Providence
Saint Joseph
Medical Center

PROVIDENCE SAINT JOSEPH MEDICAL CENTER
DEPARTMENT OF MEDICINE
RULES & REGULATIONS

The Department of Medicine and its members are bound by the Professional Staff Bylaws and General Rules and Regulations to which these departmental Rules and Regulations are additive. They are reviewed and updated annually by the Medical Committee, approved by the Executive Committee and the Providence Saint Joseph Board.

I. MEMBERSHIP

All General Internists and Medical Sub-specialists who are members of the Department of Medicine prior to March 1, 1994 shall continue as members. Applicants to the Department of Medicine after March 1, 1994 shall be Board Certified or active applicants to either the American Board of Internal Medicine (ABIM), a subspecialty of Internal Medicine, and/or an area of added qualifications, or one of the following: the American Board of Psychiatry and Neurology, the American Board of Physical Medicine Rehabilitation, the American Osteopathic Board of Internal Medicine, the American Osteopathic Board of Dermatology, the American Osteopathic Board of Neurology and Psychiatry, the American Osteopathic Board of Preventive Medicine, or the American Osteopathic Board of Rehabilitation Medicine. Physicians requesting medical sub-specialty membership shall be Board Certified or active applicants to the appropriate sub-specialty organization.

Physicians who have graduated from their Residency Program and are pending application/acceptance as an active applicant to the ABIM, a subspecialty of Internal Medicine, and/or an area of added qualifications, or the American Board of Psychiatry and Neurology, the American Board of Physical Medicine Rehabilitation, the American Osteopathic Board of Internal Medicine, the American Osteopathic Board of Dermatology, the American Osteopathic Board of Neurology and Psychiatry, the American Osteopathic Board of Preventive Medicine, or the American Osteopathic Board of Rehabilitation Medicine at the time of application to the Professional Staff and are accepted for membership in the Department of Medicine must become an "active applicant" to the ABIM or other entity within six (6) months of appointment to the Professional Staff. Physicians who fail to achieve "active applicant" status with the ABIM or other entity within six (6) months shall be considered to have voluntarily resigned from the Professional Staff.

Physicians who are active applicants to the ABIM or other entities described above at the time of application and are accepted for membership in the Department of Medicine must become Board Certified before the active application period ends (maximum (6) years). If the member does not become board certified they may petition the Department Chairman to approve continued membership in the Department. This decision shall be based on such factors as quality and volume of patient care, active participation in peer review and quality improvement activities, completion of medical records, other professional activities, and adherence to Professional Staff Bylaws and Rules and Regulations.

Allied Health Professionals assigned to the Department of Medicine for privilege recommendations, proctoring, and patient care review are not members.

II. ORGANIZATION

The Department of Medicine is supervised by the Chair of the Department of Medicine who is responsible for all departmental activities. The Chairman of Department of Medicine is the Chairman of the Medical Committee. The Department includes the sections of Cardiology, Gastroenterology, General Internal Medicine, Nephrology, Hematology/Oncology, Pulmonary, Physical Medicine and Rehabilitation, Neurology and the Subspecialty Section. The Subspecialty Section includes other specialties such as Allergy, Dermatology, Endocrinology, Infectious Disease, Psychiatry, Rheumatology, etc. General/Internal Medicine Section shall include all General Internists without subspecialty. Each section shall include members of that specialty. (rev MEC 4/07)

The Section Chair is authorized to act on behalf of the section in the interim between meetings, with conclusions and recommendations to be reported to the section.

The Chairman of each section shall be a member of the Medical Committee. The Department Chairman may appoint additional at-large members from the medical department and other members from Administration, Nursing, and other ancillary services as necessary to more efficiently carry out committee functions. A liaison member shall be appointed by the Chairman of the General/Family Practice Committee.

III. CHAIRMAN

The Chairman and Vice-Chairman of the Medical Department are elected by the membership of the department, as defined by the Bylaws (VIII, Section 2, Subsection 2B).

The Section Chairmen shall be elected as defined within the Professional Staff. Each Section Chairman shall select a Vice-Chairman for the Section.

IV. DUTIES

A. Appointment:
Each application to the Professional Staff assigned by the Credentials Committee to the Department of Medicine shall be reviewed by the Department Chairman for membership and qualifications for the requested privileges. The Department Chairman may request that Section Chairmen also evaluate applicants who, if recommended for appointment, will be assigned to their Section.

B. Reappointment:
Each member of the Department shall be reviewed for reappointment as set forth in the Professional Staff Bylaws (Article III, Section 5). The Chairperson shall be responsible for evaluating professional activity, professional performance and judgement, participation in departmental and educational activities, information from other departments and committees regarding evaluation and disciplinary actions, professional and health capacity to continue quality of medical care, and making recommendations to the Credentials Committee regarding continuation or modification of membership and privilege status. As set forth in the Professional Staff General Rules and Regulations (page 3, Current Clinical Competency at Time of Appointment/Reappointment), if at the time of reappointment the individual's activity level is not sufficient to determine current clinical competency, documentation must be provided with respect to CME, clinical activity at other facilities and/or reference verification from three practitioners.

C. Privileges:

Medical privileges are granted on the basis of education, training, experience and current competence in categories as defined in the general rules and regulations. In each of the categories listed below there are subdivisions. Please refer to the Delineation of Privileges Form for the Department of Medicine.

Categories of Privileges:

1. INTERNAL MEDICINE
These privileges include management and consultation of cases with regard to diagnosis and treatment of medical problems. These would include admission, diagnosis, and treatment of patients in the Intensive Care Unit and the Coronary Care Unit. Such physicians would include physicians in the Department of Medicine who are board certified by the American Board of Internal Medicine, active applicants, and who have documented special training or established practice patterns at PSJMC to be included in the Department of Medicine.

