Children's Hospital & Research Center Oakland

# Medical Staff

# Rules and Regulations

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# SECTION 1 Observance of Rules and Regulations

## 1.1 Applicability of Rules and Regulations

The Rules and Regulations governing the care of patients at CHRCO shall apply to all members of the Medical and Resident Staffs, to all persons exercising temporary privileges at CHRCO, to all allied health professionals and to all undergraduate medical and allied health professionals and to all undergraduate medical and allied health science students engaged in patient care activities as part of their educational program.

## 1.2 Precedence of Rules and Regulations

Divisional and departmental policies and procedures shall not conflict with these Rules and Regulations. In any point in question, these Rules and Regulations shall take precedence.

# SECTION 2 Code of Conduct and Corporate Compliance Policy

## 2.1 Compliance with the Children's Hospital Oakland Code of Conduct

The Children's Hospital Oakland Code of Conduct (See Section 2.6) is adopted by Children's Hospital and Research Center at Oakland as supplementary to its Mission and Values Statement. Each member of the Medical Staff, regardless of their status, agrees to be bound by and adhere to the Code of Conduct.

## 2.2 Compliance with the Corporate Compliance Program of Children's Hospital and Research Center at Oakland

As a tax-exempt organization that participates in the Medicare and Medicaid Program, Children's Hospital Oakland and its affiliated organizations, which include the Medical Staff, must comply with a number of Federal and State laws and regulations. The Governing Body of the Hospital, therefore, established as part of the Hospital's Policies and Procedures, a Corporate Compliance Program. This Program conveys to the Hospital's employees and to the community, the values and commitment to ethical and legal conduct of any individual who acts on behalf of the organization. Each member of the Medical Staff, regardless of their status, agrees to adhere to the Policies and Procedures of the Hospital's Corporate Compliance Program. (See Section 2.7)

## 2.3 Documentation of Intent to Comply with The Code of Conduct and Corporate Compliance Program

Each applicant to or current member of the Medical Staff, at the time of their application will receive a copy of the Code of Conduct and the Corporate Compliance Program Policy. As part of the application process, each prospective or current members will be required to document in writing their intent to comply. This documentation will remain in and a part of their credential file.

## 2.4 Medical Staff Standards of Professional Conduct

Each applicant to or current member of the Medical Staff, at the time of their application will receive a copy of the Medical Staff Standards of Professional Conduct, included with these Rules and Regulations, Section 2.5. As part of the application or reappointment process, each prospective or current members will be required to document in writing their intent to comply. This documentation will remain in and a part of their credential file.

## 2.5 CODE OF CONDUCT: MEDICAL STAFF STANDARDS OF PROFESSIONAL CONDUCT

Pursuant to 2.4 of the Medical Staff Rules and Regulations of Children's Hospital & Research Center Oakland, the Medical Executive Committee promulgates the following additional standards of professional conduct applicable to all members of the Medical Staff:

***Standards for Behavior and Conduct***

Each member of the Medical Staff shall:

Treat all patients, family members, and staff with professionalism, civility, courtesy, and respect. Refrain from engaging in the following interpersonal behaviors:

- Sexual harassment or the making of sexual innuendoes. This includes, but is not limited to, offensive sexual flirtations, advances, or propositions; engaging in unwarranted or unwanted physical touching; using sexually degrading, abusive, or suggestive words or gestures; and the display of sexually degrading or suggestive objects or pictures in the Hospital or in conjunction with any work-related activity in the Hospital.
- Using rude, demeaning, foul, or abusive language, including slander and repetitive sarcasm.
- Threatening with gestures, retribution, violence, financial harm, or litigation.
- Making racial or ethnic slurs.
- Engaging in actions that are reasonably felt by others to be intimidating, including
- inappropriate shouting or unnecessarily invading another's personal space.
- Criticizing staff in front of others while in the workplace or in front of patients or their families.
- Shaming others for negative outcomes.
- Engaging in any behavior that could reasonably be considered retribution, such as: implied
- or direct threats, physically intimidating behavior, withholding information, refusing to speak to co coworkers, and attempting to find out who might have registered a complaint.

Refrain from treating patients while impaired by alcohol, drugs, or serious illness, as this would place the patient at risk.

Support and follow hospital policies and procedures. Address any dissatisfaction with such policies and procedures through appropriate channels.

Use conflict management skills and direct verbal communication in managing disagreements with associates and staff.

Cooperate and communicate with other providers, displaying regard for their dignity.

Be truthful at all times.

***Standards for Clinical Practice***

Each member of the Medical Staff shall:

Respond promptly and professionally when called upon by fellow practitioners to provide appropriate consultation or clinical service.

Respond to patient and staff requests promptly and appropriately.

Respect patient confidentiality and privacy at all times, including following all regulations and requirements before releasing information.

Treat patient families with respect and consideration while following all applicable laws regarding such relationships (release of information, advance directives, EMTALA, etc.).

Seek and obtain appropriate consultation(s).

Arrange for appropriate coverage when not available and notify the hospital operators and Medical Staff office prospectively.

Appropriately supervise physicians in training and allied health personnel.
Provide effective and efficient care.

Prepare and maintain medical records within established time frames.

Disclose potential conflicts of interest and resolve conflicts in the best interests of the patient.

When terminating or transferring care of a patient to another physician, provide prompt, pertinent, and appropriate medical documentation to assure continuity of care.

***Standards for Relationship with Hospital and Community***

Each member of the Medical Staff shall:

Abide by all rules, regulations, policies, and bylaws the Medical Staff of CHRCO.

Serve on Hospital and Medical Staff committees as requested.

Assist in identifying colleagues who may be impaired or disruptive in their professional conduct.

Maintain professional skills and knowledge and participate in continuing medical education.

Refrain from fraudulent scientific or billing practices.

Accurately present data derived from research.

Request appropriate approval from the Research Committee and the Institutional Review Board prior to human research activities, including electronic patient data mining. Abide by all laws and regulations applying to these activities.

Comply with all applicable laws and regulations.

Cooperate with Hospital legal counsel, unless such cooperation is prohibited by law.

Participate constructively in clinical outcome review, quality assurance procedures, and performance improvement programs.

Hold in the strictest confidence all information pertaining to peer review, quality assurance, and performance improvement.

Protect from loss or theft, and not share, log-ins, passwords, and other access tools to any hospital system or data that contains patient identifiable information or other confidential patient or hospital information.

## 2.6 CODE OF CONDUCT: CHILDREN'S HOSPITAL AND RESEARCH CENTER OAKLAND

This Code of Conduct is adopted as supplementary to the Mission and Values Statements of Children's Hospital & Research Center at Oakland (CHRCO) and the Hospital Policies. The Code applies to all who perform services under the auspices of CHO. To the best of our ability:

1. We are committed to the ethical treatment of our patients and their families, our business associates, and our community

   *For our employees* we are committed to honesty, just management, confidentiality, fairness, reasonably providing a safe and healthy environment and respecting the dignity due everyone.

   *For* our patients *and their families* we are committed to providing quality medical care with respect for the privacy and the dignity of the patient and recognition of the importance of the patient's family. We maintain the confidentiality of patient information according to applicable legal and ethical standards. We will use our best efforts to assure that no information is shared in an unauthorized manner.

   *For our community* we are responsible neighbors and cooperate with other groups to improve the health status of all children. We handle our waste in keeping with environmental laws and protect the environment in which we are located.

   *For payors* we seek appropriate payment for services provided in compliance with the law and with appropriate documentation.

   *For our professional staff* we are committed to providing the technology required for quality care, the opportunity for continued professional growth, support of research and education efforts, honesty, fairness, and respect for their competence.

   *For our donors* and volunteers we respect and honor their generosity.

2. We conduct hospital activities in compliance with all applicable laws and regulations. To that end each of us cooperates with and furthers the Compliance Program. As an institution, we commit the appropriate resources to ensure compliance.

   We make the effort to educate ourselves so that we know the current status of laws applicable to our performance.

   Each of us reports appropriately any suspected wrong-doing and cooperate with activities and investigations which are conducted to ensure compliance.

   We recognize that internal discipline will result from non-compliance, and that unlawful activities must be reported appropriately.

   We know that everyone is equally responsible for high standards of lawful behavior.

3. We promote a positive work environment free of discrimination or, harassment, or workplace violence

   Harassment or discrimination of any kind, especially involving race, sexual preference, color, religion, gender, age, national origin, disability, marital or veteran status is totally unacceptable and must be reported. Acts or threats of violence or intimidation on work premises are prohibited.

4. We work safely

   Each of us is responsible for observing universal precautions when applicable and for assisting others to do so.

   We are committed to a drug-free workplace and recognize that to ensure that we may be subject to random drug tests.

   We report any environmental or safety concern promptly.

   We observe regulations regarding handling of hazardous materials. We observe posted warnings and regulations.

5. We keep accurate and complete records

   Transactions between CHRCO and all outside individuals and organizations must be promptly and accurately entered on the books in accordance with generally accepted applicable accounting standards.

   No facts are ever to be falsified, misrepresented, or omitted in any record when the omission leads to misrepresentation.

   All patient records meet the documentation standards required for quality care and to meet reimbursement regulations. Patient records are treated confidentially as provided by law, and are completed promptly.

6. We adhere to antitrust laws

   At no time will any hospital personnel, paid or unpaid, take part in any conspiracy in restraint of trade. Price fixing, disparagement, misrepresentation, or harassment of a competitor, stealing trade secrets, offering or accepting bribery or offering or receiving kickbacks are forbidden.

7. We know and follow all applicable State and Federal laws relating to government and donor contracts

   Political activities and contracts with government officials are conducted with decorum and in accordance with applicable laws. Fund raising activities are conducted so as not to violate State or Federal law.

8. We carefully bid and negotiate contracts

   In the event that bid proposals are solicited or contract negotiations are undertaken, all statements, communications and representations to prospective suppliers should be accurate and truthful.

9. We do not give or accept illegal gifts, favors, kickbacks, or other fraudulent activities

   We will not engage in any fraudulent activities
   We will abide by hospital policies on acceptable gifts and discounts.

10. We avoid conflicts

    As individuals we do not take part in any decision where we have a self-interest in the outcome. We avoid even the appearance of a conflict of interest by fully disclosing facts which may appear to be a conflict of interest, and abide by the decision of management or the Board, as the case may be, as to any potential conflict.

11. We use hospital assets wisely

    We recognize that the community has entrusted assets to us to be used for children's health. We safeguard, invest, and use assets to achieve the mission of the hospital.

    Proper use of the hospital property and equipment is the responsibility of each member of the staff and administration. We avoid waste and try to find ways to cut costs without cutting quality care. We are committed to complying with the requirements of software and other copyright licenses.

12. We use the reporting systems when we observe or suspect that this Code is not being honored

    Reports will be made to the supervisor or the supervisor's supervisor. When inaction to a report results or anyone wishes to bring the matter to the attention of the Compliance Officer, the report will be made by use of the Hotline, or directly to the Compliance Officer.

13. We conduct all research, clinical and basic, in accordance with ethical practice and government regulations

    All clinical research is approved by the Institutional Review Board process. Patients are completely and fully informed of the risks and benefits or participation in clinical research, and sign informed consents. CHRCO does not participate in any clinical research that violates our ethics or puts our patients at an undue risk of injury.

## 2.7 Corporate Compliance & Ethics Program

2.7-1 Purpose

The Corporate Compliance & Ethics Program (Program) is the framework by which Children's Hospital & Research Center at Oakland, d/b/a UCSF Benioff Children's Hospital Oakland, a California nonprofit public benefit corporation (Children's) establishes a consistent and collective process to manage the legal, regulatory, compliance and ethical challenges of our ever-changing and highly regulated organization. The Medical Staff has separately adopted the Program in these Rules and Regulations, with certain changes tailoring its application to the medical staff and its members. In so doing, the Children's Medical Staff is responsible for enforcing compliance with the Program as to medical staff members, as appropriate and applicable, and subject to and in accordance with the Medical Staff Bylaws and these Rules and Regulations.

The Program is designed to support team members, including but not limited to Members of the Governing Board, Administration, employees, volunteers, Medical Staff Members subject to and in accordance with the Medical Staff Bylaws and Rules and Regulations) and others, including subcontractors, agents and vendors within or acting on behalf of the corporate entities under Children's, by educating them on these requirements. The Program and those individuals that manage the Program are also a resource to consult and interpret corporate ethical and compliance matters.

The purpose of the Program at Children's is to:

- Promote an organizational culture that encourages ethical conduct and behaviors that embody our Mission, Vision and Values;
- Communicate our commitment to ethical business practices, and compliance with applicable laws and regulations;
- Provide a foundation for the conduct of any individual who acts on behalf of the organization; and
- Provide guidance for consistent self-monitoring and reporting functions to measure the effectiveness of the organization's compliance plan and address problems in an efficient and timely manner.

