospital recommendations, laryngoscopes and all other reusable anesthesia equipment in direct contact with the patient will be cleaned after each procedure in accordance with the acceptable standards.

iv. Spinal, epidural, and other major regional block anesthesia/analgesia will be administered only with single-use disposable needles, syringes, and medication ampules.

7. Meetings

On alternating months, the anesthesia department shall have six (6) meetings annually or as needed to include selected non-physician OR and anesthesia staff annually as a means to further communication, address PM/PI and education, and attend to administrative issues pertaining to anesthesia in the OR; and on alternating months shall have six (6) meetings annually or as needed of physician department members to discuss peer review issues and perform credentialing functions.
Credentials and/or peer review issues requiring action during months when there is no meeting to be held to address peer review and credentialing will be addressed at an ad hoc meeting of the department physician members.

The members of the Department shall elect a chairperson and a vice-chairperson of the Department of Anesthesia. Term office shall be two medical staff years, with consecutive terms allowed if elected and desired by the incumbent officers. The functions and responsibilities of the chairperson are outlined and shall be in accordance with Article XI, Section 3 of the medical staff bylaws. The PM/PI Officer of the Department of Anesthesia shall be the chairperson.

DEPARTMENT OF EMERGENCY MEDICINE

SECTION 1

RULES AND REGULATIONS

1. Definition
    a. The Department of Emergency Medicine shall be considered to consist of those physicians, at the time of their initial application, that have completed an ACGME- or AOA approved post-graduated training program in emergency medicine and are in the process of Board Certification or board certified in Emergency Medicine. Department membership will also consist of board certified or in the process of Board Certification physicians in Family Practice, Pediatrics, and Internal Medicine.
    b. Those physicians, who at the time of approval of these rules and regulations are members of the Department and are not board certified or in the process of Board Certification, will have been deemed to meet the criteria (grandfathered).
    c. Full-time physicians on Active Staff will have voting privileges in the department.
2. Functions
    a. The emergency medicine department shall have ongoing PM/PI review of a practicing physician's competence even after he/she has become a member of the active staff. This will be done periodically during a physician's membership in the department of emergency medicine, at the time of application for reappointment for staff privileges, and at any time as deemed necessary according to the Medical Staff Peer review policy as modified for the Department of Emergency Medicine. Issues regarding quality accountability should be directed to the attention of the chairperson of the department for appropriate action.
    b. The members of the department shall elect a chairperson and a vice-chairperson of the Department of Emergency Medicine. Only Active full time practitioners may hold office. Term office shall be two medical staff years, with more than two consecutive terms allowed if elected and desired by the incumbent officers. The functions and responsibilities of the chairperson are outlined and shall be in accordance with Article X, Section 3 of the medical staff bylaws. The PM/PI Officer of the Department of Emergency Medicine shall be the Department Chairperson. Removal of an officer during his/her term of office may be accomplished by a two- thirds (2/3) majority affirmative vote of the active staff members of the department.
    c. Members of the Department are expected to provide high quality care for patients, actively participate in departmental and medical staff activities and attain an ongoing basis sufficient continuing medical education to maintain competency.

3. Meetings
    a. Department meetings shall be held monthly or as needed. Voting members are required to attend 50% of the meetings held during the year unless excused by the Department Chair.
4. Clinical Privileges
   A delineation of privileges available in the department is outlined in the medical staff rules and regulations. A physician need not be a member of the emergency medicine department to apply for certain individual privileges, which cross specialties, as well as CORE privileges.
   Consideration of the physician's training, education, experience, competence, and the need for initial supervision on an individual supervision on an individual basis will be the basis for granting of privileges.

SECTION 2

DELINEATION OF PRIVILEGES

1. GENERAL
    a. Each staff physician will be classified as having certain professional privileges as outlined below. Privileges should be requested as appropriate for the physician's training, education, experience, and competence. The initial request for privileges will be reviewed by the Department Chair prior to review at the Credentials Committee, the Medical Executive Committee, the Medical Relations Committee and the Board of Directors.
    b. Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a practitioner exercises clinical privileges. The practitioner's physical and mental health status shall be compatible with the privileges requested.
    c. Any physician may take appropriate <u>emergency</u> action in a situation where, in the best judgment of the physician, lack of such immediate action would result in the patient's death or significant morbidity. It is not necessary for the physician to have privileges delineated relating to the emergency action.
    d. Any physician who does not meet the criteria for the category of privileges they desire may request further increases in their privileges in the department of emergency medicine by fulfilling one or more of the following:
        i. By completing an approved residency program or fellowship with documented proof of competency.
        ii. By becoming board certified or eligible in Emergency Medicine, Internal Medicine, Family Practice, or Pediatrics.

iii. By active participation in education programs or additional training in the area of privileges desired. Documented proof of competency will be required for review.
iv. By specifying disease or groups of diseases they wish to treat or procedures they wish to perform, and requesting authorization from the medical department for these privileges. All requests must be accompanied by proof of competency in the areas requested.

e. The department of emergency medicine may request a period of proctorship, in addition to the period required for initial FPPE to verify competence of an otherwise qualified individual.

SECTION 3

REQUIREMENTS FOR ULTRASOUND PRIVILEGES:

1. Training and credentialing of emergency physicians will be done on a voluntary basis. Physicians not interested in learning sonography will continue to order ultrasound studies under existing protocols. Emergency physicians who have completed training and proctoring will continue to have the option of calling a technician or radiologist to obtain studies.
2. To be eligible to apply for privileges in goal directed Emergency Department ultrasound, the applicant must:
    a. Be board certified or board prepared in Emergency Medicine, ***AND***
    b. Have completed a residency in emergency medicine in a training program in which formal ultrasound training is included in the curriculum in accordance with published guidelines from the American College of Emergency Medicine, ***OR***
    c. Have had ED ultrasound privileges at another hospital with equivalent credentialing requirements and have evidence of competency confirmed by that hospital, ***OR***
    d. Have successfully completed at least 24 hours of formal training through a course approved by the American College of Emergency Physicians in Emergency Department ultrasound. Following the course, there must be evidence of at least 12 hours of “hands on” training in the ultrasound suite, plus 16 hours of independent study (e.g., directed readings, computer tutorial programs, time spent working with technicians or radiologists).
3. If he/she meets these criteria, the emergency physician will be recommended for privileges in ED ultrasound. Emergency Department ultrasound studies will be goal directed. The specific goal or “rule-out” diagnosis will be noted for each study performed. Emergency Physicians will record their interpretations of all studies as positive, negative or indeterminate for “rule-out” diagnosis on the ED Ultrasound Log and on the patient’s ED record.
4. During the period of FPPE for new privileges, the ED physician must perform 25 studies, including at least 10 with positive findings. Each study must be concurrently confirmed either by a repeat study in the Medical Imaging Department or by surgical confirmation of ED findings in cases in which

surgeons choose to take patients to the OR before a repeat study can be performed because of the patient's critical condition.

a. Accuracy of studies will be judged on whether or not the study correctly identifies the presence or absence of the "rule-out" diagnosis.
b. Failure to note findings incidental to the stated goal of the study will not be considered an error on the part of the emergency physician.
c. Likewise, it will not be considered an error if an ED physician considers his/her own scan indeterminate and obtains a definitive scan through the Medical Imaging Department.
d. Indeterminate scans will not count toward the required total of 25 scans to complete the FPPE period.
e. If there are errors in the ED physician's interpretation of any of the initial 25 studies, then further training and/or proctoring may be required, at the discretion of the Emergency Department chairperson and/or the credentials chairperson, before full privileges are granted.

5. Upon attainment of the number of studies required, the physician will be granted full privileges in Emergency Department Ultrasound.
6. Once credentialed, scans from all the physician's studies will be kept in the ED in the medical record as thermal prints, on video, or on computer disk.

CORE I EMERGENCY MEDICINE DELINEATION OF PRIVILEGES

1. ELIGIBILITY REQUIREMENTS – To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board certified or in the process of Board Certification by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, the American Board of Family Practice, or the American Osteopathic Board of Family Practice (after January 1, 1989), the American Board of Emergency Medicine or the American Board of Pediatrics or the American Osteopathic Board of Pediatrics, ***OR***
        ii. Have successfully completed an ACGME or AOA approved residency in Internal Medicine, Emergency Medicine, Family Practice, Pediatrics, or their equivalents.
        iii. Have successfully completed at least BLS certification.
        iv. Applicants trained in foreign countries will be considered on an individual basis.
        v. For privileges requested, the applicant must be able to demonstrate that s/he has had training and experience as required for such privileges.
    c. Required previous experience:
        i. For privileges requested, the applicant must be able to demonstrate that s/he has had training and experience as required for such privileges.

2. Required References
    a. Initial Application – The applicant must provide references from:
        i. The Initial Applicant must provide a reference from the Residency Director or Chairperson of the Department from another hospital where s/he has been affiliated within the last two years and two physicians in the same specialty who have known the applicant at least two years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of Primary Care Emergency Medicine.
    b. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory observation process which shall consist of peer review by another emergency department staff member of at least ten (10) patients as well as the standards set forth in the physician group performance plan.
3. Minimal Requirements for Appointment/Reappointment
    a. Applicants for Reappointment must have cared for at least 50 cases in emergency primary care medicine in an ED or urgent care setting in the preceding 2 years (within the realm of CORE I privileges) if the applicant is not within two (2) years of completion of residency. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
    b. If the applicant for initial appointment is within 2 years of completion of his or her residency, he/she must have evidence of seeing and treating at least 20 cases related to emergency primary care medicine in an ED or urgent care setting in the preceding two years. Initial applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
        i. Physicians who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment, may be proctored or concurrently peer reviewed for the privileges by a physician holding similar privileges or proctoring. After favorable recommendation by the proctor/reviewer, the applicant may be considered for the requested privileges.

CORE II EMERGENCY MEDICINE DELINEATION OF PRIVILEGES

1. ELIGIBILITY REQUIREMENTS – To be eligible to request these privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board certified or in the process of Board Certification by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine, ***AND***

ii. Have successfully completed an ACGME or AOA approved residency in Emergency Medicine or equivalent.
iii. Have obtained ATLS certification
iv. Applicants trained in foreign countries will be considered on an individual basis.
v. For privileges requested, the applicant must be able to demonstrate that s/he has training and experience as required for such privileges.

c. Required previous experience:
i. For privileges requested, the applicant must be able to demonstrate that s/he has had training and experience as required for such privileges.

2. Required References
a. Initial Application – The applicant must provide references from:
i. The Initial Applicant must provide a reference from the Residency Director or chairperson of the Emergency Medicine Department from another hospital where s/he has been affiliated within the last two years and two physicians in the same specialty who have known the applicant at least two years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of Emergency Medicine.
ii. To complete the initial FPPE during the first 2-year appointment period, they must go through a mandatory observation process which shall consist of at least ten (10) patients as well as the standards set forth in the physician group performance plan.

3. Minimal Requirements for Appointment/Reappointment
a. Applicants for reappointment must have cared for at least 150 cases in emergency medicine in an ED in the preceding 2 years, if the applicant is not within two (2) years of completion of residency. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
b. Sixteen (16) hours of Trauma related CME's annually and ATLS training.
c. If the applicant for initial appointment is within 2 years of completion of his or her residency, s/he must have evidence seeing and treating at least 200 cases related to emergency medicine in an ED in the preceding two years. Initial applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
i. Physicians who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment, may be proctored or concurrently peer reviewed for the privileges by a physician holding similar privileges or proctoring. After favorable recommendation by the proctor/reviewer, the applicant may be considered for the requested privileges.

CORE II PRIVILEGES IN EMERGENCY MEDICINE

CORE II privileges are those that require additional training and/or experience beyond that gained in standard training and/or require evidence of post-residency training and evidence of current competence. The applicant must qualify for CORE II privileges in order to apply for any of the CORE III privileges. In granting of CORE II Emergency Medicine privileges, it is expected that appropriate specialty consultation will be obtained when the complexity or severity of the patient's medical illness exceeds the practitioner's level of knowledge.

Each privilege in CORE III requires additional evidence of competence:

CORE III Procedures	Minimum Requirements New Applicants	Minimum Requirements Reappointment	Invasive proctoring and non-invasive chart review	Requested	Approved
Ultrasound for Trauma*	10	5/2 years	2		
U/S for life threatening intra-abdominal emergencies with special attention to free fluid	* See written requirements	20/2 years	* See written requirements		
Fiber optic laryngoscopy (Intubation)	10	10/2 years (Proof of training)	2		
Cardiac Ultrasound for myocardial asystole*	10	5/2 years	2		
Other Ultrasound: U/S guided bladder tap, paracentesis					
Compartment Pressure Management	Hands-on Training	Evidence of knowledge of procedure	1		

TRAINING, EDUCATION, EXPERIENCE AND COMPETENCY REQUIREMENTS FOR ULTRASOUND PRIVILEGES

REQUIREMENTS FOR PRIVILEGES

1. Training and credentialing of emergency physicians will be done on a voluntary basis. Physicians not interested in learning sonography will continue to order ultrasound studies under existing protocols. Emergency physicians who have completed training and proctoring will continue to have the option of calling a technician or radiologist to obtain studies.
2. To be eligible to apply for privileges in goal directed Emergency Department ultrasound, the applicant must:
    a. Be board certified or board prepared in Emergency Medicine, ***AND***
    b. Have completed a residency in emergency medicine in a training program in which formal ultrasound training is included in the

curriculum in accordance with published guidelines from the American College of Emergency Medicine, ***OR***

c. Have had ED ultrasound privileges at another hospital with equivalent credentialing requirements and have evidence of competency confirmed by that hospital, ***OR***
d. Have successfully completed at least 24 hours of formal training through a course approved by the American College of Emergency Physicians in Emergency Department ultrasound. Following the course there must be evidence of at least 12 hours of "hands on" training in the ultrasound suite, plus 16 hours of independent study (e.g., directed readings, computer tutorial programs, time spent working with technicians or radiologists).

3. If s/he meets these criteria, the emergency physician will be recommended for privileges in ED ultrasound. Emergency Department ultrasound studies will be goal directed. The specific goal or "rule-out" diagnosis will be noted for each study performed. Emergency physicians will record their interpretations of all studies as positive, negative, or indeterminate for "rule-out" diagnosis on the ED Ultrasound Log and on the patient's record.
4. During the period of FPPE for new privileges, the ED physician must perform 25 studies, including at least 10 with positive findings. Each study must be concurrently confirmed either by a repeat study in the Medical Imaging Department or by surgical confirmation of ED findings in cases in which surgeons choose to take patients to the OR before a repeat study can be performed because of the patient's critical condition. Accuracy of studies will be judged on whether or not the study correctly identifies the presence or absence of the "rule-out" diagnosis.
    a. Failure to note findings incidental to the stated goal of the study will not be considered an error on the part of the emergency physician.
    b. Likewise, it will not be considered an error if an ED physician considers his or her own scan indeterminate and obtains a definitive scan through the Medical Imaging Department.
    c. Indeterminate scans will not count toward the required total of 25 scans to complete the FPPE period.
    d. If there are errors in the ED physician's interpretation of any of the initial 25 studies, then further training and/or proctoring may be required, at the discretion of the Emergency Department chairperson and/or the Credentials chairperson, before full privileges are granted.
5. Upon attainment of the number of studies required, the physician will be granted full privileges in Emergency Department Ultrasound.
6. Once credentialed, scans from all the physician's studies will be kept in the ED in the medical record as thermal prints, on video, or on computer disk.

ALLIED HEALTH PROFESSIONALS IN THE EMERGENCY DEPARTMENT

DELINEATION OF REQUIREMENTS AND FUNCTIONS

1. Physician Assistants, Nurse Practitioners and Advance Practice Nurses may provide care to patients in the Emergency Department provided they:
    a. Are licensed in the State of Colorado
    b. Are certified
    c. Have successfully completed a fully accredited training program in their area of specialty with additional training and experience in emergency medicine.
    d. Are the employee of the contracted Emergency Medicine physician or group for Parkview Medical Center with a written agreement whereby the physician or group assume responsibility for supervision or monitoring of the PA's practice; be continuously available or provide an alternate to provide consultation when requested and to intervene when necessary; assume total responsibility for the care of any patient when requested by the PA or by these Rules and Regulations; review and cosign all records of patient seen by the PA prior to the patient leaving the department.
    e. Have liability insurance either through their employer or independently that complies with the requirements of the Board of Directors.
    f. Are ACLS certified
2. Functions
    a. PAs in the Emergency Department may assess, work up and provide initial treatment to adults and children who present non- emergent illnesses or injures using specific protocols approved by the Department of Emergency Medicine.
3. Special Requests
    a. Special requests for procedures will be approved by the Department based on submitted evidence of training, education or experience and will require initial proctoring determined by the Department. Such procedures include:
        - Discharge Instruction/Teaching
        - Access to patient records (for reviewing purposes only)
        - Dictation of History and Physical
        - Dictation of Discharge Summary (Non-Critical, Uncomplicated cases only)
        - Documentation of Progress Notes
        - Write Scheduled Medication Orders (Must have current DEA license)
        - Write Non-Scheduled Medication Orders (Must have co-signature of supervising physician)
        - Write Restraint Orders
        - Write Other Orders
        - Assist physician with insertion of left and right Arterial Lines
        - Assist physician with removal of left and right Arterial Lines
        - Replacement of Peripheral IV

- Assist physician with insertion of Chest Tube
- Assist physician with removal of Chest Tube
- Assist physicians with Lumbar Punctures
- Nasogastric Tube placement
- Assist physician with endotracheal Intubation
- Assist physician with central Line placement
- Arthrocentesis
- Assist physician with Paracentesis
- Assist physician with Thoracentesis
- Administering local infiltrative anesthesia, cleaning and debriding wounds and suturing of wounds
- I & D
- Digital Blocks
- Dental Blocks
- Assist physician with Joint and Fracture reduction
- Splint application
- Assist physician with Traction
- Other

DEPARTMENT OF FAMILY PRACTICE

1. PURPOSE
   The purpose of the Family Practice Department is to provide a Family Physician with his/her own department for education and self-discipline as well as a framework within which family physicians may work as a group on problems affecting the whole department or any individual member of the department. This includes overseeing quality and appropriateness of professional services by monitoring and evaluating patient care and clinical performance of all members; to promote continuing education and quality improvement for members of the department; and to provide an interface for members of the department with other medical staff and with hospital administration in addressing the myriad of integrative issues of the specialty of Family Practice. It is a full clinical department with all department rights, duties, and responsibilities.
2. OBJECTIVE
   The objective of the Family Practice Department is to assure the hospital patient the availability of quality medical and surgical care.
3. MEMBERSHIP
   Qualifications for membership in the department shall be outlined in the medical staff bylaws.
   a. The applicant shall have successfully completed an accredited Family Practice residency, or be in the process of Board Certification, or be certified in Family Practice by the American Board of Family Practice or by the American College of Osteopathic Family Practitioners after January 1, 1989.
   b. Foreign applicants may be considered for membership if they have completed an accredited Family Practice residency, are board certified in their respective country, and have at least two (2) years of practice experience as a family practitioner.

