PIH HEALTH | Whittier Hospital

Medical Staff Rules and Regulations

Adopted: January 1997
Last Amended: December 17, 2021

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I. ADMISSION AND DISCHARGE OF PATIENTS

A. GENERAL

The hospital shall accept patients for care and treatment except for the following:

- Cases of contagious diseases in which appropriate isolation cannot be maintained or adequate care provided.
- Patients with critical burns, which require stabilization and transfer to a burn care facility elsewhere.

A patient may be admitted to PIH Health Hospital-Whittier dba PIH Health Whittier Hospital only by Medical Staff Members who have admitting privileges. All practitioners shall be governed by the Hospital's official admitting policy. ED physicians shall be permitted to write orders for admission but are not allowed to serve as the attending physician during any inpatient stay.

A physician member of the Medical Staff shall be responsible for directing and supervising the patient's overall medical care, 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 patient, the referring member, if any, and to the patient's family.

Each patient shall be the responsibility of a member of the medical staff or their call designee. Whenever these responsibilities are transferred to another Staff member, a note covering the transfer of responsibility shall be entered on the patient's medical record.

No patient shall be admitted to the hospital without a provisional admitting diagnosis. In the case of an emergency, such statement shall be recorded as soon as possible.

B. STAFF MEMBER RESPONSIBILITY

1. Continuity of Care:

Each member of the Medical Staff shall provide assurance of continuity of care for their patients in the hospital by being available or having available an alternate qualified practitioner with whom prior arrangements have been made. The alternate must be a member of the Medical Staff of PIH Health Hospital - Whittier dba PIH Health Whittier Hospital with appropriate privileges, or a practitioner or locum tenens, granted appropriate temporary privileges. Failure of the attending staff member to meet the above requirements may result in corrective action or summary restriction or suspension in accordance with the Medical Staff Bylaws.

2. Unavailable Alternate:

In the event the attending physician's alternate is not available for emergency care of an in-house patient, the Emergency Room physician shall be requested to provide immediate care; and the department chairperson or President of the Medical Staff must be contacted, and assume responsibility for caring for the patient or appoint an appropriate medical staff member who will assume responsibility until the attending physician can be reached.

3. Patient is a Source of Danger:
   Subject to applicable laws regarding confidentiality of patient information, the admitting staff member shall be held responsible for informing Medical Staff members and hospital personnel as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his patient might be a source of danger from any cause whatever.

C. ADMISSION PRIORITIES

The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof.

1. Emergency Admission
   Such cases are patients who have serious medical problems and may suffer death, serious injury, or permanent disability if they are not admitted and provided treatment within four hours. The history and physical examination must clearly justify the patient being admitted on an emergency basis, and these findings must be recorded on the patient's chart as soon as possible after admission.

2. Urgent Admission
   Such cases are patients who have serious medical problems who may suffer substantial injury to their health if they are not admitted and provided treatment within twenty-four hours. On designation by the admitting Medical Staff member, these admissions shall be reviewed by the Utilization Review Coordinator to determine priority when all such admissions for a specific day are not possible.

3. Preoperative Admission
   This includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chief of Staff/Chair of the Department of Surgery may decide the urgency of any specific admission.

4. Routine Admission
   This will include elective admissions involving all departments.

D. POTENTIAL SUICIDAL OR MENTALLY DISTURBED

For the protection of the patients, the medical and nursing staffs, and the hospital, certain principles are to be met in the care of the potentially suicidal, alcoholic, mentally disturbed and drug overdose patients:

1. Suicidal Patients
   Suicidal patients, when determined to require involuntary treatment in a locked ward, will be sent, if possible, to another institution where suitable facilities are available.

2. Psychiatric Consult
   Any patient who is dangerous to self or others, by attempting suicide or taking a chemical or drug overdose, must be offered consultation by a Psychiatrist or Psychologist (§5150, Health & Welfare Code), in addition to the implementation of the hospital's suicide precautions.

E. TRANSFERS

1. Transfer to Another Unit

No patient shall be transferred to or from one service or unit to another without an order for such transfer by the responsible member of the Medical Staff.

2. Transfer to Another Facility

Transfer of patients to another more suitable facility shall be carried out in accordance with the Hospital policy on transfers provided the patient is medically fit for transfer. Patients who are not stable may be transferred only if the physician finds, within reasonable medical probability, that the expected medical benefits of the transfer outweigh the risks posed by the transfer, or the patient, or their surrogate decision-maker, requests transfer, after the physician has explained the medical risks and benefits of transfer.

F. DISCHARGES

Patients will be discharged only on the order of the responsible member of the Medical Staff.

1. Against Medical Advice

Should a patient leave the hospital against the advice of the attending member, or without proper discharge, a notation of the facts and circumstances shall be documented in the patient's medical record.

2. Refusal of Treatment

The President of the Medical Staff shall be authorized to refuse to accept for admission, and/or authorized to discharge from the hospital any patient who, at any time, refuses treatment, becomes insubordinate or in any manner becomes an unfit patient. Such patient shall not be readmitted without the consent of the president of the medical staff and administrator, and only after consultation with the responsible member of the Medical Staff.

G. CASE MANAGEMENT COMPLIANCE

The responsible member of the Medical Staff is required to document the necessity for continued hospitalization for any patient in accordance with the hospital's Case Management Plan.

H. DEATHS

1. Pronouncement

When a patient dies in the hospital, the deceased shall be pronounced dead by the attending physician, another physician upon request, or in accordance with approved standard nursing policy. The body shall not be released until an entry has been made and signed in the medical record of the deceased. Policies with respect to release of dead bodies shall conform to local law.

2. Autopsy

The mechanism for documenting permission to perform an autopsy is defined per policy.

II. GENERAL CONDUCT OF CARE

A. CONSENT TO TREAT

1. Informed Consent

Except in cases of emergency, the Medical Staff member or an authorized NP or PA is responsible for obtaining a patient's informed consent prior to any procedure or treatment for which the patient's informed consent is required. Policies defined in the California Hospital Association's Consent Manual and the Patient Self-Determination Act of OBRA 1990, are adopted to serve as operating policy governing matters relating to consents in this hospital. The Medical Staff member, NP or PA shall perform a complete informed consent process which includes a discussion of the following elements:

a. The nature of proposed care, treatment, services, medications, interventions, or procedures
b. Potential benefits, risks, or side effects, including potential problems that might occur during recuperation.
c. The likelihood of achieving care, treatment, and service goals
d. Reasonable alternatives to the proposed care, treatment, and service
e. Relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment or service.
f. When indicated, any limitations on the confidentiality of information learned from or about the patient.
g. Any research or economic interest I may have regarding this treatment.

B. ORDERS

1. Entered (Written during downtime)

All orders for treatment shall be entered into the EHR or if the system is down in writing. A verbal order shall he considered to be in writing if dictated to a duly authorized person:

a. Registered Nurses
b. Licensed Vocational Nurses
c. Respiratory Care Practitioners
d. Registered Dietitians
e. X-Ray Technicians
f. Physical Therapists
g. Pharmacists
h. Occupational or Speech Therapists
i. Radiation Therapy Technologists

A verbal order for medication (or an investigational drug) shall be given only to a registered nurse, a Respiratory Therapist or licensed pharmacists by a member authorized to prescribe such medication.

All verbal orders must be signed, dated, and timed by the Medical Staff member within forty-eight (48) hours, except for TCU, where verbal orders must be signed, dated, and timed within 5 days.

All orders must be written clearly, legibly and completely. The orders shall be prefaced by the date and time the order was written. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. Nursing shall contact the physician for clarification of orders.

2. No-Code or DNR Orders

All no-code or DNR orders shall be issued only by members of the Medical Staff, if life sustaining treatment is to be withdrawn or resuscitative services are to be withheld, and shall be implemented in accordance with Hospital policy #100.87200.602.

3. Standing Orders

All Medical Staff members requesting standing orders must submit in writing to the hospital through the Nursing Office, to be approved and reviewed annually by the Pharmacy and Therapeutics/Infection Prevention Functional Team.

4. Transfer Orders

When patients go to surgery, all previous orders are canceled and rewritten. On transfer to or from a Special Care Unit, orders must be reviewed and rewritten promptly, and if necessary. Orders by emergency room physicians that accompany patients during transfer to critical care and clinical areas shall be considered interim only.

C. DRUG ORDERS

1. Formulary

The hospital shall maintain a Formulary of the preferred medications approved for administration to patients in the facility. The Formulary shall be reviewed annually by Pharmacy and Therapeutics/Infection Prevention Functional Team. Any medication deemed necessary for treatment but not included in the Hospital Formulary may be administered upon the approval by the Pharmacy and Therapeutics/Infection Prevention Functional Team Chair, or their designee, unless it is a continuation of a patient home medication (provided by patient/patient representative).

2. Investigational Drugs

Drugs for bona fide clinical investigations must be in full accordance with the Use of Investigational Drugs in Hospitals and all regulations of the U.S. Food and Drug Administration regulations pertaining to investigational drugs.

3. Automatic Stop Order

The Automatic Hard Stop Medication Orders (ASO) and Discontinuance policy shall be in effect for all medications to ensure discontinuation on all orders that are no longer needed in accordance with Hospital Policy # 100.77100.726.

4. Per Pharmacy Dosing

Pharmacy will be restricted to filling orders “per Pharmacy protocol” only when there is an official protocol approved by the Medical Executive Committee. They will decline to fill an order for treatment where there is no Medical Executive Committee approved protocol. If physicians fail to follow the above rule, the Pharmacists may contact the physician's department chairperson and/or the Chief of Staff to resolve the issue.

5. Generic Substitution

The Pharmacy and Therapeutics/Infection Prevention Function Team will establish a list of substitutions of medications ordered by name. The addition of any medication to the list must be approved by the Committee.

D. RESTRAINT and SECLUSION

Restraint and seclusion shall require use in accordance with policy. For restraints the policy is 100.87200.604 Restraints, Non-Violent/Non-Self Destructive and Violent, Self-Destructive. At this time there is no Seclusion Policy.

E. VISITORS REQUESTING TO OBSERVE

Temporary permission may be granted to a visitor (physician, student, etc.) requesting to observe a procedure only when there is consent by the attending medical staff member, NP or PA and patient. Requests must be made through the Medical Staff Office at least one week in advance (see Policy 100.87100.019).

F. CRITICAL CARE UNITS

1. Patients

Only patients requiring specialized care or intensive services will be admitted to the Critical Care Units.

2. Medical Director Authority when Unit is full

When the unit is full, the Medical Director has the authority to decide which patients may be admitted and which patients may be discharged if, in their opinion, another patient has greater need for care in the Critical Care unit.

G. FAMILY PRACTICE RESIDENCY

1. Operation

The Family Practice residency program shall operate by the rules and regulations of the Medical Staff, Section 7.6, and hospital policy on Family Practice Residency. The house staff shall be fully supervised by members of the Family Practice Residency faculty or their designees in carrying out their patient care responsibilities in accordance with Policy No. 100.82100.313.

2. Medical Records Completion

All entries in the medical records by house staff or non-physicians that require countersigning by supervisory or attending medical staff members shall be completed within the period defined by these rules and regulations.

H. DIETARY SERVICES

1. Policies and Procedures

Policies and procedures shall be developed and maintained in consultation with representatives of the Medical Staff, Nursing Staff, Dietary Staff, and Administration to govern the provision of Dietetic Services.

I. DISASTER PLAN

1. Plan

A plan of handling mass casualties and illnesses shall be developed by the Safety Committee with Medical Staff and Hospital representation, and shall be approved by the Medical Executive Committee.

2. Staff Assignment

All Active Staff members will have a disaster assignment.

3. Discharge and Transfer of Patients

In the event of a disaster, the Chief Medical Disaster Officer shall have the authority to discharge or transfer inpatients if such is deemed necessary to accommodate disaster casualties.

J. HARASSMENT PROHIBITED

Harassment by a medical staff member against any individual (e.g., against another medical staff member, house staff, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation shall not be tolerated.

Sexual harassment is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

All allegations of sexual harassment shall be immediately investigated by the medical staff and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of medical staff privileges or membership, if warranted by the facts.