The Program is based on the US Department of Health and Human Services, Office of Inspector General's (OIG's) applicable Compliance Program Guidance, which identifies seven elements that must be included:

In an effective compliance program, these elements have been modified and expanded to comprise the core of the Program Policies, Procedures & Standards:

- Program Oversight
- Education and Training
- Communication
- Enforcement and Discipline
- Monitoring and Auditing
- Response and Prevention

The Program is dynamic, and may be modified or expanded over time, subject to the rules of amendment set forth in the Medical Staff Bylaws Rules and Regulations. Effective implementation of the Program can raise a host of

sensitive and complex legal issues, and nothing stated in this policy should substitute for, or be used in lieu of, legal advice from legal counsel.

2.7-2 Scope

The Hospital's Program applies to all Members of the Governing Board, Administration, employees, volunteers, subcontractors, agents and vendors within or acting on behalf of the corporate entities under Children's, which include Children's Hospital, BayChildren's Physicians, d/b/a UCSF Benioff Children's Physicians, Children's Hospital Oakland Research Institute, and Children's Hospital & Research Center Oakland Foundation. The Program as embodied in these Rules and Regulations applies to Medical Staff Members, subject to and in accordance with the Medical Staff Bylaws and Rules and Regulations.

2.7-3 Corporate Compliance & Ethics Program Structure

A. The Governing Board of Children's Hospital & Research Center at Oakland (Board) has ultimate accountability and oversight over the Program, except as noted under Sections I and II. The Board shall be knowledgeable about the content and operation of the Program.

1. The Board, through its Audit and Compliance Committee, is responsible for high-level oversight of the Program.
2. The Board has designated the UCSF Clinical Enterprise Compliance Program Director, or her successor, as having delegated responsibility and authority to provide oversight to the Compliance Officer (CO) of Children's.
3. The Program sets compliance guidelines for all functional areas at Children's.
4. The Audit and Compliance Committee will expect periodic reports regarding the implementation of the Program and its effectiveness. Through the Audit and Compliance Committee, the Board will monitor problems and related matters brought to it by the CO, Leadership, legal counsel, and/or the Operations Compliance Committee.

B. The Compliance Officer (CO) is charged with the day-to-day responsibility for operation and oversight of the Program. The CO has direct access to the CEO and the Children's Board. The CO is given unrestricted access to information, executives and meetings related to business operations. The CO's responsibilities include:

1. Oversight and monitoring of the Program, including maintenance of documentation of all transactions that involve or implicate the Program;
2. Oversight of the Operations Compliance Committee, the progress of the Program, methods to improve efficiency and quality of services and processes designed to detect, prevent and reduce vulnerability to fraud, abuse and waste;
3. Chairing the Operations Compliance Committee and appointing sub-committees, teams or task forces as needed to operationalize implementation, auditing and monitoring of the Program;
4. Periodically updating and revising the Program in light of changes in the needs of the organization, in the law, and in policies and procedures of government and private payer health plans;
5. Coordinating and participating in a multifaceted educational and training program that focuses on the elements of the Program, and seeks to ensure that all

appropriate stakeholders (including Medical Staff Members), employees and management are knowledgeable of, and comply with, pertinent federal and state standards;

6. Ensuring that independent contractors and agents who furnish services to the organization are aware of the requirements of the Program;
7. Coordinating with Human Resources and other appropriate departments and bodies, including but not limited to the Medical Executive Committee, to ensure the use of a reasonable and prudent background investigation of new employees, volunteers, Medical Staff Members and independent contractors, as applicable;
8. Assisting the organization's financial management in coordinating internal compliance review and monitoring activities, including periodic and annual reviews;
9. Independently investigating and acting on matters related to compliance, including designing and coordinating internal investigations and any resulting corrective action with all Children's departments and units, including but not limited to the Medical Executive Committee, as appropriate, providers and sub-providers, agents and, if appropriate, independent contractors;
10. Developing policies and programs that encourage managers, employees and Medical Staff Members to report suspected fraud and other improprieties without fear of retaliation;
11. Working with appropriate Children's departments and units, including the Medical Executive Committee, as appropriate, to develop policies and procedures to promote compliance with the Program;
12. Recommending and monitoring, in conjunction with the relevant Children's departments, the development of internal systems and controls to carry out the organization's standards, policies and procedures as part of its daily operations;
13. Determining the appropriate strategy/approach to promote compliance with the Program and detection of any potential Program violations, such as through "hotlines" and other fraud reporting mechanisms; and
14. Soliciting, evaluating and responding to Program complaints and problems.

C. The Operations Compliance Committee has been established to provide operational advice/oversight to the CO, and assist in the implementation of the Program. The Operations Compliance Committee is dynamic and may be modified or expanded as necessary to fulfill its responsibility of oversight and guidance to the CO. The Operations Compliance Committee meets no less than quarterly.

1. The Operations Compliance Committee consists of members of Children's administration and management that have the authority to drive system-wide changes. Committee membership includes:
   a. CO (who will chair the committee)
   b. Chief Executive Officer (executive sponsor, ad hoc member)
   c. Chief Financial Officer
   d. VP, Human Resources
   e. VP, Ambulatory Services
   f. Chief Administrative Officer, UCSF Benioff Children's Physicians
   g. VP, Institutional Quality
   h. Medical Staff Member appointed by the Medical Staff President

i. Foundation member
j. Internal Auditor
k. Director, Health Information Management/Privacy Officer
l. Research Compliance Officer
m. Information Security Officer

Ad-hoc members – as necessary for the effective operation of the Program, including:

n. Chief Nursing Officer
o. Chief Medical Officer
p. Others as determined by the CO or Committee

2. The responsibilities of the Operations Compliance Committee include:
   a. Identifying ad hoc members to serve on the Operations Compliance Committee with ability to make recommendations and drive processes as applicable in areas of Compliance and Ethics;
   b. Ongoing analysis of Children's industry environment, the legal requirements with which it must comply, and risk areas;
   c. Ongoing assessment of existing policies and procedures, as applicable, for possible modification and incorporation of new policies and procedures, as applicable, into the Program;
   d. Receiving and acting upon recommendations from the CO;
   e. Receiving internal/external hotline reports, compliance/audit reports, and other monitoring activities for trends that may be relevant for addressing potential fraud and abuse and compliance issues as identified;
   f. Determining new and potential areas of compliance risk and recommending applicable auditing and monitoring activities;
   g. Providing direction and recommendations to the organization for the development of proactive measures that address, minimize and/or prevent violations;
   h. Evaluating the Program and the performance of the CO; and
   i. Assisting the CO in the development of subcommittees, teams or task force(s) as needed to operationalize and effectuate the Program.

3. Member responsibilities:
   a. Operations Compliance Committee Members are expected to attend regularly scheduled Operations Compliance Committee meetings. Chronic absenteeism without good cause shall be reported to the CEO and/or their Senior VP Leader; and
   b. Adherence to Children's policies and procedures regarding the confidentiality, privacy and security of confidential and sensitive information. Sensitive information regarding individuals, Children's or Board members learned by any member of the Operations Compliance Committee during his/her tenure on the Committee, is confidential and is not to be disclosed unless otherwise directed by legal counsel.

2.7-4. Compliance Policies & Procedures

Administrative (organization-wide) and departmental compliance policies and procedures are developed and implemented to comply with applicable laws, regulations, standards and guidelines. They include, but are not limited to:

Code of Conduct: The Children's Code of Conduct (our Code) is a commitment we've made to ourselves, to those with whom we conduct business, and to the patients we service. The Code is our statement of essential ethical and compliance principles that guide our daily operations.

All employees, as a condition of their employment, are expected to comply with our Code. Our Code also applies to anyone conducting business on behalf of Children's (e.g., volunteers, students, temporary or contacted employees, vendors, etc.). As a condition of their appointment to the Medical Staff, Medical Staff Members are also expected to adhere to the Code, as applicable.

Corporate Compliance & Ethics Program: This policy defines elements of the Program and conduct expectations. Under the direction and supervision of the CO, applicable Children's policies have been developed or revised to reflect the expectations set forth by the Program.

2.7-5 Effective Education and Training:

A. Children's has developed and conducts regular, effective education and training programs for all affected members of the Governing Board, Administration, employees, volunteers, and independent contractors. The Medical Executive Committee also facilitates education and training for Medical Staff Members, including compliance training and education, as appropriate.

B. As part of the Program, employees are required to receive initial and periodic education utilizing a variety of instructional methods. Training includes review of state and federal laws pertaining to fraud and abuse, and privacy, confidentiality and security of protected health information (PHI). Also included are Children's standards, and other policies and procedures relating to Corporate Compliance and Ethics. Upon hire, employees are given an explanation of their obligation to actively participate in the Program, including the duty to report suspected violations. Volunteers and others being oriented to the facility receive the same training as employees. Medical Staff Members sign an attestation form that they will abide by this policy, and are provided with the Privacy, Confidentiality and Security Handbook, both at initial appointment and at reappointment.

C. Participation in Corporate Compliance and Ethics education is a condition of: appointment as a Member of the Governing Board; employment of all Children's employees, including Administration; volunteer membership; Medical Staff membership; and retention as an independent contractor, vendor or agent. Employees and others failing to comply with educational requirements of the Program will be subject to corrective action, up to and including termination; actions for non-employees will be similar in scope and related specifically to their status, subject to and in accordance with applicable rules and regulations, including but not limited to the Medical Staff Bylaws and Rules and

Regulations. Compliance with our Code and the principles of the Program is used to evaluate the performance of all Children's employees and contractors.

D. Initial Education: Initial education is provided to employees during New Employee Orientation (NEO) to introduce the Program. As a part of initial education, new employees receive a copy of our Code. The Code serves as a reference guide stating performance expectations for all affected employees. It is intended to provide general guidance and direction regarding legal and ethical business practices and behavior.

E. Ongoing Education: Children's employees participate in Corporate Compliance and Ethics education on an ongoing (at minimum, annual) basis by completing the Corporate Compliance & Ethics update education. Education of employees is documented on the Individual Education Records and Annual education Plans as part of the Competency Assessment Program.

F. Mandatory Education: New employees sign our Code acknowledgment form, which evidences receipt and understanding of our Code and agreement to participate in and abide by the Program standards. Each year, all employees will re-certify that they have read, understood, and agree to abide by the principles outlined in our Code. The Operations Compliance Committee reviews mandatory Corporate Compliance and Ethics education compiled by the Staff Education & Development. Annual compliance statistics are prepared and presented to the Children's Board.

G. Other Education: Independent Agents/Contractors associated with Children's (such as vendors, contract employees) will be required to attend NEO when their services are for greater than 60 days of continuous service. When services are for less than 60 days, the Code along with information as to actions to take if they should become aware of a potential violation of the Program will be provided to the agent/contractor.

2.7-6 Developing Effective Lines of Communication/Reporting

A. Children's maintains a process to receive complaints, and has adopted procedures to protect the anonymity of complainants and to protect them from retaliation.

B. If individuals performing services on behalf of Children's have questions or concerns regarding a compliance or ethics related issue, they should contact their manager or obtain information from the appropriate facility resource, such as the Code, this Program policy, Administrative Policy and Procedure Manual, or the CO.

C. Managers receiving information from an employee regarding potential or suspected violations must report the concern to their director, the CO, or call the Compliance Hot Line at 800-403-4744.

D. Individuals not comfortable discussing their questions or concerns with their manager or who feel their concern has not been adequately addressed may contact the following persons until the issue is adequately resolved: CO, or call the Compliance Hot Line at 800-403-4744.

E. Children's has a confidential Compliance Hotline that may be used to anonymously report compliance concerns or problems. The Hotline may also be used for reporting suspected violations of Children's policies and procedures, the Program and other laws and regulations.

The Compliance Hotline number is 800-403-4744. This line does not utilize caller ID or any other caller tracking mechanism and is routed to a third party service for additional anonymity.

F. Employees have an obligation to report any suspected violation of Children's policies and procedures, the Program, and other laws and regulations to their manager, director, CO or the Compliance Hotline.

G. No Children's employee should be disciplined or terminated for reporting in good faith a suspected violation.

2.7-7 Auditing and Monitoring

A. Children's will use audits and/or other evaluation techniques to monitor compliance with Program and operative laws and assist in the reduction of identified compliance problem areas.

B. An evaluation process is critical to the success of the Program. Quarterly internal audits and an annual evaluation of the Program will be performed to determine that elements of the Program are being met. Audits will be performed, as necessary and appropriate, by internal and external auditors who have knowledge of federal and state health care statutes, regulations and health care program requirements. Audits, on selected subjects, will be proactively performed to detect and prevent potential violations, and reduce or eliminate potential areas of vulnerability.

C. Audit results will be reported to the CO and the Operations Compliance Committee for (1) review and determination of any variances from established acceptable baselines, and (2) recommendations for action. A report of audit results and Program evaluation will be prepared and submitted to the Children's Board via the Audit and Compliance Committee by the CO at least annually.

D. Audit areas of focus include, but are not limited to:

1. Coding;
2. Claim development and submission;
3. Reimbursement;
4. Physician contracts;
5. Privacy, Confidentiality and Security of Protected Health Information (PHI); and Research.