   In addition, department members shall be expected to:
   a. Provide high quality, continuing care for their patients and seek appropriate consultations when needed.
   b. Participate in continuing education and quality assurance programs or Performance Measurement / Performance Improvement (PM/PI) programs.
   c. Maintain and update skills and knowledge through continuing medical education
   d. Abide by the bylaws of the medical staff and the Family Practice Department rules and regulations.
4. CATEGORIES OF APPOINTMENT
   a. Members shall include both active voting and non-voting members
   b. Voting members shall be those members with staff membership as defined in the medical staff bylaws and assigned to the Department of Family Practice.
   c. Only members of the active staff can vote or hold office.

5. OFFICERS
    a. Chairperson
    b. Vice-Chairperson

    Term office shall be two medical staff years, with more than two consecutive terms allowed if elected and desired by the incumbent officers.

    Duties of Chairperson
    a. Preside at department meetings
    b. Attend executive committee meetings and credential committee meetings
    c. Appoint members of the department to standing committees as deemed necessary to facilitate the function of the department.

    Duties of the Vice-Chairperson
    a. Fulfill duties of the Chairperson in his/her absence
6. GENERAL RULES
    a. Department meetings shall be held as necessary to conduct required business
    b. Attendance is encouraged
    c. Minutes shall be kept by the medical staff secretary or coordinator and submitted to the Executive Committee
    d. Quorum shall be considered one-third or three, whichever is less
    e. Simple majority will be required to transact business
    f. Special meetings may be called by the department chairperson or by any three members of the department on request to the chairperson
    g. Qualifications committee meetings will meet every other month or as needed to conduct business and will consist of vice-chairperson and at least two other members of the department
    h. Changes in the rules and regulations can be proposed by any active member of the department and must be submitted in writing to the department at a regularly scheduled meeting. Approval of any change requires a simple majority of the quorum of members present.
7. CLINICAL PRIVILEGES
    a. POLICY
        i. New applicants for appointment to the staff in the Department of Family Practice shall submit a description of their graduate training and other medical experience along with their application form and other required credentials at the time of application.
        ii. The qualifications committee of the department will review the application.
        iii. Delineation of privileges granted in the Department of Family Practice shall be based on the individual applicant's documented training and/or experience, demonstrated abilities, current competence, judgment, and character. Advancement of privileges may be granted when the applicant can show that additional training, experience and demonstrated competence so warrant; and, conversely, restriction of privileges may result

if it can be shown that the member is no longer able to demonstrate competence to exercise the privilege or that competence has never been attained. Under certain circumstances, members may be placed under supervision or proctoring of the department. Proctoring is to be done by the physician currently holding privileges in the area of concern. Privileges recommended will be forwarded directly to the Credential's Committee, Executive Committee, and the Governing Body of the hospital in accordance with the medical staff bylaws and departmental rules and regulations.

iv. Family Medicine is a comprehensive dynamic specialty. A privilege list cannot include or describe every procedure or medical problem in the domain of family medicine, current or future. Omission of procedures or medical diagnoses in the list does not preclude an applicant to the Department from applying for and receiving such privileges.

v. It is understood that when doubt exists as to the diagnosis, or in cases in which response to treatment is not apparent, all members of the department should obtain appropriate consultation regardless of the privileges granted to the individual department member.

vi. Privileges for emergency care are covered for general conduct description for all members of the medical staff. Emergency is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. A physician may deliver any care in this situation as permitted by his license and regardless of service or staff status to save the life or prevent serious harm. When the emergency situation no longer exists, such physician may follow current staff privileges.

vii. Members shall be reviewed at least every two years with recommendations for reappointment, promotion, or other changes in status.

b. Appointments / Reappointments

i. To complete the initial FPPE during their first 2-year appointment period, at least six cases (admissions or consultations) shall be reviewed. Other proctoring may be required as outlined in actual delineation section.

ii. Active staff members shall be reviewed and recommendations for reappointment made at least every two years.

iii. Basic Obstetrical privileges require at least three months training/experience on an AMA approved obstetric unit or at least thirty vaginal deliveries with supervision. Higher obstetrical privileges require further training above this level under supervision. Reappointment includes 20 deliveries in the past 24 months.

iv. If board eligibility or certification is lapsed, reappointment shall also document at least 75 hours of continuing education over prior 3 years.
v. Documentation of care for appointment / reappointment / proctoring may be provided from other hospitals or from office records if needed or indicated.

ALLIED HEALTH PROFESSIONALS-ADVANCED PRACTICE NURSES/PHYSICIAN ASSISTANT

a. Those applicants for privileges and appointments under this area shall be covered under the specific rules and regulations of the Allied Health Personnel-Advanced Practice Nurses/Physician Assistant. AHP-APN/PA I's credentialed to do so, may write orders in critical care units, but orders must be verified by the hospital RN with a physician involved in the care of the patient prior to being carried out and must be countersigned by a physician involved in the care of the patient within 24 hours.
b. AHP-APN/PA I's credentialed to do so, may write orders in non-critical care areas, which must be countersigned by a physician involved in the care of the patient within 48 hours.

DELINEATION OF PRIVILEGES

1. GENERAL
    a. Applicant must check off CORE requested plus any desired procedure listed underneath that CORE. If requesting additional privileges to those in the CORE, applicant must list those so requested and provide documentation or experience.
    b. Any physician who does not meet the criteria for the clinical privileges they desire may request further increase in the privileges in the Department of Family Practice by fulfilling one or more of the following:
        i. Active participation in education programs in medicine in the area of privileges desired. Documented proof of competency will be required for review.
        ii. Specifying disease or groups of diseases they wish to treat, or procedures they wish to perform, and requesting authorization from the Family Practice Department for these privileges. All requests must be accompanied by evidence of competency in the areas requested.
        iii. Serving in an approved residency program or fellowship with documented evidence of competency.

DEPARTMENT OF MEDICINE

SECTION 1

RULES AND REGULATIONS

1. Definition
    a. The Department of Medicine shall be considered to consist of those physicians, at the time of their initial application, that are in the process of Board Certification or board certified in Internal Medicine by the American Board of Osteopathic Medicine or the American Board of Internal Medicine or in one of those subspecialties recognized by these boards. Department membership will also consist of specialist's board certified or in the process of Board Certification in physiatry, neurology and dermatology.
    b. Those physicians, who at the time of approval of these rules and regulations are not board certified or in the process of Board Certification, will have been deemed to meet the criteria (grandfathered).
    c. The medical department shall have ongoing PM/PI review of a practicing physician's competence even after he has become a member of the active staff. This will be done periodically during a physician's membership in the department of medicine, at the time of application for reappointment for staff privileges, and at any time as deemed necessary according to the Medical Staff Peer review policy. Issues regarding quality accountability should be directed to the attention of the chairperson of the department or the chairperson of the Medical Qualifications for appropriate action.
    d. The members of the department shall elect a chairperson of the department of medicine. Term office shall be two medical staff years, with more than two consecutive terms allowed if elected and desired by the incumbent officers. The functions and responsibilities of the chairperson are outlined and shall be in accordance with Article XI, Section 3 of the medical staff bylaws. The PM/PI Officer of the Department of Medicine shall be the chairperson of the Medicine Qualifications Committee.
    e. A delineation of privileges available in the department is outlined in the medical staff rules and regulations. A physician need not be a member of the medical department to apply for certain individual privileges which cross specialties, as well as CORE privileges. Consideration of the physician's training, education, experience, competence, and the need for initial supervision on an individual basis will be the basis for granting privileges.

SECTION 2

DELINEATION OF PRIVILEGES

1. GENERAL
   a. Each staff physician will be classified as having certain professional privileges as outlined below. Privileges should be requested as appropriate for the physician's training, education, experience and competence. The initial request for privileges will be reviewed by the department chair and/or at the Medical Qualifications Committee prior to review at the Credentials Committee, the Medical Executive Committee, the Medical Relations Committee and the Board of Directors.
   b. Requests for clinical privileges shall be evaluated on the basis of practitioner's education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a practitioner exercises clinical privileges. The practitioner's physical and mental health status shall be compatible with the privileges requested.
   c. Any physician may take appropriate emergency action in a situation where, in the best judgment of the physician, lack of such immediate action would result in the patient's death or significant morbidity. It is not necessary for the physician to have privileges delineated relating to the emergency action.
   d. Consultation is required for patients whose illnesses and needed treatment is beyond the physician's delineated privileges. When doubt exists as to the diagnosis, or in cases in which response to treatment is not soon apparent, consultation must be sought regardless of the category of privileges granted.
   e. Any physician who does not meet the criteria for the category of privileges they desire may request further increases in their privileges in the department of medicine by fulfilling one or more of the following:
      i. By completing an approved residency program or fellowship with documented proof of competency.
      ii. By active participation in education programs or additional training in the area of privileges desired. Documented proof of competency will be required for review.
      iii. By specifying disease or groups of diseases they wish to treat or procedures they wish to perform, and requesting authorization from the medical department for these privileges. All requests must be accompanied by proof of competency in the areas requested.
   f. The department of medicine may request a period of proctorship, in addition to the period required for FPPE to verify competence of an otherwise qualified individual.

ALLIED HEALTH PROFESSIONALS-ADVANCED PRACTICE NURSES/PHYSICIAN ASSISTANT

a. AHP-APN/PA I's, credentialed to do so, may write orders in critical care units, but orders must be verified by the hospital RN with a physician involved in the care of the patient prior to being carried out and must be countersigned by a physician involved in the care of the patient within 24 hours.
b. AHP-APN/PA I's, credentialed to do so, may write orders in non-critical care areas, which must be countersigned by a physician involved in the care of the patient within 48 hours.

INTERNAL MEDICINE DELINEATION OF PRIVILEGES

1. ELIGIBILITY REQUIREMENTS – To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board certified or in the process of Board Certification by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, ***OR***
        ii. Have successfully completed an ACGME approved residency in Internal Medicine or its equivalent.
        iii. Applicants trained in foreign countries will be considered on an individual basis.
        iv. For privileges requested, the applicant must be able to demonstrate that s/he has had training and experience as required for such privileges.
    c. Required previous experience:
        i. For privileges requested, the applicant must be able to demonstrate that s/he has had training and experience as required for such privileges.

2. REQUIRED REFERENCES
    a. Initial application – The applicant must provide references from:
        i. The Initial Applicant must provide a reference from the Residency Director, Chief of Medicine or Chairperson of the Medicine Department from another hospital where s/he has been affiliated within the last two years and two Internists who have known the applicant at least two years and are acquainted with the applicant's current professional status, medical practice and involvement in the field of Internal Medicine.
        ii. To complete the initial FPPE during their first 2-year appointment period they must go through a mandatory observation process which shall consist of peer review of the first six cases by another internist on staff who is not in practice with the applicant.

3. MINIMAL REQUIREMENTS FOR APPOINTMENT / REAPPOINTMENT
   a. Applicants for Reappointment must have admitted or consulted on at least 20 cases in internal medicine in the preceding 2 years (within the realm of CORE I privileges of Specialty CORE privileges) if the applicant is not within two (2) years of completion of residency in Internal Medicine. Requirements for reappointment can be fulfilled at other hospital affiliations or outpatient consultations. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
   b. If the applicant for initial appointment is within 2 years of completion of his or her Internal Medicine Residency, s/he must have evidence of admission and/or consultation on at least 20 cases related to Internal Medicine in the preceding two years. Initial applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
      i. Physicians who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment, may be proctored or concurrently peer reviewed for the privileges by a physician holding similar privileges or proctoring/observation as recommended by the Medical Qualifications Committee. After favorable recommendation by the proctor/reviewer, the applicant may be considered for the requested privileges. In the event that there is not another internist on staff, the first six cases will be peer reviewed by an internist and/or the records sent to an outside reviewer.

ALLERGY/IMMUNOLOGY DELINEATION OF PRIVILEGES

1. ELIGIBILITY REQUIREMENTS – To be eligible to request these clinical privileges the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board certified or in the process of Board Certification by the American Board of Internal Medicine or Pediatrics or the American Osteopathic Board of Internal Medicine or Pediatrics, ***AND***
        ii. Have successfully completed an ACGME approved residency in Internal Medicine or Pediatrics and successfully completed an approved fellowship or its equivalent in Allergy/Immunology, ***OR***
        iii. Board certified or eligible in Allergy/Immunology;
        iv. Applicants trained in foreign countries will be considered on an individual basis.
        v. Applicants who have completed documented additional training, education or experience in the specialty of allergy and immunology will be considered on an individual basis
    c. Required previous experience:
        i. For privileges requested, the applicant must be able to demonstrate that s/he has had training and experience as required for such privileges.
2. Required References
    a. Initial Application – The applicant must provide reference from:
        i. Residency Director, Fellowship Director, Chairperson Allergy and Immunology or the Chairperson of the Medicine Department from another hospital where s/he has been affiliated within the last two years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of Allergy/Immunology.
3. To complete the initial FPPE during their 1st 2 year appointment period they must go through a mandatory observation process which shall consist of peer review by another allergy / immunology staff member of the first six admissions or consults. In the event there is no another allergy / immunologist on staff, the first six cases will be peer reviewed by an Internist and/or the records sent to an outside reviewer.
4. Minimal requirements for Appointment / Reappointment
        i. Applicants for Reappointment must have consulted on at least 10 cases in allergy / immunology in the last 2 years. Requirements for reappointment can be fulfilled at other hospital affiliations or outpatient consultations. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.

ii. If the applicant for initial appointment is within 2 years of completion of his or her Allergy/Immunology fellowship, s/he must have evidence of admission and/or consultation on at least 25 cases related to Allergy/Immunology in the preceding two years. Initial applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
iii. Physicians who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment, may be proctored or concurrently peer reviewed for the privileges by a physician holding similar privileges or proctoring/observation as recommended by the Medical Qualifications Committee. After favorable recommendation by the proctor/reviewer, the applicant may be considered for the requested privileges.

CARDIOLOGY DELINEATION OF PRIVILEGES

1. ELIGIBILITY REQUIREMENTS – To be eligible to request these privileges, the applicant must:
    a. Be a licensed M.D. or D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board certified or in the process of Board Certification by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, ***OR***
        ii. Have successfully completed and ACGME approved residency in Internal Medicine and successfully completed an approved fellowship or its equivalent in Cardiology.
        iii. Board certified or eligible in Cardiology.
        iv. Applicants trained in foreign countries will be considered on an individual basis.
    c. Required previous experience
        i. For privileges requested, the applicant must be able to demonstrate that s/he has had training and experience as required for such privileges.
2. Required References
    a. Initial Application – The applicant must provide references from:
        i. Residency Director, Fellowship Director, Chairperson of Cardiology or the Chairperson of the Medicine Department from another hospital where s/he has been affiliated within the last two years and two physicians who have known the applicant with the applicant's current professional status, medical practice and involvement in the field of Cardiology.
3. To complete the initial FPPE during their 1st year appointment period they must go through mandatory observation process which shall consist of peer review by another cardiology staff member of the first six admissions or consults. In the event there is not another cardiologist on staff, the first six cases will be peer reviewed by an Internist and/or the records sent to an outside reviewer.
4. Minimal Requirements for Appointment / Reappointment
    a. Applicants for reappointment must have consulted on at least 10 cases in cardiology in the last 2 years. Requirements for reappointment can be fulfilled at other hospital affiliations or outpatient consultations. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
    b. Applicants for appointment and reappointment must have or apply for privileges to Internal Medicine at Parkview Medical Center.
    c. If the applicant for initial appointment is within two years of completion of his or her cardiology fellowship, he/she must have evidence of admission and/or consultation on at least 25 cases related to cardiology in the preceding two years. Initial applicants who fail to meet these criteria will be considered on an individual basis and will

need to provide proof of continued competency and maintenance of skills.

d. Physicians who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment, may be proctored or concurrently peer reviewed for the privileges by a physician holding similar privileges or proctoring/observation as recommended by the Medical Qualifications Committee. After favorable recommendation by the proctor/reviewer, the applicant may be considered for the requested privileges.

GASTROENTEROLOGY DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA – To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed education/training as follows:
        i. Board certified by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, ***OR***
        ii. Have successfully completed an ACGME approved residency in Internal Medicine and successfully completed an ACGME approved fellowship in Gastroenterology.
        iii. Board certified or in the process of Board Certification in Gastroenterology.
        iv. Applicants trained in foreign countries will be considered on an individual basis.
    c. Required previous experience:
        i. For privileges requested, the applicant must be able to demonstrate that s/he has had training and experience as required for such privileges.
2. Required References:
    a. Initial Application – The applicant must provide references from:
        i. Residency Director, Fellowship Director, Chief of Medicine or Chairperson of the Medicine Department from another hospital where s/he has been affiliated within the last two years.
        ii. Have privileges or applying for privileges in Internal Medicine at Parkview Medical Center.
        iii. A letter of reference must come from the person responsible for the applicant's fellowship training or the department chief from another hospital where applicant has been affiliated for the last two years. Two internists or gastroenterologists who have known the applicant at least two years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of gastroenterology.
3. To complete the initial FPPE during 1st year appointment period they must go through a mandatory observation process. This observation process shall consist of peer review by another gastroenterologist of the first six admissions or consults. In the event there is not another gastroenterologist on staff, the first six cases will be peer reviewed by an internist and/or the records sent to an outside reviewer.