K. MEDICAL SCREENING EXAMINATIONS

The Medical Staff acknowledges and agrees that non-physicians in certain circumstances may perform medical screening examinations for purposes of compliance with federal and state law. The following categories of non-physicians are hereby approved for the performance of such examinations: Physician Assistants and Nurse Practitioners. Non-physicians in these categories will be permitted to perform such medical screening examinations only after they have been appropriately credentialed to do so through the Interdisciplinary Practice Committee (IPC), and subject to any standardized procedures as adopted by the IPC. The performance of such examinations will be reviewed under the quality management process.

III. CONSULTATIONS

A. CRITERIA

Except in emergencies, a consultation with another qualified member of the medical staff is **required** in the following situations:

1. The diagnosis is obscure after ordinary diagnostic procedures have been completed.
2. Complicated situations where specific skills of other members may be needed.

3. The patient exhibits severe psychiatric symptoms and is not under the care of a psychiatrist.
4. Consultation is required by licensing organizations (i.e., Medicare, MediCal, 2nd Opinions for Surgery)
5. Neonatal admission to NICU

Consultation with another qualified member of the medical staff is **recommended** in the following situations:

1. The patient is a poor risk for an operation or treatment.
2. There is doubt as to the choice of therapeutic measures to be utilized.
3. When requested by the patient or their family.
4. Response to therapy is not as anticipated.

These criteria shall not preclude the requirement for consultation on any patient when the Chair of the Department or the President of the Medical Staff determines a patient will benefit from such consultation.

B. QUALIFICATIONS

The consultant must be well qualified to give an opinion in the field in which their opinion is sought. Any qualified member with clinical privileges in this hospital may be called for consultation within their area of expertise.

C. DOCUMENTATION

A consultation must include documentation of the examination of the patient and review of the medical record. The documented opinion must be signed by the consultant and becomes a part of the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded on the chart prior to the operation.

D. RESPONSIBILITY FOR CONSULT REQUEST

The attending member is responsible for requesting consultation when indicated, for calling in a qualified consultant, and for informing the patient.

E. NURSING RESPONSIBILITY

Should a nurse have any reason to doubt or question the care provided to any patient, receive an order for medication which is judged to be incorrect or inappropriate, or believes that appropriate consultation is needed and has not been obtained, they shall call this to the attention of their superior, who in turn may refer the matter to the Department Chair or the President of the Medical Staff.

1. During an inpatient Code Stroke, the RRT nurse will ensure every effort is made to contact the attending physician and update them about the change in condition.
2. If there is no response from the attending physician within 15 minutes the RRT nurse may call the on-call neurologist directly for a consult request.

IV. MEDICAL RECORDS

A. GENERAL

Medical Staff members shall be responsible for the preparation of a complete and legible medical record for each patient. Each medical record's content shall be clinically pertinent and current.

B. Electronic Medical Record Training

Practitioners must complete training in the use of the PIH Health Hospital-Whittier dba PIH Health Whittier Hospital electronic medical record system prior to exercising granted clinical privileges. An exception will be made when granting Temporary Emergency Privileges for volunteer independent practitioners in the event of a disaster.

C. COMPLETE MEDICAL RECORD

The medical record shall include:

1. The reason(s) for admission, care, treatment, and services
2. The patient's initial diagnosis, diagnostic impression or conditions
3. Findings of assessments and reassessments
4. Allergies to food and medications
5. Conclusions or impressions drawn from the patient's medical history and physical examination
6. Diagnosis or conditions established during the patient's course of care
7. Consultation reports
8. Observations relevant to care, treatment and services
9. Patient's response to care, treatment and services
10. Emergency care, treatment, and services provided to the patient before their arrival
11. Progress notes
12. Orders/verbal orders
13. Medications ordered, prescribed and administered
14. Adverse drug reactions
15. Treatment goals, plan of care and revisions to the plan of care
16. Results of diagnostic and therapeutic tests and procedures
17. Medications dispensed or prescribed on discharge
18. Discharge diagnoses
19. Discharge plan and discharge planning evaluation
20. Advanced directives
21. Informed consent
22. Operative/Procedure report
23. Postoperative/Procedure documentation including vital signs and level of consciousness and documentation of patient's readiness for discharge based on approved discharge criteria
24. Discharge summary that includes final diagnosis, the reason for hospitalization, procedures performed, care, treatment and service provided, patient's condition and disposition at discharge, information provided to the patient and family and provision for follow-up care.

Podiatrists and Dentists are responsible for those record portions applicable to their scope of practice, as required by the Bylaws of the Medical Staff.

D. IDENTIFICATION SHEET

The identification sheet shall include those items of personal patient identification as required by hospital licensure regulation.

E. ADMISSION HISTORY AND PHYSICAL

1. Admission History and Physical

A complete history and physical examination shall be documented within twenty-four (24) hours of admission or registration (72 hours for TCU admissions from PIH Health Hospital-Whittier dba PIH Health Whittier Hospital Inpatient or Observation Status). This report shall include all pertinent findings resulting from an assessment of all the systems of the body. Pelvic and Rectal examinations may be omitted if not clinically relevant or have been done within a time frame which is clinically relevant.

A brief description of the Patient Care Plan and the necessity for hospitalization is to be recorded as part of the History and Physical.

2. Preoperative/procedure History and Physical – Elective surgery/procedure requiring anesthesia

a) Prior History and Physical

If a complete History and Physical examination, as defined above, has been documented by a Medical Staff Member with appropriate Clinical Privileges within thirty (30) days prior to the patient's admission or registration to the hospital for elective surgery/procedure requiring anesthesia, an electronic copy of these reports* will be acceptable in lieu of the Admission History and Physical.

b) Interval Note

In addition to the History and Physical above, there must be an interval note recorded within 24 hours after the patient's admission stating the presence or absence of any changes to the initial History and Physical examination. This interval note must be recorded or documented prior to surgery or other procedures requiring anesthesia. The necessity for the inpatient admission must be documented in the medical record. The medical record shall include pre-existing medical conditions or extenuating circumstances, such as post-operative/procedure complications, that made the acute inpatient admission medically reasonable and necessary.

3. Readmission

If the patient is readmitted to the hospital within thirty (30) days of a previous discharge for the same or related condition, an interval admission note stating the reason for readmission and any changes in the history and physical examination that made the acute inpatient admission medically reasonable and necessary shall be documented in the patient's medical record.

*All dictations and reports mentioned in these Rules and Regulations must be in an electronic format such that the documentation is available electronically in the hospital's electronic health record (EHR).

F. HISTORY AND PHYSICAL NOT DONE PRIOR TO SURGERY/PROCEDURE

When the history and physical examination are not recorded or documented before an operation/procedure or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending member of the Medical Staff states in writing that such delay would be detrimental to the patient.

G. PREOPERATIVE/PROCEDURE ASSESSMENT FOR INVASIVE PROCEDURES

"INVASIVE PROCEDURE" means a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to,

percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy.

Invasive Procedures Requiring Anesthesia or Moderate Sedation
Prior to undergoing non-inpatient invasive procedures, patients shall have a history consisting of items 1, 2, 3, 4, 5, and 8 noted above and a physical examination pertinent to their medical condition, to include cardiac and lung examination, and the proposed invasive procedure entered into their medical record by a physician who has a current unrestricted medical license issued by the State of California.

Patients who are about to have an invasive procedure shall be evaluated prior to the procedure by the physician performing the procedure. This evaluation shall be performed and documented by the physician performing the invasive procedure and include, but not be limited to,

1. Review of the patient's identifying data
2. Review of the patient's history and pertinent physical exam
3. Review of the patient's diagnoses pertinent to the procedure
4. Review of the indications for the procedure
5. Review of any contraindications to the procedure (relative or absolute)
6. Assessment of the patient's current clinical condition *(with respect to the patient's ability to tolerate the procedure)*
7. Review of any pertinent pre-existing studies of the involved area
8. Obtaining the seven elements of Informed Consent
9. Direct communication with the ordering physician if any concerns arise.

Documentation may take the form of a brief summary of the above items recorded in the chart or as a part of the documented report of the procedure or in a separate documented report.

Specific Outpatient Services or Procedures that do not Require Anesthesia
After registration but prior to surgery or invasive procedure (i.e., wound debridement), that does not require anesthesia, the practitioner shall complete and document a focused medical assessment which shall include:

1. Presenting diagnosis/condition
2. Description of symptoms
3. Significant past medical history
4. Current medications
5. Any drug allergies
6. Indications for the procedure
7. Focused physical exam as indicated
8. Proposed treatment or procedures

H. ELECTRONIC PROGRESS NOTES

Pertinent progress notes shall be recorded electronically at the time of observation, sufficient to permit continuity of care and transferability by the recording physician. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be recorded by a member of the medical staff, dated

and timed on a daily basis on all patients, except for patients of the Transitional Care Unit who shall have progress documented at least once every 30 days.

I. OPERATIVE/PROCEDURE REPORTS

"INVASIVE PROCEDURE" means a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy.

In order to provide for continuity of care to the patient, a post-operative/procedure progress note shall be legibly recorded immediately after surgery. This note shall include the name of the procedure, the name of the primary surgeon(s) and assistant(s), pre-operative/procedure diagnosis, description of the procedure, operative/procedure findings, specimens removed, post-operative/procedure diagnosis, complications, estimated blood loss, and condition of the patient at the end of the procedure.
A complete operative report shall be documented no later than 24 hours after the surgery/procedure.

Members who fail to adhere to Section H above may not perform nor schedule another procedure until all operative/procedure reports are completed. (This includes all procedures, surgical procedures, surgical assisting, anesthetic procedures, endoscopies, bronchoscopies, treadmill tests, electromyography, angiography, angioplasty, etc., and includes the Same Day Surgery Center as well as the Main Hospital and ancillary departments.)

J. CONSULTATIONS

Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be documented and entered into the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded or documented prior to the operation/procedure.

K. CLINICAL ENTRIES

All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated. Signature stamps are not permissible. Authentication can be through electronic signature, and must confirm the CMS signature guidelines and the date stamped.

L. ABBREVIATIONS

Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations identified on the Stedman's online application on the PIH Health intranet will be used to document. Abbreviations identified on the list of prohibited abbreviations, acronyms, symbols are not to be used.

M. FINAL DIAGNOSIS

Final diagnosis shall be recorded or documented in full, dated and signed by the responsible member of the medical staff at the time of the patient's discharge.

N. DISCHARGE SUMMARY

A discharge summary shall be documented on all medical records of patients hospitalized over forty-eight (48) hours. All patients who have been hospitalized for at least forty-eight (48) hours shall have a Discharge Summary documented in the Hospital's electronic medical record within 7 days of discharge. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the patient's admission, level of care, treatment and outcome, including comorbid and pre-existing conditions of the patient. Documentation shall include the reason for hospitalization, hospital course, specific instructions given to the patient and/or family, particularly in relation to limitations, physical activity, medications, diet, education and follow up care.

O. RELEASE OF MEDICAL RECORD

Written authorization of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

P. PROPERTY RIGHTS OF MEDICAL RECORD

All records are the property of the hospital. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In case of readmission of a patient, all previous records shall be available for the use of the attending member of the medical staff, regardless of the previous attending physician. Access to all patient records shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients, and subject to approval by the Medical Executive Committee.

Q. ACCESS TO MEDICAL RECORDS BY FORMER STAFF MEMBERS

Subject to the discretion of the Chief Executive Officer (Administrator), former members of the Medical Staff shall be permitted access to information from medical records of their patients covering all periods during which they attended such patients in the hospital.

R. COMPLETE MEDICAL RECORD

A medical record shall not be permanently filed until it is completed with all required reports and signatures by the responsible member, or it is ordered filed by the Medical Executive Committee. Authentication for completion, by definition, shall be approved when either the Medical staff member or their designee signs in the designated time period, as long as the activity being signed for remains within the scope of the privileges of the signing Member.

S. PHYSICIAN'S ORDERS

A member's routine orders, when applicable to a given patient, may be entered into the patient's electronic medical record, dated, timed and signed by the practitioner.