E. In addition to audits, ongoing review of areas of specific focus will include applicable OIG Special Fraud Alerts, OIG audits and evaluations, law enforcement initiatives, Cumulative Sanctions reports, and the OIG Work Plan, offering current trends to guide Program practices.

F. Monitoring techniques to identify variation from established baseline may include:

1. Identifying frequency and/or percentile levels of certain critical factors such as diagnosis codes, length of stay, and denied claims;
2. Use of trend analyses or longitudinal studies that seek deviations, positive or negative, in specific areas over a given period;
3. Reviews of medical and financial records and other documents that support claims for reimbursement and Medicare/Medicaid cost reports;
4. Questionnaires developed to solicit impressions of a broad cross-section of the Children's employees and staff;

5. Interviews with personnel involved in management, operations, coding, claim development and submission, patient care, and other related activities; and
6. On-site visits.

G. Identified monitoring data and audit results will be documented in written reports and reviewed by the CO and the Operations Compliance Committee. With these reports, the Operations Compliance Committee will make recommendations to Children's management for necessary steps to correct past problems and prevent them from recurring. Subsequent reviews or studies will be conducted to ensure that recommended corrective actions have been implemented successfully.

H. The Operations Compliance Committee will evaluate, no less than annually, the effectiveness of the Program, our Code, this Policy and other compliance related policies, and provide the results of such evaluation to the CO and the Children's Board of Directors. The Operations Compliance Committee will review, revise and issue modifications and/or updates to the Program and distribute them to all employees based upon the results of such evaluation.

2.7-8 Enforcing Standards through Corrective Action

A. Children's has developed and maintains a system to respond to allegations of improper/illegal activities. It has adopted procedures for appropriate corrective action against employees who have violated internal compliance policies, applicable statutes, regulations or federal health care program requirements.

B. The Program includes corrective action guidance for all Children's workforce members and Members of the Governing Board where a suspected violation of the Program occurs. Commitment to the Program applies to all workforce members, including management, employees, volunteers, vendors, independent contractors and other health care professionals performing services for Children's. Members of the Medical Staff shall be accountable for compliance with the Program in accordance with the Medical Staff Bylaws and Rules and Regulations.

C. Children's will investigate and correct identified systemic problems and develop policies addressing the non-employment of sanctioned individuals.

D. Corrective Action

1. Children's will not tolerate the behavior of those who engage in wrongdoing which has the potential to impair our status as a provider of quality, reliable and honest health care services. Failure to comply with Children's standards, policies and procedures, the Program, or federal and state laws will result in the strict enforcement of this policy.
2. Managers are held accountable for failure to comply with the Program or for the foreseeable failure of their reporting staff to comply. All managers will be evaluated on their effectiveness in educating and enforcing the standards of the Program.

E. Violations and Investigations

1. When there has been a report of non-compliance to the Hotline or any other reporting mechanism, the CO will initially assess the report, in consultation with legal counsel if warranted. If the initial assessment indicates that there is a basis for believing that the conduct reported constitutes non- compliance with the Program,

applicable state or federal law, or other Children's policies, an investigation will be commenced. The investigation will be directed by either legal counsel or the CO, as appropriate. Children's Hospital's investigation of possible noncompliance with the Program by Medical Staff Members will be conducted in coordination with the Medical Executive Committee, subject to and in accordance with Medical Staff, Rules and Regulations. Corrective action imposed upon Medical Staff Members will be subject to and in accordance with Medical Staff Bylaws and Rules and Regulations.

2. The investigation will begin as soon as reasonably possible, but no more than thirty (30) days following the receipt of the report, information, or complaint regarding the potential non-compliance.
3. If an investigation of an alleged violation is undertaken and the CO believes the integrity of the investigation may be at stake because of the presence of employees under investigation, the affected personnel will be removed from their current work activity until the investigation has been completed.
4. The investigation will be conducted through the use of appropriate internal and external resources, with may include, but are not limited to, review of relevant documents, interviews of witnesses, use of internal and/or external auditors or consultants, etc. All such investigations will be conducted so as to maintain confidentiality and protect their results from disclosure to the greatest extent feasible.
5. Records of the investigation will contain documentation of the alleged violation, a description of the investigative process, copies of interview notes, any other key documentation, a log of the witnesses interviewed, the documents reviewed, the results of the investigation, any disciplinary action taken, and the corrective action implemented.
6. A Summary Report will be prepared with recommendations for the CO and Operations Compliance Committee on corrective actions including proposed disciplinary measures to be taken against the person(s) whose activities or conduct is subject of the investigation.
7. The Operations Compliance Committee may periodically report violations and investigations to the Board that could result in reputational, regulatory, and/or ethical consequences.

F. Self Reporting

1. After an investigation, if it is determined that there is credible evidence of a violation and that a voluntary report is required, Children's will promptly report the misconduct to the appropriate governmental authority. Prompt reporting in accordance with applicable law, including rules and regulations regarding the reporting and returning of overpayments, demonstrates Children's good faith and willingness to correct and remedy the problem.
2. When reporting misconduct to the Government, Children's will provide evidence relevant to the alleged violation and potential cost impact. The organization will take appropriate corrective action, including prompt identification and restitution of any overpayment to the affected payer and the imposition of proper corrective action. The Program requires overpayments obtained from any source to be promptly returned to the payer that made the erroneous payment.

3. Children's will document all inquiries made to government agencies or other entities when advice regarding compliance is being sought. All documentation related to the Program will be retained by Children's under the supervision of the CO for 6 years,
4. All violations or suspected violations of this policy, or the Program, must be reported in accordance with this policy, and may require Corrective Action, up to and including termination.

2.7-9 Applicable Regulatory Standards

Federal Register: Compliance Program Guidance for Hospitals (February 23, 1998)
Federal Register: Supplemental Compliance Program Guidance for Hospitals (January 31, 2005
Office of Inspector General, US Department of Health and Human Services
US Sentencing Commission Compliance Recommendations Deficit Reduction Act of 2005

# SECTION 3 General Requirements for Medical Staff Membership

## 3.1 Malpractice Insurance

3.1-1 Malpractice Insurance General Requirements

As a condition for exercising clinical privileges and as a condition for membership and continued membership on any category of medical staff membership involving the exercising of clinical privileges (see Bylaws, Section 3.1 and 5.6), each member and applicant to the Medical Staff shall carry professional liability insurance, consistent with the member's/applicant's existing and/or intended privileges, in the amount of at least $1,000,000 per incident with an annual aggregate coverage of at least $3,000,000, The practitioner shall provide proof of compliance with this requirement.

In addition, at the time of the application and reapplication to the Medical Staff, each applicant and member shall advise the Medical Staff Office (1) of the name of his insurance carrier (2) that coverage provided by such insurance is consistent with the member's or applicant's existing and/or intended privileges, and (3) of the coverage limits of his policy. Each applicant and member must immediately notify the Medical Staff Office of any cancellation or change in his policy, including a change in carrier, amounts, or scope of coverage.

3.1-2 Acceptable Insurance Carriers

Acceptable insurance carriers include:

A. Any carrier admitted to transact the business of medical malpractice liability insurance in the State of California with an acceptable Best's or Standard and Poor's rating, or
B. A carrier who demonstrates adequate financial stability to the Medical Staff Executive Committee.

3.1-3 Failure to Provide Evidence of Insurance – Grounds for Discipline

Failure to provide evidence of such professional liability insurance shall be grounds for the rejection of any applicant or reapplicant for Medical Staff membership and for automatic suspension for existing members. Any such rejection or suspension shall afford the affected practitioner the right to a hearing as specified in the Bylaws (Section 8). However, the sole issue to be determined at such hearing will be whether the affected practitioner has complied with this requirement.

## 3.2 Categories and Privileges of the Medical Staff

The following chart summarizes the general requirements and privileges of the various categories of Medical Staff membership. Membership requirements are more fully described in Article 4 of the Bylaws.

Chart Summary of Requirements and Privileges by Medical Staff Category

| Categories | Privileges & Responsibilities | Dues | Vote in MS Affairs | Hold Office | Voting Member Medical Staff Committees | Receive Educational Notices | Serve as a Proctor |
|---|---|---|---|---|---|---|---|
| **Active** | ALL* | Full | Yes | Yes | Yes | Yes | Yes |
| **Courtesy** | ALL* & ** | Full | No | No | Yes | Yes | Yes*** |
| **Corresponding** | None | Reduced | No | No | No | Yes | No |
| **Emeritus** | None | None | No | No | Yes | Yes | No |

* As limited by specific privileges granted to each Medial Staff member
** Excluding meeting attendance and minimum patient care requirements
*** Only under special circumstances when requested by the Division Chief

3.2-1 Focused Professional Practice Review:

A. Applicants for New Membership or Privileges

Each new staff member or current staff member requesting new privileges shall be reviewed using an FPPE process in accordance with Bylaws Section 3.7 and according to the written procedures established by each Department, below.

B. Written Reports

Departmental rules for Initial FPPE shall require that reviewers provide a written critique of each reviewed procedure. In addition, upon completion of the FPPE process, a written report shall be prepared by the proctor and submitted by the respective Division/Department Chief to the Credentials Committee for action and recommendation to the Executive Committee.

C. Location of Reports

The reviewer’s critique and final report shall be maintained in the staff member’s confidential file in the Medical Staff Office.

D. Service as a Reviewer:

1. Active Staff:
Each member of the Active Staff no longer under proctorship must be willing to function as a proctor when requested by the respective Department or Division Chief to maintain his/her Active Staff status.
2. Courtesy Staff:
In unusual circumstances, where suitable, Courtesy Staff members shall serve as proctors at the discretion of the appropriate Division/Department Chairperson.

E. Proctoring from other institutions:

CHRCO may accept evidence of FPPE from other healthcare institutions. The following conditions shall apply:

1. The healthcare institution where the surgery is performed must be accredited by the JCAHO; and
2. The procedures to be reviewed shall be subject to approval of the responsible Division Chief, or the Chair of the Department or his or her designee.
3. For non- procedural based proctoring, current FPPE based on chart review of privileges' similar to those held at CHO.
4. The most recent OPPE for the provider may be accepted if the provider has had his or her initial proctoring, or FPPE, completed greater than 2 years ago. The OPPE Information must be sufficient to support current clinical competence of the provider, and must contain all of the usual elements found in FPPE.

F. See Section 3.7, Medical Staff Bylaws, and Section 24, Rules and Regulations

## 3.3 Infection Prevention Requirements

3.3-1. Tuberculous: Tuberculosis (TB): All members of the Medical Staff must provide evidence of TB screening at the following times:

A. Upon initial application for Medical Staff privileges, a completed TB screening form must accompany the application and must include:

1. Documentation of a negative tuberculin skin test (TST) using a two step process or blood assay for Mycobacterium tuberculosis (BAMIT) such as Quanteiferon TB Gold or other IGRA assay performed within the prior 6 months or
2. Applicants with a history of a positive TST or BAMT must complete a symptom review form and show documentation of a chest

B. At the time of reappointment, physicians must complete the TB screening form and provide documentation of a negative TST or BAMT performed within the prior year. Applicants with a history of a positive TST or BAMT must complete a symptom review form.

3.3-2. Immunity and Immunizations

Immunity and Immunizations: All applicants and members of the Medical Staff requesting patient care privileges must provide documentation of the following immunity or immunizations in order to be approved for Medical Staff or Allied Health staff membership. For those who are not immune or do not know their status, testing for immunity and vaccines will be made available free of charge to members or applicants of the medical staff, allied health staff and to hospital employees.

A. Baseline immunity/immunizations required at the time of initial application:

1. Rubeola (Measles)
2. Mumps
3. Rubella
4. Varicella
5. Hepatitis B
6. Tdap (documentation of vaccine is required

B. Influenza immunization annually (within the preceding year):

Mandatory influenza immunization of all health care personnel is recommended by the American Academy of Pediatrics, the Infectious Disease Society of America, and the American Medical Association. According to the AAP: "Mandatory influenza immunization for all health care personnel is ethically justified, necessary, and long overdue to ensure patient safety." In addition, Alameda County Public Health Department (ACPHD) issued a memorandum on 3/28/12 to all health care facilities in its jurisdiction, strongly recommending implementation of policies of mandatory influenza vaccination for all healthcare workers, including clinicians. ACPHD is also strongly recommending that unimmunized health care workers be required to wear masks during influenza season whenever they are in a patient's room or inpatient or outpatient areas where patients are seen, evaluated, treated, or waiting to be seen.

Therefore, all members of the medical staff must get an influenza vaccine annually.

Influenza vaccines are made available to all members of the medical staff through Employee Health (x3620).