4. Minimal Requirements for Appointment/Reappointment
    a. If the applicant for initial appointment is within 2 years of completion of his or her fellowship in Gastroenterology, s/he must have evidence of admission and/or consultation on at least 25 cases related to gastroenterology in the preceding 12 months, and must have performed at least 200 procedures listed in CORE I. References must come from the individual responsible for formal endoscopic training that the applicant is competent to perform those procedures listed in CORE I. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
    b. If the applicant for initial appointment is within 2 years of completion of his or her fellowship in Gastroenterology, must have evidence of competency and/or consultation on at least 25 cases in the prior year and must provide evidence that they have performed at least 100 procedures among those listed in CORE I. The Department Chair of their prior affiliation(s) may provide confirmation of competency. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
    c. For reappointment, the Department will monitor incidence and number of complications and other indicators appropriate to patient management in the endoscopy suite. The results of this monitoring and evaluation activity will be considered at the time of reappointment.
    d. The Department will monitor the volume of clinical activity by each practitioner to assure that each practitioner maintains current clinical competence by regular exercise of gastroenterology privileges. At each practitioner's first reappointment a minimum of 50 gastroenterology procedures, among those listed in CORE I, are required in order to be eligible for reappointment. At the next reappointment, the practitioner must have a minimum of 100 among those listed in CORE II cases in order to be eligible for reappointment.
    e. Physicians who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment, may be proctored by direct observation for the privileges, by a physician holding such privileges or proctoring as approved by Medical Qualifications Committee. When the proctor or a proctoring program acceptable to the Medical Qualifications Committee makes a favorable recommendation, re-credentialing for the privileges may be considered. (Attach documentation)

DERMATOLOGY DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board certified by the American Board of Dermatology or has successfully completed an ACGME approved residency in Dermatology or its equivalent.
        ii. Applicants trained in foreign countries will be considered on an individual basis.
    c. Required previous experience:
        i. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
2. Required References:
    a. Initial Application – The applicant must provide references from:
        i. Dermatology Residency Director or Chairman of the Department of Medicine / Dermatology from another hospital where he/she has been affiliated within the last two years and two (2) physicians who have known the applicant at least two years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of Dermatology.
    b. To complete the initial FPPE during their first 2-year appointment period, members must go through a mandatory observation process. This observation process shall consist of peer review by an active dermatology staff member of the first six admissions or consults, or more if deemed necessary. In the event that there is not another dermatologist on staff, the first six cases will be peer reviewed by an internist and/or the records sent to an outside reviewer.
3. Minimal Requirements for Appointment / Reappointment
    a. If the applicant is not within two (2) years of completion of his/her dermatology fellowship, he/she must have evidence of admission and/or consultation on at least 25 cases in the preceding two years. Applicants, who fail to meet the criteria in (A) above, will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
    b. The applicant must have admitted or consulted on (25) cases in dermatology in the last two (2) years.
    c. Requirements for reappointment can be fulfilled at other hospital affiliations or via outpatient consultations (in-office). (Attach documentation)
    d. Physicians who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment, may be proctored by direct observation for the privileges by a physician holding such privileges or proctoring as approved by Medical

Qualifications Committee. When the proctor or a proctoring program acceptable to the Medical Qualifications Committee makes a favorable recommendation, re-credentialing for the privileges may be considered.

INFECTIOUS DISEASE DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board certified by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, OR
        ii. Have successfully completed an ACGME approved residency in Internal Medicine.
        iii. Have successfully completed a fellowship in Infectious Disease or its equivalent.
        iv. Applicants trained in foreign countries will be considered on an individual basis.
        v. Applicants who have completed documented additional training; education or experience in the specialty of infectious disease will be considered on an individual basis.
    c. Required previous experience:
        i. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
2. Required References:
    a. Initial Application – The applicant must provide references from:
        i. Residency Director, Fellowship Director, Chairperson of Infectious Disease or Chairperson of the Medicine Department from another hospital where he/she has been affiliated within the last two years.
        ii. Two physicians who have known the applicant at least two years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of infectious disease.
    b. To complete the initial FPPE during their first 2-year appointment period staff members must go through a mandatory observation process. This observation process shall consist of peer review by another infectious disease staff member of the first six admissions or consults, or more if deemed necessary. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills. In the event that there is not another infectious disease specialist on staff, the six records will be peer reviewed by a staff internist and/or sent to an outside reviewer.

3. Minimal Requirements for Appointment / Reappointment
    a. If the applicant is not within two (2) years of completion of his/her infectious disease fellowship, s/he must have evidence of admission and/or consultation on at least 25 cases related to infectious disease in the preceding two years.
    b. The re-applicant must have admitted or consulted on 20 cases in infectious disease in the last two (2) years. Requirements for appointment/reappointment can be fulfilled at other hospital affiliations. (Attach documentation)
    c. Physicians, who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment, may be proctored by direct observation for the privileges by a physician holding such privileges. When the proctor or a proctoring program acceptable to the Medical Qualifications Committee makes a favorable recommendation, re-credentialing for the privileges may be considered. (Attach documentation)

NEPHROLOGY DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed education / training as follows:
        i. Board certified by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, or
        ii. Have successfully completed an ACGME approved residency in Internal Medicine.
        iii. Have successfully completed a fellowship in nephrology or its equivalent.
        iv. Applicants trained in foreign countries will be considered on an individual basis.
        v. Applicants who have completed documented additional training; education or experience in the specialty of nephrology will be considered on an individual basis.
    c. Required previous experience:
        i. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
2. Required References:
    a. Initial Application – The applicant must provide references from:
        i. Residency Director, Fellowship Director, Chief of Medicine or Chairperson of the Medicine Department from another hospital where he/she has been affiliated within the last two years and two (2) internists or nephrologists who have known the applicant's current professional status, medical practice, and involvement in the field of nephrology.
    b. To complete the initial FPPE during their first 2-year appointment period members must go through a mandatory observation process. This observation process shall consist of peer review by another nephrologist of the first six admissions or consults, or more if deemed necessary. In the event that there is not another nephrologist on staff, the first six cases will be peer reviewed by an internist and/or the records sent to an outside reviewer. Applicants who fail to meet these criteria, will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
3. Minimal Requirements for Appointment / Reappointment
    a. If the applicant is not within two years of completion of his or her fellowship, he/she must have evidence of admission and/or consultation on at least 25 cases related to nephrology in the preceding two years.
    b. For reappointment, the Department will monitor incidence and number of complications and other indicators appropriate to patient management in the dialysis unit. The results of this monitoring and evaluation activity will be considered at the time of reappointment.

c. The Department will monitor the volume of clinical activity by each practitioner to assure that each practitioner maintains current clinical competence by regular exercise of nephrology privileges. At each practitioner's first reappointment, a minimum of 25 nephrology cases are required in order to be eligible for reappointment. At the next reappointment, the practitioner must have a minimum of 50 cases in order to be eligible for reappointment.
d. Physicians who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment, may be proctored by direct observation for the privileges by a physician holding such privileges or proctoring as approved by the Medical Qualifications Committee. When the proctor or proctoring program acceptable to the Medical Qualifications Committee makes a favorable recommendation, re-credentialing for the privileges may be considered. (Attach documentation)

NEUROLOGY DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board Certified by the American Board of Neurology, or
        ii. Have successfully completed an ACGME approved residency in Neurology or its equivalent
        iii. Applicants trained in foreign countries will be considered on an individual basis.
    c. Required previous experience
        i. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges
2. Required References:
    a. Initial Application—The applicant must provide reference from:
        i. Neurology Residency Director or Chairman of the department of Medicine/Neurology from another hospital where he/she has been affiliated within the last two years and two (2) physicians who have known the applicant at least two years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of Neurology.
    b. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory observation process. This observation process shall consist of peer review by an active Neurology staff member of the first six admissions or consults, or more if deemed necessary. In the event that there is not another neurologist on staff, the first six cases will be peer reviewed by an internist and/or the records sent to an outside reviewer.
3. Minimal Requirements for Appointment/Reappointment
    a. If the applicant is not within two (2) years of completion of his/her Neurology Fellowship, he/she must have evidence of admission and/or consultation on at least 25 cases in the preceding two years. Applicants, who fail to meet these criteria, will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
    b. Physicians who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment may be proctored by direct observation for the privileges by a physician holding such privileges or proctoring as approved by Medical Qualifications Committee. When the proctor or proctoring program acceptable to the Medical Qualifications Committee makes a favorable recommendation, re-credentialing for the privileges may be considered. (Attach documentation)

4. Neurological Telemedicine Intraoperative Neurophysiological Monitoring (IONM)
   Privileges may be granted and services may be provided under delegated credentialing contract with a Joint Commission Accredited entity to meet the needs of remote Intraoperative Neurophysiological Monitoring . These services may be provided by qualified MD, DO, or Doctor of Audiology with specialized training in IONM. These IONM privileges include the ability to independently monitor a variety of surgical procedures (including neurosurgery, otolaryngology, vascular surgery and orthopaedic surgery) in which neural structures are at risk and may consist of the following:
   - Collect and/or analyze intraoperative and clinical neurophysiologic data remotely
   - Provide technical professional interpretation of IONM data to physicians remotely
   - Perform real-time remote monitoring, providing timely interaction with onsite clinicians
   - Auditory brainstem response (ABR)
   - Dermatomal somatosensory evoked potentials (DSEP)
   - Descending neurogenic evoked potentials (DNEP)
   - EEG including electrocorticography
   - Spinal nerve electromyography (EMG)
   - Pedicle screw testing
   - Cranial nerve electromyography (EMG)
   - Spinal Reflex
   - H-Reflex and F-Response
   - Bulbocavernosus Reflex
   - Peripheral nerve monitoring (nerve action potentials – NAP)
   - Somatosensory evoked potentials (SSEP)
   - Transcranial motor evoked potentials (TCMEP)
   - Visual evoked potentials (VEP)
   - Other MEPs
   - Cerebral oximetry (CO)
   - Cortical Mapping (CM)
   - Sensory cortical mapping phase reversal
   - Motor cortical mapping
   - Language cortical mapping
   - WADA Activation
   - Transcranial Doppler (TCD)

HEMATOLOGY DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board Certified by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, or
        ii. Have successfully completed an ACGME approved residency in Internal Medicine and successfully completed a fellowship in Hematology or its equivalent.
        iii. Board Certified or in the process of Board Certification in Hematology and/or Oncology or its equivalent.
        iv. Applicants trained in foreign countries will be considered on an individual basis.
        v. Applicants who have completed documented additional training, education or experience in the specialty of Hematology will be considered on an individual basis.
    c. Required previous experience:
        i. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
2. Required References:
    a. Initial Application—The applicant must provide references from:
        i. Residency Director, Fellowship Director, Chairperson of Hematology or Chairperson of the Medicine Department from another hospital where he/she has been affiliated within the last two years and two (2) physicians who have known the applicant at least two years and are acquainted with the applicant's current professional status, medical practice and involvement in the field of Hematology.
    b. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory observation process. This observation process shall consist of peer review by another Hematology staff member of the first six admissions or consults, or more if deemed necessary. Applicants, who fail to meet these criteria, will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills. In the event that there is not another hematologist on staff, the first six cases will be peer reviewed by an internist and/or the records sent to an outside reviewer.

3. Minimal Requirements for Appointment/Reappointment
    a. If the applicant for initial appointment is within 2 years of completion of his/her Hematology Fellowship, he/she must have evidence of admission and/or consultation on at least 25 cases related to Hematology in the preceding two years. Initial applicants, who fail to meet these criteria, will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
    b. The applicant for reappointment must have admitted or consulted on 25 cases in Hematology in the last two (2) years. Requirements for appointment/reappointment can be fulfilled at other hospital affiliations. (Attach documentation)
    c. Physicians who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment, may be proctored by direct observation for the privileges by a physician holding such privileges or proctoring as approved by the Medical Qualifications Committee. When the proctor or a proctoring program acceptable to the Medical Qualifications Committee makes a favorable recommendation, re-credentialing for the privileges may be considered. (Attach documentation)

ONCOLOGY DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board Certified by the American Board of internal Medicine or the American Osteopathic Board of Internal Medicine, or
        ii. Have successfully completed an ACGME approved residency in Internal Medicine and successfully completed a fellowship in Oncology or its equivalent.
        iii. Board Certified or in the process of Board Certification in Oncology
        iv. Applicants trained in foreign countries will be considered on an individual basis.
    c. Required previous experience:
        i. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
2. Required References:
    a. Initial Application: The applicant must provide references from:
        i. Residency Director, Fellowship Director, Chairperson of Oncology or Chairperson of the Medicine Department from another hospital where he/she has been affiliated within the last two (2) years and two (2) physicians who have known the applicant at least two years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of Oncology.
    b. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory review by another Oncology staff member of the first six admissions or consults, or more if deemed necessary. Applicants, who fail to meet these criteria, will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
3. Minimal Requirements for Appointment/Reappointment:
    a. If the applicant is not within two (2) years of completion of his/her Oncology Fellowship, he/she must have evidence of admission and/or consultation on at least 25 cases related to Oncology in the preceding two years.
        i. Applicants for reappointment must have admitted or consulted on 25 cases in Oncology in the last 2 years. Requirements for appointment /reappointment can be fulfilled at other hospital affiliations.

ii. Physicians who previously held such privileges and do not meet the minimum number of case to be considered for reappointment, may be proctored by direct observation for the privileges by a physician holding such privileges or proctoring as approved by The Medical Qualifications Committee makes a favorable recommendation, such re- credentialing for the privileges may be considered. (Attach documentation)

THERAPEUTIC RADIOLOGY (RADIATION ONCOLOGY)
DELINEATION OF PRIVILEGES

1. ELIGIBILITY REQUIREMENTS—To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D.., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board Certified by the American Board of Radiology or the American Osteopathic Board of Radiology in Therapeutic Radiology (Radiation Oncology), or
        ii. Have successfully completed an ACGME or AOA approved residency and/or fellowship in Therapeutic Radiology (Radiation Oncology) or its equivalent.
        iii. Applicants trained in foreign countries will be considered on an individual basis.
        iv. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
2. Required References:
    a. Initial Application—The applicant must provide references from:
        i. The Initial Applicant must provide a reference from the Residency Director, Chief of Radiation Oncology or Chairperson of the Radiology or Medicine Department from another hospital where he/she has been affiliated within the last two years and two (2) physicians who have known the applicant at least two (2) years and are acquainted with the applicant's current professional status, medical practice and involvement in the field of Radiation Oncology.
    b. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory observation process, which shall consist of peer review by another Radiation Oncologist staff member of a sample of at least six (6) consultations and treatments. Such reviews may be performed by an outside reviewer when appropriate.
3. Minimal requirements for Appointment/Reappointment
    a. Appointment
        i. If the applicant for initial appointment is within two (2) years of completion of his or her Therapeutic Radiology Residency/Fellowship, he/she must have evidence of consultation and treatment on at least 20 cases in the

preceding two (2) years. Initial applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.

b. Reappointment
    i. Applicants for reappointment must have admitted or consulted on at least 20 cases in radiation oncology in the preceding two (2) years (within the realm of CORE I privileges or Specialty CORE privileges). Requirements for reappointment can be fulfilled at other hospital affiliations or outpatient consultations. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
    ii. Physicians, who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment, may be proctored or concurrently peer reviewed for the privileges by a physician holding similar privileges or proctoring/observation as recommended by the Department Chair. After favorable recommendation by the proctor/reviewer, the applicant may be considered for the requested privileges.

ENDOCRINOLOGY AND METABOLISM DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board Certified by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, or
        ii. Have successfully completed an ACGME approved residency in Internal Medicine.
        iii. Have successfully completed a fellowship in Endocrinology & Metabolism or its equivalent.
        iv. Applicants trained in foreign countries will be considered on an individual basis.
        v. Applicants who have completed documented additional training, education or experience in the specialty of Endocrinology & Metabolism will be considered on an individual basis.
    c. Required previous experience:
        i. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
2. Required References:
    a. Initial Application—The applicant must provide references from:
        i. Residency Director, Fellowship Director, Chairperson of Endocrinology or Chairperson of the Medicine Department from another hospital where he/she has been affiliated within the last two years.
        ii. Two physicians who have known the applicant at least two (2) years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of Endocrinology & Metabolism.
    b. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory observation process. This observation process shall consist of peer review by another endocrinology staff member of the first six admissions or consults, or more if deemed necessary. Applicants, who fail to meet these criteria, will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills. In the event that there is not another Endocrinologist on staff, the six records will be peer reviewed by a staff internist and/or sent to an outside reviewer.

3. Minimal Requirements for Appointment/Reappointment:
    a. If the applicant is not within two (2) years of completion of his/her Endocrinology Fellowship, he/she must have evidence of admission and/or consultation on at least 25 cases related to Endocrinology/Metabolism in the preceding two (2) years.
    b. The re-applicant must have admitted or consulted on 20 cases in Endocrinology in the last two (2) years. Requirements for appointment/reappointment can be fulfilled at other hospital affiliations. (Attach documentation)
    c. Physicians, who previously held such privileges and do not meet the minimum number of cases to be considered for re-appointment, may be proctored by direct observation for the privileges by a physician holding such privileges. When the proctor or a proctoring program acceptable to the Medical Qualifications Committee makes a favorable recommendation, re-credentialing for the privileges may be considered. (Attach documentation)

PHYSICAL MEDICINE AND REHABILITATION

DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board Certified or in the process of Board Certification by the American Board of Physical Medicine and Rehabilitation, or
        ii. Have successfully completed an ACBME approved residency in Physical Medicine and Rehabilitation or its equivalent.
        iii. Applicants trained in foreign countries will be considered on an individual basis.
    c. Required previous experience
        i. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
2. Required References:
    a. Initial Application—The applicant must provide references from:
        i. Physical Medicine and Rehabilitation Residency Director or Chairman of the department of Medicine/Physical Medicine and Rehabilitation from another hospital where he/she has been affiliated within the last two (2) years and two (2) physicians who have known the applicant at least two (2) years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of Physical Medicine and Rehabilitation.
    b. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory observation process. This observation process shall consist of peer review by an active Physical Medicine and Rehabilitation staff member of the first six admissions or consults, or more if deemed necessary. Applicants who fail to meet these will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills. In the event that there is not another physiatrist on staff, the first six cases will be peer reviewed by an outside reviewer.