T. DELINQUENT RECORDS

Records remaining incomplete fourteen (14) days after the patient's discharge shall be declared delinquent. Failure to complete such records within fourteen (14) days of a patient's discharge shall result in an automatic suspension of the member in accordance with the Bylaws of the Medical Staff and subject to a fine.

If a provider has been automatically terminated from staff due to failure to pay assessed fines (see Bylaws 6.7.3.2) the provider will be required to pay a $550.00 reapplication fee.

Physicians who have any operative/procedure reports which remain undocumented 24 hours after the performance of the procedure may not perform, nor schedule another procedure until all such operative procedure reports are documented/captured electronically. (This includes all inpatient and outpatient: procedures, surgical procedures, surgical assisting, anesthetic procedures, endoscopies, bronchoscopies, treadmill tests, electromyography, angiography, angioplasty, etc.), and includes the Same Day Surgery Center as well as the main hospital and ancillary departments.

All discharge summaries are to be documented/captured electronically within 7 days of patient discharge with the exception of: a) patients who are hospitalized for less than 48 hours, b) normal newborn infants, and c) uncomplicated obstetrical deliveries.

A documented/captured electronically discharge summary is required for any patient admitted under the two (2) midnight rule that does not stay two (2) midnights.

A transfer summary is required for any patient transferred from one level of care to another.

A documented/captured electronically death summary is required for all expired patients.

All history and physicals for patients admitted for other than Same Day Surgery or Short Stay Surgery must be documented/captured electronically with the exceptions of emergency cases which can be handwritten but documented/captured electronically within 24 hours of the patient's admission.

All history and physicals and discharge summaries of patients treated by a physician of the Family Medicine Residency Program must be documented/captured electronically regardless of the nature of the case.

Physicians shall be assessed $25/day for every day they are on the Delinquent Records list beginning on the 15th day of delinquency. Physician vacations and illnesses will not be counted in delinquent days.

U. NOTIFICATION

Each week a list of physicians who have outstanding medical records will be notified by Medical Records, of the delinquency.

On or about the ninth day of delinquency, Medical Records will send a second notice.

A third notice will be sent to the physician on or about the twelfth day of the delinquency, reminding them of the charts and consequences.

On the fifteen day, Medical Records will notify the physician of the suspension.

Physicians who have accumulated 10 or more days but less than 15 suspension days are sent a warning letter.

Physician who accumulate 15 or more days of suspension are referred to the appropriate department chair for action.

Physicians who have accumulated 30 days of suspension in a calendar year are immediately referred to the President of the Medical Staff and maybe asked to appear before the Medical Executive Committee.

V. Suspension and Other Disciplinary Action

Failure to meet the completion requirements as delineated will result in suspension of admission privileges and suspension of procedural and/or privileges. In addition, physicians shall be assessed a $25/day for every day there on the Delinquent Records list beginning on the 15th day of the delinquency and have their badge and meal card inactivated.

Suspension will result in the following:

a. Admitting privileges are suspended
b. ER-Call Coverage is suspended
c. Physician is unable to schedule a new surgery/procedure
d. Badge/Meal Card will be inactivated

It is the responsibility of the suspended physician to make arrangements for ER Call coverage during their suspension.

Suspension will be lifted once all medical records are complete and penalty fees are paid.

If a physician is placed on the suspension list a second time, their assessment fees will be doubled and will continue to double every time they are placed on the suspension list.

W. ELECTRONIC SIGNATURE

Medical records shall be authenticated through in house or remote electronic signature software. Physicians must sign a statement that they agree to be the only one who has access to and use of their password and personal identification number. The sharing of password/PIN with anyone is strictly prohibited. All electronic signatures will conform with CMS signature guidelines and be date stamped.

V. EMERGENCY SERVICES

A. MEDICAL COVERAGE

The Medical Staff shall adopt a method of providing medical coverage in the emergency services area. This shall be in accord with the hospital's basic plan for the delivering of such services, including the delineation of clinical privileges for all Medical Staff members who render emergency care.

B. BACKUP EMERGENCY CALL PANELS

1. Participation

Participation on Emergency call panels as determined below (5.2.2) is not a right nor a privilege but is an obligation of Medical Staff membership. No Medical staff member has a right to serve on any call panel. Such service is at the discretion of the Department, Section and/or Medical Executive Committee. A decision to remove a member from a Call Panel shall not constitute a denial or restriction of clinical privileges, does not entitle the member to any Hearing Rights, and is subject only to review by the Medical Executive Committee.

2. Establishment (Voluntary vs Assignment)

Whenever possible, each Service should establish a voluntary Emergency Call Panel which provides continuous coverage. In the absence of such voluntary continuous coverage, the Department or Section Chairperson shall assign all Active, Associate and qualified Provisional members of a Service or Section to a Backup Emergency Call Panel Schedule in alphabetical rotation for each month of the year. For any month in which there is no voluntary continuous coverage for a given Service, the Service Backup Emergency Call Panel for that month shall be substituted.

3. Provisional Staff

Provisional Staff members may participate in voluntary or Backup Call Panels as soon as their proctoring requirements have been satisfactorily met with regard to those privileges which are necessary to provide emergency services in their specialty.

4. Exemption

A Service may, at its discretion, elect to exempt members over the age of 65 years from participation in the Backup Emergency Call Panel Schedule. Exemptions are subject to review by the Medical Executive Committee.

5. Medical Executive Committee Relief

If there are less than five (5) qualified staff members in a given service, they may petition the Medical Executive Committee for relief.

C. CONDUCT OF CALL PANEL MEMBERS

1. Response

Practitioners on call must respond promptly when requested to see a patient. The response time must be reasonable in view of the patient's clinical circumstances. Each panelist must let the Hospital know how to reach him/her immediately and remain close enough to the Hospital to be able to arrive within a reasonable time.

2. Responsibility for Alternate Coverage

A panelist who is unable to provide panel coverage during their scheduled time is responsible for arranging for coverage by a practitioner who meets the criteria for panel eligibility. The panelist shall inform the Hospital of the name of the practitioner who will provide back-up coverage.

3. Acceptance of Patients

When scheduled on call, each practitioner shall accept the care of all patients who are appropriately referred without discrimination on the basis of the patient's

race, creed, sex, age, national origin, ethnicity, citizenship, religion, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay.

4. Transfers

All transfers shall be carried out in accordance with the Hospital policy on transfers.

5. Cooperation with Other Caregivers

A panelist shall cooperate with and assist the Emergency Services, Emergency Physicians, and all Departments, Sections, and Staff who may call a panel member for assistance. The panelist shall act in the best interests of patient care and in accordance with the Hospital's mission, the Medical Staff bylaws, and these Rules and Regulations.

6. Period of Call

ED Call is for a 24-hour period beginning at 7:00 am and ending the following day at 6:59 am. When the ED physician makes the decision to call the physician on call, the physician scheduled to be on call at the time the phone call is made is the one who shall be called. The time the patient actually arrived in the ED will not be the determining factor on which physician to call.

VI. CLINICAL DEPARTMENTS

A. RULES & REGULATIONS

Each clinical department shall establish its own rules and regulations, policies and procedures, including evaluation procedures for delineation of clinical privileges for members, subject to the approval of the Medical Executive Committee and the Board of Directors.

B. MORBIDITY & MORTALITY CONFERENCES AND CASE REVIEW

Each clinical department may hold morbidity and mortality conferences to review select cases. The purpose of these conferences is to evaluate cases to educate peers and other health care professionals about performance improvement measures and to address the quality of health care provided to patients. The activities of these conferences as well as the information presented and discussed therein shall be confidential, as provided in Article 12 of the Medical Staff Bylaws.

C. PROCTORING

1. Requirements

Upon satisfactory performance and completion of the designated number of proctored cases within the designated time frame, as specified below, the department or appropriate committee shall make a recommendation to the Credentials Committee regarding whether the member should be released from proctoring requirements for the privileges requested. The Credentials Committee shall make a recommendation to the Medical Executive Committee. Proctors must have current, unrestricted privileges to perform the procedure(s) which they are proctoring. Proctoring of Staff Members with Probationary Privileges is a responsibility of Medical Staff Membership.

2. Standard Privileges

1. Admissions/Consultations: The first six (6) consecutive admissions or consultations including all management, as well as the quality and timeliness of chart entries shall be proctored.
2. Procedures: The first six (6) consecutive major procedures, including preparation, post-procedure care, as well as the quality and timeliness of chart entries shall be proctored ("Major" to be defined by the department as to type and variety of cases.)
3. There shall be a minimum of two (2) different proctors for standard privileges. If possible fifty percent (50%) of the cases shall be proctored by a physician who is not also a partner or associate of the physician being proctored.
4. Proctoring of standard privileges must be completed within the time required for completion of Provisional Staff membership (two years). Only admissions/consultations may be proctored by chart review.

3. Specific Privileges

1. Each department may specify the number of procedures that must be proctored, but may not require that more than six (6) cases be proctored unless the proctoring reports, notification forms or other information including but not limited to Ongoing or Focused Professional Practice Evaluation information indicates a potential problem.
2. The number of cases required to be proctored shall be determined by the type of procedure irrespective of the departmental affiliation of the physician being proctored.
3. Proctoring of specific privileges must be completed within a two year period.

VII. MEDICAL STAFF STANDING COMMITTEES

A. BIOETHICS COMMITTEE *(added April 2020)*

1. Composition

The Committee shall be composed of at least three Medical Staff Members, appointed by the Medical Executive Committee, and representatives from nursing, social services, and pastoral care, appointed by the Chair. Whenever possible, the Committee should include the risk manager, an ethicist, and a community member. Committee members shall be available to Medical Staff Members to consult on an as needed basis.

2. Duties

The duties of the Bioethics Committee include:

1. Providing consultation services to any physician, employee, patient, family member or patient representative who requests a consultation. The goals of these consultations are: 1) to promote an ethical resolution, 2) to establish comfortable and respectful communication among those involved, 3) to help those involved learn to work through ethical uncertainties and disagreements on their own, and 4) to help the Committee recognize patterns within the hospital and consider reviewing hospital procedures or policies.

2. Development, periodical review and implementation of policies that pertain to patient rights and ethics.
3. Overseeing and participating in 1) promoting an environment throughout the hospital that respects patient wishes and legal rights, 2) ensures healthcare is provided in an ethical manner, and 3) ensures compliance with patient rights and ethics regulations. An Ethics Triage Team is a multidisciplinary team that serves to provide guidance for resource allocation.
4. Educating members within the Hospital concerning ethical issues and dilemmas.
5. Facilitating communication regarding ethical issues and dilemmas among Hospital Staff and Medical Staff Members in general, and among participants involved in ethical dilemmas and decisions in particular.
6. Reviewing and providing recommendations concerning organizational ethical practices, issues and policies. Organizational ethical practices include, but are not necessarily limited to patient rights, employee rights, billing, marketing, admission, discharge, transfers, relationships with other healthcare providers, educational institutions, payers and avoidance of conflict of interest. The Committee shall perform its duties in accordance with the Hospital's Code of Organizational Ethics
7. Retrospectively review cases to evaluate ethical implications as well as providing policy and education guidance relating to such matters.

3. Meetings and Reporting

The Committee shall meet as often as necessary, but not less than annually. The Committee shall report to the Medical Executive Committee.

B. CANCER COMMITTEE (Cancer Program)

1. Composition

The Cancer Committee of the **Comprehensive Community Cancer Program** shall be a multidisciplinary standing committee and represent the full scope of cancer care. Each member must attend at least 75% of the meetings. The Cancer Committee monitors the individual attendance of all members and addresses attendance that does not fulfill the needs of the program or falls below the requirements set by PIH Health Hospital – Whittier dba PIH Health Whittier Hosptial. Required members include at least one physician representing each of the diagnostic and treatment services. The Committee shall include at least one board certified physician member required from each of the following categories: surgery, diagnostic radiology, pathology, medical oncology, radiation oncology and the American College of Surgeons (ACOS) Cancer Physician Liaison. Required non-physician members shall include representatives from Administration and clinical support services of the following categories: Cancer Program Administrator, Oncology Nurse, Social Worker or Case Manager, Certified Tumor Registrar (CTR), Performance Improvement or Quality Management Representative, Palliative Care Team Member. Additional members strongly recommended, but not required, include the following: Specialty physicians representing the major cancer experience(s) at the program, Registered Dietitian, Pharmacist, Rehabilitation, Pastoral Care, Psychiatric or Mental Health Professional trained in the psychosocial aspects of cancer care and ACOS representative. The chair and physician

membership, not members by virtue of position (i.e., ACoS Cancer Physician Liaison) shall be appointed by and may be removed by the President, subject to consultation with and approval of the Medical Executive Committee.