1. Once immunized, medical staff members will be given a colored sticker to affix onto the upper left corner of their name badges to indicate receipt of vaccine.
2. Unimmunized medical staff will be required to wear a mask whenever they are in a patient's room or inpatient or outpatient areas where patients are seen, evaluated, treated, or waiting to be seen, for the duration of the influenza season, which is determined by the Infection Control Officer.
3. Anyone who was immunized against influenza outside CHRCO or who declines to be immunized will be required to attest to one of the following:
   a. I got a flu vaccine on (date) at (clinic) OR.
   b. I decline to receive a flu vaccine for the following reason (a list is included on the attestation form) and I understand that if I do not get a flu vaccine, I will be required to wear a mask during the influenza season whenever I

am in a patient's room or inpatient or outpatient areas in which patients are seen, evaluated, treated, or waiting to be seen.

4. Members of the medical staff will be required to complete an attestation about their influenza immunization status annually. This attestation may be submitted electronically, with similar information as listed above. Those who receive vaccines will be able to get the sticker to affix to their badges from the medical staff office in person or by mail once the attestation is received.

C. Pertussis immunization (Tdap) is required once, as recommended by the Centers for Disease Control and the Advisory Committee on Immunization Practices and as required by the Aerosol Transmissible Diseases Standard issued by Cal/OSHA.

Tdap may be obtained from Employee Health or from primary care providers or private offices. However, an attestation must be signed if the Tdap is received outside CHRCO to provide documentation for medical staff records.

Anyone immunized elsewhere OR not immunized in the past and declining vaccine now will be required to sign an attestation indicating one of the following:

1. *I got a Tdap vaccine on (date) at (clinic).*
2. *I decline to receive a Tdap vaccine for the following reason (a list of reasons is included in the attestation form).*

The following physicians/clinicians are excluded from the Tdap requirement:

3. Medical staff members who work exclusively at CHORI and do not have any patient contact, except if they work in a laboratory in which the pathogens causing diphtheria, tetanus, and pertussis (*Corynebacterium diphtheriae, Clostridium tetani, or Bordetella pertussis)* are being used or studied and in which there is a possibility of occupational exposure; in this case, OSHA requirements include Tdap vaccine.
4. Medical staff members who work exclusively with the Electronic Medical Record development

D. Any and all HCWs (including physicians) who develop a fever and respiratory symptoms, regardless of immunization status, will be excluded from work for at least 24 hours after they no longer have a fever, without the use of fever-reducing medications.

# SECTION 4 Confidentiality and Medical Staff Credentials Files Confidentiality Requirements

## 4.1 Confidentiality Requirements

In order to encourage voluntary and candid participation by Staff members and others engaged in essential peer review and patient care committees, it is the policy of the Medical Staff that all files, records, and proceedings of Medical Staff Committees shall be afforded every confidentiality protection allowable by law. (See Bylaws, Sections 12.1-8 and 12.1-9).

4.1-1 Participation in Reliance on Confidentiality

Medical Staff committee members participate in credentialing, peer review and performance improvement activities in reliance upon the preservation of confidentiality. They understand that the confidentiality of these activities is to be maintained and that these communications and information will be disclosed only in furtherance of credentialing, peer review, and performance improvement activities.

4.1-2 Preservation of Confidentiality and Protections Afforded by Law

Members of Children's Hospital and Research Center at Oakland medical staff recognize that confidentiality is vital to effective credentialing, peer review and performance improvement activities. Accordingly, members of the Medical Staff shall respect and preserve the confidentiality of those activities and the confidentiality of all communication and information generated in connection with committee business. Members pledge to invoke the protection of California Evidence Code Section 1157 as applicable in legal proceedings, in order to preserve the confidentiality of committee information.

4.1-3 Responsibility of Chairperson of Committee

The Chair of each Medical Staff committee engaged in performance improvement, credentialing, or peer review activities shall ensure that all committee members that are not employees are formally reminded of these confidentiality requirements at the beginning of their committee tenures. In addition, the committee chairs shall obtain a signed pledge to respect confidentiality from all committee members who are not members of the Medical Staff, or CHRCO employees.

4.1-4 Breach of Confidentiality

In compliance with Bylaws Section 12.1-9, any breach of the confidentiality of Medical Staff committee confidentiality by a member of the Medical Staff will be considered grounds for appropriate corrective action, as defined in the Bylaws (See Article 7). Any breach of confidentiality by a non- member of the Medical Staff will be referred to Hospital Administration for hospital employees or, for non-hospital employees, to the agency that the committee member represents.

## 4.2 Confidentiality of Medical Staff Committee Information (Signature Statement)

This statement is provided in accordance with Children's Hospital & Research Center Oakland Medical Staff Bylaws Section 12.1-9, and Medical Staff Rules and Regulations, Section 4.1

The Medical Staff of Children's Hospital & Research Center at Oakland recognizes that in order to encourage effective, voluntary and candid participation in Medical Staff committee activities related to peer review, credentialing and quality and performance improvement, it is vital that the confidentiality of committee proceedings and records be preserved.

The Medical Staff further recognizes that each member of such Medical Staff committee participates in reliance on the preservation of confidentiality. Accordingly, it is the policy of the Medical Staff of Children's Hospital and Research Center at Oakland that any and all records, proceedings, testimony, discussions and other information presented by or to a committee of the Medical Staff engaged in peer review, credentialing, or quality and performance improvement activities shall be strictly confidential.

Each member of the Medical Staff, as a condition of membership, agrees to maintain committee information confidentiality to the fullest extent permitted by laws. Committee discussions and written materials shall not be disclosed or discussed outside the committee context except as specifically mandated by Medical Staff policies and procedures in furtherance of peer review, credentialing or quality and performance improvement activities.

Each member of the medical staff specifically agrees to invoke the protection of California Evidence Code Section 1157, as applicable in legal proceedings, in order to preserve the confidentiality of committee information.

In accordance with Medical Staff Bylaws, Section 12.1-9, and Rules and Regulations section 4.1, any breach of these confidentiality requirements shall be a breach of the conditions of Medical Staff membership and shall constitute grounds for appropriate corrective action, including suspension or termination of eligibility to hold office or to serve as a member of any Medical Staff committee, or any other action against membership and privileges authorized by the Medical Staff Bylaws and Rules and Regulations.

I have read and understand the foregoing, and agree to abide by the requirements for confidentiality of medical staff committee information.

Signature: ______________________________

Printed Name: ______________________________

## 4.3 Medical Staff Records Confidentiality Policy

This policy applies to all records maintained by or on behalf of the Children's Hospital and Research Center at Oakland Medical Staff, including the records and minutes of all Medical Staff committees, departments, and divisions, the credentials and peer review files concerning individual practitioners, and the records of all Medical Staff credentialing, peer review and performance improvement activities.

The Medical Staff recognizes that it is vital to maintain the confidentiality of Medical Staff records for reasons of both law and policy. Medical Staff members participate in credentialing; peer review and performance improvement activities, and others contribute to these activities, in reliance upon the preservation of confidentiality. The members of the Medical Staff understand and agree that the confidentiality of these activities, and of all Medical Staff records, is to be preserved and that these communications, information and records will be disclosed only in the furtherance of those credentialing, peer review and performance improvement activities, and only as specifically permitted under the conditions described in this policy.

This requirement of confidentiality extends to the records and minutes of all Medical Staff committees, departments and divisions, to the records of all Medical Staff credentialing, peer review and performance improvement activities, to the credentials and peer review files concerning individual practitioners, and to the discussions and deliberations which take place within the confines or under the aegis of Medical Staff committees, departments and divisions.

4.3-1 Location and Security Precautions

The Medical Staff credentials files and records and minutes of Medical Staff committee, department and division meetings, will be maintained in the Medical Staff Office, under the custody of the Medical Staff Coordinator or an authorized representative. The Medical Staff Office will be locked except during those times the Medical Staff Coordinator or an authorized representative is present and able to monitor access in accordance with this policy. These files, records and minutes will be released from that office only in accordance with this policy.

The files and records of Medical Staff peer review and performance improvement activities, including copies of minutes arising out of such activities, will be maintained in the Quality Improvement Office, under the custody of the Director of Quality Improvement. The Quality Improvement Office will be locked except during those times the Director of Quality Improvement or an authorized representative is present and able to monitor access in accordance with this policy.

4.3-2 Access by Persons within the Hospital and Medical Staff

A. Means of Access to Medical Staff Office Files

All requests for Medical Staff records by persons within the Hospital and Medical Staff shall be presented to the Medical Staff Coordinator who will maintain a record of requests made and granted. Those requests which require notice to, or approval by, other officials shall be forwarded to those persons by the Medical Staff Coordinator in a timely manner.

A person permitted access under this section shall be given a reasonable opportunity to inspect the records in question and to make notes regarding them, but will not be allowed to remove them from the Medical Staff Office, to make copies of them, nor to remove items from them. Removal or copying shall be allowed only upon the express permission of the President of the Medical Staff or his designated representative. The inspection of such records shall be made in the presence of the Medical Staff Coordinator or his designee.

B. Means of Access to Quality Improvement Office Files

All requests for Medical Staff records by persons within the Hospital and Medical Staff shall be presented to the Director of Quality Improvement who maintains a record of requests made and granted. Those requests which require notice to, or approval by, other officials shall be forwarded to those persons by the Director of Quality Improvement in a timely manner.

A person permitted access under this section shall be given a reasonable opportunity to inspect the records in question and to make notes regarding them, but will not be allowed to remove them from the Quality Improvement Office, to make copies of them, nor to remove items from them. Removal or copying shall be allowed upon the express permission of the President of the Medical Staff or his designated representative. The inspection of such records shall be made in the presence of the Director of Quality Improvement or his designee.

Except as expressly provided in this policy, it is understood that all provisions of this policy relating to Medical Staff files, records, and minutes, shall pertain to both the Medical Staff Office and the Quality Improvement Office.

C. Access by Persons Performing Official Hospital or Medical Staff Functions

To the extent necessary to perform Hospital or Medical Staff functions, Medical Staff Officers, members of the Executive Committee, Chiefs of the Medical Staff Departments and Divisions, Medical Staff committee members, members of the Board of Directors, consultants, the Chief Executive Officer or designated representative, Director of Quality Improvement, Medical Staff Coordinator, and any other persons assisting in credentialing, peer review or performance improvement

activities, will have access to Medical Staff records, except as hereafter provided. More particularly:

1. Medical Staff Officers: To the extent necessary to discharge official responsibilities under the Bylaws of the Medical Staff, Medical Staff Officers shall have access to all Medical Staff records, other than their own records except such information as is allowed in paragraph D, below.

2. Department and Division Chiefs: Department and Division Chiefs shall have access to all Medical Staff records pertaining to the activities of their respective Department and Division. Department and Division Chiefs also shall have access to the credentials, peer review and quality improvement files of practitioners whose qualifications or performance are reviewed as part of their official functions.

3. Executive Committee Members: To the extent necessary to discharge official responsibilities under the Bylaws of the Medical Staff, Executive Committee members shall have access to all Medical Staff records, other than their own records.

4. Medical Staff Committee Members: Medical Staff Committee members shall have access to the records of committees on which they serve and to the credentials, quality improvement and peer review files of practitioners whose qualifications or performance the committee is reviewing as part of its official functions.

5. Consultants: Consultants (who may or may not be members of the Medical Staff) engaged by a Medical Staff Committee or department shall have access to the credentials and peer review files of the practitioner being reviewed and to any other pertinent Medical Staff records if the engaging committee or department authorizes such access.

6. Board of Directors and Chief Executive Officer: The Board of Directors, and the Chief Executive Officer as the Board's designated representative, all have access to Medical Staff Records to the extent necessary to discharge their lawful obligations and responsibilities.

7. Director of Quality Improvement and Chairperson of Quality Improvement Committee: To the extent necessary to discharge their responsibilities under the Bylaws of the Medical Staff, the Director of Quality Improvement and the Chairperson of the Quality Improvement Committee shall have access to all Medical Records, other than their own.

8. Quality Improvement Manager and Coordinator: The Quality Improvement Manager and Quality Improvement Coordinator shall have access to those records maintained in the Quality Improvement Office pertaining to Medical

Staff peer review and performance improvement activities. They shall not have access to Medical Staff credentials file.

9. Medical Staff Director, Coordinator, and other employees of the Medical Staff Office: The Medical Staff Coordinator shall have access to all Medical Staff records as required for the conduct of his/her responsibilities.

10. Questions regarding access to any Medical Staff files and records that are not addressed in this policy shall be referred to the Medical Staff President or his designee. Information which is disclosed to any of the above named shall be maintained in strict confidence.

D. Access by Medical Staff Members to the Medical Staff Records

1. Credentials Files:

   a. A Medical Staff member will have access to the credentials files of other Medical staff members and to the records of other practitioners credentialed by the Medical Staff, only as set forth above.
   b. A Medical Staff member shall be granted access to any documents in their credentials file provided by or addressed personally and may have copies of such information, subject to timely notice. A member may also have access to, but not copies of, any records or reports generated by the Quality Improvement Office regarding the member's peer review activities.

A summary of all other information shall be provided to the member in writing, within a reasonable period of time. Such summary shall disclose the substance, but not the source, of the information.