3. Minimal Requirements for Appointment/Reappointment
    a. If the applicant is not within two (2) years of completion of his/her Physical Medicine and Rehabilitation residency, he/she must have evidence of admission and/or consultation on at least 25 cases in the preceding two (2) years. Applicants, who fail to meet these criteria, will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
    b. The re-applicant must have admitted or consulted on 25 cases in PM&R in the last two (2) years. Requirements for re-appointment can be fulfilled at other hospital affiliations or via outpatient consultations (in-office). (Attach documentation)
    c. Physicians who previously held such privileges and do not meet the minimum number of cases to be considered for re-appointment, may be proctored by direct observation for the privileges, by a physician holding such privileges or proctoring as approved by the Medical Qualifications Committee. When the proctor or a proctoring program acceptable to the Medical Qualifications Committee makes a favorable recommendation, re- credentialing for the privileges may be considered. (Attach documentation)

PULMONARY DISEASE DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request clinical privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed education/training as follows:
        i. Board Certified in Internal Medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, or
        ii. Have successfully completed an ACGME approved residency in Internal Medicine and successfully completed an ACGME approved fellowship in Pulmonary Disease.
        iii. Board Certified or in the process of Board Certification in Pulmonary Disease.
        iv. Applicants trained in foreign countries will be considered on an individual basis.
        v. Applicants who have completed documented additional training, education, or experience the specialty of Pulmonary Disease will be considered on an individual basis.
    c. Required Previous Experience:
        i. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
2. Required References:
    a. Initial Application—the applicant must provide references from:
        i. Residency Director, Fellowship Director, Chief of Medicine or Chairperson of the Medicine Department from another hospital where he/she has been affiliated within the last two (2) years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of Pulmonary Disease.
    b. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory observation process. This observation process shall consist of peer review by another Pulmonologist of the first six admissions or consults. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills. In the event that there is not another Pulmonologist on staff, the first six cases will be peer reviewed by an Internist and/or sent for outside review.

3. Minimal Requirements for Appointment/Reappointment
    a. If the applicant is not within two (2) years of completion of his/her fellowship he/she must have evidence of admission and/or consultation on at least 25 cases related to Pulmonary Disease in the preceding two (2) years. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
    b. For reappointment, the department will monitor incidence and number of complications and other indicators appropriate to patient management in the respiratory suite. The results of this monitoring and evaluation activity will be considered at the time of reappointment. The department will monitor the volume of clinical activity by each practitioner to assure that each practitioner maintains current clinical competence by regular exercise of Pulmonary Disease privileges.
    c. At each practitioner's first reappointment, a minimum of 25 Pulmonary Disease procedures are required in order to be eligible for reappointment. At the next reappointment, the practitioner must have a minimum of 50 cases in order to be eligible for reappointment. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
    d. Physicians who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment may be proctored by direct observation for the privileges, by a physician holding such privileges or proctoring as approved by the Medical Qualifications Committee. When the proctor or proctoring program acceptable to the Medical Qualifications Committee makes a favorable recommendation, re-credentialing for the privileges may be considered. (Attach documentation)

RHEUMATOLOGY DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board certified by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, or
        ii. Have successfully completed an ACGME approved residency in Internal Medicine and successfully completed an ACGME approved fellowship in Rheumatology or its equivalent.
        iii. Board certified or in the process of Board Certification in Rheumatology.
        iv. Applicants trained in foreign countries will be considered on an individual basis.
        v. Applicants who have completed documented additional training, education or experience in the specialty of Rheumatology will be considered on an individual basis.
    c. Required previous experience:
        i. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
2. Required References:
    a. Initial Application—The applicant must provide references from:
        i. Residency Director, Fellowship Director, Chairperson of Rheumatology or Chairperson of the Medicine Department from another hospital where he/she has been affiliated within the last two (2) years and two (2) physicians who have known the applicant at least two (2) years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of Rheumatology.
    b. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory observation process. This observation process shall consist of peer review by another Rheumatology staff member of the first six admissions or consults, or more if deemed necessary. Applicants, who fail to meet these criteria, will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills. In the event that there is not another Rheumatologist on staff, six cases will be peer reviewed by an Internist and/or sent for outside review.

3. Minimal Requirements for Appointment/Reappointment
    a. If the applicant is not within two (2) years of completion of his/her Rheumatology fellowship, he/she must have evidence of admission and/or inpatient or outpatient consultation on at least 25 cases related to Rheumatology in the preceding two (2) years. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
    b. The re-applicant must have admitted or consulted 12 cases in Rheumatology in the last two (2) years. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills. Requirements for appointment/reappointment can be fulfilled at other hospital affiliations. (Attach documentation)
    c. Physicians who previously held such privileges and do not meet the minimum number of case's to be considered for reappointment may be proctored by direct observation for the privileges by a physician holding such privileges or proctoring as approved by the Medical Qualifications Committee. When the proctor or a proctoring program acceptable to the Medical Qualifications Committee makes a favorable recommendation, re-credentialing for the privileges may be considered. (Attach documentation)

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

RULES AND REGULATIONS

SECTION I

PURPOSE

1. To establish rules and regulations for the clinical and administrative functions of the department.
2. To establish criteria for the granting of clinical privileges.
3. To regularly review and evaluate patient care within the department.

SECTION II

MEMBERSHIP

1. As outlined by the bylaws of Parkview Medical Center medical staff, the Executive Committee shall recommend initial department assignment for all members of the medical staff and for other approved practitioners with clinical privileges.
2. The Department of Obstetrics and Gynecology shall be considered to consist of those physicians and physician-sponsored certified midwives or certified midwives employed by a physician/physicians who at the time of their initial application, are in the process of Board Certification or Board Certified in Obstetrics and Gynecology by the American Board of Osteopathic Medicine or the American Board of Obstetrics and Gynecology or physicians credentialed through the Department to provide surgical assistance.
3. The departmental officers shall consist of a chairperson and a vice-chairperson.
    a. The chairperson and a vice-chairperson shall be members of the active medical staff who are qualified by board certification, eligibility or equivalency for this position.
        i. Term office shall be two medical staff years, with more than two consecutive terms allowed if elected and desired by the incumbent officers.
        ii. Duties of the officers are as stated in Article XI of the medical staff bylaws.
4. Qualifications Committee
    a. The qualifications committee of the department shall consist of the chairperson and three department members appointed by the chairperson.
    b. The Obstetrics and Gynecology department shall have ongoing PM/PI review of a practicing physician's competence even after he/she has become a member of the active staff. This will be done periodically during a physician's membership in the department of Obstetrics/Gynecology, at the time of application for reappointment for staff privileges, and at any time as deemed necessary according to the Medical Staff Peer Review Policy. Issues regarding quality accountability should be directed to the attention of the Chairperson of the OB/GYN Qualifications for appropriate action.

c. This committee will review all applications for clinical privileges and present its recommendations to the department for approval.
d. This committee or representatives will assign department member(s) to monitor surgical cases and deliveries of the provisional members during their initial Focused Professional Practice Evaluation (FPPE).
e. The committee will be convened in an immediate *ad hoc* meeting for any sentinel event pertaining to OB/GYN as defined by Parkview's Sentinel Event Policy.
f. Voting privileges in the department will be limited to OB/GYN physicians who are department members and on active staff of the hospital.

SECTION III

CLINICAL PRIVILEGES

1. Criteria for clinical privileges are established in accordance with the credentialing policies of the medical staff. Clinical privileges will be divided into three (3) general Core groups for simplicity. These categories are not rigid, but are intended to indicate the minimum level of training and experience needed to perform the procedures within the category.
2. Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a practitioner exercises clinical privileges. The practitioner's physical and mental health status shall be compatible with the privileges requested.
3. It is understood that any physician must take appropriate emergency action in a situation where, in the best judgment of the physician, lack of such immediate action would result in the patient's death or significant morbidity and no medical staff member with the appropriate training is immediately available, even though the physician may not have privileges delineated relating to the emergency action.
4. Consultation is required for patients whose illness and needed treatment is beyond the physician's delineated privileges. It is understood when doubt exists as to the diagnosis, or in cases in which response to treatment is not soon apparent, consultation must be sought regardless of the category of privileges granted.
5. The department may request a period of proctorship, in addition to the period required for initial FPPE to verify competence of an otherwise qualified individual.
6. Obstetrics and Gynecology privileges do not include general, spinal, regional or epidural anesthesia. Obstetricians may not provide anesthesia for cesarean sections.
7. Obstetrics and Gynecology privileges do include saddle block, local, and pudendal anesthesia.

SECTION IV

CONSULTATION AND CONSENT

1. Physician privileges are outlined in Section 3, Clinical Privileges and delineated at the end of the Department Rules and Regulations. Consultation will be obtained with management of any clinical problem beyond the scope of the member's privileges.
2. Except in an emergency, all procedures to be performed on a patient shall have an informed consent. Tubal ligations or other sterilization procedures that follow a delivery will be preceded by a written informed consent signed by the patient prior to anesthesia or initiation of the procedure.

SECTION V

RULES AND REGULATIONS

1. The following rules and regulations for the department of Obstetrics and Gynecology are established in accordance with Article XVI of the medical staff bylaws of Parkview Medical Center.
2. Antepartum care:
    a. Physicians shall endeavor to have a legible copy of the patient's antepartum chart on the hospital labor and delivery ward by the patient's 37th week of gestation. This chart shall include the following elements and information:
        i. Initial history and physical exam, including pertinent information about the patient's possible risk for congenital defects, such as Down's syndrome, Neural Tubal Defect's, Tay-Sachs Disease, Hemophilia, Sickle Cell Disease, etc.
        ii. Laboratory data including at least blood type and Rh, hematocrit, serologic tests for syphilis and HIV (or informed refusal), rubella status, hepatitis B surface antigen and glucose.
        iii. When indicated, additional test results should also be provided, such as:
            1. Results of ultrasound examinations performed
            2. Maternal serum AFP determination/Neural Tube Defect screen
            3. Genetic screening
            4. Gonorrhea test, Chlamydia test, etc.
            5. Group B Streptococcus (GBS)
    b. If the type and Rh status of the patient is not documented on the chart by 12 hours following the delivery, the postpartum unit will order this information from the hospital laboratory as a routine order of the attending physician.
    c. Newly appointed members of the department must undergo a period of monitoring. During this period, not to exceed 24 months, which may include retrospective monitoring or assisting/proctoring of surgical cases, the physician member who is providing the monitoring shall attest to the competency of the newly appointed member. When competency is satisfactory, the monitoring period will end.
    d. All tissue obtained from D&C procedures and Tubal Ligations will be sent to pathology lab for evaluation.

e. Residents in training in an AMA or AOA approved residency program, who may be working with a staff physician at Parkview Medical Center, will be directly supervised by their attending staff member at all times. Residents in training are not allowed to perform services or procedures for which their supervising staff physician does not hold privileges. In no instance shall a resident be allowed to "take call" for a staff physician and perform services in the absence of that physician. All residents will display visible identification on their person at all times in the hospital.
f. Patients presenting to the hospital without a staff physician will be assigned a physician as follows:
    i. Obstetrical patients greater than 20 weeks will be assigned to the physician on emergency call for obstetrical cases.
    ii. Gynecological patients not pregnant or pregnant less than 20 weeks gestation will be assigned to the physician on emergency call for gynecologic cases.
g. Obstetric patients arriving in the emergency room will be triaged according to hospital policy.
h. Policies and protocols for use of medications, emergency situations, etc., will be jointly established and approved by the nursing staff and the department. Such examples include, but are not limited to the following:
    i. Use of oxytocics
    ii. Treatment of post-partum hemorrhage
    iii. Treatment of severe fetal bradycardia
    iv. Administration of magnesium sulfate
    v. Prophylaxis of GBS
i. Physicians with appropriate privileges may make use of the protocols, but they are permitted to vary from the protocols when clinical judgment so dictates.
j. Visitors are allowed in the labor rooms and the cesarean section room when in the opinion of the attending physician, in conjunction with the anesthesiologist involved, the benefits of such attendance outweigh the potential hazards for the mother, infant, visitor, and/or staff. The number of such visitors will be limited to the number deemed appropriate to the attending physician &/or hospital policy.
k. Basic care requirements:
    i. Admission and discharge of patients, medical records, general conduct of care, etc., shall be in accordance with medical staff bylaws.
    ii. Progress notes shall be written daily on any patient with complications, and at least every three days on all patients.
l. The department shall review and provide a list of criteria for peer review.
m. All members of the department are responsible to carry out peer review activities.
n. Corrective action shall be carried out in accordance with Article VII of the medical staff bylaws.

SECTION VI

PROCTORING AGREEMENT BETWEEN CERTIFIED NURSE MIDWIVES AND THEIR SUPPORTING PHYSICIANS

1. The following guidelines will be instituted and observed:
    a. Direct observation of at least the first twenty (20) deliveries including the repair of episiotomy and laceration by the sponsor. The cases can be observed at either Parkview Medical Center or St. Mary Corwin Medical Center if the sponsoring physician possesses privileges at both facilities; however, a minimum of ten (10) cases must be at Parkview. Documentation of competency by the sponsor to include:
        i. Review of labor management on all of the initial 20 deliveries.
        ii. Chart review of all deliveries and admissions during the probationary period by a member of the OB/GYN Medical Staff.
    b. Ongoing quality assurance (QA) and chart review of cases that include, but are not limited to:
        i. Fourth degree lacerations
        ii. Post-Partum hemorrhage
        iii. Fetal distress
        iv. Assisted deliveries
        v. Perinatal death and Maternal mortality
        vi. Other maternal/fetal complications not specified above
    c. Following the probationary period, the nurse midwife will notify the sponsoring or supervisory OB/GYN physician on call when a patient is in labor. The physician will then be on notice in the event that a complication occurs. If a physician is notified to come in due to complications, the physician's response time will be monitored.

OBSTETRICS AND GYNECOLOGY DEPARTMENT DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must:
    a. Be a Colorado-licensed M.D. or D.O.
    b. Have successfully completed education/training as follows:
        i. Have successfully completed an ACGME or AOA accredited Obstetrics and Gynecology Residency Program.
        ii. Board certified and/or in the process of Board Certification by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology.
        iii. Board candidate in either of the above, and must become Board certified within five years of finishing an approved ACGME/AOA Obstetrics and Gynecology Residency Program.
        iv. Applicants trained in foreign countries will be considered on an individual basis.
        v. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.

vi. Current members, having been members of the Obstetrics and Gynecology Department prior to 1986, are grandfathered with regard to these requirements and are exempt from board certification requirements.

2. Required References:
    a. Initial Application—The applicant must provide references from:
        i. Residency Director if within three years of residency graduation and, if applicable, Chairperson of Obstetrics and Gynecology Department where he/she has been affiliated within the last two years.
        ii. Two Obstetrics and Gynecology practitioners or OB/GYN residency faculty who have known the applicant at least two (2) years and are acquainted with the applicant's current professional status, regarding medical knowledge, clinical abilities and mental and physical soundness to safely practice in the field of Obstetrics and Gynecology.
    b. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory Obstetrics and Gynecology peer review. The process shall consist of chart review by an OB/GYN active staff member of two vaginal deliveries, two minor surgeries and two medical consultations. In addition, six major surgical procedures (three OB and three GYN) shall be first assisted/proctored by an active OB/GYN staff member in order to determine satisfactory competence during the initial FPPE period. At the end of the monitoring period, the surgical assistant(s) shall provide, in writing, a recommendation for competence if the applicant is qualified. Certain procedure-specific proctoring is outlined further in the section.
3. Minimal Requirements for Appointment/Reappointment:
    a. For each privilege requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges:
        i. Appointment—must have evidence of admission of at least 25 cases in the preceding two (2) years. If the applicant is within two (2) years of completion of his/her residency program, the 25 case requirements can be fulfilled through the Residency Training Program. If applicant has not practiced medicine for the two (2) preceding years, the reason for not practicing has to be fully disclosed. The applicant will then provide outcome review of his/her last 25 admissions with a minimum of five major surgeries to be included in that group.
    b. Reappointment—must have admitted or treated at least 25 cases in the last two (2) years.
        i. Requirements for appointment/reappointment of CORE I privileges can be fulfilled at other hospital affiliations. The applicant must provide documentation.
        ii. Physicians, who previously held such privileges and do not meet the minimum number of cases to be considered for

reappointment, may be proctored or concurrently peer reviewed for the privileges by a physician holding similar privileges or proctoring/observation if available and as recommended by the OB/GYN Qualifications Committee. After favorable recommendation by the proctor/reviewer, the applicant may be considered for the requested privileges.