2. The Breast Program Leadership Committee (BPLC)

This is a sub-committee of the Cancer Committee and shall include at least one board certified physician from each of the following categories: surgery, diagnostic radiology, pathology, medical oncology, radiation oncology and the Breast Program Director. There must be a single Breast Program Director with authority and accountability for the operations of the breast center. Non-physician members of the BPLC shall consist of representation from Administration, clinical support services of the following categories: Breast Health Center Director, Cancer Program Director, and Breast Center Nurse Navigator.

3. Duties

The Committee is responsible for goal setting, planning, initiating, implementing, evaluating and improving all cancer-related activities at the hospital. The members shall make certain that current American College of Surgeon's Commission on Cancer standards required for approval are met to maintain approval as a Comprehensive Community Cancer Program (CCCP). The Committee is responsible to ensure that the care of cancer patients is managed by a multidisciplinary team, including diagnosticians, pathologists, surgeons, radiation oncologists, and medical oncologists and that treatment services are provided by or referred to physicians who are currently board certified or in the process of becoming board certified.

The **BPLC** is responsible for goal setting, planning, initiating, implementing, evaluating, managing and improving all breast cancer-related activities at the hospital. The members shall make certain that current American College of Surgeon's standards for the National Accreditation Program for Breast Centers (NAPBC) required for approval are met to maintain accreditation. The BPLC is responsible to ensure that the care of breast cancer patients is managed by a multidisciplinary team, including diagnosticians, pathologists, surgeons, radiation oncologists, and medical oncologists and that treatment services are provided by or referred to physicians who are currently board certified or in the process of becoming board certified.

4. Responsibilities

a) Activity Coordinators

The coordinators are as follows: Cancer Conference, Quality Improvement, Cancer Registry Quality, Community Outreach, Clinical Research and Psychosocial Services. An individual cannot fulfill more than one coordinator role.

b) Goals

Each year, the Committee establishes, implements, and monitors at least one clinical and one programmatic goal related to cancer care. Each goal is evaluated at least twice annually. A clinical goal involves the diagnosis, treatment and care of the program's patients. A programmatic goal is

directed toward the scope, coordination and processes of care for patients in the cancer program.

c) Cancer Conferences

The Committee establishes the cancer conference frequency and format. The conferences will be held once a week. Ensure that the required number of cases is discussed. A minimum of 15% of the annual analytic case load must be presented at general cancer conference and lung conference, (approximately 4-6 cases per week) at least 80% of the cases discussed are presented prospectively. Breast conference must present 85% of annual analytic cases. Establishes multidisciplinary attendance requirements for the general cancer and site-focused conference held. Mandatory physicians at each conference include: Pathologist, Radiologist, Medical Oncologist, Radiation Oncologist, and General Surgeon. Other disciplines will be invited if required. Ensure that education and consultative cancer conferences cover all major cancer site.

d) Cancer Conference Coordinator

Monitors and annually evaluates the conference frequency, multidisciplinary attendance, total case presentation, prospective cases, discussion of stage, including prognostic indicators, treatment planning using evidence-based treatment guidelines, options for clinical trials, adherence to conference policy. He or she will report the findings to the cancer committee at least annually and recommend corrective action if activity falls below annual goal or requirements.

e) Quality Control

Establish and implement a quality control plan to evaluate the quality of Cancer Registry data, AJCC stage, collaborative stage, first course of treatment and, activity to include case-finding, accuracy of data collection, abstracting timeliness, follow-up (including date of first recurrence, type of first recurrence and cancer status), and NCDB and data reporting.

f) Scope of Services

Ensure that the scope of clinical services needed to provide high-quality cancer care is available to patients.

g) Prevention and Early Detection

Ensure that an active supportive care system, prevention and early detection opportunities are available for patients, families and staff. Each year the committee provides at least one cancer prevention program targeted to meet the needs of the community and should be designed to reduce the incidence of a specific cancer type. The prevention program is consistent with evidence-based national guidelines for cancer prevention. The committee provides at least one cancer screening program that is targeted to decreasing the number of patients with late-stage disease. A process is developed to follow-up on all positive findings.

h) Quality Improvement

Each year, the quality improvement coordinator, under the direction of the cancer committee, develops, analyzes and documents the required two studies that measure the quality of care and outcomes for patients with cancer. Two improvements to patient care must be implemented annually. One of the improvements must be based on the results of a completed study that measures cancer patient quality of care outcomes,

i) Education

The Cancer Committee shall offer at least once cancer-related educational activity each year to physicians, nurses, and other allied health professionals. The activity is focused on the use of AJCC or other appropriate staging in clinical practice, which includes the use of appropriate prognostic indicators and evidence based national guidelines used in treatment planning.

j) Community Outreach

The Committee monitors the community outreach activities. Each year one prevention and one early detection program shall be provided to the community.

k) Monitoring

The Committee monitors and reports compliance with patient management and national treatment guidelines required by the Commission on Cancer.

l) Advancing Treatment

The Committee promotes advancement in cancer treatment and clinical research. Ensures the required 4% of analytic cases (6% for OAA) are accrued to cancer-related clinical trials annually.

m) Reporting

Annually, the Cancer Committee develops and disseminates a report of patient or program outcomes to the public. The report is in an electronic or printed format and is distributed to an audience external to the facility and medical staff.

n) Patient Experience

The Committee evaluates the patient navigation process annually. The results are reported in the Cancer Committee minutes. The patient's navigation process is modified or enhanced each year to address additional barriers identified by the community needs assessment.

o) Psychosocial

The Committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care.

p) Care Summary and Follow-up

The Committee develops and implements a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment. The process is monitored, evaluated, and presented at least annually to the Cancer Committee and documented in the minutes.

q) Consultative Services

Multidisciplinary consultative services are available to cancer patients through the weekly Cancer Conferences.

Breast Program Leadership Committee (BPLC) Responsibilities

The BPL conducts annual audits of the following: Breast Cancer Conference activity; breast conservation rate; sentinel lymph node biopsy rate; breast cancer staging; needle biopsy rate; radiation oncology quality assurance; support and rehabilitation; reconstruction surgery referral rate; clinical trial accrual; quality and outcomes; quality improvement per NAPBC standards and reports outcomes to the Cancer Committee at least quarterly.

5. Meetings

The Cancer Committee and BPLC shall meet as least quarterly, shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

C. CONTINUING MEDICAL EDUCATION/LIBRARY COMMITTEE

1. Composition

The Continuing Medical Education/Library Committee, otherwise known as the CME/Library Committee shall consist of the Chair and at least one representative from each of the clinical departments. Committee members shall serve staggered terms to ensure continuity. The In-service Education Director, Medical Librarian, CME coordinator, and a representative from the QM department will serve as ex-officio members.

2. Chair

The Chair of the CME/Library Committee shall be appointed by the President and approved by the Medical Executive Committee and be responsible for coordinating the activities of the CME/Library Committee with departmental and professional groups which have responsibility for individual education programs. The chairman will serve at least two consecutive years.

3. Duties

The CME/Library Committee shall be responsible for the continuing medical education of the Medical Staff, including the following specific activities:

1. Schedule a range of high quality educational activities as indicated by an evaluation of areas identified by the quality assurance program as those in which professional education is needed. The following mechanism shall be used to assure activities are relevant to the needs of PIH Health Hospital-Whittier dba PIH Health Whittier Hospital Medical Staff.
2. Review opportunities for CME submitted by the committees and Functional Teams who are responsible for quality improvement.
3. Show hospital-wide commitment to the overall CME program by establishment of a separate CME Program Policy.
4. Oversee and/or have input in all areas directly related to the CME Program including the Conference rooms where CME activities are held.
5. Recommend educational opportunities available outside the hospital.
6. See that CME activities are granted Category 1 CME Credit according to CMA and ACCME Standards.
7. Support the development of the Medical Library.
8. Act as advisor to the Medical Library through the following:
    - Review of Library policies
    - Evaluate the Library's effectiveness in meeting the informational needs of its users.
    - Provide advice on the selection of materials and other library resources.
    - Review and recommend textbooks and journals for the library's collection.

4. Meetings

The CME/Library Committee shall meet at least quarterly, shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

D. CRITICAL CARE COMMITTEE

1. Composition

The Critical Care Committee shall be a multidisciplinary committee including at least three (3) physicians representing a broad spectrum of medical practice. The Director of the Critical Care Center shall be the non-voting executive of the Committee responsible for implementing the Committee's policies and such other functions and activities as specified by the Committee.

The chair of the committee shall be a physician member of the Active medical staff appointed by the President, subject to consultation with and approval of the Medical Executive Committee.

2. Duties

The duties of the Critical Care Committee shall be to:

1. Establish ongoing monitoring and evaluation systems for the Critical Care Center which comply with the requirements of regulatory and licensing agencies.
2. Assure that the quality, safety, and appropriateness of patient care services are monitored and evaluated on a regular basis and that appropriate actions are taken, based on the evaluations.
3. Formulate and implement policies for proper utilization of the Critical Care Center, including admission and discharge criteria and priorities.
4. Review applicable programs of continuing education provided for hospital personnel and make recommendations concerning other programs.
5. Review statistical data bearing on clinical care in the Critical Care Center.
6. Recommend equipment requirements.
7. Review policies and make recommendations relating to standardized nursing procedures, independent nursing protocols, and staffing levels.
8. Review and investigate referrals from the Medical Staff Excellence Committee regarding the quality of care in the Center.

3. Meetings

The Critical Care Committee shall meet as least quarterly, shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

E. GRADUATE MEDICAL EDUCATION COMMITTEE

1. Composition

The Graduate Medical Education Committee shall consist of at least six (6) medical staff members, the Family Practice Residency program director, and two Family Practice Residency program faculty members, the chief resident(s), the DIO (Designated Institutional Official), a representative from Quality Management, a representative of the governing body and the hospital Vice President of Ambulatory/Special Services. The Chief of Staff and the hospital's Administrator are ex-officio members. The Chief of Staff shall appoint two members from the

medical staff to the Committee each year. These members shall be appointed for a three-year term staggered to promote continuity of Committee effectiveness. The chair of the committee shall be a physician member of the Active medical staff appointed by the President, subject to consultation with and approval of the Medical Executive Committee.

At least one (1) Supervising Physician for each specialty which has a current Resident/Fellow rotation agreement with the Hospital shall be a member of the committee.

2. Duties

Overall supervision of the Family Practice Residency Program which shall include, but not be limited to:

1. Direction of the professional activities of the program within the hospital.
2. Policy making related to the residency training program.
3. Evaluation and approval of budget recommendations.
4. Annual review and approval of curriculum.
5. Assistance in the selection of resident candidates.
6. Participation in faculty selection.

3. Family Practice Residency Program Requirements

1. The Program must and will adhere to the Essentials of the American Board of Family Practice.
2. The Committee shall receive timely reports from the Director, reviewing the Residents' activities, projects, and status of progress within the program. These reports shall also make recommendations to the Committee to promote the effectiveness of the Residency Program.
3. The Chief Resident will give a monthly summary of the Program and bring appropriate problems or concerns to the attention of the Committee.
4. The professional activities of each Resident will be monitored. This will include awareness of staff evaluations as well as achievement on national test scores. A description of the role, responsibilities, and patient care activities of Residents is provided to the Medical Staff through the Resident Job Description.

4. The Graduate Medical Education Committee shall

1. Oversee all GME Resident/Fellow Rotation agreements between the Hospital and the sponsoring institution
2. Create and oversee the application and reporting documentation for the GME Program
3. Create and oversee the Participation in Graduate Medical Education Programs Policy
4. Communicate to the MEC and Governing Body information about the safety and quality of patient care, treatment, and services provided by, and related education supervisor needs of, the participants in professional graduate education programs.