2. SUBSPECIALTY PRIVILEGES
These privileges include management and consultation in subspecialty care by any appropriate use of procedures applicable to their subspecialty.

Members who have privileges in one of these categories may apply for specific medical procedural privileges in which the applicant has documented training and competency and which they expect to use in their ongoing practice at Providence Saint Joseph Medical Center. They are delineated by sub-specialty; the section Chairman may review and make recommendations to the Department Chairman regarding applied-for procedures. The Department Chairman shall approve or modify these recommendations and in turn make the departmental recommendations to the Credentials Committee.

<u>Sub-specialty Coverage Privileges</u>

<u>Cardiology Coverage Privileges:</u>
Sub-specialty privileges may be considered prior to completion of the fellowship according to the following criteria:
- Meet all Medical Staff and Department of Medicine membership requirements;
- Currently enrolled in the third year of an approved cardiology fellowship program
- Successfully completed of two years clinical training within that fellowship, verified by the fellowship director or designee.

- The following privileges may be requested:

  - Admission Discharge
  - Management and consultation
  - Pulmonary Arterial catheterization
  - Cardioversion
  - Thrombolytic therapy

There shall be an agreement between the "hiring" physician and the covering Fellow to provide any procedures needed while the Fellow is covering will be performed in a timely manner by a physician with appropriate privileges. *MEC 10/18/06*

GI Coverage Privileges:
Sub-specialty privileges may be considered prior to completion of a GI fellowship for physicians providing coverage for current staff members only, according to the following criteria:

- Meet all Medical Staff and Department of Medicine membership requirements;
- Currently enrolled in the third year of an approved GI Fellowship program;
- Successfully completion of two years clinical training within that Fellowship, verified by Fellowship Program Director or designee;
- The following privileges may be requested:
  - Admission and Discharge
  - Management and Consultation
- There shall be an agreement between the "hiring" physician and the covering Fellow to provide any procedures needed while the Fellow is covering will be performed in a timely manner by a physician with appropriate privileges. *MEC 2/21/07*

Pulmonary Coverage:
Privileges to provide Pulmonary specialty coverage including consultation and pulmonary rounds may be considered prior to completion of Fellowship training according to the following criteria:

- Physician meets all Medical Staff and Department of Medicine membership requirements
- Currently enrolled in the third year of an approved Pulmonary/Critical Care Fellowship program
- Successfully completion of two years clinical training within that Fellowship, verified by Fellowship Program Director or designee;
- The following privileges may be requested:
  - Admission and Discharge
  - Management and Consultation

There shall be an agreement between the "hiring" physician and the covering Fellow to provide any procedures needed while the Fellow is covering will be performed in a timely manner by a physician with appropriate privileges. *MEC 2/21/07*

Hematology/Oncology Coverage:
Sub-specialty privileges may be considered prior to completion of an ACGME Hematology/ Oncology fellowship for physicians providing coverage for current staff members only, according to the following criteria:

- Meet all Medical Staff and Department of Medicine membership requirements
- Currently enrolled in the third year of an approved Hematology/Oncology Fellowship program
- Verification of successful completion of all clinical rotation components within that fellowship, verified in writing by the fellowship director.
- The following privileges may be requested:
  - Admission and Discharge
  - Management and Consultation
- There shall be an agreement between the "hiring" physician and the covering Fellow to provide any procedures needed while the Fellow is covering will be performed in a timely manner by a physician with appropriate privileges. *MEC 1/16/08*

3. CARDIOVASCULAR LABORATORY PRIVILEGING RECOMMENDATIONS

A. Cardiac Catheterization Laboratory Privileges Including:
   Right heart catheterization
   Left heart catheterization
   Diagnostic angiography
   Temporary transvenous pacemaker

REQUIREMENTS:

1) Current fluoroscopy certificate.
2) No history of ongoing revocation or permanent loss of similar privileges at another institution

3) Board certification or active applicant in Cardiovascular Disease. Members not in this category shall be evaluated as defined in the Rules and regulations of the Department of Medicine.

4) a. Letter of certification from Fellowship director delineating case volume (minimum 250 cases diagnostic angiography), experience and outcomes

OR

b. Unsupervised catheterization privileges at another hospital and letter from laboratory director delineating case volume, experience, outcomes, and ability to perform catheterization as primary operator.

5) Operator must have performed a minimum of 75 diagnostic procedures within the 3 years preceding application for privileges.

6) Unsupervised privileges requires, in addition, satisfactory proctoring of minimum of the first 5 cases.

7) Maintenance of technical proficiency and/or procedural competence requires performance of a minimum number of procedures. It is recommended that a minimum number of 60 diagnostic procedures be performed during the preceding 3 year time period. If the operator does not meet these minimal requirements, then his case work will be reviewed by the Cardiology Q.A. Committee regarding continued maintenance of diagnostic privileges in the Cardiovascular Laboratory.

B. Interventional Privileges including:
Percutaneous Transluminal Coronary Angioplasty (PTCA)
Coronary Stent Implantation

1) Unsupervised cardiac catheterization privileges as delineated above.

2) a. Documentation of training during fellowship including minimum 125 interventional cases, and including letter from fellowship director delineating experience with specific interventional techniques, judgment, case selection and outcomes.

OR

b. Unsupervised interventional privileges at another hospital including minimum 125 cases and with letter from laboratory director delineating experience and documenting volume.

OR

c. Participation in a post-graduate interventional training program with letter delineating experience and documenting volume.

3) Proof of completion of required FDA or manufacturer's approved training course for each coronary stent or other implanted coronary device.

4) Unsupervised privileges requires, in addition, satisfactory proctoring of the first 5 cases, no less than 3 of which include stent implantation.

5) Maintenance of technical proficiency and/or procedural competence requires performance of a minimum number of procedures. It is recommended that a minimum of number of 40 interventional procedures be performed during the preceding 3-year time period. If the operator does not meet these minimal requirements, then his case work will be reviewed by the Cardiology Q.A. Committee regarding maintenance of interventional privileges in the Cardiovascular Laboratory.