ROBOTIC ASSISTED OB/GYN SURGERY PRIVILEGES (that may be requested):

1. Hysterectomy
2. Ovarian Cystectomy
3. Oophorectomy
4. Myomectomy
5. Complex Endometriosis Surgery
6. Sacrocolpopexy

Initial Privileges:

1. Provider must meet criteria and eligibility to be granted Active or Affiliate member of the Medical Staff.
2. Provider must be licensed in the State of Colorado as an MD or DO.
3. Provider must have Core privileges in general surgery/surgical specialty along with privileges to perform the specific procedures being requested for use with the robotic assisted system.
4. Provider must be privileged to perform the procedure by Laparoscopic and/or Open approach.
    a. For Providers who have completed the technology training pathway with evidence of prior use of Robotic-Assisted Technology and/or are Residency/Fellowship trained in use:
        i. Evidence of completion of the da Vinci Technology Training Pathway (Intuitive Surgical Specialty specific training course) must be provided to the credentialing office;
        ii. Documentation of case log of 15 cases, as primary surgeon, within the previous 12 months submitted to the credentialing office OR completion of the Intuitive Surgical Specialty specific training refresher course and any additional requirements mandated by the Surgical Qualifications Committee. If provider is within the first five years of completion of residency/fellowship training, an attestation from the residency/fellowship director of specific robotic training/competence must be provided to the credentialing office;
        iii. Evidence of completion of robotic training for the specific model used at Parkview; and
        iv. Focused Professional Practice Evaluation (FPPE) will be performed for first 15 cases by a provider with privileges to perform the procedure laparoscopically and/or open approach.
    b. For providers who are seeking initial training and privileges in Robotic-Assisted Surgery:

i. Initial privileges may be granted conditionally upon documentation of:
   - Acceptance into the Intuitive Surgical Training Course (specialty specific); and
   - Submission of a training plan delineating physician's statement of intent for requesting robotic privileges, outline of the education schedule to complete the Intuitive Surgical Training Course and specifying the surgeries to be completed during training – form will be provided by credentialing office;

ii. Evidence of completion of the da Vinci Technology Training Pathway (specific to the model used at Parkview) must be provided to the credentialing office;

iii. The Intuitive Surgical Training Course and the first 5 cases, which are to be proctored by a provider with privileges/or vendor credentialed to perform Robotic-Assisted Surgery, must be completed within four (4) months; if this is not completed within four months, the training process must start again from the beginning. The proctor may not be acting as assistant in the procedure and must be of the same specialty and will complete and return the proctoring form provided by the credentialing office;

<u>Privileges at Reappointment:</u>

1. Documentation of at least 15 robotic-assisted surgeries in the past 24 months
2. Request to continue robotic-assist surgeries on privilege request form

OBSTETRIC AND GYNECOLOGY ALLIED HEALTH PROFESSIONAL - NURSE MIDWIFE

CORE I DELINEATION OF PRIVILEGES

1. ELIGIBILITY REQUIREMENTS: To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed Registered Nurse in the State of Colorado;
    b. Have successfully completed additional education/training as follows:
        i. Graduation from a program of nurse-midwifery accredited by the American College of Nurse-Midwives with at least thirty vaginal deliveries with supervision.
        ii. Current certification in Neonatal Resuscitation by the American Heart Association.
    c. Required previous experience:
        i. For privileges requested, the applicant must be able to demonstrate prior performance of at least 20 deliveries in the past 12 months.
    d. Have an identified physician sponsor who is a member of Parkview Medical Center's Medical Staff with at least CORE I privileges in Obstetrics and Gynecology.
    e. A letter of reference from the physician sponsor assuming supervision, accepting liability for, attesting to the competency of the applicant, and indicating any additional activities, justification for, or restrictions to privilege delineation.
2. Required References
    a. Initial application—the applicant must provide references from:
        i. The initial applicant must provide a reference from applicant's nurse-midwifery course director, or the appropriate department chair at the hospital where the applicant was formerly on staff.
3. Minimal requirements for appointment/reappointment:
    a. Reappointment should be based on unbiased, objective results of care according to the governing body's quality assurance mechanisms.
    b. S/He must possess an ongoing agreement with a supervisory sponsoring physician who holds at least CORE I privileges in Obstetrics and Gynecology.
    c. The applicant must demonstrate that he/she has maintained competence through the performance of at least 20 deliveries in the past 12 months; and
    d. By the first reappointment, obtain Board Certification in Nurse Midwifery; and
    e. At subsequent reappointment(s), ongoing Continuing Education related to Midwifery will be deemed adequate by (1) Maintenance of Board Certification through the American Midwifery Certification Board, or (2) 20 Continuing Education hours (= 2 AMCB CEU hours).

DEPARTMENT OF PATHOLOGY

RULES AND REGULATIONS

1. FUNCTIONS
    a. The pathology and clinical laboratory shall be directed and chaired by a physician who is Board Certified or in the process of Board Certification in Clinical and Anatomic Pathology and is qualified to assume professional, organizational, and administrative responsibility for the facilities and for the services rendered. Term office shall be two medical staff years, with more than two consecutive terms allowed if elected and desired by the incumbent officers.
    b. Duties of the Director and Chairperson:
        i. Participate with hospital leadership to assure that sufficient personnel who have adequate training and experience to supervise and conduct the work of the laboratory shall be available.
        ii. Participate with hospital leadership to assure that there shall be sufficient space, equipment, and supplies within the pathology and clinical laboratory to perform the required volume of work with optimum accuracy, precision, efficiency, and safety.
        iii. Maintain channels of communication within the pathology and clinical laboratory, as well as with other departments and services of the appropriate for the size and complexity of the hospital.
        iv. Assist the Laboratory Director to design quality control systems of the clinical laboratory to ensure the medical reliability of laboratory data.
        v. Direct performance measurement and performance improvement activities, with regular communication between the pathology department and other clinical departments, intended to achieve the highest quality of patient care possible.
2. STANDARDS
    a. Specimens removed during a surgical procedure shall be properly labeled and sent to the pathologist, who shall determine the extent of examination necessary for diagnosis. The list of specimens which may be exempted from the requirement to be examined by the hospital pathologist is developed and re-evaluated from time to time by the department of pathology and appears as part of the Department of Surgery Rules and Regulations. Exempt specimens do not require examination provided that the surgeon documents the specimen in the operative report.
    b. A pathologist shall be available at all times for consultation with members of the medical, laboratory and hospital staff.

DELINEATION OF PRIVILEGES

Any physician who practices pathology in the hospital shall be eligible or certified by the American Board of Pathology in Clinical and/or Anatomical Pathology and shall practice under the supervision of the pathologists holding a contractual arrangement with the hospital and charged with the responsibilities for the department. Each physician requesting privileges in the department of pathology must meet all of the general hospital requirements necessary for staff membership and must demonstrate current competence.

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D.., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board certified by the American Board of Pathology or the American Osteopathic Board of Pathology or has successfully completed an ACGME or AOA approved residency in Clinical and Anatomic Pathology or its equivalent.
        ii. Applicants trained in foreign countries will be considered on an individual basis.
    c. Required previous experience:
        i. For privileges request, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
2. Required References:
    a. Initial application—the applicant must provide reference from:
        i. Pathology Residency Director or Chairman of the Department of Pathology from another hospital where he/she has been affiliated within the last two (2) years and two (2) physician who have known the applicant at least two (2) years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of Pathology.
    b. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory observation process. This observation process shall consist of peer review by an active Pathology staff member of the first six weeks of work or more if deemed necessary. In the event that there is not another Pathologist on staff, an outside reviewer will be brought in to perform retrospective review.
3. Minimal Requirements for Appointment/Reappointment
    a. If the applicant is not within two (2) years of completion of his/her Pathology residency, he/she must have evidence that they have provided full-time, in-hospital pathology/laboratory services for at least 12 of the past 18 months in the fields of pathology that he/she will be performing at this hospital during the preceding two (2) years. Applicants, who fail to meet the criteria in (A) above, will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.

b. Requirements for reappointment can be fulfilled at other hospital affiliations. (Attach documentation)
c. Physicians who previously held such privileges and do not have sufficient activity in pathology to evaluate competency for reappointment, may be proctored by direct observation for the privileges by a pathologist holding such privileges as approved by Department Chair. When the proctor or a proctoring program confirms competence, re-credentialing for the privileges may be considered. (Attach documentation)

DEPARTMENT OF PEDIATRICS

RULES AND REGULATIONS

The Department of Pediatrics at Parkview Medical Center shall consist of those members of the staff who have shown an interest in pediatrics and whose training and ability have been reviewed by the credentials committee and assigned to the pediatrics service.

All members of the pediatric service will have a vote at the meetings of the pediatric service as per Article IV, Section 2. The department will be headed by a chairperson who has pediatric admitting privileges and will be selected in alphabetical order from the members of the department and required to serve their two-year term as a condition of medical staff appointment to the Department of Pediatrics. More than two consecutive terms allowed if elected and desired by the incumbent officers. It will be his/her function to chair department and qualifications committee meetings and to see that the practice of pediatrics in the pediatric department will conform to the highest standards of medical practice and he/she will conduct meetings to review these services and submit regular reports as required. Consultations are generally requested when there is difficulty in obtaining a diagnosis or for various serious illnesses. The consultant will be generally selected from the list of consultants to the Pediatric Service.

The Pediatric Department will meet quarterly or as needed and the Pediatric Qualifications Committee will meet quarterly or as needed.

Members of the Department of Pediatrics with twenty (20) admissions and/or newborn attendance will be required to provide emergency room coverage and become members of the active staff.

This change differs from the bylaw requirements for other departments as the treatment of pediatric patients has minimal inpatient treatment and a greater number of emergency room visits and outpatient treatment.

1. Pediatric consultations should be considered for the following conditions:
    a. Respiratory tract obstructions and severe respiratory infections with secondary complications, including cyanosis, laryngotracheobronchitis, or severe croup; any patient requiring any type of assisted respirations.
    b. Acute heart disease, rheumatic fever, arrhythmia's, pleural effusion, congestive heart failure, and undiagnosed congenital heart disease.
    c. Pneumonia with cyanosis.
    d. Gastrointestinal and acute abdominal disorders requiring surgery.
    e. Gastroenteritis with severe dehydration, severe diarrhea with dehydration, and celiac disease; acute, uncontrolled metabolic diseases such as uncontrolled diabetes mellitus, hypo or hyperthyroidism, goiter, failure to thrive and fibrocystic disease.
    f. Kidney failures of any type, acute glomerulonephritis, anuria, oliguria, acute renal tract obstructions.

g. Convulsive seizures, status epilepticus, muscular dystrophy congenital disorders that are typically pediatric syndromes.
h. Trauma, if a nature involving organ systems other than bones, battered children syndrome, or burns involving over 20% of the body.
i. Hemic disorders, severe anemias (below 5mg), leukemias, hemophiliac, reticuloendothelial disorders.
j. Infectious diseases, syphilis, gonorrhea, tuberculosis, acute exanthematous disorders with encephalitis or meningitis, chicken pox, encephalitis, severe mumps, meningitis, blood exchanges and severe jaundice.
k. Severe poisoning, accidental ingestion of unknown substances.
l. Any patient with primary diagnosis of malignancy on first admission.

CONSULTS FOR ACUTELY ILL INFANTS

PURPOSE:

To improve the quality of patient care, all acute ill infants need a consult by a pediatrician.

1. When the infant is acutely ill, pediatric consultations should be considered for the following conditions:
    1. Congenital Heart Disease
    2. Depressed Infant
    3. High risk mother (being defined as any mother) with:
        i. Diabetes
        ii. Hypertension
        iii. Toxemia
        iv. Anemia
    4. History of drugs
    5. Hyperbilirubinemia of 20mg or above
    6. Hypoglycemic infant
    7. Multiple severe congenital malformation
    8. Pneumothorax
    9. Polycythemia
    10. Prolonged rupture of membranes (after 24 hours)
    11. Premature infants
    12. Renal problems, especially no void for 36 hours
    13. Respiratory distress syndrome
    14. Seizures
    15. Septic infant
    16. Small for gestational age

INFECTIOUS DISEASES

The following diseases are to be automatically isolated and consultation obtained when necessary. The following diseases shall be isolated upon admission. They shall remain in isolation until they are no longer considered infectious:

a. Hepatitis
b. Meningitis
c. Tuberculosis
d. Diphtheria
e. Communicable childhood diseases
f. Plague
g. Salmonella
h. Shigella
i. AIDS

All physicians who admit patients to the pediatric service will conform to the rules and regulations of the pediatric service and will be under the supervision of the chairperson of the pediatric department.

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges in Pediatrics, the applicant must:
    a. Be a licensed M.D.., D.O.
    b. Have successfully completed an ACGME three year Pediatric Residency program; OR
    c. Board certified by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics; OR
    d. In the process of Board Certification in either of the above.
    e. Members of the Pediatric Department prior to January 1, 2003 are grandfathered and are exempt from board certification requirements.
2. REQUIREMENTS FOR INITIAL APPOINTMENT:
    a. REQUIRED REFERENCES: The applicant must provide references from:
        i. Residency Director and, if applicable, Chairperson of Pediatric Department where he/she has been affiliated within the last two (2) years;
        ii. Two pediatric practitioners who have known the applicant at least two (2) years and are acquainted with the applicant's current professional status, medical practice, and involvement in the field of pediatrics.
    b. Documentation of Clinical Performance
        i. Each applicant must have evidence of admission and/or consultation on at least 25 cases. If the applicant is within two (2) years of completion of his/her residency program the 25 cases requirement can be fulfilled through a Residency Training program. For each privilege requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
    c. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory Pediatric observation process. The observation shall consist of peer review by an active Pediatric staff member of the first six admissions or consultations. Procedure specific proctoring will be initiated whenever questions regarding evidence of competency arise.

3. REQUIREMENTS FOR PRIVILEGING
    a. For each privileges requested, the applicant must be able to demonstrate that he/she has had training and experience and evidence of current competence as required for such privileges.
    b. Documentation of admission or consultation on at least 12 cases in the previous two (2) years, which can be fulfilled through documentation from another hospital.

NEWBORN CARE PRIVILEGES

Newborn Care privileges allow the physician to provide care to newborns and perform procedures in the designated nursery area. The applicant must meet the basic eligibility criteria and requirements for appointment to the Pediatrics Department and apply for a minimum of CORE I Pediatric privileges before newborn care privileges are granted. For each privilege requested, the applicant must be able to demonstrate that he/she has had the ***training and experience*** as required for such privileges.

In the granting of Newborn Care privileges it is expected that appropriate specialty consultation will be obtained as needed.

ATTENDANCE AT C-SECTION DELIVERIES

Attendance at C-Section deliveries shall be at the obstetrician's discretion to be selected from those physicians maintaining his/her skills in neonatal resuscitation. While a neonatal resuscitation course does not assure competence, maintenance of a current Neonatal Resuscitation certificate is encouraged.

NEONATAL NURSE PRACTITIONER

CORE I DELINEATION OF PRIVILEGES

1. ELIGIBILITY REQUIREMENTS: To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed Advance Practice Nurse in the State of Colorado
    b. Have successfully completed additional education/training as follows:
        i. Previous experience of at least 2 years of NICU RN practice.
        ii. Graduation from a master's program for neonatal nurse practitioners accredited by the National League of Nursing Accrediting Commission (NLNAC) or the Commission on Collegiate Nursing Education (CCNE) and qualified as Acute Care Nurse Practitioners.
        iii. Current certification in Neonatal Resuscitation by the American Heart Association and certification through Neonatal Nursing Specialties (NCC).
        iv. Met the qualifications for Conscious Sedation privileges.
    c. Required Previous Experience:
        i. For privileges requested, the applicant must be able to demonstrate the ability to perform NNP privileges.
    d. Have an identified physician sponsor who is a member of Parkview Medical Center's Medical Staff with at least CORE III Pediatric privileges in Neonatology.
    e. A letter of reference from the physician sponsor assuming supervision accepting liability for, attesting to the competency of the applicant and indicating any additional activities, justification for, or restrictions to privilege delineation.
2. Required References:
    a. Initial Application: The applicant must provide references from:
        i. The Initial Applicant must provide a reference from the applicant's NNP course director or from the appropriate department chair at the hospital where the applicant was formerly on staff.
3. Minimal requirements for Appointment/Reappointment:
    a. Reappointment should be based on unbiased, objective results of care according to the governing body's quality assurance mechanisms.
    b. The applicant must demonstrate that he/she has maintained competence through the care of at least 20 newborns >32 weeks in the past 12 months. In addition, continuing medical education related to NNP should be required.

DEPARTMENT OF PSYCHIATRY

RULES AND REGULATIONS

a. Definition

1. The Department of Psychiatry shall consist of those members of the medical staff who are either in the process of Board Certification or Board Certified in the specialty of psychiatry, as defined by the American Psychiatry Association.
2. Those physicians, who at the time of approval of these rules and regulations are not Board Certified or in the process of Board Certification, will have been deemed to meet the criteria (grand-fathered).
3. The department shall have on-going PM/PI review of a practicing physician's competence even after he has become a member of the active staff. This will be done periodically during a physician's membership in the department, at the time of application for reappointment for staff privileges, and at any time as deemed necessary according to the Medical Staff Peer Review policy. Issues regarding quality accountability should be directed to the attention of the chairperson of the department or the Chairperson of the Medical Qualifications for appropriate action.
4. There shall be a chairperson of the Department of Psychiatry to be elected by the members of the department. Term office shall be two medical staff years, with more than two consecutive terms allowed if elected and desired by incumbent officers. The functions and responsibilities of the chairperson are outlined and shall be in accordance with Article XI, Section 3 of the medical staff bylaws. The chairperson shall also promote educational programs in order to assist the general staff and nursing staff in keeping abreast of the various developments in psychiatry.
5. All members of the department will have one vote within the department with the exception that no one may vote in more than one clinical department.

b. Medical Staff Consultation Requirements:

i. A member of the medical staff is allowed to admit and treat uncomplicated psychiatric patients, except that a psychiatric evaluation by a member of the behavioral health team who consults with a psychiatrist must be obtained in potentially suicidal or homicidal patients, in cases of suicidal attempts, in patients with extreme agitation whose behavior may be disruptive to the functioning of the ward or hospital, or with patients who are diagnosed psychotic.

ii. Medical staff may admit to psychiatric units only with psychiatric consultation.

c. Delineation of Privileges:

ii. Each staff physician will be classified as having certain professional privileges as outlined below. Privileges should be requested as appropriate for the physicians training, education, experience and competence. The initial request for privileges will be reviewed by the Department Chair and/or at the Psychiatry Qualifications Committee prior to review at the Credentials Committee, The Medical Executive Committee, The Medical Relations Committee, and The Board of Directors.

iii. Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, demonstrated professional competence and judgment, clinical performance and the documented results of patient care and other quality review and monitoring which the staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a practitioner exercises clinical privileges. The practitioner's physical and mental health status shall be compatible with the privileges requested.

iv. It is understood that any physician must take appropriate emergency action in a situation where, in the best judgment of the physician, lack of such immediate action would result in the patient's death or significant morbidity and no medical staff member with the appropriate training is immediately available, even though the physician may not have privileges delineated relating to the emergency action.

v. The department of psychiatry may request a period of proctorship, in addition to the period required for the initial FPPE to verify competence of an otherwise qualified individual.