5. Meetings

The Graduate Medical Education Committee shall meet at least bi-monthly or as needed. It shall maintain a record of its activities and report to the Medical

Executive Committee. This report shall communicate information about the safety and quality of the patient care provided by, and the related educational and supervisory needs of, the residents.

F. INTERDISCIPLINARY PRACTICE COMMITTEE

1. Composition

The Interdisciplinary Practice Committee shall consist of the Director of Nursing, the administrator or designee, and an equal number of physicians and registered nurses. Licensed or certified health professionals other than registered nurses who perform functions requiring standardized procedures shall be included in the committee. The chair of the committee shall be a physician member of the Active medical staff appointed by the President, subject to consultation with and approval of the Medical Executive Committee.

2. Duties

1. The Interdisciplinary Practice Committee shall evaluate and make recommendations regarding:
2. The qualifications and credentials of Allied Health Practitioners who are eligible to apply for and provide hospital services and patient care.
3. The standards of training, education, character, and competence of Allied Health Practitioners eligible to perform hospital services.
4. Identification of hospital services which may be performed by an allied health Practitioner or category of allied health practitioners, as well as any applicable terms and conditions thereon.
5. The professional responsibilities of the allied health practitioners who have been determined eligible to perform hospital services.
6. Make recommendations regarding appropriate monitoring, supervision, and evaluation of Allied Health Practitioners who may be eligible to perform hospital services.
7. Evaluate and report whether hospital services proposed by Allied Health Practitioners are consistent with the delivery of quality health care and with responsibilities of members of the Medical Staff.
8. Evaluate and report on the effectiveness of supervision requirements imposed upon Allied Health Practitioners who are providing health services.
9. Periodically evaluate and report on the efficiency and effectiveness of hospital services performed by Allied Health Practitioners.
10. Evaluate and recommend approval or disapproval of standard nursing policies pertaining to medical staff function, and consistent with the requirements of law and regulation.
11. Monitor and assure compliance with the Allied Health Practitioner Policies and Procedures defined in the Medical Staff Rules and Regulations.

3. Meetings

The Interdisciplinary/Practice Committee shall meet at least quarterly, shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

G. MANAGEMENT OF INFORMATION COMMITTEE

1. Composition

The Management of Information Committee is a multidisciplinary team made up of a physician from each medical staff department, and representative from the Health Information Management, Informatics, Quality Management, Case Management, Business Services and Corporate Compliance departments, and non-physician staff. The chair and physician membership shall be appointed by and by the President, subject to consultation with and approval of the Medical Executive Committee.

2. Duties

1. To oversee and provide direction regarding all medical records related issues so that the hospital maintains compliance to all state, federal and outside regulatory agency requirements regarding complete and accurate medical records, timelines of completion, and retention.
2. Review eMD related documentation issues and make recommendations for solutions to the informatics department or appropriate eMD physician/nursing committee(s).

3. Meetings

The Management of Information Committee shall meet at least quarterly and shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee. A quorum shall consist of the Chair, one physician member and the Director of Health Information Management.

H. PHARMACY & THERAPEUTICS/ INFECTION PREVENTION COMMITTEE

1. Composition

The Pharmacy & Therapeutics/ Infection Prevention Committee is a multidisciplinary team made up of physicians and non-physician staff. The chair and physician membership (with input from the Chair) shall be appointed by and may be removed by the President, subject to consultation with and approval of the Medical Executive Committee.

2. Duties

1. Has the responsibility and authority for ensuring the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, safety, and all other matters relating to drugs, control of infection, and nutrition therapy in the hospital.
2. To link the organization with external institutional support systems in order to maintain public safety and reduce the risk of exposure to environmental hazards.
3. Ensure that medication selection and monitoring is a collaborative process that considers patient need and safety as well as economics, with input from the patient and various professional disciplines. Formulary additions requires at least three (3) physician members of the committee for a vote.
4. Distribution and administration of controlled medications, including adequate documentation and record keeping.
5. Plan for proper storage, distribution, and control of investigational medications, emergency medications, those brought in from home by the patient, discharge medications, radioactive agents, blood derivatives, and those medications in clinical trial.

6. Review and analyze medication events and trends and develop systems for the prevention of such medication errors. Data to include trending by event category and by drug type. Further analysis will be conducted on significant medication events as well as identified trends to determine why the errors occurred and strategies to prevent future occurrences. The results of the analysis will be discussed at the P&T/ICFT and detailed discussion will be reflected in the minutes up to the governing bodies.
7. Ensure the hospital adheres to law, professional licensure, and practice standards governing the safe operation of pharmacy services.
8. Ensure nutrition screening is conducted to determine the patient's need for a comprehensive nutrition assessment, and that nutritional therapy is implemented for all patients determined to be at nutritional risk.
9. Establish a multidisciplinary approach to collaborate in developing and maintaining standardized methods of nutrition care.
10. Take precautions to identify and reduce the risks of acquiring and transmitting infections among patients, employees, physicians and other members of the organization.
11. Receive surveillance data on case findings and identification of demographically important nosocomial infections.

3. Meetings

The Pharmacy & Therapeutics / Infection Prevention Committee shall meet at least 10 times per year and shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

I. PHYSICIANS WELL-BEING COMMITTEE

1. Composition

The Physicians Well-Being Committee shall be comprised of at least three members of the Active Medical Staff. Each member shall be expected to serve a term of several years to achieve continuity. Members of this Committee shall not serve as active participants of other peer review or quality assurance committees. The chair of the committee shall be a physician member of the Active medical staff appointed by the President, subject to consultation with and approval of the Medical Executive Committee.

2. Duties

1. The Physicians Well-Being Committee shall improve the quality of patient care, protect patient welfare, and promote the competence of the Medical Staff by receiving and investigating reports related to the health and well-being or impairment of an individual Medical Staff member.
2. With respect to matters involving individual Medical Staff members, the Committee may, on a voluntary basis, provide advice, counseling, or referrals as may seem appropriate. These recommendations shall be confidential. However, in the event information received by the Committee clearly demonstrates that the health or known impairment of a Medical Staff member poses risk or harm to a hospitalized patient, that information shall be referred to the President of the Medical Staff and the respective department chairperson for corrective action. Any action taken will be in compliance with the applicable provisions of these Bylaws.

3. The Committee shall also consider other general matters relating to the health and well-being of the Medical Staff with the goal of developing educational programs or other activities to support the emotional, behavioral and physical health of the Medical Staff.

3. Meetings

The Physicians Well-Being Committee shall meet as often as necessary to conduct business. The Committee shall report its activities to the Medical Executive Committee; however, records of its proceedings shall be maintained only as deemed advisable.

Confidentiality regarding the medical staff member's referral should be maintained except as limited by applicable law, ethical obligation or when the health and safety of a patient is threatened.

J. UTILIZATION MANAGEMEN COMMITTEE (UM)

1. Composition

The utilization management committee shall consist of sufficient members to afford fair representation. Subcommittees may be appointed by the committee for departments or divisions as the committee may deem appropriate. The chair of the committee shall be a physician member of the Active medical staff appointed by the President, subject to consultation with and approval of the Medical Executive Committee.

2. Duties

The duties of the utilization management committee shall include:

1. Conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services. The committee shall communicate the results of its studies and other pertinent data to the Medical Executive Committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety.

2. Establishing a utilization review plan which shall be approved the Medical Executive Committee, and
3. Obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by the hospital's case management system.

3. Meetings

The utilization management committee shall meet at least quarterly and shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

VIII. ALLIED HEALTH PRACTITIONERS

A. DEFINITIONS

1. Allied Health Practitioner (AHP)

A health care professional, other than a physician, dentist, podiatrist or clinical psychologist, who holds a license or other legal credential, as required by California law, to provide certain professional services and to exercise independent judgment within areas of their professional licensure and competence. AHP's are not eligible for medical staff membership or any of the rights of medical staff membership.

2. Service Authorization

The permission granted to an AHP to provide specified patient care services within their qualifications and scope of practice.

3. Supervising Physician

Any physician currently licensed by the State of California has current privileges to perform each and every service or procedure their supervisee(s) has been credentialed to perform, and is a current member in good standing of the Medical Staff of PIH Health Hospital-Whittier dba PIH Health Whittier Hospital.

B. QUALIFICATIONS

An AHP is eligible for a Service Authorization in this hospital if they:

1. Holds a license, certificate, or other legal credential in a category of AHPs which the Governing Board has identified as eligible to apply for Service Authorizations. Only AHPs who are certified, where certification exists for any specific category of AHP, are eligible for appointment and service authorizations. AHPs must maintain certification for the duration of their appointment and service authorizations. If certification lapses the AHP shall have a maximum of one year to re-certify. AHPs currently appointed as of the date of adoption of this rule may be considered for renewal of appointment if they can otherwise meet the requirements of AHP appointment and service authorizations.

2. Documents their background, training, current competence, judgment, physical and mental health status, and ability with sufficient adequacy to demonstrate that any patient treated by the practitioner will receive care of the generally recognized professional level of quality established by the Medical Staff.

3. Is determined, on the basis of documented references to adhere strictly to the lawful ethics of his or her profession, to work cooperatively with others in the hospital setting, and to be willing to commit to and regularly assist the Medical Staff in fulfilling its obligations related to patient care, within the areas of the practitioner's professional competence and credentials.

4. Agrees to comply with all Medical Staff and Department bylaws, rules and regulations, and protocols to the extent applicable to the AHP.

5. Maintains professional liability insurance with a suitable insurer, with minimum limits as determined by the Governing Board.

6. CME, AHPs must maintain twelve (24) hours of CME every 2 years to obtain privileges.

C. CATEGORIES

The Board of Directors shall determine, based upon recommendation of the Medical Executive Committee and such other information as it has before it, those categories of AHPs that shall be eligible to practice under a Service Authorization in the Hospital.

Such AHPs shall be subject to the supervision requirements developed in each Medical Staff Department and approved by the Interdisciplinary/Allied Health Committee, the Medical Executive Committee, and the Board of Directors.

The categories currently approved:

1. Certified Nurse Midwives
2. Clinical Psychologist
3. Neonatal Nurse Practitioner
4. Nurse Practitioner
5. Pathology Assistant
6. Physician Assistant
7. Registered Nurse First Assist
8. Registered Nurse in Expanded Role

D. DEVELOPMENT OF SERVICE AUTHORIZATION

The Interdisciplinary Practice Committee shall, with input from the Medical Staff departments as needed, develop and forward recommended delineation of services that may be provided by each approved category of AHP. The documents are entitled "Service Authorizations" and shall be forwarded to the Medical Executive Committee which shall forward its recommendations to the Board of Directors for final decision.

E. PROCEDURE FOR CREDENTIALING AHPS

1. Initial Application

a) Submission of Application

An AHP in a category approved by the Board of Directors as specified in Section 9.3, who wishes to provide specific patient care services in PIH Health Hospital-Whittier dba PIH Health Whittier Hospital, shall submit a completed application and all requested supporting documentation. The application shall be reviewed by the Interdisciplinary Practice Committee to determine if the applicant has the qualifications to provide requested services. All physician assistants and advanced practice registered nurses, who practice within the hospital, including employees, are credentialed and privileged and re-privileged through the medical staff process for AHPs.

b) Discontinuation of Credentialing Process

If the Medical Staff Office does not receive all of the supporting documentation within 180 days of the date that the application is received, the application will be considered withdrawn. In the event that the credentialing process is discontinued, the AHP may reapply only by submitting a new application and all requested supporting documentation to the Medical Staff Office.

c) Changes of Information

AHPs shall provide the Medical Staff Office with information regarding any changes or supporting documents as soon as they become aware of such

change. Failure to update the information or to provide accurate and complete information at any time shall be grounds for termination of the Hospital's permission for the AHP to provide any services.

d) Interdisciplinary Practice Committee Review

The Interdisciplinary Practice Committee shall review the application, together with all supporting documentation and make recommendations with regard to approval or disapproval of the application. Such recommendation shall also include any restrictions on specific tasks or services that the AHP may provide under the Service Authorization applicable to that category of AHP. Services/tasks listed on the corresponding Service Authorization may be granted in total or may be limited in accordance with the training and experience of the applicant. The recommendation of the Interdisciplinary Practice Committee shall report to Credentials Committee, and shall be submitted to the Medical Executive Committee and the Board of Directors for final decision.

e) Assignment to a Clinical Service

The AHP shall be assigned to a clinical service and shall carry out all professional activities under the supervision of the designated member of the attending Medical Staff, subject to the clinical department's regulations and in conformance with applicable provisions in the Medical Staff Bylaws and Rules and Regulations, and in conformance with the AHP's license, certificate or other legal credentials.

f) Length of Appointment

Appointments to the AHP classification shall be for a maximum period of two years. AHPs shall be considered for reappointment and each AHP shall supply updated information to be used in considering their reappointment.

g) On-Going Monitoring

In addition, a process of on-going monitoring and review of the quality of care provided by individual AHPs will be done by the clinical service/department of the AHP. The department shall forward the results of these activities to the Interdisciplinary Practice Committee which recommends any appropriate action to the Medical Executive Committee.

h) Evaluations of the AHP's performance may include:

1. The evaluation form and copy of the Service Authorization to be forwarded to the Department Chair in which the independent AHP performs their services.
2. Documentation by the head of the hospital department, of the performance based upon submitted and approved Service Authorizations. The Supervising Physician will be asked to provide the evaluation of AHP's performance/current competence as well as a recommendation for continuation of service.