A Medical Staff member will be allowed access to further information in his/her credentials file only if, following a written request by the Medical Staff member, the Medical Staff Executive Committee and either the Board of Directors, or its designated representative, find that the Medical Staff member has a compelling need for such information and grants written permission. Factors to be considered include the reasons for which access is requested, whether the practitioner might further release the information, whether the information could be obtained in a less intrusive manner, whether the information was obtained in specific reliance upon continued confidentiality, whether the practitioner will suffer specific serious adverse consequences unless the information is released, and whether a harmful precedent might be established by the release.

2. Access to Peer Review Files:

   a. Department and Division Chiefs, Medical Staff Officers, Director of Quality Improvement, Chairperson of Quality Improvement Committee and Chairperson of the Credentials Committee and those individuals specifically authorized in writing by the President of the Medical Staff shall have access to peer review files to the extent necessary to discharge their responsibilities under the Bylaws of the Medical Staff.
   b. A Medical Staff member will have access to all information in his peer review file, except such information for which confidentiality has been expressly warranted. In such cases, a member will be provided a summary of the information submitted, which summary shall disclose the substance, but not the source. A member may have copies of any information submitted by or addressed personally to him, subject to timely notice and agreement to pay for the copying of same.

3. Access to Medical Staff Committee, Department and Division Files:

   A Medical Staff member shall be allowed access to Medical Staff Committee, department and division files, including minutes thereof, only if, following a written request by the Medical Staff member, the Medical Staff Executive Committee and either the Board of Directors or its designated representative find that the practitioner has a compelling need for the information and grants written permission. Factors to be considered include the reasons for which access is requested, whether the member might further release the information, whether the information could be obtained in a less intrusive manner, whether the information was obtained with specific reliance upon continued confidentiality, whether the practitioner will suffer specific serious adverse consequences unless the information is released, and whether a harmful precedent might be established by the release.

4 Requests for Correction, Deletion or Addition to Information in Medical Staff Credentials and Peer Review Files:

   a. When a Medical Staff member has reviewed his/her file as provided above, he/she may submit to the President of the Medical Staff a written request for correction, deletion or addition of information to the appropriate files. Such request shall include a statement of the basis for the action requested.
   b. The President of the Medical Staff will review such a request within a reasonable time and shall recommend to the Medical Staff Executive Committee whether or not to make the correction, deletion or addition requested. The Medical Staff Executive Committee, when so informed, shall either ratify or initiate action contrary to the recommendation, by a majority vote.

c. The member shall be notified promptly, in writing, of the decision of the Medical Staff Executive Committee.

d. Regardless of the decision, a member shall have the right to add to his own credentials and/or peer review file, upon written request to the Medical Staff Executive Committee, a statement responding to any information contained in said files.

4.3-3 Access by Persons or Organizations Outside of the Hospital or Medical Staff

A. Credentialing or Peer Review at Other Hospitals

1. The Hospital and the President of the Medical Staff (or designee) may release information contained in a credentials and/or peer review file, or other information which is the subject of this policy, in response to a request from another hospital or its medical staff. That request must include information that the Medical Staff member is a member of the requesting hospital's medical staff, exercising privileges at the requesting hospital, or is an applicant for medical staff membership or privileges at the hospital, and must include a release for such records signed by the member whose records are being requested. In lieu of a signed release form provided directly by the provider, a representative from the requesting entity must attest that the signed release is in place. However, the foregoing exception to the Medical Staff Office obtaining a copy of the release does not apply in cases where the medical staff member's information contains information that is negative or adverse, or potentially negative or adverse, regarding the physician's educational or training history, quality of care, professional conduct, ethics or character. Nothing in this section precludes the Medical Staff Office from requiring a separate and updated signed release from the physician for this purpose on a form approved by the Medical Executive Committee.

2. No information should be released until a copy of the specific signed authorization and release from liability has been received, or the attestation has been completed. This often takes the form of the member's signature on an application for Medical Staff membership. Disclosure shall generally be limited to the specific information requested.

3. If a Medical Staff member has been the subject of disciplinary action at this Hospital which is required to be reported to Medical Board of California (MBC), or by law to any other agency, or has recently challenged an Executive Committee recommendation or action which, if upheld, will require a report to MBC or other agency, special care must be taken. All responses to inquiries regarding that member shall be reviewed and approved by the President of the Medical Staff or his designee, and legal counsel should be consulted.

B. Requests by Hospital Surveyors

Hospital surveyors (from the Joint Commission on Accreditation of Healthcare Organizations, the State Department of Health Services, the Centers for Medicare and Medicaid Services, the Institute for Medical Quality, etc.) shall be entitled to inspect records covered by this policy on the Hospital premises in the presence of Hospital or Medical Staff personnel, provided that: (1) no originals or copies may be removed from the premises, (2) access is only with the concurrence of the Chief Executive Officer of the Hospital (or his designee), and (3) the surveyor demonstrates the following to the Hospital and Medical Staff representatives:

1. Specific statutory or regulatory authority to review the requested materials.

2. That the materials sought are directly relevant to the matter being investigated.

3. That the materials sought are the most direct and least intrusive means to carry out the pending investigation, bearing in mind that credentials and peer review files regarding individual practitioners are considered the most sensitive of materials.

4. Sufficient specificity to allow for the production of individual documents without undue burden to the Hospital or Medical Staff.

5. In the case of requests for documents with physician identifiers not eliminated, the need for such identifiers.

C. Subpoenas

All subpoenas of Medical Staff records shall be referred to the Chief Executive Officer and President of the Medical Staff, who will consult with legal counsel regarding the appropriate response.

D. Requests from the Medical Board of California, Board of Osteopathic Examiners and Board of Dental Examiners

Current law allows the Medical Board of California (MBC) the Board of Osteopathic Examiners (BOE), and the Board of Dental Examiners (BDE), to review certain materials pertaining to Medical Staff hearings concerning corrective action recommendations or decisions. Given the current requirements of law, copies of the following records of Medical Staff disciplinary hearings shall be made available to the MBC, BOE, or BDE upon the specific written request of the Board:

1. The Notice of Charges presented to the Medical Staff member before the beginning of a Medical Staff hearing.

2. Any document, medical record, or other exhibit received in evidence at that hearing.
3. Any written opinion, findings, or conclusions of the Medical Staff hearing committee in the disciplinary hearing which were made available to the concerned member.

The President of the Medical Staff (or designee) must review and approve the disclosure before it is made. Any request for documents other than those listed above shall be disclosed only in accordance with Paragraph E., below.

E. Other Requests

All other requests by persons or organizations outside the Hospital for information contained in the Medical Staff records shall be forwarded to the President of the Medical Staff and the Chief Executive Officer. The release of any such information shall require the concurrence of the Medical Staff Executive Committee, or its designated representative, and the Board of Directors, or its designated representative. The Executive Committee and the Board of Directors may enact disclosure policies applying to such requests from specific entities. When such disclosure policies are enacted, they shall be appended to this policy.

## SECTION 5 Credentials Files

The procedures for appointment and reappointment to the Medical Staff are described in the Medical Staff Bylaws Article 6.

### 5.1 Information to be included in the Credentials File

The credentials files of the Medical Staff and Advance Practice members contain the objective, validated information which will enable the Medical Staff of Children's Hospital and Research Center at Oakland to fairly assess the competence of applicants for appointment and reappointment to the Medical Staff or membership as Allied Health Practitioners.

Items listed below may also be stored in the Medical Staff Credentialing database.

### 5.2 The Credentials File of Each Medical Staff Member Contain The Following:

1. Applications for appointment and reappointment(s); which includes attestations and any explanations for:
   a. Challenges to any licensure or registration
   b. Voluntary and involuntary relinquishments of any license or registration
   c. Voluntary and involuntary termination of medical staff membership
   d. Voluntary and involuntary limitation, reduction, or loss of clinical privileges
   e explanation of any professional liability actions
   f. Attestation regarding the applicants health status
2. current California medical license, including primary source verification of such;
3. current DEA certificate, including primary source verification of such;
4. Board Certification as applicable, verified by the primary source
5. Verification, from the primary source when available, of all education from Medical or Professional school to highest level of education obtained, including internship, residency and/or fellowship. Verification from the primary source and/or the American Medical Association(AMA) profile
6. Life support training as required;
7. Evidence of malpractice insurance coverage commensurate with requirements of the Medical Staff Bylaws
8. Correspondence related to references for both initial appointment and reappointment, and any documentation in support of those references;
9. Delineation of privileges, and documentation of competence for any criteria for the privileges requested as defined on the privilege request form
10. Temporary privileges information;
11. Initial FPPE information;

12. Professional References, including one authoritative reference, i.e, a recent fellowship or training director, or current Division Chief/Department chair or equivalent with information regarding the applicants ability to perform the privileges requested according to the ACGME Competencies.
13. Hospital activity information, from other affiliated hospitals where the applicant/reapplicants holds privileges as applicable, e.g., department meetings, committee participation, communications; Including relevant practitioner specific data as compared to aggregate data as available, and morbidity and mortality data as available.
14. Results of a criminal background check performed by the Medical Staff Office in accordance with criteria recommended by the Credentials Committee and approved by the Medical Executive Committee;
15. Evidence of training and proficiency of use of the Electronic Medical Record, or confirmation that this information has been provided to the applicant.
16. Communications sent to provider regarding approvals for initial medical staff membership, medical staff change in staff status, change in privileges, reappointment notifications.
17. Documentation of performance of physical identification of the provider, using a government picture ID
18. Documentation of compliance with immunization requirements, see Section 3.3 of these Rules and Regulations for specific requirements
19. Explanation for any adverse answers on the attestation section of the application
20. National Practitioner Databank Query, and/proof of enrollment
21. Any additional information required by law, by accrediting or licensing agencies, or by Medical Staff policy.

## 5.3 Primary Source Verification Requirements

Primary and secondary source verification will be performed as listed in the below table. Primary and secondary source verified items may be stored in the electronic credentialing database. At all times, verifications will be completed in accordance best practices, with the requirements of the Joint Commission, the State of California, and other regulatory agencies.

5.3.1 Sources and definition of Primary and Secondary Source verifications:

A. Primary source verification: Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. Example of primary source verification (PSV) include, but are not limited to, direct correspondence, telephone verification, internet verification, the ECFMG, the American Board of Medical Specialties. The American Osteopathic Association Physician Masterfile or the American Medical Association (AMA) Masterfile can be used to verify education and training.

B. Secondary Source Verification: Methods of verifying a credential that are not considered an acceptable form or primary source verification. These methods may be used when primary source verification is not required. Examples of secondary source verification include, but are not limited to, the original credential, notarized copy of the credential, a copy of the credential.

5.3.2 Table of verification requirements

| **Credentialing Or Privileging Activity** | **Method** | **Source** |
|---|---|---|
| Licensure (as applicable), registration or certification, also verified at the time of renewal or revision of privileges, and at the time of license expiration | Primary Source | State Medical Board(s)<br>or<br>AMA profile (JC Acceptable Primary Source) |
| DEA (as required for prescribing provider) | Primary Source (Note secondary source is acceptable) | DEA-using NTIS electronic verification service |
| Education including, as examples:<br>Medical School<br>Dental School<br>Nursing School<br>Psychology Program | Primary Source | Direct verification from institution<br>or<br>AMA Profile<br>Or ECFMG |
| Professional training program:<br>Internship/Residency<br>Fellowship | Primary Source | Direct verification including verification directly from either institution directly or the program director<br>or<br>AMA Profile |
| Competency–Ability to perform privileges requested | Primary Source | See specific privilege request forms. As applicable, direct verification from primary source |
| Confirmed Statements of Health fitness (ability to perform the requested privileges) | Primary and secondary | 1: Statement from applying provider<br>2: Confirmation from professional reference, confirmed by the director of a training program, the chief of services, or the chief of staff at another hospital at which the applicant holds privileges. |
| Personal Identification | Secondary | Verification of comparison of photo of government issued identification directly with provider |
| Immunizations and PPD Status | Secondary | Copies acceptable. See R&R section 3.3 |

| Life Support training (As required) | Secondary | Copies acceptable |
|---|---|---|
| Hospital Admitting Privileges- | Primary Secondary acceptable if Primary not available | As applicable. Verification of privileges, and status from all current and past accredited hospitals at appointment and from all current accredited hospitals at reappointment. |
| National Practitioner Data Bank Query, also will enroll all Medical Staff and Advanced Practice Allied Health Staff members into the Continuous Query process for ongoing updates | Primary Source | Direct from NPDB |
| Peer Recommendations including- Medical/clinical knowledge - Technical and clinical skills - Clinical judgment - Interpersonal skills - Communication skills - Professionalism Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of practitioner-specific data collected from various sources for the purpose of validating current competence | Primary Source | Names provided by applicant, must include an authoritative reference including one or more of the following: the director of a training program, the chief of services, or the chief of staff at another hospital at which the applicant holds privileges. |

## 5.4 Reappointment Quality Report

The Professional Practice Evaluation Report shall be a report of the cumulative quality data concerning activity of the Medical Staff member during the two (2) years preceding reappointment to the Medical Staff. Its purpose is to provide information to Medical Staff Leadership and the Credentialing Committee for objective and evidenced-based assessment of the Medical Staff member's activity and eligibility for reappointment.