PSYCHIATRY DELINEATION OF PRIVILEGES

1. ELIGIBILITY REQUIREMENTS: To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D., D.O.
    b. Have successfully completed additional education/training as follows:
        i. Board Certified or in the process of Board Certification in psychiatry, as defined by the American Psychiatry Association, or
        ii. Have successfully completed an ACGME approved residency in psychiatry or its equivalent.
        iii. Applicants trained in foreign countries will be considered on an individual basis.
        iv. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
2. Required References:
    a. Initial Application: The applicant must provide references from:
        i. The Residency Director, Chief of Psychiatry or Chairperson of the Psychiatry Department from another hospital where he/she has been affiliated within the last two years and two Psychiatrists who have known the applicant at least two (2) years and are acquainted with the applicant's current professional status, clinical practice and involvement in the field of Psychiatry.
    b. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory observation process which shall consist of peer review by another psychiatry staff member of the first six admissions or consults. In the event there is not another psychiatrist on staff who is not in practice with the applicant, the first six cases will be peer reviewed by an outside reviewer.

3. Minimal Requirements for Appointment/Reappointment:
    a. Applicants for reappointment must have admitted or consulted on at least 20 cases in psychiatry or with a psychiatric diagnosis in the preceding two (2) years (within the realm of CORE I privileges) if the applicant is not within two (2) years of completion of residency in Psychiatry. Requirements for reappointment can be fulfilled at other hospital affiliations or outpatient consultations. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
    b. If the applicant for initial appointment is within two (2) years of completion of his/her consultation on at least 25 cases related to Psychiatry in the preceding two (2) years. Initial applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
        i. Physicians, who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment, may be proctored or concurrently peer reviewed for the privileges by a physician holding similar privileges or proctoring/observation as recommended by the Psychiatric Qualifications Committee. After favorable recommendation by the proctor/reviewer, the applicant may be considered for the requested privileges. In the event that there is not another internist on staff, the first six cases will be sent to an outside reviewer.

ALLIED HEALTH PROFESSIONAL IN THE PSYCHIATRY DEPARTMENT

1. Be licensed in the State of Colorado.
2. Have successfully completed education/training/competence as follows:
    a. <u>Allied Health Professional I's:</u>
    Certified Physician Assistant, Registered Nurse Practitioner (Advanced Registered Nurse Practitioner, Clinical Psychologists), or
    <u>Allied Health Professional II's:</u>
    Certified Child Health Associate, Registered Nurse Specialist, Registered Nurse Clinician or RN/LPN with additional formal training
    b. Licensed Social Worker I (Allied Health Professional II's)
    c. Applicants trained in foreign countries will be considered on an individual basis.
    d. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
    e. Must have a physician on the Parkview Medical Center medical staff who is a member of the Department of Psychiatry who will sponsor and attest to their competency for the privileges requested.
    f. In order to maintain privileges, Category II Allied Health Professionals in the Department of Psychiatry must have at least 4 patient contacts during the 2-year reappointment cycle or a letter from the physician

sponsor attesting to the Allied Health Professional's current competence.

DEPARTMENT OF RADIOLOGY

RULES AND REGULATIONS

a. DEFINITION

1. The Department of Radiology shall be considered to consist of those physicians who at the time of their initial application:
   i. Are Board Certified in Radiology or Therapeutic Radiology (Radiation Oncology) by the American Osteopathic Board of Radiology or the American Board of Radiology, or
   ii. Have successfully completed an ACGME or AOA approved residency or fellowship training program in radiology or radiation therapy, or
   iii. Those physicians, who at the time of approval of these rules and regulations are not Board Certified or in the process of Board Certification, will have been deemed to meet the criteria (grand-fathered).
2. The Radiology Department shall have ongoing PM/PI review of a practicing physician's competence even after he/she has become a member of the active staff. This will be done periodically during a physician's membership in the Department of Radiology, at the time of application for reappointment for staff privileges, and at any time as deemed necessary according to the Medical Staff Peer Review policy. Issues regarding quality accountability should be directed to the attention of the chairperson of the Department. Departmental PM/PI may include:
   i. Over-read of x-ray examinations,
   ii. Monitoring and verification of typed x-ray reports,
   iii. Pathologic correlations,
   iv. Feedback from other clinical departments.
3. The members of the Department shall elect a chairperson and a vice-chairperson of the Department of Radiology. Term office shall be two medical staff years, with consecutive terms allowed if elected and desired by the incumbent officers. The functions and responsibilities of the chairperson are outlined and shall be in accordance with Article XI, Section 3 of the medical staff bylaws. The PM/PI Officer of the Department of Radiology shall be the Chairperson.

DELINEATION OF PRIVILEGES

a. Each staff physician will be classified as having certain professional privileges as outlined below. Privileges should be requested as appropriate for the physician's training, education, experience and competence. The initial request for privileges will be reviewed by the Department Chair or at the Department meeting prior to review at the Credentials Committee and the Board of Directors.

b. Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a practitioner exercises clinical privileges. The practitioner's physical and mental health status shall be compatible with the privileges requested.
c. Any physician may take appropriate emergency action in a situation where, in the best judgment of the physician, lack of such immediate action would result in the patient's death or significant morbidity. It is not necessary for the physician to have privileges delineated relating to the emergency action.
d. Any physician who does not meet the criteria for the category of privileges they desire may request further increases in their privileges in the Department of Radiology by fulfilling one or more of the following:
    i. By completing an approved residency program, fellowship or special training with documented proof of competency
    ii. By active participation in education programs or additional training in the area of privileges desired. Documented proof of competency will be required for review.
e. The Department of Radiology may request a period of proctorship, in addition to the period required for the initial FPPE to verify competence of an otherwise qualified individual.

DEPARTMENT FUNCTION

a. Radiology means conventional imaging procedures, nuclear medicine, ultrasound, fluoroscopy, CT and MRI.
b. The Radiology group, which is responsible for the Department of Radiology and all procedures performed in the department, will negotiate a contract with the hospital to provide complete service, including 24-hour coverage. Any radiologist practicing at the hospital or non-radiologists performing procedures in the department shall do so under the supervision and direction of the radiologists who hold the hospital contract and shall comply with their directives. Radiological equipment utilized in the Operating Suites shall be under the supervision of the Radiology group
c. Each request for a radiological procedure shall be considered a "radiological consultation" and the type and number of views will be determined by the radiologist in charge of the examination. If additional views are determined to be needed, they will be ordered by the radiologist.
d. The department shall meet quarterly or as needed to conduct department business.

RADIOLOGY DELINEATION OF PRIVILEGES

1. ELIGIBILITY REQUIREMENTS—To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed M.D.., D.O. and have a nuclear medicine license as applicable.
    b. Have successfully completed additional education/training as follows:
        i. Board Certified by the American Board of Radiology or the American Osteopathic Board of Radiology, or
        ii. Have successfully completed and ACGME or AOA approved residency in Radiology or its equivalent.
        iii. Applicants trained in foreign countries will be considered on an individual basis.
        iv. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
2. Required References:
    a. Initial Application—The applicant must provide references from:
        i. The Initial applicant must provide a reference from the Residency Director, Chief of Radiology or Chairperson of the Radiology Department from another hospital where he/she has been affiliated within the last two (2) years and two physicians who have known the applicant at least two years and are acquainted with the applicant's current professional status, medical practice and involvement in the field of Radiology.
    b. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory observation process, which shall consist of peer review by another radiology staff member of a sample of at least six (6) radiological consultations. Such reviews may be performed by an outside reviewer when appropriate.
3. Minimal Requirements for Appointment/Reappointment:
    a. Appointment:
        i. If the applicant for initial appointment is within 2 years of completion of his or her Radiology Residency, he/she must have evidence of procedures and/or consultation on at least 20 cases in the preceding two (2) years. Initial applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.

b. Reappointment:
    i. Applicants for Reappointment must have admitted or consulted on at least 20 cases in radiology in the preceding two years (within the realm of CORE I privileges or Specialty CORE privileges). Requirements for reappointment can be fulfilled at other hospital affiliations or outpatient consultations. Applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance of skills.
    ii. Physicians, who previously held such privileges and do not meet the minimum number of cases to be considered for reappointment, may be proctored or concurrently peer reviewed for the privileges by a physician holding similar privileges or proctoring/observation as recommended by the Department Chair. After favorable recommendation by the proctor/reviewer, the applicant may be considered for the requested privileges.

DEPARTMENT OF SURGERY

RULES AND REGULATIONS

MEMBERSHIP

The surgery department is composed of staff members assigned to it by the medical staff credentials committee and accepted by the department.

MEETINGS

The department shall meet periodically as necessary to conduct its functions outlined below.

1. Vote—Active staff members will be entitled to vote
2. Chairperson—Chairperson and Vice Chairperson shall be elected to serve for a two-year period, with more than two consecutive terms allowed if elected and desired by incumbent officers.

FUNCTIONS

1. Quality—To assist in maintenance of quality of care and PM/PI activities
2. Policies—To discuss policy matter, problems, and corrective actions, including day-to-day operating room policies and rules.
3. Rules and Regulations—To delineate departmental rules and regulations governing the department. Rules and Regulations may be changed by a majority vote of active staff members.
4. Education—To present education materials of common interest
5. Functions of Chairperson—The chairperson shall organize and lead departmental meetings, represent the department to the executive committee and administration, and appoint members to the surgical qualifications committee. The chairperson may appoint or delegate other responsibilities as appropriate.
6. Review of Performance—The duty of the chairperson of the department of surgery is to review any issue of potential incompetence by department members brought to their attention and to make recommendations to the executive committee concerning that matter.
7. Executive Session—A call for executive session may be brought to the attention of the chairperson of the department of surgery as a point of order by any member of the surgery department or a representative from Parkview Medical Center's administration or nursing services. Executive session will begin when the call for executive session is seconded by a member of the Parkview Surgery Department. Executive session is appropriately used when peer review issues are discussed and shall include members of Parkview Medical Center's surgery department and at the invitation of the department chairperson, medical staff coordinator, administrative representatives and representative from other hospital departments who are required for evaluation of the business under discussion.

8. Other meeting members specifically excluded are:
    a. Non-members of the department of surgery who are not involved with the matter to be discussed.
    b. Support personnel from St. Mary Corwin Hospital
    c. Surgeons who are not members of the Parkview Medical Staff.

SURGICAL QUALIFICATIONS COMMITTEE

THE SURGICAL QUALIFICATIONS COMMITTEE SHALL:

1. Evaluate new applicants for surgical privileges.
2. Participate in monitoring activities of department members.
3. Evaluate initial FPPE data and make recommendations regarding advancement to OPPE or continuing under FPPE.
4. Evaluate department member's privileges periodically for re-credentialing.
5. Report to the chairperson and the department.

QUALIFICATIONS/CREDENTIALING

Eligibility to perform surgical procedures in Parkview Medical Center as a responsible surgeon must be based on an individual's education, training, experience, and demonstrated proficiency.

Acceptable education will consist of graduation from a medical school approved by the Council on Medical Education of the American Medical Association, American Podiatric Medical Association, or from a foreign school acceptable to the medical licensing board of Colorado, plus education leading to qualifications as a surgical specialist.

A surgical specialist is defined as a physician who:

1. Has been certified by an American Surgical Specialty Board approved by the American Board of Medical Specialties, or is certified or qualified by the American Board of Podiatric Surgery; or is certified by the American Osteopathic Board of Surgery; or
2. By reason of education, training and experience, is judged eligible by such a board for its examination; or
3. Has obtained in a country outside the United State, graduate surgical education that satisfies the training requirements for Fellowship in the American College of Surgeons.

It is recognized that surgical procedures may also be performed by physicians who do not meet this definition under the following conditions:

1. A physician who renders surgical care in emergency in which there is no time to obtain qualified surgical consultation.
2. A physician who has just finished formal training in an approved surgical residency program as defined in a specialty, for which the appropriate surgical board has not yet determined eligibility (ordinarily this would not exceed one year plus the board's practice requirement, if any).

3. A resident in training in an approved surgical program, under supervision, may provide surgical care as determined by the surgical staff.
    a. The granting and continuation of surgical privileges will be based upon the staff members' record of demonstrated performance as evaluated by an established medical center peer review mechanism and medical audit.
    b. Request for privileges not generally associated with the field in which the applicant has been trained must be specifically documented with evidence of appropriate training and experience.

All new staff members should be evaluated by the department as follows: Clinical performance in the operating room shall be evaluated in at least six cases (varying type, reflecting privileges requested). Pre-operative and post-operative care shall be included in those evaluations.

1. Additional retrospective review of charts shall be done so that at least 20 cases total are evaluated.
2. Such concurrent and retrospective review is a function of peer review and is confidential and protected.
3. It is realized that different sub-specialties have different needs in regard to number and types of cases and selection of evaluators. Evaluators shall be selected or approved by the department chairperson, who may delegate that duty to the surgical qualifications committee.

POLICIES OF THE SURGICAL DEPARTMENT

Residency/Availability

1. Members of the department shall reside within Pueblo County and be close enough to Parkview Medical center to care for an urgent post- operative problem, should one arise.
2. If a surgeon is not immediately available, he/she shall assign another surgeon to assume his/her responsibilities.

Allied Health Professionals-Advanced Practice Nurses/Physician Assistant

1. The surgeon must be physically present in the surgical department and immediately available if an AHP-APN/PA, credentialed to do so, is performing any part of a surgical procedure, except closing. The "surgery department" is defined as: the area within the operating room suites, same day surgery, recovery room and the attached surgery lounge.
2. Allied Health Professionals-Advanced Practice Nurses/Physician Assistant may not work in the hospital in any of the following circumstances: their sponsor is not available; their sponsor is not immediately available to come to the hospital; or their sponsor has signed out to another physician who is not a sponsor.
3. For AHP-APN/PAs who have opening and closing privileges, the AHP-APN/PA may open the incision down to the fascia if the sponsor is in the surgery department and the surgical site has been marked by the surgeon; closing shall only be allowed if the sponsor remains in the hospital until the procedure has been completed.

Emergency Room Coverage

1. All department members who are on active staff shall take backup emergency room call as assigned.
2. Members of the department may voluntarily request removal from community call obligations at age 55 or after at least 10 years of community emergency room call rotation at Parkview Medical Center whichever is greater.
    a. Requests will be honored if:
        i. 75% of the physicians currently taking call in the specialty in question agree to allow that physician off of call obligations, or
        ii. The physician enters into recruiting arrangements to bring another physician of the same specialty into Pueblo in order to maintain the same complement of specialists available for call.
3. Recommendations by the department for approval of requests for removal from community call obligations will be forwarded to the Medical Executive Committee.

Documentation on Charts

1. A history and physical examination shall be on the chart, dictated or written, prior to the start of any surgical case.
2. Any cases going to the operating room shall have a statement in the chart, authored by the surgeon, indicating findings and reasons for the surgical procedure.
3. All operative procedures require consent of the patient or legal representative.
4. In case of emergency, when legal consent cannot be obtained, this should be documented on the chart by the surgeon.
5. The surgeon is responsible for dictation of the surgical technique and finding, immediately following the operation.

Scheduling

1. An emergency surgical case shall take precedence over all scheduled elective cases.
2. Cases are to start at the time scheduled. Chronic offenders will be penalized.
3. Conflicts in the schedule will be resolved with the best interest of the remaining scheduled patients in mind.
4. A surgeon with a requested time on the schedule may fill an empty time slot earlier, or follow a case scheduled in that time slot.

Assistance

1. The primary surgeon will decide if a qualified physician should assist at the operation and arrange for one if necessary.

OR Procedures

1. Prior to the procedure, a “time out” will occur in which all members of the hospital and physician teams will confirm the correct patient, correct procedure and correct location or side.

Tissue

1. All specimens removed from any invasive procedure will be sent to the Pathology Department for examination, except those listed in Policy No. 200.029 for the Department of Pathology.

AHP IN CRITICAL CARE SETTING

1. ELIGIBILITY REQUIREMENTS

To be eligible to request these clinical privileges, the applicant must:

a. Be a licensed Advance Practice Nurse or PA with prescriptive authority in the State of Colorado.
b. Have previous experience of at least 2 years of emergency department or critical care practice.
c. Required previous experience:
    i. For privileges requested, the applicant must be able to demonstrate ability and competence to perform critical care services.
d. Have an identified physician sponsor who is a member of Parkview Medical Center's Medical Staff with critical care/ICU privileges OR have an identified physician sponsor(s) who is active in the Trauma Program or who actively participate(s) in trauma call and trauma meetings.
e. A letter of reference from the physician sponsor assuming direct and indirect supervision of the AHP in the critical care setting, attesting to the competency of the applicant and indicating any additional activities, justification for, or restrictions to privilege delineation.
f. Approval by the appropriate Surgery Department chair for privileges and approval by the Medical Executive Committee for privileges based on their assessment of training, education, experience and competence.
g. Demonstrate hospital need for the requested privileges.

CORE PRIVILEGES IN ACUTE / CRITICAL CARE PRACTICE

CORE privileges include provision of patient care in all care settings to include critical care units under the sponsorship of a physician(s) with appropriate privileges. Care includes initial and ongoing assessment of patients' medical, physical, and psychosocial status, including but not limited to the following:

- Obtain a relevant health and medical history.
- Write orders in the critical care areas that may be initiated by pharmacy, nursing, and ancillaries without verification by a physician involved in the care of the patient, but require co-signature within 24 hours.
- Perform a physical examination based on age and history.
- Conduct preventive screening procedures based on age and history.
- Identify medical and health risks and needs.
- Update and record changes in health status.
- Formulate the appropriate differential diagnosis based on history, physical examination, and clinical findings.
- Identify the needs of the individual, family, or community as a result of the evaluation of the collected data.
- Order appropriate diagnostic tests in all care settings and co-signed by a physician involved in the care of the patient within 24 hours.

- Identify and prescribe appropriate pharmacologic agents in all care settings and co-signed by a physician involved in the care of the patient within 24 hours.
- Conduct and interpret diagnostic tests.
- Provide relevant patient education.
- Make appropriate referrals to other health professionals and community agencies.
- Determine the effectiveness of the plan of care through documentation of client care outcomes.
- Reassess and modify the plan as necessary to achieve medical and health goals.
- Participate in quality assurance review on a periodic basis, including systematic review of records and treatment plans.
- Perform any other acute/critical care services within the scope of their licensure.