2. Reapplication

An AHP shall not be eligible to reapply for a Service Authorization for a period of at least 12 months when that AHP: (i) has received a final adverse decision regarding their application for a Service Authorization; (ii) withdrawn their application for a Service Authorization following an adverse recommendation by the Medical Executive Committee; (iii) after having been granted a Service Authorization, has received a final adverse decision resulting in termination of the authorization; or (iv) has relinquished their Service Authorization following the issuance of a Medical Staff, or Board of Directors recommendation adverse to their Service Authorization. The 12-month period shall begin on the date that the adverse decision became final, the application was withdrawn, or the AHP relinquished their Service Authorization.

F. PREROGATIVES

AHPs shall have the prerogative to:

1. Provide specified patient care services under the supervision or direction of a physician member of the Medical Staff and consistent with the Service Authorization granted to the AHP and within the scope of the AHP's licensure or certification and in accordance with the applicable clinical department regulations, Medical Staff Bylaws, Rules and Regulations.
2. Write orders only to the extent provided in the Service Authorization but not beyond the scope of the AHP's license, certificate, or other legal credentials. The Supervising physician needs to co-sign the Admit and Discharge order.
3. Exercise such other prerogatives as designated by the Interdisciplinary Practice Committee and approved by the Medical Executive Committee and Board of Directors.
4. Provide service on medical staff, department, and hospital committees as requested by that department or committee chairperson. An AHP may not serve as chair of medical staff committees.
5. Attend meetings of the department to which they is assigned, as permitted by the applicable department rules and regulations, and attendance at medical staff educational programs in their field of practice. An AHP may not vote at department/section meetings.

G. RESPONSIBILITIES

AHPs must:

1. Retain Responsibility

Retain appropriate responsibility within their area of professional competence for the care of each patient in the hospital for whom are providing services.

2. Participation

Participate as appropriate in the patient care monitoring and evaluation activities required by the Medical Staff and in discharging other staff functions as may be required from time to time.

3. Abide by the Bylaws

Strictly abide by the applicable provisions of the Medical Staff and Hospital Bylaws and all other applicable standards, rules and regulations, and policies and procedures of the Medical Staff and Hospital, all applicable laws and regulations of governmental agencies, and the Hospital's ethical standards contained in its compliance plan.

4. Medical Records
Prepare and complete in a timely manner the medical and other required records for all patients for whom they provide care in the hospital.

5. Ethics
Abide by the principles of medical ethics and by any other appropriate code of ethics insofar as they are consistent with federal and state laws.

H. Identification of Practitioner:
When rendering services, the AHPs shall wear an identification badge on an outer garment and in plain view, which shall state the practitioner's name and licensure category.

I. Liability Insurance:
Non-employee Allied Health Professionals must maintain professional liability insurance in the amounts of $1/3 million.

J. Employer Responsibilities:
If a supervising physician employs the Allied Health Professional, they agree that the Allied Health Professional shall be solely their employee and not the employee or agent of the Hospital. The supervising physician must assume full and sole responsibility for making all payments to and establishing all working conditions and terms for the Allied Health Professional and for complying with all relevant laws with respect thereto, including those pertaining to withholding of federal and state income taxes, FICA, payment for overtime, and provision of workers' compensation insurance coverage.

IX. Sponsorship of Allied Health Professional

A. Utilization of Allied Health Professional who are employees of a Member of the Medical Staff:

1. Any Member of the Medical Staff desiring to utilize and supervise an employee as an Allied Health Professional to perform patient care services in the Hospital must submit an application for permission to do so to the Medical Staff. The application shall be processed through the appropriate Clinical Department, Interdisciplinary Practice Committee, Credentials Committee, and the Medical Executive Committee for approval prior to recommendation to the Board of Directors. It shall be the responsibility of the Medical Staff Member applicant to:
2. Specifically delineate, in writing, the functions which the employee is to perform which shall be approved by the Clinical Department to which the employee is assigned;

3. Establish the employee's legal authority to perform these functions and document the employee's training, experience and demonstrated clinical competence to perform these functions.

4. If granted permission, the applying Staff Member must agree to:
   a. Supervise and control the employee;
   b. Present evidence of adequate liability coverage to cover the acts or omissions of the employee;

5. Abide by all the Federal, State, local, Hospital and Medical Staff statues, rules and regulations governing the use of Allied Health Professionals.

6. Any permission to utilize and supervise an Allied Health Professional applies solely to the Medical Staff Member so authorized and shall be limited to the specific Allied Health Professional but shall not create in any said Allied Health Professional any right against the Hospital, Medical Staff or their supervisor. Any Allied Health Professional so approved by the Board of Directors shall, at all times, remain the employee of the supervising Medical Staff Member. Due process, as provided for in the Bylaws, is available only to the Medical Staff Member in relation to matters concerning the sponsored Allied Health Professional. Such employees shall be required to pay dues, shall be charged an application fee as determined by the Medical Executive Committee, and is subject to paying fines for Medical Records Suspension days.

7. The Board of Directors, upon the advice of the Medical Staff, reserves the right at any time to revoke permission granted hereby and, if not so revoked, to review this permission on an annual basis.

8. Termination of an Allied Health Professional's employment with the supervising practitioner shall automatically terminate approval for their performance of patient services within the Hospital. Likewise, termination limitations or restrictions of the supervising practitioner's privileges shall terminate, limit or restrict the approval of the Allied Health Professional.

B. Utilization of an Allied Health Professional who is self-employed

1. A self-employed Allied Health Professional may make an application to perform patient care services in the Hospital, or may be sponsored by a Clinical Department of the Medical Staff and will be assigned to a Clinical Department of the Medical Staff by the Medical Executive Committee. The applicant shall comply with those conditions, which are set forth for employed Allied Health Professional in these Rules and Regulations.

2. The Department to which the applicant has been assigned by the Medical Executive Committee shall be required to define privileges and develop protocols for the performance of the Allied Health Professional's actions and to monitor the performance of the Allied Health Professional. Appointment and continued approval for the performance of patient services within the Hospital is dependent upon continuing sponsorship by the Clinical Department. Due process, as provided for in the Medical Staff Bylaws, is available only to the sponsoring physician in relation to the sponsored Allied Health Professional. If the results of such due process are unsatisfactory to the Allied Health Professional, they may petition the Board of Directors of the Hospital directly. Practitioner shall be required to pay dues, shall be charged an application fee as determined by the Medical Executive Committee, and is subject to paying fines for Medical Records Suspension days.

3. Members of the Medical Staff who have no employment relationship with the Allied Health Professional and are merely supervising the patient's general medical condition as required by law shall not be considered to be supervising

the Allied Health Professional's practice unless they are specifically assigned such duties by the Allied Health Professional's Clinical Department.

4. The Board of Directors, upon the advice of the Medical Staff, reserves the right at any time to revoke permission granted hereby and, if not so revoked, to review this permission on an annual basis.

X. Privileges and Responsibility Provisions for Allied Health Professionals are to be determined by the individual Medical Staff Departments.

A. Standardized Procedures:

A Standardized Procedure is a special kind of nursing procedure, which enables registered nurses in the State of California or licensed professionals who are not members of the Medical Staff, under strict defined circumstances, to perform certain tasks or procedures, which normally fall within the realm of medical practice. A Standardized Procedure (including medication administration) may be implemented without obtaining physician order first.

Each standardized procedure shall:

1. Be in writing and show date or dates of approval including by the Interdisciplinary Practice Committee;
2. Specify the standardized procedure functions which registered nurses are authorized to perform and under what circumstances;
3. State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure;
4. Specify any experience, training or special education requirements for performance of the functions;
5. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform the functions;
6. Provide for a method of maintaining a written record of those persons authorized to perform the functions;
7. Specify the nature and scope of review and/or supervision required for the performance of the standardized procedure functions; for example, if the function is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated;
8. Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition;
9. State any limitations on settings or department within the facility where the standardized procedure functions may be performed;
10. Specify patient record keeping requirements;
11. Specify for periodic review of the standardized procedure.

Under special circumstances, Registered Nurses may perform specialized procedures when defined skills and knowledge have been provided in advance, and privileges are granted to perform the defined procedure(s) under a medically approved and prescribed protocol.

If nurses have been approved to perform procedures pursuant to a standardized procedure, the names of the nurses so approved shall be on file in the office of the Chief Nursing Officer (CNO).

XI. Credentialing of Allied Health Professionals:

The Credentials file shall include:

1. Application approval signed by the supervising physician if applicable.
2. Licensure and credential documents.
3. Proof of malpractice insurance
4. Proof of educational credentials.
5. Continuing education records.
6. Quality assurance monitoring data.
7. Recent evaluation.
8. Record of any disciplinary actions.
9. Responsibility for the AHPs files belongs to the Department of Medical Staff Services.
10. An AHP shall apply for privileges using an online application. A request for delineated privileges must be approved by the supervising physician, the chief of the appropriate clinical department, the Interdisciplinary Practice Committee, Credential's Committee, Medical Executive Committee and the Board of Directors.
11. Temporary privileges may only be granted to AHPs after recommendation by the Interdisciplinary Practice Committee.
12. Proctoring/skills validation shall be required and provided for all independent and dependent AHP applicants and for individuals requesting additional privileges.
13. AHPs will be evaluated every two years by the clinical department manager as appropriate, Department Chair and supervising physician who will conduct a review of the qualifications and performance of each AHP and may recommend to the Interdisciplinary Practice Committee that privileges be continued, extended, limited or revoked.
14. Privileges may be terminated or suspended by the President of the Medical Staff, Chief Executive Officer or Department Chair as appropriate, without the involvement of the committee, except clinical psychologists who are afforded rights under the Medical Staff Bylaws relative to hearing procedures. All actions will be reviewed by the committee at the next scheduled meeting.
15. The Interdisciplinary Practice Committee shall be responsible for recommending policies and procedures for the granting of expanded role privileges to registered nurses, whether or not employed by the facility, to provide for the assessment, planning and direction of the diagnostic and therapeutic care of a patient in a licensed health facility. These policies and procedures will be administered by the Interdisciplinary Practice Committee, which shall be responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges.

A. Scope and Setting of Practice:

1. Perform all functions consistent with their educational background and experience, and with the standards of practice in the community.
2. Perform functions overlapping with medicine and nursing under a standardized procedure/protocol describing that function.
3. Responsible for accurate documentation, which will reflect consultation with referral sources and physicians.

4. Functions not consistent with the level of practice or knowledge of the AHP will be handled by referral or in collaboration with the appropriate referral source.
5. Physician consultation is available to the AHP either in person, by telephone, or electronic communication.
6. The physician will be notified immediately of patient problems and treatment regimens that deviate from the Standardized Procedure and/or protocol, will be co-signed by the attending physician or physician designee within 24 hours.
7. Participates in quality assessment and improvement programs.
8. The AHP will participate in all appropriate organizational activities.