6) It is recommended that a minimum 15 CME hours dedicated to invasive and interventional cardiology be obtained on a yearly basis.

C. Atherectomy Privileges including:
Directional Coronary Atherectomy
Extraction Atherectomy
Rotational Atherectomy

1) Unsupervised interventional privileges as delineated above with minimum volume of 75 interventional cases in the preceding 3 years.

2) a. Certification from fellowship or post-graduate training director delineating experience with specific device or technique requested, judgment, case selection and outcomes,

OR

b. Proof of attendance at required training or certification course for each listed device requested AND minimum 24 CME hours training in Atherectomy techniques, complications and case selection.

AND

c. In addition, first 5 interventions for each technique (with practitioner as independent operator) require satisfactory proctoring by physician with unsupervised privileges for that specific technique.

3) Documentation that approved training course, FDA, manufacturers, and/or other regulatory requirements are met.

4) Maintenance of technical proficiency and/or procedural competence for rotational atherectomy requires performance of a minimum number of procedures. It is recommended at a minimum number of 24 cases of a specific technique be performed in the preceding 3 year time period. If the operator does not meet these minimal requirements, then his case work will be reviewed by the Cardiology Q.A. Committee regarding continued maintenance of atherectomy privileges in the Cardiovascular Laboratory.
5) FOR ROTATIONAL ATHERECTOMY ONLY - Privileging will require first 5 cases to be performed with physician with unsupervised rotational atherectomy privileges with prospective review of case selection, complications and outcome.

D. Permanent Pacemaker Implantation:
1) Letter of Certification from Fellowship or post-graduate training Director delineating experience, case volume (minimum 15 implants, at least 10 dual chamber), case selection and outcomes.
2) Unsupervised privileges requires satisfactory proctoring of first 3 implants.
3) Maintenance of technical proficiency and/or procedural competence requires performance of a minimum number of procedures. It is recommended a minimum of 10 implants be performed during the preceding 3-year time period. If the operator does not meet these minimal requirements, then his case work will be reviewed by the Cardiology Q.A. Committee regarding continued maintenance of diagnostic privileges in the Cardiovascular Laboratory.

E. Biventricular Pacing/Cardiac Resynchronization Therapy:
Education and training criteria for supervised biventricular pacemaker privileges at PSJMC are:
1) Operator must hold permanent pacemaker privileges
2) Completion of the FDA required instruction with company certified proctoring

Indications for procedure are:
1) Class III and Class IV heart failure
2) QRS greater or equal to .13 seconds, and ejection fraction less than 35 percent.

Mechanisms for review are:
1) Retrospective proctoring of at a minimum, the first 3 cases performed by each practitioner.
2) 100% review by the Cardiology Q.A. Committee.

Only physicians privileged in Electrophysiology or in the insertion and follow up of an Implanted Cardiac Defibrillator ("ICD") device shall be allowed to insert, manipulate or otherwise disconnect leads of an Implanted Cardiac Defibrillator (ICD) device, including biventricular pacemakers with combined or built-in ICD's.

F. IVUS (Intravascular Ultrasound) Privileges:
Education and training criteria for supervised IVUS privileges at PSJMC are:
1) Operator must hold PTCA and stent privileges.
2) Documentation of IVUS training during Cardiology Fellowship
-OR-
Evidence of formal training & instruction course
Proctoring requirements shall consist of a minimum of one (1) successful case proctored concurrently. *MEC 1/18/12*

G. Supervised Basic Cardiac Electrophysiology ("EP") Privileges including:
Invasive Intracardiac Electrogram Recording and Mapping. Programmed Electrical Stimulation (Invasive and Non-invasive using Implanted Cardiac Defibrillator [ICD] implants). Intraoperative stimulation and testing during ICD implantation by another MD.
1) Board certification (or eligibility) in Cardiovascular Disease and Electrophysiology AND letter of certification from Fellowship or Post-graduate training Director delineating case volume (minimum 100 cases each of Mapping and PES), experience and outcomes,
OR
Unsupervised cardiac Electrophysiology privileges at another hospital and letter from laboratory director delineating case volume, experience, and outcomes. Operator must have performed a minimum of 50 electrophysiology procedures during the 3-year period preceding application for privileges.
2) Unsupervised privileges require satisfactory proctoring of first 5 diagnostic EP cases by physician with unsupervised electrophysiology privileges.
3) To maintain privileges, operator must perform a minimum of 50 procedures during the preceding 3-year time period.

Only physicians privileged in Electrophysiology or in the insertion and follow up of an Implanted Cardiac Defibrillator ("ICD") device shall be allowed to insert, manipulate or otherwise disconnect leads of an Implanted Cardiac Defibrillator (ICD) device, including biventricular pacemakers with combined or built-in ICD's.

H. Supervised Interventional Electrophysiology Privileges including:
Transcatheter Radio frequency Ablation
Transvenous ICD implantation and Testing

1) Letter of Certification from Fellowship or post-graduate training Director delineating specific experience, case volume (minimum 50 cases for each procedure requested) and outcomes,

OR

Unsupervised Interventional EP privileges at another hospital and letter from laboratory director delineating case volume, experience and outcomes. Operator must have performed a minimum of 25 cases for each procedure requested during the 3-year time period preceding application.

2) Unsupervised privileges require satisfactory proctoring of 3 cases of radio frequency ablation, and 5 implantations of ICD devices. Successful proctoring of the 5 ICD devices may be counted toward proctoring of permanent pacemaker implantations. To maintain privileges, operator must perform a minimum of 10 cases of each procedure during any 3-year period.