5.4-1. The decision as to what information should be included in Professional Practice Evaluation Report shall be made by the Medical Executive Committee upon recommendation by the Institutional Quality Department. The Professional Practice Evaluation Report shall be prepared by the Institutional Quality Department acting as agent for the Medical Staff. The Department Chair or Division Chief of the Medical Staff Member's Division shall review the Report at time of reappointment. if, at the time of review, the Division Chief or Department Chair feels that the information on the Professional Practice Evaluation Report is inappropriate or misleading, he may ask that the Report be revised.

5.4-2 The reappointment to Medical Staff process shall include participation by the Medical Staff member in any review regarding his management of patient care in which the appropriateness of that care is of concern. In addition, the reappointment process will address all aspects of the Medical Staff member's fulfillment of his responsibilities and the conditions of Medical Staff membership.

5.4-3 The Reappointment to Medical Staff process shall include informing the Medical Staff member when any adverse information is being placed or recorded in his Quality File, pursuant to the review and recommendation of the appropriate committee of the Medical Staff.

5.4-4 A summary of practice pattern data i will be included in the Professional Practice Evaluation Report

5.4-5 As described in these Rules and Regulations Section 4.3, the Medical Staff member shall be afforded the opportunity to review his Quality File and Professional Practice Evaluation Report at the time of reappointment. Further, any Medical Staff member shall be provided access to his Quality File at any time, with reasonable notice to the Institutional Quality Department, in compliance with the Institutional Quality Department's protocols and these Rules and Regulations, after approval from the Medical Staff President.

5.4-6 The Professional Practice Evaluation Report shall include as appropriate for the two-year reappointment period:

Volume Data
Procedure Data
Number of cases referred for peer review through screening or referral;
Description of cases rated other than "care acceptable"
Description of concerns regarding cases in which care has been determined through data analysis or peer review to be inconsistent with accepted standards of medical practice;
Such other data as may be required by accrediting or licensing agencies, or Medical Staff policy.
OPPE data and any FPPE resulting from concerns regarding clinical care.

# SECTION 6 Admission, Transfer and Discharge of Patients

## 6.1 Non-Discrimination

No member shall deny any patient acceptance for care or assignment for services on the basis of color, religion, ancestry, national origin or financial resources. However, the Chief Executive Officer, or his designee, reserves the right to exclude patients who are:

6.1-1 Dangerous to themselves or others

6.1-2 Suffering from any disease recognized by the Infection Control Officer to be so contagious and communicable as to be dangerous to the attending personnel and/or other patients despite proper technique.

## 6.2 Adult Patients

6.2-1 Medical Staff members are encouraged to adopt into their Children's Hospital practice the following recommendation:

A. new patients to the practice be limited to those up to 18 years of age, and
B. patients over 18 years of age currently followed in the practice be transitioned to adult care before age 22 years.

6.2-2 The admission of patients 22 years of age and older by members of the Medical Staff is strongly discouraged. Exceptions will be made on a case-by-case basis subject to bed availability and the approval of either the Medical Director or the Medical Staff President. The physician requesting admission must agree to serve as the Attending Physician. House staff will not automatically be assigned to provide coverage of these patients. In exceptional circumstances when house staff coverage is desired for a patient 22 years of age and older, prior approval of the Chief Medical Officer, or in their absence, the President of the Medical Staff, is required. With the exception of Diagnostic Imaging and Pathology, pediatric subspecialties will not be required to provide consultation services to patients 22 years of age and older as specified in the Medical Staff Rules and Regulations (Section 7).

6.2-3 The Emergency Department will not take any "expects" or accept in transfer from another facility any patient 19 years of age or older unless the request is made by a member of the Medical Staff who will assume responsibility for that patient's care as the Attending Physician. Requests to accept a patient 22 years and older require approval of either the Medical Staff President, the Medical Director, or the Medical Director's designee

6.2-4 The Critical Care Unit will not accept the transfer of a patient over 18 years of age from an outside facility unless the request is made by an active member of the Medical Staff who is currently following the patient in their practice. Requests to accept the transfer of a patient over 21 years of age requires approval of the Critical Care Attending and either the Medical Staff President, the Medical Director or the Medical Director's designee.

6.2-5 The Rehabilitative Service will not accept the transfer for inpatient services of any patient 19 years of age and older.

## 6.3 Compliance with Hospital Admission, Transfer and Discharge Policies

All members to the Medical Staff shall make every reasonable effort to comply with Hospital policies and procedures regarding admission, transfer and discharge of patients.

## 6.4 Admission of Non-Emergency Patients

6.4-1 Admission by Attending Practitioner

All patients shall be admitted by a member of the Medical Staff who will act as the patient's attending practitioner, having primary responsibility for the patient until such time as that responsibility is transferred to another member of the Medical Staff, pursuant to Section 6.101

6.4-2 Physician Primary Responsible

The Admitting Office shall accept the name of only one practitioner in the space designated "Attending Physician" on the Face Sheet and shall not accept a team designation.

6.4-3 Podiatric and Dental Admissions

Podiatrists and Dentists may initiate the admission of a patient in accordance with the Bylaws Sections 5.2 and 5.3 with the concurrence of a physician member of the Medical Staff. The name of the physician member of the Medical Staff shall appear on the Face Sheet of the patient's chart.

A. The podiatrist's or dentist's responsibility shall include:

1. A detailed podiatric or dental history justifying Hospital admissions.
2. A detailed description of the examination of the foot or oral cavity and preoperative diagnosis.
3. A complete operative report, describing the findings and techniques used.
4. Progress notes as are pertinent to the foot or dental condition.
5. A Discharge Summary for all observation and inpatients
6. A Discharge statement for all outpatient surgery patients

7. Compliance with the Medical Staff Rules and Regulations Section 11, Medical Records pertinent to the foot or dental condition
8. The podiatrist or dentist may write orders within the scope of his license as may be limited by his privileges or by the Medical Staff Bylaws or these Rules and Regulations.
9. It shall be the podiatrist's or dentist's responsibility to alert the co-admitting physician to any medical problem which may arise during the patient's hospitalization and to ensure that the patient receives appropriate medical care.

B. The physician's responsibilities shall include:

1. Medical history pertinent to the patient's general health.
2. Physical examination to determine the patient's condition prior to anesthesia and surgery. The physician shall determine, with consultation if necessary, the overall risk assessment and effect of any operative procedures on the patient's health.
3. The care of any medical problem that 1) may be present upon patient admission, or 2) that arises during hospitalization provided that the physician is promptly notified of the problem.
4. Compliance with the Medical Staff Rules and Regulations Section 9 Medical Records

The physician may delegate the history and physical examination to a medical student, resident or nurse practitioner. Nurse practitioners performing this function must be credentialed by the Interdisciplinary Practice Committee.

C. Concurrence of Opinion Necessary

When either the physician or dentist or podiatrist is of the opinion that a significant medical abnormality relative to the procedure for which the patient is admitted is present, the physician and dentist or podiatrist must concur on the plan for treatment before that planned procedure may be performed.

## 6.5 Admission of Emergency Patients

6.5-1 Definition – Emergency Admission

Emergency admissions are those in which serious or permanent harm will result to the patient or in which the life of the patient is in immediate danger and any delay in administering treatment would add to that danger.

6.5-2 Justification of Emergency Admission

Members of the Medical Staff admitting an emergency case shall justify the existence of a bona fide emergency by appropriate evidence in the recorded history and physical examination as soon as possible after admission.

6.5-3 Assignment of Physicians to Emergency Patients without Admitting Practitioners

Patients, without an attending practitioner on staff, who are admitted from the emergency room, shall be assigned, as their attending practitioner, the current attending physician for the appropriate ward. The acute care area-attending physician shall assume primary responsibility for the patient's care until such time as that responsibility is transferred or the patient is discharged. In the case of a patient with whom the ward attending physician has terminated a prior physician-patient relationship, it is the responsibility of the acute care area attending to arrange for another practitioner to accept the role of attending practitioner for that patient.

## 6.6 Admission of Patients with Psychiatric Disorders

It is the policy of Children's Hospital Oakland to not admit patients with the primary diagnosis of a psychiatric disorder.

6.6-1 Patients with both a psychiatric diagnosis and who are medically unstable, e.g., exhibiting signs of cardiovascular instability, hypothermia, electrolyte imbalance, may be admitted for acute stabilization and then be transferred as soon as possible to facilities licensed for psychiatric admissions or to outpatient management at the discretion of the attending physician and consultants.

6.6-2 The primary diagnosis of these patients should be listed as the medical condition requiring stabilization, not a psychiatric disorder.

6.6-3 No medically unstable patient will be transferred. All reasonable attempts will be made to transfer medically stable patient to an inpatient psychiatric setting. (See Interdisciplinary Manual (IPM 192. Suicide Risk Assessment and Patient Management)

## 6.7 Provisional Diagnosis

No patient shall be admitted without a provisional diagnosis.

## 6.8 Admissions History and Physical Examination

There will be evidence of a physical examination, including a health history, performed no more than thirty (30) days prior to admission or no more than twenty-four (24) hours after an inpatient admission and within 24 hours of a procedure or surgery. If changes to the patient's condition have occurred since the performance of the history and physical, or if the exam has been completed prior to the day of the admission or surgery, but less than 30 days from the admission or procedure, interval history and physical should be documented. An Emergency Room evaluation that includes the required elements noted in Section 11.6 is acceptable to fulfill this requirement.

If the H&P is greater than 30 days old at the time of admission or procedure, a new, complete history and physical will be required.

## 6.9 Information Necessary to Protect Patients

Medical Staff members admitting a patient shall give voluntarily such information about that patient as is necessary to assure the protection of other patients and Hospital personnel from those who are a potential source of danger from any cause whatever or to assure protection of the patient from self- harm. In all such cases, the Admitting Resident and the Nursing Supervisor shall be notified of the situation, as soon as is practically possible. In case of a potentially or actively suicidal patient, the Standing Order for Suicidal Patients shall be followed (See IPM 192. Suicide Risk Assessment and Patient Management) with the understanding that all Child Psychiatry consultations will be performed by either a psychiatrist or a psychologist.

## 6.10 Transfer of Patients

6.10-1 Transfer of Primary Responsibility within the Hospital

The transfer of primary responsibility for the care of a patient from one attending practitioner to another requires:

A. verbal hand-off communication between the attending physician or resident acting on their behalf and accepting physician, following standard hospital procedure (see Interdisciplinary Policy Manual, Policy 8.1 Hand-Off Communication)
B. an order for transfer by the attending practitioner or a resident acting on their behalf relinquishing his responsibility, and
C. documentation acknowledging acceptance of primary responsibility by another practitioner.

6.10-2 Priorities of Transfer Within the Hospital

The following transfers require prompt notification to the patient’s attending practitioner. Transfer priorities shall be as follows:

A. Acute care unit to intensive care unit.
B. Emergency room to appropriate patient bed.
C. From intensive care units to general care area; except that, instances when either intensive care unit is full, first priority shall be given to transferring patients from the full unit to the acute care units or to the other intensive care unit.
D. From temporary placement in available space to the area appropriate for the patient.

6.10-3 Transfers to another Facility

No patient shall be transferred or discharged for the purpose of affecting a transfer to another facility unless arrangements have been made in advance for admission to such facility, including obtaining acceptance of primary responsibility from the new attending practitioner. In addition, no such transfers shall be made unless the person legally responsible for the patient (i.e., the parent or guardian) has been notified or attempts have been made to notify such person. No transfer or discharge to affect such transfer shall be made if, in the opinion of the attending practitioner, transfer or discharge would endanger the patient's health.

## 6.11 Discharge of Patients

6.11-1. General Requirements

Discharge of a patient requires the following:
A discharge order signed by the patient's attending physician, or designated resident acting as the attending physician's agent. Podiatric and dental discharge orders may be signed exclusively by the attending podiatrist or dentist only where the patient has experienced no medical problems during hospitalization. In podiatric/dental discharge of patients who did experience medical problems, the discharge order must be signed by the responsible physician. The listing of the final diagnosis on the discharge abstract of the patient's chart by the designated resident or, if there is no designated resident, by the attending practitioner. This does not preclude a change in diagnosis at a later date if additional information becomes available warranting a change.

A. A discharge summary dictated or entered by the assigned resident or, if there is no assigned resident, by the attending practitioner.
B. The attending physician must authenticate the discharge summary.
C. The listing of the final diagnosis in the discharge summary of the patient's chart by the designated resident or, if there is no designated resident, by the attending practitioner. This does not preclude a change in diagnosis at a later date if additional information becomes available warranting a change.
D. The attending physician must authenticate the discharge summary.
E. Drug allergies discovered during an admission shall be documented in the discharge summary.
F. The discharge summary must be faxed or otherwise provided to the patient's primary physician, and must include resident (if applicable) and attending physician contact information should questions arise.