DEPARTMENT OF DENTISTRY

SECTION 1

RULES AND REGULATIONS

1. The officers of the department of dentistry (chairman, vice-chairman) will serve two (2) year terms.
2. The department shall participate in the hospital PM/PI activities.
3. The department shall meet at least twice per year or as needed.
4. All new applicants of the dental staff must be reviewed by the dental department. Their recommendations are then forwarded to the credentials committed.
5. Provisional proctoring as follows:
    a. Refer to the proctoring guidelines of the medical staff office
    b. New applicants who have not had advanced formal training or experience in a hospital setting would be required to have a sterile technique course
6. If any staff member wishes to have another dentist (who is not a member of the staff) assist on any operating dental procedure in this hospital, privileges must first be obtained as specified in the medical staff bylaws and rules and regulations of the medical and dental staff.
7. To maintain their voting privileges, regular members of the dental staff are required to attend 50% of their meetings per year. Absences because of illness or being out of the city are accepted as legitimate excuses for non-attendance at meetings if proper notification has been made prior to the meeting.
8. Department members are required to attend 50% of their department and medical staff meetings over a two (2) year period to maintain staff privileges. Members will be given a six-month probationary period to comply with the meeting requirements before their non-compliance is deemed a voluntary resignation from staff. This rule does not apply to affiliate or non-privileged.

GENERAL SURGERY

DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must meet the following criteria:
    a. Be a licensed M.D., D.O.
    b. Completed additional education/training as follows:
        i. Completion of approved General Surgery Residency, and
        ii. Certification by the American Board of Surgery, American Osteopathic Board of Surgery, American Board of Thoracic surgery or judged eligible by any of the above, or
        iii. Has obtained in a country outside the United States, graduate surgical education that satisfies the training requirements for Fellowship in the American College of Surgeons.
        iv. Those not meeting the above requirements and currently holding privileges will be grandfathered.
    c. Have the following past experience:
        i. SEE GENERAL SURGERY CORE AND/OR NON-CORE PRIVILEGES
            1. CORE I
            2. CORE II
            3. CORE III
            4. CORE IV
            5. CORE V
            6. CORE VI
        ii. Be able to secure clinical references as outlined in the Bylaws.
2. DESCRIPTION OF CLINICAL PRIVILEGES: GENERAL SURGERY CORE AND NON-CORE PRIVILEGES:

CORE I SCRUB AND ASSIST ONLY:

i. To be eligible for scrub and assist only, the applicant must have completed a surgical residency in an approved program and have recent experience in surgery and surgical technique.

CORE II GENERAL SURGERY PRIVILEGES:

i. To be eligible to apply for CORE II privileges, the applicant must meet the requirements noted under eligibility AND have performed 50 cases within the CORE group listed below within the last two (2) years to request and maintain privileges. New applicant's completing their training program will be evaluated on an individual basis.

ii. The broad base of general surgical privileges includes basic general surgery armamentarium. This includes performance of, or surgical assisting at any surgical procedure below.
iii. Biopsy of benign and malignant skin lesions, drainage of abscesses, repair of skin lacerations-simple or complex, minor scar repairs, breast biopsies, IV cut down, minor burn care, assisting at surgery on own patients.
iv. This general area of general surgery competence includes soft tissues surgery of the head and neck, including limited management of airways including tracheostomy, laryngoscopy and pharyngoscope, and also management of soft tissue problems of the oral cavity and head and neck (e.g. thyroid, parathyroid).
v. Basic thoracic privileges include emergency thoracotomy, decortication, thoracic approach for hiatal hernia, transthoracic vagotomy, thoracentesis; chest tube placement and management.
vi. Privileges include surgery of the abdominal cavity, the abdominal wall, surgery of the gastrointestinal tract from the esophagus to the anus, including emergent or operative endoscopy, rigid and/or flexible sigmoidoscopy, surgery of the liver and biliary tract and pancreas, surgery for ascites and portal hypertension, surgery of the spleen and of retroperitoneal abnormalities of disease processes, surgery of the adrenal gland, vena cava interruptions or clippings and also included is urgent/emergent surgery of the female genital tract, including abdominal, lumbar sympathectomy.
vii. Privileges include peripheral venous surgery and straightforward amputations involving above knee, below knee, transmetatarsal or digital amputations and other non- complex surgery of the extremities. Breast surgery, including biopsies, mastectomies, or other soft tissue diseases of the breast, is included. Diseases of the male genital tract, such as hernias, hydroceles, orchiopexies, and/or orchiectomies will be included in these basic privileges. Also included are non-complex pediatric privileges.
viii. Basic anesthesia privileges will include local anesthesia infiltration, topical, local anesthesia administration, minor nerve blocks, including dental, digital, wrist or ankle blocks, and intercostal nerve blocks.
ix. Physicians who have neither training nor experience in the last 5 years in laparoscopic procedures should request laparoscopic privileges separately.

ROBOTIC ASSISTED GENERAL SURGERY PRIVILEGES (that may be requested)

1. Cholecystectomy
2. Inguinal Hernia
3. Ventral Hernia
4. Colectomy/Proctectomy
5. Nissen Fundoplication
6. Splenectomy
7. Adrenalectomy
8. Pancreatectomy

Initial Privileges:

1. Provider must meet criteria and eligibility to be granted Active or Affiliate member of the Medical Staff.
2. Provider must be licensed in the State of Colorado as an MD or DO.
3. Provider must have Core privileges in general surgery/surgical specialty along with privileges to perform the specific procedures being requested for use with the robotic assisted system.
4. Provider must be privileged to perform the procedure by Laparoscopic and/or Open approach.
    a. For Providers who have completed the technology training pathway with evidence of prior use of Robotic-Assisted Technology and/or are Residency/Fellowship trained in use:
        i. Evidence of completion of the da Vinci Technology Training Pathway (Intuitive Surgical Specialty specific training course) must be provided to the credentialing office;
        ii. Documentation of case log of 15 cases, as primary surgeon, within the previous 12 months submitted to the credentialing office OR completion of the Intuitive Surgical Specialty specific training refresher course and any additional requirements mandated by the Surgical Qualifications Committee. If provider is within the first five years of completion of residency/fellowship training, an attestation from the residency/fellowship director of specific robotic training/competence must be provided to the credentialing office;
        iii. Evidence of completion of robotic training for the specific model used at Parkview; and
        iv. Focused Professional Practice Evaluation (FPPE) will be performed for first 15 cases by a provider with privileges to perform the procedure laparoscopically and/or open approach.
    b. For providers who are seeking initial training and privileges in Robotic-Assisted Surgery:
        i. Initial privileges may be granted conditionally upon documentation of:
            - Acceptance into the Intuitive Surgical Training Course (specialty specific); and

- Submission of a training plan delineating physician's statement of intent for requesting robotic privileges, outline of the education schedule to complete the Intuitive Surgical Training Course and specifying the surgeries to be completed during training – form will be provided by credentialing office;

ii. Evidence of completion of the da Vinci Technology Training Pathway (specific to the model used at Parkview) must be provided to the credentialing office;

iii. The Intuitive Surgical Training Course and the first 5 cases, which are to be proctored by a provider with privileges/or vendor credentialed to perform Robotic-Assisted Surgery, must be completed within four (4) months; if this is not completed within four months, the training process must start again from the beginning. The proctor may not be acting as assistant in the procedure and must be of the same specialty and will complete and return the proctoring form provided by the credentialing office; and

<u>Privileges at Reappointment:</u>

a. Documentation of at least 15 robotic-assisted surgeries in the past 24 months
b. Request to continue robotic-assist surgeries on privilege request form

CORE III VASCULAR PRIVILEGES

1. Each procedure must be requested separately.
2. The applicant must have had recent training or current experience in vascular surgery.
3. Vascular privileges include invasive and non-invasive vascular imaging, major peripheral arterial reconstructions, major peripheral venous reconstructions, arterial or venous embolectomy or thrombectomy, vascular access procedures, peripheral perfusion procedures, carotid artery surgery, repair of aortic aneurysm, aortofemoral bypass.
4. Carotid Stenting
   a. The applicant must have had training or current experience in vascular surgery regarding the performance of, or surgical assisting at any surgical procedure contained within the CORE group.
   b. Procedure Requirements:
      i. Initial Privileges:
         - Core II Vascular Surgery Privileges
         - Documentation of at least fifteen (15) cases as primary operator; or
         - Submit request of privileges for carotid stenting and proctoring of fifteen (15) case, to include name of proctor
      ii. Re-credentialing
         - Core II Vascular Surgery Privileges

- Documentation of at least twelve (12) cases as primary operator or proctor

iii. Modification of Privileges
- Core II Vascular Surgery Privileges
- Submit request of modification of privileges for carotid stenting to include name of proctor.
- Submit case list of 15 proctored cases

CORE IV GASTROINTESTINAL ENDOSCOPY PRIVILEGES

i. To be eligible to apply for CORE IV privileges, the applicant must have performed 20 cases within the last two (2) years to request or maintain privileges.
ii. Surgeons who have not completed a gastroenterology fellowship may be granted privileges for upper endoscopy with and without biopsy and colonoscopy with or without biopsy or snare polypectomy pending documentation. Limitations may allow privileges for only one procedure.
iii. Surgeons who have completed an approved residency or fellowship in Colorectal Surgery meet the requirements for all colonoscopy-related procedures.

CORE V BASIC THORACIC PRIVILEGES

i. The applicant must have added training and/or experience in thoracic surgery and provide evidence that he/she is currently exercising these privileges. Basic thoracic privileges include video-assisted thoracoscopy, lung biopsy, wedge resection and biopsy/resection of mediastinal nodes.

CORE VI ADVANCED THORACIC PRIVILEGES

i. The applicant must have added training and/or experience in thoracic surgery and provide evidence that he/she is currently exercising these privileges. Advanced thoracic privileges for non-cardiac open or thorascopic procedures include: first rib removal, thoracoplasty, pulmonary resection and mediastinal surgery.

ROBOTIC ASSISTED THORACIC SURGERY PRIVILEGES (that may be requested)

1. Bronchoscopy
2. Esophagectomy
3. Lobectomy
4. Thoracoscopy
5. Thoracotomy
6. VATS
7. Wedge Resection
8. Mediastinal Mass Resection

Initial Privileges:

1. Provider must meet criteria and eligibility to be granted Active or Affiliate member of the Medical Staff.
2. Provider must be licensed in the State of Colorado as an MD or DO.
3. Provider must have Core privileges in general surgery/surgical specialty along with privileges to perform the specific procedures being requested for use with the robotic assisted system.
4. Provider must be privileged to perform the procedure by Laparoscopic and/or Open approach.
    a. For Providers who have completed the technology training pathway with Evidence of prior use of Robotic-Assisted Technology and/or are Residency/Fellowship trained in use:
        i. Evidence of completion of the da Vinci Technology Training Pathway
        ii. (Intuitive Surgical Specialty specific training course) must be provided to the credentialing office;
        iii. Documentation of case log of 15 cases, as primary surgeon, within the previous 12 months submitted to the credentialing office OR completion of the Intuitive Surgical Specialty specific training refresher course and any additional requirements mandated by the Surgical Qualifications Committee. If provider is within the first five years of completion of residency/fellowship training, an attestation from the residency/fellowship director of specific robotic training/competence must be provided to the credentialing office;
        iv. Evidence of Completion of robotic training for the specific model used at Parkview; and
        v. Focused Professional Practice Evaluation (FPPE) will be performed for first 15 cases by a provider with privileges to perform the procedure laparoscopically and/or open approach.
    b. For providers who are seeking initial training and privileges in Robotic-Assisted Surgery:
        i. Initial privileges may be granted conditionally upon documentation of:
            - Acceptance into the Intuitive Surgical Training Course (specialty specific); and
            - Submission of a training plan delineating physician's statement of intent for requesting robotic privileges, outline of the education schedule to complete the Intuitive Surgical Training Course and specifying the surgeries to be completed during training – form will be provided by credentialing office;

ii. Evidence of completion of the da Vinci Technology Training
Pathway (specific to the model used at Parkview) must be provided to the credentialing office;

iii. The Intuitive Surgical Training Course and the first 5 cases, which
are proctored by a provider with privileges/or vendor credentialed to perform Robotic-Assisted Surgery, must be completed within four (4) months; if this is not completed within four months, the training process must start again from the beginning. The proctor may not be acting as assistant in the procedure and must be of the same specialty and will complete and return the proctoring form provided by the credentialing office;

Privileges at Reappointment:

a. Documentation of at least 15 robotic-assisted surgeries in the past 24 months
b. Request to continue robotic-assist surgeries on privilege request form

CREDENTIALING LAPAROSCOPIC PROCEDURES

1. Basic Laparoscopic Privileges
   a. Must have credentials to perform the procedure done in an "open" or traditional manner.

Must have adequate training as demonstrated by training in residency (documented by the director of the residency program), or a course felt to be adequate by the Surgical Qualifications Committee. Such a course must have an agenda acceptable to the committee and the applicant must have a certificate demonstrating completion of the course. The course must include hands-on operative experience.

i. Basic laparoscopic procedures are procedures felt not to require advanced training or experience. These include cholecystectomy with or without cholangiography, transcystic duct, common duct exploration, liver biopsy, exploration of the abdomen, and appendectomy. There may be other procedures that the committee will include.

ii. Proctoring or monitoring of cases may be required by the committee.

ADVANCED LAPAROSCOPIC PROCEDURES

a. All the criteria listed above for basic laparoscopic privileges must be met.
b. Adequate competence in basic laparoscopic procedures must be demonstrated, with a minimum of twenty such cases being available for review.

i. Adequate training demonstrated either through residency training or an acceptable course to include advanced laparoscopic procedures. (Such a course should include laparoscopic stapling techniques, intra-corporeal and extra-corporeal suturing techniques, prevention and handling of complications, and a hands- on operative experience).
ii. Proctoring or monitoring may be required by the committee.
iii. Preceptors for new procedures are encouraged by the committee, and such precepting may take place either in Parkview Medical Center operating room or an outside facility.

Gastrointestinal Endoscopy

PROCEDURE	PRIVILEGE REQUESTED	PRIVILEGE RECOMMENDED
Diagnostic EGD		
Total Colonoscopy		
Snare Polypectomy		
Nonvariceal Hemostasis		
Variceal Hemostasis		

Surgeons who have not completed a gastroenterology fellowship may be granted the above gastrointestinal endoscopy privileges pending documentation of competency. Limitations may allow privileges for only one procedure.

Surgeons who have completed an approved residency or fellowship in Colorectal Surgery meet the training requirements for all colonoscopy-related procedures.

Surgeons who have demonstrated competence at Parkview Medical Center will be grandfathered for the procedures they have been performing.

CARDIOTHORACIC SURGERY DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must meet the following criteria:
    a. Be a licensed M.D., D.O.
    b. Completed additional education/training as follows:
        i. Completion of an approved General Surgery Residency and Cardiothoracic Residency/Fellowship, and
        ii. Certified by the American Board of Thoracic Surgery or the American Osteopathic Board of Thoracic Surgery, or judged eligible, or
        iii. Has obtained in a country outside of the United States, graduate surgical and/or cardiothoracic surgical education/training that satisfies the training requirements for fellowship in the Society of Thoracic Surgeons.
    c. Those not meeting the above requirements and currently holding privileges will be grandfathered.
    d. Have the following past experience:
        i. See CORE I Cardiovascular and CORE II Vascular Privileges
    e. Be able to secure clinical references as outlined in the Bylaws

DESCRIPTION OF CLINICAL PRIVILEGES CORE (privilege delineation to follow)

CORE I PRIVILEGES IN CARDIOTHORACIC SURGERY

a. To be eligible to apply for this CORE group the surgeon must have performed 50 procedures in the CORE in the previous 2 years. Surgeons who do not meet this threshold may be eligible for proctoring in order to obtain privileges if proctoring confirms competence.
b. Cardiothoracic privileges include performance of surgical procedures including related admission, consultation, work-up, pre- and post-operative care; to correct and treat various conditions, illnesses and injuries of the Cardiothoracic System.
c. A representative of **CORE I** procedures is stated on the next page. It is assumed that other procedures and problems of similar complexity will fall within the identified **CORE I** privileges.

MINIMUM CRITERIA OF 50 CORE I PROCEDURES WITHIN TWO YEARS CAN BE FULFILLED FROM OTHER HOSPITAL AFFILIATIONS, ATTACH DOCUMENTATION

CORE II PRIVILEGES IN VASCULAR SURGERY

To be eligible to apply for this CORE group the surgeon must have performed twenty-five (25) procedures in the CORE in the previous two (2) years. Surgeons who do not meet this threshold may be eligible for proctoring in order to obtain privileges if proctoring confirms competence.

The applicant must have had training or current experience in vascular surgery regarding the performance of, or surgical assisting at any surgical procedure contained within the CORE group:

- Vascular Access Procedures
- Management of Vascular Trauma
- Peripheral Perfusion Procedures
- Arterial and Venous Thrombolytic Therapy
- Surgery of the Extracranial Cerebral Vasculature
- Performing and Interpreting Invasive and Non-Invasive Vascular Imaging and Testing
- Peripheral Arterial Reconstruction (Open)
- Peripheral Arterial Reconstruction (Endovascular)
- Visceral Arterial Reconstruction (Open)
- Visceral Arterial Reconstruction (Endovascular)
- Visceral and Peripheral Arterial Aneurysm Repair (Open)
- Visceral and Peripheral Arterial Aneurysm Repair (Endovascular)
- Repair Aortic Aneurysm (Open)
- Repair Aortic Aneurysm (Endovascular)
- Aortic Iliac Reconstruction (Open)
- Aortic Iliac Reconstruction (Endovascular)
- Carotid Stenting
- First Rib Resection
- Central Venous Reconstruction or Interruption (Open)
- Central Venous Reconstruction or Interruption (Endovascular)
- Peripheral Venous Reconstruction or Ablation
- Renovascular Reconstruction (Open)
- Renovascular Reconstruction (Endovascular)
- Portosystemic Shunt
- Upper and Lower Extremity Amputation
- Surgery for Treatment of Benign and Malignant Tumors of the Extrathoracic Circulatory System

All Carotid Artery Stenting (CAS) procedures will be performed by qualified surgeon according to the Rules and Regulations (see attached Vascular Delineation of Privileges) of the Medical Staff for Vascular Procedures as follows:

CORE III PRIVILEGES IN VASCULAR SURGERY

1. Carotid Stenting
    a. The applicant must have had training or current experience in vascular surgery regarding the performance of, or surgical assisting at any surgical procedure contained within the CORE group.
    b. Procedure Requirements:
        i. Initial Privileges:
            - Core II Vascular Surgery Privileges

- Documentation of at least fifteen (15) cases as primary operator; or
- Submit request of privileges for carotid stenting and proctoring of fifteen (15) case, to include name of proctor

ii. Re-credentialing
- Core II Vascular Surgery Privileges
- Documentation of at least twelve (12) cases as primary operator or proctor

iii. Modification of Privileges
- Core II Vascular Surgery Privileges
- Submit request of modification of privileges for carotid stenting to include name of proctor.
- Submit case list of 15 proctored cases

LASER PRIVILEGES

1. The minimum number of requirements can be fulfilled from other affiliations (attach all documentation).
    i. CO2 Laser
    ii. Initial Application: Training documentation from initial certificate or residency program.
    iii. Reappointment Application: 2 cases per year or documentation of laser safety training.
    iv. Regain Privileges: 1 proctored procedure by another physician with privileges for this laser.