XII. Certified Nurse Midwife:

The "nurse midwife" means a person who is licensed as a registered nurse and who is currently certified as a nurse midwife by the California Board of Registered Nursing.

A. Criteria for granting privileges:

1. Must be currently licensed by the State of California of Registered Nursing as a Registered Nurse and Certified by the state of California as a Certified Nurse Midwife;
2. Current active certification by the American Midwifery Certification Board (or its predecessor, the American College of Nurse Midwives Certification Council), or be actively seeking initial certification;
3. Basic Life Support (BLS) or Advanced Cardiac Life Support (ACLS) must be issued through the American Heart Association;
4. Current Neonatal Resuscitation Program (NRP) certification through the American Heart Association and the American Academy of Pediatrics;
5. Completion of a course on fetal heart rate monitoring, that utilizes the National Institute of Child Health and Human Development (NICHD), approved standardized nomenclature;
6. Experience and demonstrated competence in performance of at least 25 deliveries in the past twelve months.

B. Scope of Privileges:

Nurse midwife services permitted under state law are covered when provided by a certified nurse midwife. Services are limited to:

1. The care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks.
2. May write management orders, take and complete a history and physical, management of normal intrapartum patients, assessment of fetal status including internal and external monitoring.
3. Diagnosis and assessment of labor, order and interpret laboratory/diagnostic test data.
4. Management of spontaneous vaginal delivery, resuscitation of newborn.
5. Management of placental expulsion, midline episiotomy and repair.
6. Assessment/repair of birth canal trauma including 1st and 2nd degree lacerations.
7. Perform intrauterine exam when indicated.

8. Evaluation of need for analgesia and anesthesia (including oral, intramuscular, and intravenous.
9. Identify complications and institute emergency measures, perform amniotomy when indicated.
10. Intrauterine pressure catheter insertion.
11. Administer pudendal block and/or local infiltration anesthesia.
12. Provide care to mothers and infants in the postpartum period, hemorrhage stabilization with physician consultation if needed, manage patients with moderate to high risk conditions with supervising physician(s), monitor vital signs, lochia, fundus and bladder functions in the immediate postpartum period, postpartum rounds, examination and discharge.
13. Assist in a cesarean section.

C. General:

A nurse midwife may perform consultations requested by attending clinical staff.

XIII. Clinical Psychologists:

The Clinical Psychologist is an independent practitioner who has a doctorate degree in psychology, state licensure, and has successfully demonstrated psychiatric inpatient treatment experience. The Clinical Psychologist may perform testing and assessment services and provide psychotherapy to all patients, including children and geriatrics. Also, with additional training, the Clinical Psychologist may provide neuropsychological treatment, biofeedback therapy, hypnotherapy and educational testing.

A. Criteria for granting privileges:

All psychologists shall be appointed to the Allied Health Professional staff. A psychologist will be appointed to serve on the Interdisciplinary Practice Committee in order to provide peer evaluations and recommendations; however, privileging is performed through the Department of Medicine.

The minimum qualifications for appointment shall be for New Applicants or Current Allied Health Members:

1. Completion of a doctorate degree in Clinical Psychology from an accredited institution;
2. Pre and post doctorate internship comprising a total of 3,000 supervised hours of clinical supervision;
3. Two years of inpatient psychological treatment experience;
4. Licensure by the Medical Board of California

   OR Current National Register Membership;

   OR FOR CURRENT ALLIED HEALTH MEMBERS ONLY: Successful completion of an approved training program; OR demonstrated acceptable practice in the privileges being requested for a minimum of five (5) years;
5. Individual privileges will be proctored as per Department Proctoring Protocol.

B. Scope of Privileges:

An appropriately qualified psychologist may be approved for the following practice privileges:

1. Diagnosis and provision of treatment to patients with mental disorders requiring any psychological service involving the application of psychological principles, methods and procedures of understanding, predicting and influencing behavior.

C. General:

A psychologist may perform consultations requested by attending clinical staff.

XIV. Neonatal Nurse Practitioner:

Use of the title "nurse practitioner" is limited to registered nurses who have been approved for that purpose by the California Board of Registered Nursing (BRN), e.g., registered nurses who possesses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary health care, and who have been prepared in programs that conform to BRN standards. A nurse practitioner approved by the California BRN may use the abbreviation "RN, NP".

A. Criteria for granting privileges:

1. Successful completion of a Nurse Practitioner master's degree from an accredited nursing program;
2. Must be currently licensed by the State of California of Registered Nursing as a Registered Nurse and as a Nurse Practitioner;
3. Shall be certified in Neonatal Resuscitation Program (NRP) through the American Heart Association and the American Academy of Pediatrics;
4. Basic Life Support must be issued through the American Heart Association;
5. Must have at least three (3) years of recent clinical experience and expertise in Neonatal Intensive Care, one of which must be in a Level II or Level III NICU;
6. Any certifications above and beyond the RN and NP license required to perform duties such as furnishing drugs and devices (including but not limited to special educational and other requirements for furnishing Schedule II drugs, e.g., a federal Drug Enforcement Administration (DEA) number);
7. For initial competency, procedure checklists, signed and dated by both supervising physician and nurse practitioner;
8. For ongoing competency/reappointment, patient activity summary (PAS) form and demonstrated competency according to the most recent annual review by the supervising physician.

B. Scope of Privileges:

The NPs practice privileges will be based on each NPS standardized procedure. Any tasks or functions within the expanded scope of nursing practice must be defined in the standardized procedures, will be defined by the NP and the supervising physician, and must adhere to the format developed by Hospital Administration along with health professionals including physicians and nurses, and required by the Hospital as mentioned previously. Once a supervising physician deems the NP to be competent, the NP may perform the standardized procedure functions independently, e.g., without the physical presence of direct supervision of the physician. Typically, the practice will include, but not be limited to, the following in strict accordance with the standardized procedures and applicable law:

1. Disease management/primary care/urgent care
2. Ordering laboratory work and diagnostic studies
3. Ordering prescription drugs and devices
4. Furnishing medication, provided the NP has a furnishing number issued by the BRN, and meets any additional requirements such as a DEA number for furnishing particular drugs, as specified in the relevant standardized procedure (a patient-specific protocol is required for an NP to furnish any Schedule II or III controlled substance).

XV. Nurse Practitioner

Use of the title "nurse practitioner" is limited to registered nurses who have been approved for that purpose by the California Board of Registered Nursing (BRN), e.g., registered nurses who possess additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary health care, and who have been prepared in a program that conforms to BRN standards. A nurse practitioner approved by the California BRN may use the abbreviation "RN, NP".

A. Criteria for granting privileges:

1. Successful completion of a Nurse Practitioner master's degree in an accredited nursing program;
2. Must be currently licensed by the State of California of Registered Nursing as a Registered Nurse and as a Nurse Practitioner;
3. Basic Life Support (BLS) or Advanced Cardiac Life Support (ACLS) must be issued through the American Heart Association;
4. Any certifications above and beyond the RN and NP license required to perform duties such as furnishing drugs and devices (including but not limited to special educational and other requirements for furnishing Schedule II drugs, e.g., a federal Drug Enforcement Administration (DEA) number);
5. For initial competency, procedure checklists, signed and dated by both supervising physician and nurse practitioner;
6. For ongoing competency/reappointment, patient activity summary (PAS) form and demonstrated competency according to the most recent annual review by the supervising physician.

B. Scope of Privileges:

The NPs practice privileges will be based on each NPs standardized procedure. Any tasks or functions within the expanded scope of nursing practice must be defined in the standardized procedures, will be defined by the NP and the supervising physician, and must adhere to the format developed by Hospital Administration along with health professionals including physicians and nurses, and required by the Hospital as mentioned previously. Once a supervising physician deems the NP to be competent, the NP may perform the standardized procedure functions independently, e.g., without the physical presence of direct supervision of the physician. Typically, the practice will include, but not be limited to, the following in strict accordance with the standardized procedures and applicable law:

1. Disease management/primary care/urgent care

2. Ordering laboratory work and diagnostic studies
3. Ordering prescription drugs and devices
4. Furnishing medication, provided the NP has a furnishing number issued by the BRN, and meets any additional requirements such as a DEA number for furnishing particular drugs, as specified in the relevant standardized procedure (a patient-specific protocol is required for an NP to furnish any Schedule II or III controlled substance)
5. Serves as first or second assistant in surgery under supervision of the Supervising Physician.

XVI. Pathology Assistant

These practitioners provide assistance to the Medical Director of Pathology.

A. Criteria for Granting Privileges:

1. Baccalaureate degree from a regionally accredited college/university and successful completion of a Clinical Laboratories Standards Institute (formerly NACCLS) accredited Pathologists Assistants program; or
2. Equivalent Baccalaureate degree from outside of the United States or Canada as verified by an approved agency prescribed by the ASCP for certification eligibility;
3. Shall be a fellow member of the American Association of Pathologists' Assistants (AAPA) and have passed the American Society of Clinical Pathologists (ASCP) Board Certification Pathologists' Assistants examination or American Association of Pathologists' Assistants Fellowship examination;
4. Must have at least twelve (12) months experience as a Pathologists' Assistant in a College of American Pathologists accredited hospital laboratory.

B. Privileges:

A Pathology Assistant may be granted practice privileges in the following:

1. Describing and documenting gross anatomic features of surgical specimens as defined in hospital laboratory procedure HT014.02
2. Preparing and submitting tissue sections for histologic examination
3. Receiving and verifying the identity and labeling of pathology specimens and entering data into the hospital laboratory information system

C. Supervision:

A pathology assistant is supervised by the Medical Director of Pathology.

XVII. Physician Assistant

A Physician Assistant (PA) may only provide those medical services, in which are competent to perform and which are consistent with the Physician Assistant's education, training, and experience, and which are re-delegated in writing by a supervising physician who is responsible for the patient's care by the PA. The Service to which the Physician Assistant is assigned will require proof or demonstration of clinical competence from any Physician Assistant for any tasks, procedures or management they are performing. A PA shall consult with a physician regarding any task, procedures or diagnostic problems, which the PA determines exceeds their level of clinical competence, or shall refer such cases to a physician.

A. Criteria for Granting Privileges:

1. Completion of an accredited training program as a Physician Assistant;
2. Current licensure by the Medical Board of California Physician Assistant Examining Committee as a Physician Assistant (PA);
3. Current certificate in CPR;
4. Physician sponsorship (must be Actively practicing and in good standing);
5. Demonstrated competence in requested practice protocol/procedures will be reviewed and evaluated biennially.

B. Medical Services Performable:

The practice of a Physician Assistant is directed by a supervising physician, and a Physician Assistant acts as an agent for that physician. The orders given and tasks performed by a Physician Assistant shall be considered the same as if they have been given and performed by the supervising physician. Unless otherwise specified in these regulations or in the delegation or protocols, these orders may be initiated without the prior patient specific order of the supervising physician.

A Physician Assistant may:

1. Take a patient history, perform a physical examination and make an assessment and diagnosis.
2. Order or perform routine laboratory and screening procedures including, but not limited to drawing of venous blood and blood examination, catheterization and routine urinalysis, nasogastric intubation and gastric lavage, pelvic examination, rectal exam and papanicolaou smears.
3. Order or perform routine therapeutic procedures including, but not limited to injections and/or immunizations, debridement, suturing and care of superficial wounds, strapping, casting and splinting of sprains, incision and draining of superficial skin infections.
4. Recognize and evaluate situations, which call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.
5. Instruct and counsel patients regarding matters pertaining to their physical and mental health, such as diets, social habits, family planning, normal growth and development and the aging process.
6. Serve as first or second assistant in surgery under the supervision of the Supervising Physician.
7. Endoscopic vein harvesting
8. Contrast Administration, requires a *Fluoroscopy permit*
9. Image guided catheter placement
10. Thoracentesis
11. Chest tube placement
12. PICC line insertion
13. Abscess and fluid drainage procedures

14. Paracentesis
15. Image guided central venous catheter insertion
16. Lumbar puncture and myelography
17. Image guided biopsy and aspiration
18. Treatment of anaphylaxis
19. Joint aspiration and arthrography
20. Feeding tube placement and exchange
21. Hysterosalpingography
22. Lexiscan stress test
23. Treadmill stress test with or without ECHO

A PA may not administer, provide or transmit a prescription for controlled substances in Schedule II through V inclusive without patient-specific authority by a supervising physician.