6.11-2 Criteria for Discharge from the PACU Post Anesthesia Care Unit

See the Department of Anesthesiology Discharge Criteria Policy "Discharge from Post Anesthesia Care Unit"

6.11-3 Discharge Orders – Contents

Discharge medications will be ordered either in the discharge orders or on separate prescription forms, and in either case will be also described in the discharge instructions.

6.11-4 Release of Patients

A minor not legally authorized to consent to and contract for medical care shall be discharged only to the custody of his parent, legal guardian or custodian, unless such parent, guardian or custodian shall otherwise direct in writing.

6.11-5 Temporary Transfer of Responsibility within the Hospital

The responsibility for a patient's care is frequently transferred on a temporary basis (for example: on call coverage, or care of a medical patient by a surgical team for an operative or invasive procedure). Whenever a temporary transfer of care occurs, a "hand-off" communication shall take place between transferring and receiving attending physicians or residents acting on their behalf, following standard hospital protocol as outlined in the interdisciplinary policy manual.

# SECTION 7 Death of a Patient

## 7.1 Notification of Attending Practitioner

Upon the death of the patient, the attending practitioner should be informed immediately. If possible, the attending practitioner should be responsible for ensuring that the next of kin are notified. (See IPM 5.2 End of Life Care)

## 7.2 Organ and Tissue Donation

The attending physician should recognize that the hospital is required as a condition of participation in the MediCare and MediCal programs to have in place a protocol for identifying potential organ and tissue donors. The protocol must require that at or near the time of a patient's death the organ procurement agency be notified. (See IPM 5.2.e End of Life Care: Organ Donation)

## 7.3 Pronouncement of Death; Release of Body

It shall ordinarily be the responsibility of the attending physician to pronounce the patient dead. In the event he is unavailable, the deceased may be pronounced dead by the assigned resident, the PICU attending, or the emergency department physician. This shall be accomplished as promptly as possible after the demise of the patient. The body ordinarily shall not be released until the following information appears in the medical record:

7.3-1 Time of death.
7.3-2 Disposition of body, including autopsy request and whether or not coroner has been notified.
7.3-3 Persons contacted, including attending and/or referring physician.
7.3-4 When appropriate, the physician writing the death note should write a brief summary of the events leading to the physician being called to the bedside.

## 7.4 Guidelines for the Determination for Brain Death

The Guidelines for Determination of Brain Death are provided in (See IPM 5.2.f End of Life Care: Brain Death) and copies shall be available in the Intensive Care Units, the Medical Director's Office and the Emergency Room.

## 7.5 Policy on Orders Not to Resuscitate and Foregoing Life-Sustaining Medical Treatment

See IPM 5.2.b and c End of Life Care: Physician Orders for Life Sustaining Treatment, and Physician Orders for Withdrawing or Withholding Life Sustaining Treatment and IPM 1.2 Advance Directives

## 7.6 Sudden Infant Death Protocol

The Sudden Infant Death Syndrome Protocol is located in the Emergency Department Policy Manual. (ED Policy 20.05).

## 7.7 Autopsies

7.7-1 Duty to Secure Autopsies

Except in coroner's cases, it shall be the duty of the attending practitioner to secure an autopsy whenever possible. In coroner's cases, no autopsy shall be requested, unless authorized by the coroner. The criteria for reporting cases to the coroner are listed in IPM 5.2 End of Life Care.

7.7-2 Criteria for Requesting Autopsies

A. Criteria for requesting an autopsy shall include the following:
B. Patients in whom diagnoses are in doubt.
C. Patients in whom effectiveness of therapy or surgical or diagnostic procedure is in doubt.
D. Patients for whom autopsy is needed to identify genetic or metabolic disorders.
E. Patient with a new or undefined, or evolving disease in whom autopsy will add to scientific knowledge.
F. Patients whose families desire an autopsy.

7.7-3 Authorization of Autopsy

Permission for autopsy shall be in writing (e.g., an autopsy permit signed by an authorized person, a telegram, or written statement) except that verbal permission by an authorized person is acceptable where obtained over the telephone and recorded on tape or other recording device, or when witnessed by two persons who know the person giving permission.

(NOTE: Verbal authorization by telephone is acceptable under California law (Health and Safety Code, Section 7113) where it is made known to the physician who is to perform the autopsy that the deceased, at the time of death, was a member of a religion, church, or denomination which relies solely upon prayer for the healing of disease).

Hospital personnel may accept authorization provided by a person representing himself to be any of the following persons, with no order of priority among them, except as noted in A. below:

A. An individual who has been appointed as an "attorney-in-fact" under the deceased's execution of a Durable Power of Attorney for Health Care. (NOTE: Unless otherwise stated in the Durable Power, the attorney-in-fact has priority over all others who may authorize an autopsy. Otherwise, there are no priorities among those who may authorize the autopsy).
B. A parent.
C. Surviving spouse, child, parent, brother, or sister.
D. Any other kin or person who has acquired the right to dispose of the remains.
E. A public administrator.
F. A coroner or other duly authorized public official.

7.7-4 Entry in Progress Notes

Before an autopsy is performed, the physician requesting the autopsy shall list in the progress notes the suspected major cause(s) of death and the major finding expected at autopsy.

7.7-5 Performance of Autopsies

All autopsies will be performed by the Department of Pathology, unless the Chairperson of the Department of Pathology authorizes an autopsy to be performed by a pathologist from another institution, in order to avoid a conflict of interest or to obtain special expertise needed in a specific case.

7.7-6 Disposition of the Remains

The right to control disposition of the remains of a deceased person (unless other instructions have been given by the decedent) devolves upon the following persons in order of priority listed:
A the surviving spouse
B. the surviving child or children
C. the surviving parent or parents
D. next of kin under California law
E. the public administrator where deceased has insufficient assets

7.7-7 Coroner 's Cases

California Law requires that deaths occurring under the specified circumstances shall be "immediately reported to the coroner" IPM 5.2 End of Life Care and Emergency Department Policy 20.04 Protocol for Coroner's Cases and DOA.

As it is the duty of the coroner to investigate circumstances surrounding such deaths, the coroner shall be notified before removal of the remains from the place of death, so that he/she can order any necessary investigation.

# SECTION 8 Patient Consent to Treatment

## 8.1 General Rule for Informed Consent

A competent patient or, in the case of a child, the child's parent or guardian, has a right to decide what will happen to his/her body with regard to medical care. This includes the right to consent or refuse any recommended medical procedure and the right to sufficient information to make that consent meaningful. Simple and common procedures, i.e. those involving risks that are commonly understood to be remote do not require consent. Procedures that require consent are those where risks are not considered to be remote. (CMA Document #0415, January 2003). See IPM 3.1 Consent to Treatment.

## 8.2 Procedural Sedation, General Anesthesia and Emergencies

When performing a procedure under general anesthesia or procedural sedation, documentation of discussion regarding risks, benefits and alternatives for the anesthesia or sedation is necessary, even if the procedure itself does not require written consent. Using the checkbox on the sedation monitoring record is sufficient documentation of informed consent for sedation.

In an emergency, written consent is not necessary before the procedure if a parent or legal guardian is not readily available or if time taken to obtain the consent would result in a delay in the procedure and harm to the patient. Procedures required for initial stabilization of the patient are exempt from the need to obtain a written consent. The emergent nature of the procedure must be documented in the progress notes in cases where consent is not feasible. (See IPM 16.10 Procedural Sedation Policy)

## 8.3 Informed Consent Required

The following list is intended as a reference to help guide CHRCO medical staff members in determining which procedures require informed consent.

A. Surgical procedures performed in an operating room.
B. Administration of general anesthesia or procedural sedation.
C. Endoscopic procedures.
D. Diagnostic procedures where tissue is removed.
E. Interventional radiology procedures.
F. Cardiac catheterization.
G. Any other procedure where the physician judges the risk of complications to be more than remote.

## 8.4 Telephone Consent

It is the policy of this hospital to permit obtaining or verifying consent for medical or surgical treatment by the telephone in emergency or other urgent situations, where a delay in treatment would jeopardize the life or health of the patient and the legally responsible representatives are available only by telephone.

The attending physician should describe and discuss all aspects of the procedure, which would normally be discussed with the patient in obtaining consent.

Hospital personnel should verify that the physician has obtained consent and should also obtain the legal representative's agreement to the Conditions of Admission. Any questions regarding the proposed treatment or associated risks and benefits will be referred to the attending physician.

## 8.5 Hospital's Consent Form

8.5-1 Responsibility of Hospital

The hospital requires that a consent form, entitled "Authorization for and Consent to Surgery or Special Diagnostic or Therapeutic Procedures" be signed whenever patients are undergoing surgery or a diagnostic procedure where Informed Consent is generally obtained. It shall be the responsibility of the Hospital to prepare the hospital's consent form for the signature of the patient or authorized representative and to seek to obtain such signature.

8.5-2 Responsibility of the Attending Practitioner

It is the responsibility of the Attending Practitioner to obtain the Informed Consent and to explain the procedure and any of its associated risks to the patient or legal representative.

## 8.6 Conditions of Admission

Upon admission, the legally authorized person (parent, adult patient, patient who is a liberated minor, guardian or designee) must sign the Conditions of Admissions form, which includes a general authorization for treatment. If not obtained, the attending physician shall be notified and shall endeavor to assist the admission's staff in obtaining the necessary authorization as soon as possible after admission.

## 8.7 Consent to Participation in Medical Research

The form of consent required in connection with medical research conducted at Children's Hospital Oakland shall be approved by the Institutional Review Board.

## 8.8 Refusal to Consent to Treatment

Whenever the patient or minor patient's legal representative refuses to consent to any recommended medical treatment or procedure, the attending practitioner is responsible for advising that person of all material risks and potential consequences of which a reasonable person would wish to be informed in deciding to decline treatment. This responsibility applies to refusal of simple or common procedures (e.g., blood tests) as well as the refusal of more complex procedures. The attending practitioner is responsible for ensuring documentation in the patient's chart of both the facts of the refusal and that appropriate advice was given. In the case of refusal to consent to treatment of a minor or a pregnant patient where the survival of the minor or fetus is at issue, it may be advisable to petition a court to authorize treatment. In such instances, practitioners should consult with the CEO or his designee concerning the appropriate course.

## 8.9 California Hospital Association (CHA) Consent Manual

Except as otherwise specified in these Rules and Regulations, practitioners may refer to the California Hospital Association's Consent Manual for general guidance in matters related to patient consent.

## 8.10 Duration of Consent Form Validity

A consent form is valid as long as the patient's condition does not change and the surgery or procedure remains the same. Special care should be taken to review those consents that were obtained more than one month prior to the proposed surgery or procedure. However, there are no strict rules governing how far in advance of the procedure a consent discussion can occur. As a general rule; however, the discussion should occur, with sufficient time allowed for the patient, parent and/or legal decision maker, to consider his/her decision. Several weeks may not be unreasonable, provided the patient's condition has not changed, and the nature of the risks and benefits remains the same.

## 8.11 Blood Transfusion Policy

The most recently approved Blood Transfusion Policy of CHRCO is located in the IPM, Policy 20.1.A Blood Transfusion Guidelines: General Transfusion Guidelines.

## 8.12 Consent to Blood Transfusion for Medical or Surgical Procedure

8.12-1. Whenever there is a reasonable possibility, as determined by a physician or surgeon, that a blood transfusion may be necessary as a result of a medical or surgical procedure, a physician, by means of a standardized written summary as most recently developed or revised by the

State Department of Health Services, shall inform the patient of the positive and negative aspects of receiving autologous blood and directed and nondirected homologous blood from volunteers. For purposes of this section, the term "autologous blood" includes, but is not limited to, pre-donation, intraoperative autologous transfusion, plasmapheresis, and hemodilution. This consent will be valid for the duration of the hospitalization, or if the patient has a chronic condition, for one year.

8.12-2 The physician shall note on the patient's medical record that the standardized written summary was given to the patient.

8.12-3 8.12-1 and 8.12-2 shall not apply when medical contraindications or a life threatening emergency exists. Until such time as the Department of Health develops a written consent form, members of the Medical Staff shall evidence an informed consent either by a note on the medical chart to this effect or by obtaining the patient's signature on a hospital form developed for this purpose.

8.12-4 When there is no life threatening emergency and there are no medical contraindications, the physician shall allow adequate time prior to surgery for predonation to occur, unless the patient waives this requirement. Waiver should be documented in writing.

## 8.13 Unanticipated Outcomes

The responsible licensed independent practitioner, generally the Attending Physician, must clearly explain the outcomes of any treatment or procedure to the patient, and family, including whenever the outcomes differ significantly from anticipated outcomes. Refer to IPM Policy 3.3 Communication, Recognition and Disclosure of Unanticipated or Adverse Medical Event's and/Or Outcomes.