Only physicians privileged in Electrophysiology or in the insertion and follow up of an Implanted Cardiac Defibrillator ("ICD") devices shall be allowed to insert, manipulate or otherwise disconnect leads of an Implanted Cardiac Defibrillator (ICD) device, including biventricular pacemakers with combined or built-in ICD's.

I. Additional Proctoring and Privileging Guideline

1) In the absence of a proctor with unsupervised privileges in a specific technique (e.g. with new interventional procedures or newly privileged procedures), proctoring will be at the discretion of the Department Chairman, upon recommendation of the Medical Director of the Cardiovascular Laboratory, his designee, or Chairman of Cardiology.
2) The Medical Director of the Cardiovascular Laboratory, with approval of the Cardiology Q.A. Committee and the Clinical Cardiology Section, may recommend increase or decrease the number of proctored cases prior to application for unsupervised privileges.
3) Case volume recommended for privileges may include cases performed at another institution.

J. Trans-Septal Cardiac Cath Procedures
(Specific to Electrophysiology)

1) Interventional electrophysiology privileges at PSJMC
2) Successful completion of a fellowship or post-graduate training in trans-septal cardiac catheterization including a minimum of 10 cases,

- OR -

1) Unsupervised trans-septal cardiac catheterization privileges at another hospital
2) Verification of a minimum of 10 procedures within the past three (3) years

Proctoring Provisions:
A minimum of the first five (5) cases proctored concurrently by a physician who holds unsupervised privileges.

Requirements for Proctor:

In order to serve as a proctor a practitioner must be an:

1) Electrophysiologist with unsupervised privileges at PSJMC
or if the above is not available
2) Electrophysiologist from area hospital who meets the following:
   a) Active Staff at an area hospital
   b) Board Certified in Cardiovascular Disease
   c) Actively practicing endovascular procedures and can attest to the performance of a minimum of 12 cases in the past 24 months.
3) The selection of proctor will be approved by the Chief of Cardiology division in conjunction with the Chairman of the Department of Medicine.

Requirements to Maintain Current Clinical Competence
Within each 24 month reappointment cycle

1) Documentation of 12 cases performed at PSJMC to maintain skills
2) Documentation of continued cognitive training through participation in educational activities related to the procedures requested
3) Concurrent review by the Cardiology Q.A. Committee of all cases

K. ENDOVASCULAR PROCEDURES

Endovascular procedures consist of the following:

1) Diagnostic peripheral angiography - Includes the performance of the procedure and the interpretation
   Non-selective
      aortic arch
      abdominal aorta
      abdominal aorta with run-off
      Selective
      brachiocephalic
      mesenteric
      renal
      aorto-iliac, femoral
      peripheral/infra-inguinal
      A-V fistulas
2) Percutaneous thrombolysis
3) Percutaneous endovascular interventions
   (balloon angioplasty, stenting, atherectomy)
      brachio-cephalic
      abdominal visceral
      renal
      aorto-iliac, femoral
      infra-inguinal
      A-V fistulas

Diagnostic Peripheral Angiography

Physician Training Requirements:

1) Formal fellowship training in coronary (for cardiologists) and peripheral catheter-based procedures
   Or
2) Current unsupervised privileges in coronary interventions and preceptorship programs with adequate didactic and clinical training in the anatomy, pathophysiology, diagnosis and medical management of peripheral vascular disease and endovascular techniques, which may be achieved in inpatient and outpatient vascular consultation settings, noninvasive vascular laboratories, and interventional laboratories. This should include at least 12 hours of didactic training at a recognized training facility and should include active participation in at least 10 diverse endovascular cases.

Proctoring provisions:

1) All procedures are expected to meet indications recognized by evidence-based studies of vascular medicine, and recognized as such by professional societies such as the American College Cardiology, the Society for Cardiovascular Angiography and Interventions, the Society for Vascular Medicine and Biology, and the Society for Vascular Surgery.
2) Retrospective review by the Cardiology Quality Assurance Committee of a minimum of six (6) cases

Endovascular Interventions

1) Formal fellowship training in coronary (for cardiologists) and peripheral catheter-based procedures (for cardiologists, vascular surgeons and radiologists.)
2) Current unsupervised privileges in coronary interventions and preceptorship programs with adequate didactic and clinical training in the anatomy, pathophysiology, diagnosis and medical management of peripheral vascular disease and endovascular techniques, which may be achieved in inpatient and outpatient vascular consultation settings, noninvasive vascular laboratories, and interventional laboratories. This should include at least 8 hours of didactic training at a recognized training facility and should include active participation in at least 20 diverse endovascular cases.

Proctoring provisions:
Concurrent proctoring of a minimum of five (5) cases in a variety of beds:
brachiocephalic,
abdominal visceral,
renal,
aorto-iliac, femoral,
infra inguinal,
A-V fistulas

All case performed during the first year of the program will be reviewed by a multi-disciplinary endovascular sub-committee of the Cardiology QA committee. The endovascular sub-committee of the Cardiology QA Committee will consist of members of the Cardiology QA Committee and other experts in vascular medicine on staff at PSJMC and/or outside experts.

Requirements to maintain clinical competence:
Current requirements for interventional cardiology and category 1 postgraduate education courses in peripheral vascular intervention, hospital conferences including endovascular mortality and morbidity, and documented self-education.

Requirements to function as proctor:
In order to serve as a proctor a practitioner must be an:

1. Interventionalist with similar training and unsupervised privileges at PSJMC
   - or if not available -
2. Peripheral Interventionalist from area hospital who meets the following:
   a) Active Staff at an area hospital
   b) Board Certified in Cardiovascular Disease and Interventional Cardiology
   c) Actively practicing peripheral interventions and can attest to the performance of a minimum of 30 variety of cases in the past 24 months.
3. The selection of proctor will be approved by the Chief of Cardiology Division in conjunction with the Chairman of the Department of Medicine. *rev: MEC 01/06*

L. EXERCISE/PHARMACOLOGICAL STRESS TESTS BY NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

1. NURSE PRACTITIONERS
   Requirements - Documentation of successful performance of a minimum of 30 procedures within the past 3 months. Must have approved prescribing privileges.