NEUROLOGICAL SURGERY DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must meet the following criteria:
    a. Be a licensed M.D., D.O.
    b. Completed additional education/training as follows:
        i. Completion of one year of an approved General Surgery Residency, and
        ii. Completion of five year approved Neurosurgery, comparable Osteopathic Board or in the process of Board Certification
    c. Those not meeting the above requirements and currently holding privileges will be grandfathered.
    d. Have the following past experience: *See privilege criteria*.
    e. Be able to secure clinical reference from:
2. Initial Applicant References:
    a. Program Director of Chief of Neurosurgery of Chair Neurosurgery from another hospital with which you have been associated for the last two (2) years;
    b. One Neurosurgeon familiar with your practice, but not a current or future partner.

DESCRIPTION OF NEUROSURGICAL CLINICAL/MEDICAL MANAGEMENT:

Performance of neurosurgical procedures is the discipline of medicine and specialty of surgery which deals with the diagnosis, evaluation and treatment of disorders of the central, peripheral and autonomic nervous systems, including their supporting structures and vascular support and the evaluation and treatment of pathological processes which modify function or activity of the nervous system, including the operative management, diagnosis, evaluation, treatment, critical care and rehabilitation of patients with disorders of the nervous system (including related admission, consultation, work-up, pre- and post-operative care).

NEUROSURGERY CORE III PRIVILEGES

1. Applicants requesting Neurosurgery CORE III privileges must have the following past experience:
    a. Completion of an accredited residency and/or fellowship training program, which included training in CORE III procedures—SUPPLY DOCUMENTATION FOR INITIAL APPLICATION.

OPHTHALMOLOGY DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must meet the following criteria:
    a. Be a licensed M.D., D.O.
    b. Have completed additional education/training as follows:
        i. Completion of an ACGME approved Ophthalmology residency program, and
        ii. Certified by the American Board of Ophthalmology or comparable Osteopathic Board, or
        iii. NEW APPLICANTS MUST have completed a training program which fulfills the prerequisites for Board Eligibility
    c. Those not meeting the above requirements and currently holding privileges will be grandfathered.
    d. Be able to secure clinical reference for initial application as outlined in the Bylaws/Rules and Regulations.

ORTHOPEDIC DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these CORE I and II Orthopedic clinical privileges, the applicant must meet the following criteria:
    a. Be a licensed M.D.., D.O.
    b. Have completed and additional education/training as follows:
        i. Completion of a recognized Orthopedic ACGME approved residency training program; and
        ii. Board Certified by the American Board of Orthopedic Surgery or the American Osteopathic Board of Orthopedic Surgery;
        iii. In the process of Board Certification in either of the above
    c. Those not meeting the above requirements and currently holding privileges will be grandfathered.
    d. Have the following past experience: refer to each CORE for specific criteria.
        i. Twenty five (25) procedures within the CORE I and II privileges as the operating surgeon in the past two (2) years.
        ii. Twenty five (25) procedures waived if directly from an approved ACGME training program.
        iii. Be able to secure clinical references as outlined in the Bylaws.

DESCRIPTION OF CLINICAL PRIVILEGES

a. Performance of surgical procedures (including related admission, consultation, work-up, pre- and post-operative care) to correct or treat various Orthopedic conditions, including illnesses and injuries.

OTOLARYNGOLOGY/HEAD AND NECK SURGERY (ENT)

DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must meet the following criteria:
    a. Be a licensed M.D.., D.O.
    b. Have completed additional education/training as follows:
        i. Completion of one year ACGME approved General Surgery Residency, and
        ii. Completion of three years approved ACGME Otolaryngology Residency,
        iii. Completion of one year additional training in and accredited ACGME residency, and
        iv. Certification by the American Board of Otolaryngology Head and Neck Surgery, or
        v. Completion of residency program, which would otherwise make the applicant in the process of Board Certification.
        vi. Those not meeting the above requirements and currently holding privileges will be grandfathered.
        vii. Be able to secure clinical references for initial appointment as outlined in the Bylaws.

DESCRIPTION OF CLINICAL PRIVILEGES: ENT SURGERY

CORE I privileges delineation on the following pages

c. To be eligible for CORE I ENT privileges the surgeon must have performed fifty (50) procedures with the ENT Surgery CORE I within the last 2 years. Surgeons who do not meet this threshold may be eligible for proctoring in order to obtain or maintain privileges if proctoring confirms competence.
d. The provision of comprehensive and clinical aspects of diagnosis medical and surgical care of patients with diseases and disorders of the head and neck that affect the ears, the facial skeleton, the respiratory and upper alimentary systems and related structures.
e. Performance of surgical procedures (including related admission, consultation, work-up, pre-and post-operative care) to correct or treat various conditions, illness and injuries of the: head, neck and ear system. A representative list, but of necessity not a complete list, of ENT SURGERY CORE I procedures is stated below. It is assumed that other procedures and problems of similar complexity will fall within the identified ENT SURGERY CORE I privileges.

LASER PRIVILEGES

a. The minimum number of requirements can be fulfilled from other affiliations-attach all documentation.
b. CO2 Laser
    i. Initial Applications: training documentation from initial certificate, or residency program.

ii. Reappointment Application: 2 cases per year or documentation of laser safety training.
iii. Regain Privileges: 1 proctored procedure by another physician with privileges for this laser.

PLASTIC SURGERY DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must meet the following criteria:
    a. Be a licensed M.D., D.O.
    b. Have completed additional education/training as follows:
        i. Completion of approved Plastic Surgery Residency, and
        ii. Certification in the American Board of Plastic Surgery or comparable Osteopathic Board within 5 years of completed residency or completion of requirements for eligibility.
        iii. Those not meeting the above requirements and currently holding privileges will be grandfathered.
    c. Have the following experience:
        i. Twenty five (25) procedures within the PLASTIC SURGERY CORE privileges in the past two years.
        ii. Be able to secure clinical references for initial application as outlined in the Bylaws

PODIATRIC SURGERY

DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must:
    a. Be a licensed D.P.M.
    b. Have successfully completed a minimum of one-year surgical residency in a Podiatric program approved by the Council on Podiatric Medical Education and the APMA.
    c. Must be Board Qualified or eligible to sit for the qualifications examination in podiatric surgery or board certified in podiatric surgery by the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery. Other Board certifications may be considered on an individual basis.
    d. For privileges requested, the applicant must be able to demonstrate that he/she has had training and experience as required for such privileges.
    e. Those podiatric surgeons who are currently members of the Department with clinical privileges and who at the time of approval of these rules and regulations are not Board Certified or Board Qualified will have been deemed to have met the criteria and maintained current privileges (grandfathered).
2. REQUIRED REFERENCES:
    a. Initial Application—The applicant must provide references from:
        i. Residency Director or Chairperson of the Podiatric Surgery Department from another hospital where he/she has been affiliated within the last two years; or,
        ii. Previous Department Chair, Medical Director or Medical Staff President in an organization where privileges have been held and exercised previously.
    b. To complete the initial FPPE during their first 2-year appointment period, staff members must go through a mandatory observation process as described under privileges.
3. Minimal Requirements for Appointment/Reappointment
    a. If the applicant for initial appointment is not within 2 years of completion of his or her residency in Podiatric Surgery, he/she must have evidence of 10 cases related to Podiatric Surgery in the preceding two years. Applicants who fail to meet these criteria will be competency and maintenance of skills.
    b. For reappointment, the Department of Surgery and Division of Podiatric Surgery will monitor incidence and number of complications and other indicators appropriate to patient management in the operating suite. The results of this monitoring and evaluation activity will be considered at the time of reappointment.

c. The Department will monitor the volume of clinical activity by each practitioner maintains current clinical competence by regular exercise of Podiatric Surgical privileges. At each practitioner's reappointment a minimum of (10) podiatric procedures are required in order to be eligible for reappointment. Re-applicants who fail to meet these criteria will be considered on an individual basis and will need to provide proof of continued competency and maintenance skills.
d. THREE CORE CLASSES of surgical delineation have been defined with additional criterion for the special area of arthroscopy. The classes are listed as follows:
    i. CORE I-Foot
    ii. CORE II-Ankle
    iii. CORE III-Arthroscopy

4. CASE MONITORING PROTOCOL
    a. All proctoring will be done by a podiatric surgeon with equal or greater privileges or an orthopedic surgeon or per the recommendation of the Department of Surgery Chairperson.
        i. If the applicant is applying for CORE I privileges only, then he/she must be proctored for a total of six (6) cases reflecting the privileges requested. These six (6) cases would include at a minimum: 3 in CORE I and 3 in CORE II with an additional three (3) in either at the monitor's request.
        ii. If an applicant that already has CORE I privileges and is applying for CORE II privileges, then he/she must be proctored for a total of three (3) cases reflecting the privileges requested (3 in CORE II) with an additional three (2) in CORE II at the monitor's request.

CORE II PRIVILEGES IN PODIATRIC SURGERY

a. Ankle (Corresponds to Category B in previous Rules and Regulations) Privileges include admission, workup, diagnosis and surgery on patients of all ages presenting with disorders limited to CORE I (Foot) and CORE II (Ankle). Minimum criteria for these privileges include meeting the requirements for CORE I and Board Certification by the American Board of Podiatric Surgery.
b. Internal and external fixation devices which extend above the ankle must be placed only for fixation of the ankle or foot.
c. All applicants may apply for Provisional CORE II privileges:
    i. <u>For Applicants licensed in the State of Colorado BEFORE July 1, 2010:</u>
    These applicants must perform procedures only under the supervision of a Podiatric Surgeon with CORE II privileges or a Board Certified Orthopedic Surgeon (ABOS or AOBOS) and in accordance with the Colorado Podiatry Practice Act.
    ii. <u>For Applicants licensed in the State of Colorado ON or AFTER July 1, 2010:</u>

Surgical procedures on the ankle below the level of the dermis may be performed if applicant has completed a 3-year surgical residency approved by the Colorado Podiatry Board.

CORE IIA PRIVILEGES IN PODIATRIC SURGERY

a. Surgical (open) reduction of fractures and dislocations of the ankle with and without fixation
b. Minimum requirements for CORE IIA include CORE I and II privileges AND additional evidence of residency training in surgical management of ankle fractures as the primary resident surgeon. The applicant must provide evidence that he/she has performed a minimum of 10 cases as primary resident surgeon as evidence by submitted operative reports. In the absence of the minimum number of cases the applicant may become qualified for these privileges after direct supervision of four (4) cases and attestation of competence by an orthopedist or podiatrist who currently has CORE IIA privileges on the Parkview Medical Staff.

CORE IIB PRIVILEGES IN PODIATRIC SURGERY

a. CORE IIB ANKLE ARTHROSCOPY PRIVILEGES
    i. Minimum requirements for CORE IIB ankle arthroscopy include CORE II privileges including arthrotomy of the ankle and additional evidence of training in arthroscopy
    ii. Pathways of training include:
        1. Residency training in diagnostic and surgical arthroscopy should include training in both conventional arthrotomy as well as significant number of arthroscopies (at least 10); or
        2. Podiatric surgeons trained prior to the advent of arthroscopy must be able to document that they are competent/qualified in conventional arthrotomy through the regular hospital surgery credentialing process. The applicant must present evidence of one APMA, CPME or ACFAS approved course with a skills workshop in arthroscopy and with a certificate of completion or letter from the course director documenting this fact. The applicant must submit documentation that he/she has participated as the surgeon of record or a technical surgical assistant of record in a minimum of three (3) arthroscopy cases; and, must be proctored for the first three (3) arthroscopies by a surgeon who is skilled and credentialed in this procedure with an additional three (3) at the proctor's request.

UROLOGY DELINEATION OF PRIVILEGES

1. ELIGIBILITY CRITERIA: To be eligible to request these clinical privileges, the applicant must meet the following criteria:
    a. Be a licensed M.D., D.O.
    b. Completed additional education/training as follows:
        i. Board Certified by the American Board of Urology or
        ii. In the process of Board Certification in the above board, and must become board certified within three years of eligibility
    c. Have the following past experience:
        i. Fifty (50) representative CORE procedures within the past two years, (can be from any hospitals or outpatient surgical centers where you have privileges)
        ii. If applicant does not meet this requirement, the Surgery Department can recommend specific privileges or define a proctoring period.
        iii. Those not meeting the above requirements and currently holding privileges will be grandfathered.
    d. Be able to secure clinical references for initial appointment as outlined in the Bylaws.
    e. The first two years of appointment requires:
        i. All new staff members must go through a mandatory surgical review process as described in the Rules and Regulations.
        ii. Minimum of 50 representative cases (from the CORE in this institution) must be done within the first two years of appointment. Procedures may be done at another institution. Applicant must provide documentation.
2. DESCRIPTION OF CLINICAL PRIVILEGES: CORE privilege delineation on following pages. Performance of surgical procedures (including related admission, consultation, work-up, pre- and post-operative care) to correct or treat various conditions, illnesses, and injuries of the Genitourinary System.

NON-CORE PRIVILEGES IN UROLOGY

a. For each of the NON-CORE procedures, the applicant must do one or all of the following:
    i. Documentation of course taken.
    ii. Must be proctored and demonstrate ability to perform procedure adequately.

CONTIGEN INJECTIONS/IMPLANTS

a. Only urologists adequately trained to determine indications for Contigen implantation treatment by supplying evidence of completion of training, be proficient in the use of endoscopy and completed an AUA approved course for collagen implantation or currently holding such privileges may request this procedure.
    i. Establishment of AV shunt
    ii. Correction of ambiguous genitalia

iii. Clitoral reduction
iv. Clitoridectomy
v. Vaginoplasty
vi. Vaginal reconstruction
vii. Epispadias repair
viii. Repair of bladder exstrophy
ix. Contigen injection/implant

LASER PRIVILEGES

a. Must have evidence of training from an accredited course or current experience
b. CO2 Laser and Holmium Laser
    i. Initial Application: training documentation from initial certificate or residency
    ii. Reappointment: 2 cases per year of documentation of laser safety program
    iii. Regain Privileges: 1 proctored procedure by another physician with privilege for this laser.

ROBOTIC ASSISTED UROLOGICAL SURGERY PRIVILEGES (that may be requested)

1. Simple Prostatectomy
2. Radical Prostatectomy
3. Partial Nephrectomy
4. Radical Nephrectomy
5. Pyeloplasty
6. Cystectomy
7. Ureteral Reimplantation
8. Pelvic Lymph Node Dissection

<u>Initial Privileges:</u>

1. Provider must meet criteria and eligibility to be granted Active or Affiliate member of the Medical Staff.
2. Provider must be licensed in the State of Colorado as an MD or DO.
3. Provider must have Core privileges in general surgery/surgical specialty along with privileges to perform the specific procedures being requested for use with the robotic assisted system.
4. Provider must be privileged to perform the procedure by Laparoscopic and/or Open approach.
    a. For Providers who have completed the technology training pathway with evidence of prior use of Robotic-Assisted Technology and/or are Residency/Fellowship trained in use:
        i. Evidence of completion of the da Vinci Technology Training Pathway (Intuitive Surgical Specialty specific training course) must be provided to the credentialing office;
        ii. Documentation of case log of 15 cases, as primary surgeon, within the previous 12 months submitted to the credentialing

office OR completion of the Intuitive Surgical Specialty specific training refresher course and any additional requirements mandated by the Surgical Qualifications Committee. If provider is within the first five years of completion of residency/fellowship training, an attestation from the residency/fellowship director of specific robotic training/competence must be provided to the credentialing office;

iii. Evidence of completion of robotic training for the specific model used at Parkview; and

iv. Focused Professional Practice Evaluation (FPPE) will be performed for first 15 cases by a provider with privileges to perform the procedure laparoscopically and/or open approach.

b. For providers who are seeking initial training and privileges in Robotic-Assisted Surgery:

i. Initial privileges may be granted conditionally upon documentation of:

- Acceptance into the Intuitive Surgical Training Course (specialty specific); and
- Submission of a training plan delineating physician's statement of intent for requesting robotic privileges, outline of the education schedule to complete the Intuitive Surgical Training Course and specifying the surgeries to be completed during training – form will be provided by credentialing office;

ii. Evidence of completion of the da Vinci Technology Training Pathway (specific to the model used at Parkview) must be provided to the credentialing office;

iii. The Intuitive Surgical Training Course and the first 5 cases, which are to be proctored by a provider with privileges/or vendor credentialed to perform Robotic-Assisted Surgery, must be completed within four (4) months; if this is not completed within four months, the training process must start again from the beginning. The proctor may not be acting as assistant in the procedure and must be of the same specialty and will complete and return the proctoring form provided by the credentialing office;

<u>Privileges at Reappointment:</u>

a. Documentation of at least 15 robotic-assisted surgeries in the past 24 months
b. Request to continue robotic-assist surgeries on privilege request form