C. Delegated Procedures:

The delegation of procedures to a PA under this rule shall not relieve the supervising physician of primary continued responsibility for the patient's welfare.

D. Supervision Required:

1. A supervising physician shall be available in person or by electronic communication at all times when the PA is caring for patients.
2. A supervising physician shall delegate to a PA only those tasks and procedures consistent with the supervising physician's privileges, usual and customary practice, and with the patient's health and condition.
3. A supervising physician shall observe or review evidence of the Physician Assistant's performance of all tasks and procedures to be delegated to the PA until assured of competency.
4. The PA and the supervising physician shall establish in writing back-up procedures for the immediate care of patients who are in need of emergency care beyond the PA's scope of practice for such time when a supervising physician is not on the premises.
5. A PA and supervising physician shall establish in writing guidelines for the adequate supervision of the PA, which shall include one or more of the following mechanisms:

    a) Practice protocols reviewed every two years.

6. Perform surgical procedures without the personal presence of the supervising physician, which are customarily performed under local anesthesia. Prior to delegating any such surgical procedures, the supervising physician shall review documentation that indicates that the Physician Assistant is trained to perform the surgical procedures. All other surgical procedures requiring other forms of anesthesia may be performed by a Physician Assistant only in the personal presence of an approved supervising physician. A Physician Assistant may also act

as first or second assistant in surgery under the supervision of an approved supervising physician.

7. The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the PA does not function autonomously. The supervising physician shall be responsible for all medical services provided by a PA under their supervision.

8. Each time a PA cares for a patient and enters their name, signature, initials on the patient record, the PA shall also enter the name of the supervising physician who is responsible for the patient. When a PA transmits an oral order, they shall also state the name of the supervising physician who is responsible for the patient.

XVIII. Registered Nurse in Expanded Role

A. Criteria for Granting Privileges:

Licensed by the state board of nursing.

B. Privileges:

The practice privileges will be based on each standardized procedure. Any tasks or functions within the expanded scope of nursing practice must be defined in the standardized procedures, will be defined by the RN and the supervising physician, and must adhere to the format developed by Hospital Administration along with health professionals including physicians and nurses, and required by the Hospital as mentioned previously.

XIX. Registered Nurse First Assistant

The RN First Assistant to the surgeon during a surgical procedure carries functions that will assist the surgeon in performing a safe operation with optimal results for the patient. The RN First Assistant practices perioperative nursing and has acquired the knowledge, skills and judgments necessary to assist the surgeon through organized instruction and supervised practice. The RN First Assistant practices under the direct supervision of the surgeon during the first assisting phase of the perioperative phase. The First Assistant does not concurrently function as a scrub nurse.

A. Criteria for granting privileges:

RN First Assistants may be employees of the hospital and/or be an employee of a physician. The minimum qualifications for appointment shall be:

1. Current California license;
2. Three years' experience as a perioperative nurse, both scrubbing and circulating proficiency;
3. Current professional liability insurance;
4. Certified in perioperative nursing (CNOR) or NP Licensure;
5. Certified in Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) by the American Heart Association;
6. Successful completion of didactic or university course in First Assisting;
7. Validation of the necessary clinical skills by an internship with a member of the surgical staff as a preceptor.

B. Scope of Privileges:

1. Performs preoperative patient assessment and teaching
2. Applies principles of asepsis and infection control
3. Performs positioning, prepping, and draping of the patient
4. Provides hemostasis by clamping blood vessels, coagulating bleeding points, ligating vessels, and by the other means as directed by the surgeon
5. Provides exposure through use of instruments, retractors, suctioning, and sponging techniques
6. Handles tissue as directed by the surgeon during the operative procedure
7. Performs wound closure as directed by the surgeons, suturing fascia, subcutaneous layers, and skin
8. Assists with affixing and stabilizing drains, cleaning the wound and applying the surgical dressing and applying casts
9. Assists with transfer of the patient from the operating room
10. Performs postoperative services as directed by physician

C. Supervision:

RN First Assistant provides services under the direct supervision of the surgeon.

XX. Proctoring/Skills Validation:

Each AHP initially appointed to the AHP Staff or granted new practice privileges shall be subject to a period of proctoring or evaluation. At the discretion of the Committee, proctoring shall be performed by a Medical Staff member, Allied Health Professional in the same category who has unrestricted privileges to provide the services that will be proctored, or a Hospital employee in the same category as the Allied Health Professional being proctored. Generally, proctoring shall consist of prospective case review, and Allied Health Professionals exercising surgery practice privileges shall be observed during surgery.

Skills validations or evaluations shall be performed according to the following:

Category	Proctored and/or Evaluated by
Certified Nurse Midwife	Supervising physician and Unit Director
Clinical Psychologist	A psychologist or psychiatrist as appropriate
Neonatal Nurse Practitioner	Supervising physician and Unit Director
Nurse Practitioner	Supervising physician and Unit Director
Pathology Assistant	Supervising physician and Unit Director
Physician Assistant	Supervising physician and Unit Director
RN in expanded role	Supervising physician and Unit Director
RN First Assistant	Supervising physician and Unit Director

A. TERMINATION, SUSPENSION OR RESTRICTION OF SERVICE AUTHORIZATIONS

1. General Procedures

AHPs shall not be entitled to the procedural rights afforded by Article VII of the Medical Staff Bylaws because the AHP's request for a specific Service Authorization is refused or because any or all portions of the tasks/services are terminated or suspended. All services performed by AHPs within the hospital shall be subject to the review and evaluations performed by Medical Staff committees and/or departments.

At any time, the President of the Medical Staff or Chair of the Department to which the AHP has been assigned may recommend to the Medical Executive Committee that an AHP's Service Authorization be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Interdisciplinary Practice Committee), the Medical Executive Committee agrees that corrective action is appropriate, it shall recommend specific corrective action to the Board of Directors. A Notification Letter regarding the recommendation shall be sent by certified mail to the subject AHP. The Notification Letter shall inform the AHP of the recommendation and the circumstances giving rise to the recommendation.

An AHP shall have the right to challenge any recommendation which would constitute grounds for a hearing for a Medical Staff Member under Article VII of the Bylaws (to the extent that such grounds are applicable by analogy to AHPs) by filing a written grievance (i.e. a letter objecting to the recommended action and requesting an interview) with the Medical Executive Committee within fifteen (15) days of receipt of the Notification Letter. Upon receipt of a grievance, the AHP will be afforded an opportunity for an interview concerning the grievance with the Medical Executive Committee or its designee. Such interview shall not constitute a "hearing" as established by Article 7 of the Bylaws and need not be conducted according to the procedural rules applicable to such hearings. The purpose of the interview is to allow both the AHP and the party recommending the action the opportunity to discuss the situation and to produce evidence in support of their respective positions. A written record of the interview shall be prepared.

Within 30 days following the interview, the Medical Executive Committee, based on the interview and all other aspects of the investigation, shall make a final recommendation to the Board of Directors, which shall be communicated in writing and sent by certified mail to the subject AHP. The final recommendation shall discuss the circumstances giving rise to the recommendation and any pertinent information from the interview. Prior to acting on the matter, the Board of Directors may, in its discretion, offer the affected practitioner the right to appeal to the Board or a subcommittee thereof. The Board of Directors shall adopt the Medical Executive Committee's recommendation, so long as it is reasonable, appropriate under the circumstances and supported by substantial evidence. The final decision by the Board of Directors shall become effective upon the date of its adoption. The AHP shall be provided promptly with notice of the final action by certified mail.

2. Summary Suspension

Notwithstanding Subsection 9.8.1.2, an AHP's Service Authorization may be immediately suspended or restricted where the failure to take such action may result in an imminent danger to the health of any individual. Such summary suspension or restriction may be imposed by the President of the Medical Staff, the Medical Executive Committee, or the Chair of the department or designee to which the AHP has been assigned. Unless otherwise stated, the summary action shall become effective immediately upon imposition and the person responsible for taking such action shall promptly give written notice of the action to the Board of Directors, the Medical Executive Committee, and the Clinical Department Administrator. The notice shall also inform the AHP of their right to file a grievance. The AHP's right to file a grievance and subsequent interview procedures shall be in accordance with subsection 9.8.1.3., except that all reasonable efforts shall be made to ensure that the AHP is given an interview and that final action is taken within 45 days or as promptly thereafter as practical.

Within one (1) working day of the summary action the affected AHP shall be provided with written notice of the action. The notice shall include the reasons for the action and that such action was necessary because of a reasonable probability that failure to take the action could result in imminent danger to the health of an individual.

Within five (5) working days following the action, the Interdisciplinary Practice Committee shall meet to consider the matter and make a recommendation to the Medical Executive Committee as to whether the summary suspension should be vacated or continued pending the outcome of any interview with the affected AHP. Within eight (8) working days following the imposition of the action, the Medical Executive Committee shall meet and consider the matter in light of any recommendation forwarded from the Interdisciplinary Practice Committee. Within two (2) working days following the Medical Executive Committee's meeting, the Medical Executive Committee shall provide written notice to the affected AHP regarding a determination on whether the summary action should be vacated or continued pending the outcome of any interview proceeding.

3. Automatic Termination, Suspension, or Restriction

Notwithstanding any other provision of this Section 8, an AHP's Service Authorization shall automatically terminate in the event that:

A. The Medical Staff privileges of the Supervising Physician is terminated, whether such termination is voluntary or involuntary.

B. The Supervising Physician no longer agrees to act as the Supervising Physician for any reason, or the relationship between the AHP and the Supervising Physician is otherwise terminated, regardless of the reason therefore.

C. The AHP's certification, license or other legal credential is revoked or suspended. In the event that the AHP's certification or license is restricted, suspended, or made the subject of an order of probation, the AHP's Service Authorization shall automatically be subject to the same restrictions, suspension, or conditions of probation.

D. An AHP's Service Authorization shall be summarily terminated by the Medical Executive Committee upon findings of gross mismanagement.

E. For AHPs who have been credentialed and privileged to provide specific patient care services, the AHP's ability to provide such specific patient care services shall be automatically terminated or suspended in the event that the AHP's Supervising Physician's clinical privileges to provide the specific patient care service or services the AHP provides is suspended, terminated or relinquished.

F. Where the AHP's privileges are automatically terminated, suspended, or restricted pursuant to this subsection, the notice and interview procedures under Subsection 9.8.1 shall not apply and the AHP shall have no right to any interview except, within the discretion of the Medical Executive Committee, regarding any factual dispute over whether or not the circumstances giving rise to the automatic termination, suspension, or restriction actually exist.

G. Applicability of Section
The rights afforded by this Section 9.8 shall not apply to any decision regarding whether a category of AHP shall be eligible for a Service Authorization and the terms or conditions of such decision.

XXI. DUES AND APPLICATION FEES

A. Dues

The annual dues for Medical Staff members shall be the following amounts:

CATEGORY	AMOUNT
Active	$250
Affiliate	$300
AHPs	$125
Associate	$400
Courtesy	$500
Provisional	$250
Retired/Honorary	No Dues
Teaching	No Dues

Annual Medical Staff dues are waived for the elected Officers of the Medical Staff and for the Department Chairpersons.

In accordance with Article 11, Section 11.7.1 of the Bylaws, those members of the Active Staff, who fail to meet the attendance requirements, shall be transferred to the category of membership applicable to the attendance achievement of the member. Such transfer of staff category will incur a change in dues to correspond to the new category.

B. Application Fees

Each applicant shall be required to pay a non-refundable application fee in the following amounts:

Medical Staff	$550
AHP	$200
Temporary privileges	$200

XXII. ADOPTION OF RULES AND REGULATIONS

Initially adopted by the Medical Staff on January 7, 1997
Initially approved by the Governing Board on January 27, 1997

Historical copies of reviews/revisions approvals that have been made are located in the PIH Health Hospital - Whittier dba PIH Health Whittier Hospital Medical Staff Office.

The latest review/revision/approvals were:
Medical Executive Committee: December 7, 2021
Board of Directors: December 17, 2021