   Performance of Exercise & Pharmacological Stress Test by Nurse Practitioner. Supervising Cardiologist shall be immediately available.

   Proctoring - Ongoing FPPE for a minimum of 12 months, retrospectively reviewed by a physician not within the same group.

2. PHYSICIAN ASSISTANTS
   Requirements - Documentation of successful performance of a minimum of 30 procedures within the past 3 months. Must have approved prescribing privileges.

   Performance of Exercise & Pharmacological Stress Test by Physician Assistant. Supervising Cardiologist shall be immediately available.

   Proctoring - Ongoing FPPE for a minimum of 12 months, retrospectively reviewed by a physician not within the same group.

VENTILATOR PRIVILEGES

<u>Non-Invasive Mechanical Ventilator Privileges</u>

1) The acute use of non-invasive mechanical ventilation
   (excludes chronic use ie: sleep apnea)
2) Training Requirements:
   a. Pulmonary, Cardio/Thoracic Surgery, Emergency Medicine and Anesthesia, No additional training required.

3) Proctoring Requirements:
Pulmonary, Cardio/Thoracic Surgery, Emergency Medicine, Anesthesia
Minimum of 3 cases proctored retrospectively

Short-Term Ventilator Management Privileges

1) For patients whose intubation/ventilation duration is anticipated for 24 hours or less.
2) These patients will most often be:
   a. Patients with acute problems who do not have chronic cardio-pulmonary problems.
   b. Patients with chronic problems where short-term intubation is likely
3). These privileges may be granted by:
   a. Department of Medicine to:
      (1) General Internists
      (2) Medical Sub-specialists
      (3) General/Family Practitioners
   b. Department of Surgery to:
      (1) General Surgeons
      (2) Thoracic Surgeons
      (3) Cardiac Surgeons
      (4) Other Surgeons with training/experience in ventilation management
      (5) PA's working under approved protocols and supervision of Surgeon with Short Term Ventilator Privileges
      (6) Anesthesiologists
4) The Department of Medicine and Surgery may grant Short Term Ventilator Privileges to Professional Staff Members or PA's who are currently managing such patients.
5) For new members, or existing members not currently managing these patients but who want to do so, they must apply for the privileges to the appropriate Department (Medicine or Surgery) documenting training and experience with concurrent and/or retrospective proctoring of at least three cases. *rev MEC 5/23/12*

Prolonged Ventilator Management Privileges

1) For patients where intubation/ventilation duration may well extend > 24 hours, or short term patients that cannot be successfully weaned off the ventilator in 24 hours, or patients where short term intubation was anticipated but ventilator management becomes more difficult and complex, or short term patients who were extubated but require reintubation.
2) These privileges may be recommended for approval by the Pulmonary Section, to the Department:
   a. Pulmonologists
   b. Critical Care Specialists
   c. Members of the Department of Medicine or Surgery who can document training, experience and current competence in the management of complex, prolonged ventilator patients.
3) In consultation with the Department Chairman these privileges may be recommended to Pulmonologists actively working in the hospital at this time.
4) In consultation with the Department Chairman, recommendation may be made to grant supervised privileges to existing members who document current clinical competence, or too new members who qualify in one of the categories noted above with concurrent and/or retrospective proctoring of at least three cases.
5) PULMONARY PROCTORING REQUIREMENTS
   A. General Pulmonary - admission, discharge, patient management and consult: A minimum of 3 cases. May be combined with procedural proctoring listed below (excluding laser)
   B. Procedures: A minimum of 5 concurrent proctoring reports of a variety of cases including at least 2 bronchoscopies with at least 1 biopsy:

      Bronchoscopy
      Thoracentesis
      Endotracheal intubation
      Closed pleural biopsy
      Pulmonary artery catheterization
      Chest tube insertion

   Ventilator management (long term): 3 cases (may be retrospective)

   YAG Laser: Minimum of 3 concurrent procedures (in addition to other procedural proctoring)

6) GASTROENTEROLOGY PRIVILEGES

A. Capsule Enteroscopy

Education and training criteria for supervised capsule enteroscopy privileges are:

1) Board Certified or active applicant in Gastroenterology, General Surgery, or Colorectal Surgery
   - AND -
2) Operator must hold unsupervised privileges for endoscopy and colonoscopy
   - AND -
3) Documentation of completion of either course:
   a. "Capsule Endoscopy of the Small Bowel: Practice and Diagnosis." This course is produced by the manufacturer and is available in the GI Lab.
      - OR -
   b. American Society of Gastrointestinal Endoscopy (ASGE) certification course on video endoscopy, available through the Internet.

Indications for the procedure:

Capsule enteroscopy is a procedure that is primarily intended for visualization of the small bowel mucosa. It is indicated for evaluation of obscure small bowel pathology (including obscure GI bleeding, abdominal pain, evaluation of inflammatory bowel disease and diarrhea). Because of the evolving nature of this technology, the PSJMC Small Bowel Enteroscopy Steering Committee of the Gastroenterology Section will review indications on a biennial (every two years) basis.

Strong consideration should be made to ensure that a small bowel follow through radiographic study be performed prior to capsule endoscopy. Capsule enteroscopy is contraindicated in the following:

1) Patients with the following known or suspected conditions:
   a. Gastrointestinal obstruction
   b. Strictures
   c. Fistulas
   d. Pregnancy
2) Patients with cardiac pacemakers or other implanted electromedical devices.
3) Patients scheduled for an MRI within 72 hours of the procedure.
4) Children aged 17 and under.

Mechanisms for review for unsupervised privileges are:

A minimum of three cases proctored by a physician holding these unsupervised privileges at PSJMC, or proctored by a physician holding these unsupervised privileges at another facility and approved by the PSJMC Small Bowel Enteroscopy Steering Committee on a biennial (every two years) basis.

Monitoring the Evolution of the Procedure:

The GI Section has established a Small Bowel Enteroscopy Steering Committee to oversee the medical and the operational activities of the small bowel enteroscopy program. This will include Small Bowel Capsule Enteroscopy as well as push video enteroscopy. The functions of the committee will be as follows:

1) Review current literature and provide guidance to the medical use of the instrument as more information becomes available
2) Explore participation in research related activities
   a. Develop internal protocols
   b. Participate in multi-center or industry protocols
   c. Educate the GI Lab staff, PSJMC physicians, and the public about the Small Bowel Enteroscopy Program at PSJMC
3) Review and supervise policy and procedures to insure the highest standards are maintained in performing the procedures.
   a. Conduct quality assurance audits
   b. Revise credentialing and privilege requirements when indicated.
4) The above criteria will be reviewed on a biennial (every two years) basis.

B. Esophageal Motility

Education and training criteria for interpretation are:

1) Board Certified or active applicant in Gastroenterology or General Surgery With Endoscopy training.
2) Unsupervised Upper GI Endoscopy privileges at PSJMC
3) Documented training in Esophageal Manometry in a General Surgery or Gastroenterology training program

- OR -

4) Written documentation of specific training and experience and/or a certificate of completion in a postgraduate course or seminar.

Indications for the procedure:

This procedure involves passing a soft, narrow tube through the nostril and into the esophagus. This tube measures pressure to evaluate how strongly the esophagus muscle contracts with swallowing and how competent the sphincter is at the end of the esophagus. This procedure is useful in the evaluation of Gastroesophageal Reflux Disease (GERD), Dysphagia, and Atypical Chest pain.

Mechanisms for review for unsupervised privileges are:

A minimum of three (3) successful interpretations proctored by a physician holding these unsupervised privileges at PSJMC, or proctored by a physician holding these unsupervised privileges at another facility and approved by the Department of Medicine as having documented expertise in Esophageal Manometry.

C. Esophageal pH Study Interpretation

Education and training criteria for interpretation are:

1) Board Certified or active applicant in Gastroenterology or General Surgery with Endoscopy training
2) Unsupervised Upper GI Endoscopy privileges at PSJMC
3) Documented training in Esophageal pH in a General Surgery or Gastroenterology training program

- OR -

4) Written documentation of specific training and experience and/or a certificate of completion in a postgraduate course or seminar

Indications for the procedure:

Esophageal pH monitoring involves a probe being placed in the esophagus to keep track of the level of acidity in the lower esophagus. This is done over a 24-hour period. This procedure is useful in the evaluation of Gastroesophageal Reflux Disease (GERD), and Atypical Chest pain.

Mechanisms for review for unsupervised privileges are:

A minimum of three (3) successful interpretations proctored by a physician holding these unsupervised privileges at PSJMC, or proctored by a physician holding these unsupervised privileges at another facility and approved by the Department of Medicine as having documented expertise in Esophageal pH Study Interpretation.

D. Anorectal Manometry and Pudendal Nerve Testing

Education and training criteria for interpretation are:

- Board certified or active applicant in Gastroenterology, General Surgery or Colorectal Surgery
- Must have unsupervised privileges for colonoscopy

AND

- Documentation of completion of anorectal physiology training during fellowship or Documentation of completion of a course in anorectal physiology training approved by American Society of Colon and Rectal Surgeons

Indications for the procedure:

Anorectal manometry and pundendal nerve testing are procedures that are indicated for the evaluation of anorectal dysfunction. Such conditions include but are not limited to, fecal incontinence, constipation, anorectal pain, as well as other anorectal conditions.

Mechanisms for review for unsupervised privileges are:
A minimum of three cases involving anorectal manometry and pudendal nerve testing proctored by a physician who holds privileges for these procedures at PSJMC.

E. Anorectal Ultrasound

Education and training criteria for interpretation are:

- Board certified or active applicant in Gastroenterology, General Surgery, Colorectal Surgery or Radiology with certified training in anorectal ultrasound or an equivalent course
- Must have documented completion of anorectal ultrasound past experience ten (10) cases. To include at least 5 each for rectal tumor staging and anal canal imaging for various anal conditions

Indications for the procedure:
Endorectal ultrasound is used for pre-treatment staging and post-treatment follow up for anorectal tumors. It is also used in the evaluation and diagnosis of fistula-in-ano, perirectal abscess conditions, and the imaging of the anal sphincters in the evaluation of fecal incontinence.

Mechanisms for review for unsupervised privileges are:
A minimum of three cases proctored of each tumor staging and anal imaging by a physician who has approved privileges at Providence Saint Joseph Medical Center.

F. Endoscopic Ultrasound (EUS)

Education and Training Criteria
Completion of an approved GI fellowship program
Completion of an approved EUS fellowship including documentation of the following per ASGE recommendations:

Endoscopic Ultrasound (EUS)
75 mucosal tumors (esophagus, stomach, excluding rectum)
40 submucosal abnormalities
75 pancreaticobiliary

EUS - Guided Fine Needle Aspiration (FNA)
25 EUS-guided FNA, - pancreatic
25 EUS-guided FNA, - non-pancreatic

Proctoring Requirements
Approval of unsupervised privileges may be considered following successful completion of the following proctoring requirements:

Endoscopic Ultrasound (EUS)
Concurrent proctoring of the first two (2) cases of each procedure
Proctoring may be combined with EUS-FNA
EUS - Guided Fine Needle Aspiration (FNA)
Concurrent proctoring of the first two (2) cases of each procedure

E. Proctoring:
Definitions:
The following definitions will be used in these Rules & Regulations in regards to proctoring:

Prospective Proctoring
Prospective proctoring is a review by the proctor of either the patient's chart or the patient personally before treatment. This type of proctoring may be used if the indications for a particular procedure are difficult to determine or if the procedure is particularly risky.

Concurrent Proctoring
Concurrent proctoring is when the proctor actually observes the physician's work. This is usually used for invasive procedures so that the medical staff has first-hand knowledge necessary to satisfy itself that the physician is competent.

Retrospective Proctoring
Retrospective proctoring involves a retrospective review of patient charts by the proctoring physician. Retrospective review is usually adequate for proctoring of non-invasive procedures.

Provisional members with supervised medical privileges shall be proctored concurrently by section members to which they are assigned. The proctoring shall include an evaluation of clinical judgment, appropriateness of services provided, clinical outcomes, and quality of documentation. When procedural privileges are requested they will require concurrent observation and review with separate proctor cards.

Proctoring for general privileges (admit/discharge, write orders, complete history and physical examinations, participate in ongoing patient care) will continue for a minimum of three cases. Proctoring requirements for general privileges are separate from proctoring requirements for specialty procedure privileges, such as those included in item IV., C., page 2, of these Medical Department Rules and Regulations. Unsupervised privileges may be recommended in some areas or procedures and continued supervised in other areas or procedures.

Unless otherwise specified in these Rules and Regulations, reciprocal proctoring may be accepted for up to 50% of the proctoring requirement under the following conditions:

- Proctoring was carried out at a local JCAHO accredited hospital,
- Proctoring was performed within the past 24 months to demonstrate current competence,
- Copy of the proctor report is supplied to the Professional Staff Office by the facility,
- The proctor is a member of the PSJMC Professional Staff who is eligible to proctor at PSJMC and the outside facility.

In the majority of cases, the physician must have adequate clinical activity to allow for evaluation and recommendations regarding unsupervised privileges within the two year Provisional Category period or be dropped from the medical staff. In areas of practice where hospital activity is traditionally low, the Medical Committee may make specific exceptions to these recommendations. In other cases with minimal clinical activity, where the physician may demonstrate clinical activities with documented outcomes at another hospital, and acceptable reasons for continuing Providence Saint Joseph Medical Center membership, the committee may also make exceptions.

Members of the Professional Staff requiring additional medical privileges, if granted, shall be proctored for an adequate period or number of cases to justify recommendation regarding unsupervised status.

F. Quality Assurance:
Patient care review of outcomes, focused study review, and participation in multi-disciplinary evaluations is a Medical Department responsibility. These functions are carried out in an ongoing way by each Medical Department Section. Results and recommendations from these reviews are reported to the Medical Committee. Any recommendations regarding adverse actions to membership or privileges by the Section must be approved by the Medical Committee. Results of these departmental functions shall be reported on a regular basis to the Executive Committee.

Each section's area of review responsibilities, in addition to the Medical Department indicators and criteria of the Medical Department includes section specific focused studies when indicated, a review of procedures specific to the section, professional overview of specific laboratories and clinical functions.

The Medical Sections, having defined diagnostic and/or therapeutic laboratories to support their functions, are responsible to review the quality and appropriateness of the laboratories and procedures performed therein. Section committees may appoint sub-section committees to carry out this review function (Cardiology QA Committee). For those sections in which these laboratories have a Medical Director, the Director shall take an active role in those evaluations.

The Medical Committee may assign specific reviews related to diagnosis, procedures, or practitioners to a Medical Section. The section shall then be responsible to carry out the review and report its findings and recommendations to the Medical Committee on a timely basis.

The Medical Committee shall review and validate or modify screening criteria on an annual basis. Each section will annually plan its review functions, including anticipated focused studies or multi-disciplinary reviews.

G. Temporary Privileges:
Temporary privileges and locum tenens shall be considered and processed in accordance with the Bylaws of the Professional Staff.

H. Panels: The diagnostic interpretation panels are available to provide readings for studies where no physician has been specified or contracted by the ordering physician or medical group to interpret the study.

1. NEURODIAGNOSTIC LABORATORY READING PANEL
All physicians applying for the Neurodiagnostic Laboratory Reading Panel must meet the following criteria:
* Must meet eligibility criteria for Board Certification or be Board Certified.
* Must have been on staff for one year
* Proctoring will consist of a minimum of retrospective review of the first 4 cases.

Appointment to the physician reading panel shall follow letter application wherein the applicant shall certify as to his/her qualifications, training, and experience in the appropriate areas of diagnostic neurologic testing and interpretation. All studies performed by or at the behest of Providence Saint Joseph Neurodiagnostic Lab shall be officially read and a report dictated. All studies shall be read and a report dictated within 48 hours. Noncompliance with this rule may result in administrative suspension of panel privileges. Physicians not completing their dictations within 48 hours will not be able to read or schedule new cases until the delinquent reports are completed. The remainder of their panel cases will be given to the next physician on the panel rotation.

2. NEUROLOGY ER CALL PANEL

All members of the Neurology Section are required to participate on ED call panel as scheduled by the Section Chairman. In the event a member is not available on a scheduled date, it is the member's responsibility to arrange for alternate coverage with another member of the Section. Failure to respond to call shall be deemed to constitute imminent danger to patient safety and may be cause for summary suspension from the Professional Staff.

<u>STAT EEG</u>

All orders for STAT EEG require consultation with a Neurologist. STAT EEGs will be read by the Neurologist on call.

3. PULMONARY FUNCTION TEST INTERPRETATION PANEL

All physicians applying for the Pulmonary Function Tests (PFTs) Panel must be Active or Associate Category, must have been on staff for three years, must have demonstrated advanced training in the field of Pulmonary Medicine, and must be either Board Certified in Pulmonary Medicine or meet eligibility criteria for Pulmonary Medicine. PFTs shall be interpreted by members of the Panel on a rotating basis. PFTs shall be interpreted in a timely manner – within 24 hours. The Pulmonary Section is charged with the responsibility of quality assurance in PFT interpretation." All studies shall be read and a report dictated within 48 hours. Noncompliance with this rule may result in administrative suspension of panel privileges. Physicians not completing their dictations within 48 hours will not be able to read or schedule new cases until the delinquent reports are completed. The remainder of their panel cases will be given to the next physician on the panel rotation.

4. CARDIOLOGY PANELS

All physicians applying for Cardiology Panel privileges must meet the minimum criteria of Board Certification and/or Eligibility, must be of Associate or Active status, and must have been on the staff for 3 years.

Cardiology Panels for unassigned patients include:
- EKG & Holter Panel;
- Echo Panel;
- Treadmill Panel;

The assigned physician is responsible to monitor the patients as scheduled or to arrange for another physician with the privilege to do so. If they cannot provide coverage, the next person in rotation will be assigned patients and the physician will relinquish their right to rotation until the next time their name comes up.

Physicians who are unable to read tests timely or unable to monitor patients or are late to scheduled procedures will be reported to the Chairman of Cardiology Section for possible disciplinary action, which may include suspension from or removal from treadmill monitoring of one or more panels.

All interpretations (Except Echo's): shall be read and a report dictated within 48 hours.

- Echo Reading; All routine inpatient Echo studies must be interpreted within 24 hours of completion of the examination. Outpatient studies must be interpreted by the end of the next business day. The final signed report must be completed within 48 hours after the interpretation.

If ordered STAT, turn-around-time within 1 hour with reading within 1 hour. (Addition: 03/18)

Any tests not read in the above timeframes (panel or non-panel tests) will be transferred to the next physician on the reading panel. Three violations of the requirement within a rolling 12 month period will result in the physician being removed from the reading panel for three months. Repeat violations will result in permanent removal from the reading panel. It is the responsibility of the Panel member to arrange panel coverage if he/she will not be available as scheduled.

5. GASTROENTEROLOGY PANELS

Effective January 21, 2016 and as a condition of membership, all current members and future Gastroenterology applicants with Gastroenterology privileges who are not already on the Gastroenterology Emergency Room Call Panel shall be required to serve on the Gastroenterology Emergency Room Call Panel. Effective March 1, 2017, those members who are 70 years of age and older have the option to "opt-out" of taking call. It is the responsibility of each practitioner to formally advise the Section Chair in writing should he/she choose to exercise this option.

The following details Panel operations:

- Panel hours are 7:00 am - 7:00 am the following day
- Panel physician shall be called at the discretion of the attending, Hospitalist or ED physician when he/she determines a G.I. consultation is required (regardless of when the patient presented to the E.D.) in accordance with the published Gastroenterology Panel rotation.
- Current physician "contact" information shall be maintained by both the Professional Staff Office and E.D.
- Response time to an E.D. call shall be thirty (30) minutes. Failure of timely response may result in disciplinary action.
- It is the responsibility of each assigned panel member to personally notify the Section Chair, E.D., and Professional Staff Office by both telephone and in writing in the event he/she is not available on their assigned day. The assigned panel member is responsible for ensuring his/her assigned day is staffed. This is also applicable should an assigned day be traded with another panel member.
- Failure to comply with this section shall be referred to the Medical Executive Committee for disciplinary action.

That all G.I. physicians must hold privileges to perform ERCP or coverage by an ERCP privileged physician. Physicians who do not demonstrate this criteria shall be removed from the Call Panel and have their inpatient consultative privileges placed on Administrative Suspension until such time as they can provide evidence of coverage.

G.I. physicians that perform inpatient consultative services shall meet the same criteria for Call Panel.

V. MEETINGS

A. General Staff Meetings:
All members of the Medical Department are encouraged to attend the General Staff meetings, especially the annual meeting in November.

B. Medical Department Meetings:
These meetings are held as often as necessary to discuss departmental and Staff functions, and to participate in patient care evaluation and educational programs. When appropriate, these meetings may be combined with the General Staff meetings.

C. Medical Committee Meetings:
The Medical Committee shall meet at least quarterly. Additional meetings may be called as necessary. Meetings may be postponed or canceled if there are no significant agenda items or for unexpected contingencies.

All Section Chairmen are expected to attend the majority of Medical Committee meetings, or when attendance is impossible, to arrange for attendance by the Vice-Chairman or another Section member.

D. Section Meetings:
In accordance with the Professional Staff Bylaws, each Section may meet at the discretion of the specialty Section Chairman in order to transact the business of the Section. The Section Chairmen shall act as representatives of their respective specialty sections, serve as members of the Medical Committee, and perform those tasks assigned to them by the Department and/or the Department Chair.

Since the activities of the Section are important to Section members, members are encouraged to attend the majority of their Section meetings.

V. ATTENDANCE

Attendance shall be considered and processed in accordance with the Bylaws of the Professional Staff. Professional Staff meeting attendance requirements for Active, Associate, and Provisional Categories of membership shall not be applicable to Allied Health Professionals assigned to the Department of Medicine.

Revision / Approval
MED: 07.16.03
Revised: MEC: 01.18.17 Board: 03:17
Revised: 02.04.04sp Approved MEC: 03:17:04 Board: 04:04
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Approved MEC: 08/17/05;1/18/06;3/15/06;7/19/06;2/21/07;4/18/07;11/28/07;1/16/08;4/16/08;6/18/08;1/21/09;6/17/09; 7/28/10; 2/16/11; 1/18/12; 5/23/12; 07/17/13
Approved MACB 1/23/06 BOD 7/21/08; 2/10/09; 8/20/09; 8/12/10; 4/14/11; 3/19/12; 7/16/12;
Signature Updates: 02.2015: 2016: 2017: 2020: 2024

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