# SECTION 9 Consultation

## 9.1 Responsibility of the Attending Physician

Only the Attending Physician or his designee may request a consultation on his patient. It is the requesting practitioner's obligation to ensure that the consultant is made aware of the request and all pertinent patient information. Consultations must be documented by an order in the Electronic Medical Record.

## 9.2 Critical Care Consultation

All patients admitted to the ICU or Monitored Care Unit require mandatory consultation by a member of the Critical Care Division.

## 9.3 Psychiatric Consultation for Suicidal Patients

9.3-1. For patients who are emotionally ill, who become emotionally ill while in the Hospital, or who suffer the results of alcoholism or drug abuse, psychiatric consultation is strongly recommended as part of the treatment plan while at CHRCO.

9.3-1 Psychiatric consultations must be offered within twenty four (24) hours to all patients who attempt suicide while in CHRCO or who are admitted primarily for having attempted suicide. If such consultation is rejected by the patient of majority age or by the patient's legal representative, such rejection must be documented in the patient's chart. All practitioners shall follow the Standing Order for Suicidal Patients (IPM 19.2 Suicide Risk Assessment and Patient Management)

## 9.4 Responsibility of Nursing Staff to Suggest Consultation

If a nurse believes that consultation is needed and is not being requested, he shall notify the Nurse Manager who shall refer the matter to the Medical Director. The Medical Director at his discretion, takes the appropriate action or refers the matter to the Medical Staff President.

## 9.5 Medical Director's/Medical Staff President's Right to Require Consultation

The Medical Director or Medical Staff President shall have the right to require consultation when deemed necessary for the patient's best interest.

## 9.6 Consultation Coverage by Medical Staff Members

9.6-1 Consultation coverage includes availability to the Emergency Department, Urgent care Clinic and all Hospital inpatient units.

9.6-2 It is the responsibility of the Director of each Division, or in the case of Pathology, Radiology and Anesthesiology, the Department Chairs, to provide an accurate monthly on-call list of practitioners who shall be available both during regular business hours, Monday through Friday from 8 a.m. to 5 p.m., after hours 5 p.m. to 8 a.m., and on weekends and holidays. Copies of the list should be given to the Medical Staff Office, Telecommunications, the Emergency Department and the Chief Medical Officers Office by the 15th day of the preceding month.

9.6-3 All members of the Division/Department with Active and Courtesy Staff membership may participate in providing consultation (call) coverage. In addition, Provisional Staff members, with unsupervised privileges, in accordance with the Medical Staff Bylaws, section 3.7-1, may participate in providing call coverage with the approval of the Division Chief and/or Department Chair. In Divisions/Departments with three or more members, call coverage is to be a shared responsibility mutually agreed upon with the Division Director or Department Chair. Disputes over the call schedule will be decided by the Department Chair whose decision will be binding. For Diagnostic Imaging and Pathology, disputes will be resolved by the Medical Staff President.

9.6-4 For Divisions with only one or two members, after hours and weekend call coverage is subject to a joint decision by the Medical Director and Medical Staff President.

9.6-5 Any changes to the on-call list requires written notification of both Telecommunication and the Emergency Department at least 24 hours prior to the change.

9.8-6 Call lists, including any changes, shall be retrieved from Telecommunications at the end of each month and stored in the Telecommunications Department for a period of six years.

## 9.7 Emergency Department Consultations

9.7-1 Before a consultant is called, the Emergency Room Attending Physician must have seen the patient and determined that the call to the consultant is both appropriate and necessary.

9.7-2 Response to the Emergency Department shall be within one hour. Failure to respond within a one hour time period will result in a call to the Division Director or Department Chair. It will be the responsibility of the Division Director or Department Chair to make immediate provisions for call coverage if the on-call physician cannot be reached, and to investigate the reason for the delay. This investigation should be summarized in writing and copies sent to the Medical Director and Medical Staff President.

9.7-3 In the event of a disagreement between the Emergency Department Attending Physician and the consultant as to the necessity of coming to the Hospital to see the patient to rule in or out an emergency medical condition, or to provide a specialized treatment with which the treating physician is unfamiliar, it is the responsibility of the consultant to see the patient as requested by the treating physician.

9.7-4 Under the federal Emergency Medical Treatment and Active Labor Law, it is the responsibility of the Emergency Department Attending Physician to report to any receiving facility the name and address of the consultant who was unavailable or refused to come in, if the result of such unavailability or refusal results in transfer of the patient to another facility. The Emergency Department Physician will notify the Medical Director or his designee prior to commencing such a transfer.

9.7-5 It is the responsibility of the Emergency Department Attending Physician to clearly document on-call notification and arrival times in the patient's medical history.

9.7-6 As per Section 4.1 of the Rules and Regulations, care by any on-call consultant shall be provided in an entirely non-discriminatory manner including providing care to adults as needed until a safe and proper transfer can be executed to an adult facility.

9.7-7 The consultant shall record his findings and conclusions in the patient's chart within twenty-four (24) hour or prior to surgery, whichever occurs first. Counter signature of a resident's note fulfills this obligation so long as there is adequate documentation of participation in the assessment and decision making process.

## 9.8 Inpatient Consultation

9.8-1 Intensive Care Unit consultations must be done on the day requested, unless requested as urgent or emergent by the ICU Attending. Under such circumstances, the patient should be seen within one hour.

9.8-2 All other inpatient consultations must be done within twenty-four (24) hours and the findings and recommendations recorded in the chart or prior to surgery, whichever comes first. Counter signature of a resident's note fulfills this obligation so long as there is adequate documentation of participation in the assessment and decision making process.

9.8-3 When, after a reasonable effort or a lapse of a prescribed response time for a consultation, the on- call Medical Staff member has not responded to the consultation request, the requesting Medical Staff member will contact the Division Director to resolve the issue. If the Division Director cannot be reached, the Department Chair will be contacted.

## 9.9 Outside Consultants

Practitioners who are not members of the Medical Staff may be called into consultation provided that they have been granted temporary privileges under Sections 6.1 and 6.4 of the Bylaws.

# SECTION 10 Diagnostics

## 10.1. Required Laboratory Tests

10.1-1 Inpatient Admissions

All patients, medical and surgical, admitted to the inpatient service shall have appropriate screening tests, based on the needs of the patient, accomplished and recorded not more than seventy-two (72) hours prior to admission.

## 10.2 Tissues and Specimens Removed at Surgery

10.2-1 Requirement for Submitting Specimens for Pathological Examination

All tissue, specimens and foreign bodies removed at surgery must be submitted to Pathology for examination (California Code of Regulations – Title 22).

10.2-2 Specimens For Gross Examination Only

Some surgical pathology specimens may require gross examination only with the diagnosis based upon the gross examination. By mutual agreement with the Department of Surgery, these would include:

1. Foreskin if "Gross Examination Only" is stated on the requisition sheet, and if grossly normal on inspection.
2. Ear and shunt tubes.
3. Pins, beads, and other foreign bodies.
4. Some scars and keloids, if "Gross Examination Only" is stated on the requisition sheet.
5. Teeth
6. Bone chips, ligaments and cartilage, if "Gross Examination Only" is stated on the requisition sheet.
7. Extra digits.
8. Bullets and knife blades (save).
9. Tonsils and adenoids, unless grossly abnormal
10. Umbilical hernia sacs, unless grossly suggestive of vitelline duct remnant or other gross abnormality.
11. Inguinal hernia sacs.
12. Ureter and ureteropelvic junction segments.
13. Aortic coarctation segments.
14. Cardiac atrial septal resections
15. Cardiac endomyocardial subvalvular obstruction resections.
16. Skin: scars, burn debridement, or trauma debridement.

However, any of these may be prepared for microscopic examination at the discretion of the pathologist when unusual features may be evident.

10.2-3 All tissues or specimens removed surgically shall be accompanied by the following:

1. Patient's name and medial record number;
2. Date;
3. Surgeon's name;
4. Attending physician's name, if different from surgeon;
5. Preoperative or clinical diagnosis.

10.2-4 Referral of Specimens To Outside Pathology Departments or Laboratories

When special studies are required, which cannot be performed at Children's Hospital, or when contract arrangements require specimens to be examined at other laboratories, the pathology department or clinical laboratory will forward the specimen with appropriate requisition and clinical information to the reference pathology department or laboratory. This occurrence will be documented in the patient's medical record. For any specimens leaving the hospital for evaluation, or any other purpose, an entry shall be maintained in the Department of Pathology including:

1. The patient's name and medical record number or specimen accession number;
2. Date specimen sent;
3. Reference department or laboratory to whom specimen has been sent;
4. Type of specimen;
5. Date of receipt of reference department or laboratory report.

A report of the findings from the outside pathology department or laboratory will be entered in the patient's medical record.

## 10.3 Radiology; Use of C-Arm Fluoroscope

10.3-1 Permitted Use

The C-Arm Fluoroscope may only be used by (or under the direct supervision of) a physician holding a valid California Department of Health X-ray Supervisor and Operator Certificate. Technicians and residents may use the machine under the direct supervision of an appropriately certified physician.

10.3-2 Permitted/Prohibited Locations for Use

The C-Arm Fluoroscope may only be used in one of the surgical suites. A small, low-dose, portable C- arm fluoroscope (Flouroscan) may be used in other locations.

10.3-3 List of Certified Physicians and Surgeons

A list of physicians and surgeons who have a valid California Department of Health X-ray Supervisor and Operator Certificate shall be maintained in the surgical suite and in the Department of Diagnostic Imaging. Copies of the certificates shall be maintained in the Department of Diagnostic Imaging.

# SECTION 11 Medical Records

## 11.1 Medical Record Documentation

Only Medical Staff members, Allied Health professionals, and employees authorized by the Hospital to be professionally involved in the patient's care may make entries into the medical record. The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its content shall be pertinent, accurate, timely and current so as to ensure the coordination of patient care with other practitioners.

Documentation in the medical record should be entered as close to the date and time of the care, treatment and/or services were provided. This does not preclude a change in documentation including diagnosis and/or procedure at a later date if additional information becomes available warranting a change. Exception: the Caregiver Controlled Analgesia Communication Tool may also be included in the Medical Record. This tool documents critical assessments and administration of analgesia by authorized non-employees-nonprofessional caregivers as part of the Hematology/Oncology/BMT Interdisciplinary Caregiver Controlled Analgesia Protocol.

All documentation, including but not limited to the history and physical exam, progress notes, consult notes, orders and discharge summaries must be completed in the Electronic Medical Record.

In order to ensure patient safety, all medical staff members with privileges, allied health professionals and employees authorized by the hospital to be professionally involved in patient care must undergo training in the use of the EMR. This training will be provided by the hospital. Prior or concurrent training at another institution does not substitute for this training requirement. Training will be based on the provider's role and use. The training requirements will be determined by the hospital. A competency exam will be given at the completion of training. A passing grade is required prior to granting any patient care privileges and for access to the hospital EMR system. All patient care privileges require Electronic Medical Record training and a passing grade on the competency exam. In addition, computer system security training provided by the hospital is required as assigned on an annual basis. Verified training at another similar institution approved by the hospital may be accepted. A passing grade is required to maintain access to the hospital network and EMR.

At the time of implementation of any new Electronic Medical Record system or any significant changes in the current system, all current staff must undergo new user training and successfully complete the required competency exam to maintain their privileges. Failure to complete training and pass the exam will result in suspension of privileges at the time the system is implemented.

## 11.2 Patient Identification for Medical Record and Content of the record

11.2-1 Identification sheet to include but not be limited to the following patient information:

- Name, Address, identification number
- Hospital number
- Social Security number
- Medicare number
- Medical number
- Age
- Sex
- Marital Status
- Religious preference
- Date and time of arrival
- Date and time of departure
- Name, address and telephone number of person or agency responsible for the patient
- Name of patient's medical staff member responsible for care
- Initial diagnostic impression
- Discharge or final diagnosis
- Disposition for Inpatient admission

The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. For patients seen in the inpatient or outpatient surgical settings, the Electronic Medical Record will contain at least the following elements, if applicable for Inpatient, Observation and Outpatient Surgery

11.2-2 Content of Medical record:

A. A medical record shall be maintained for every patient receiving care. Care and examination of every patient will be performed by a licensed practitioner whose scope of licensure permits prior to discharge. For Inpatient, Observation, Outpatient Surgery and other Outpatient services the medical record should include but not limited to the following documents:

1. Medical History and Physical Examination: Chief complaint, history of the present illness, immunization record, screening tests, allergy information, nutritional evaluation, neonatal and medical history, review of systems, past surgical history, home medications, family history, social history, vitals, physical examination report, labs, imaging, assessment, active problems and plan,

2. Psychiatric history and physical examination

3. Legal authorization for admission, all consent forms including informed operative consent

4. Consultation reports, including neurologic examination

5. Order sheet including medication, treatment and diet orders

6. Treatment plan

7. Progress notes to include current or working diagnosis, the complaints of others regarding the patient, as well as the patient's comments.

8. Nurse's notes shall include but not be limited to the following-concise and accurate record of nursing care provided, record of pertinent observation of the patient and the response to treatment, name, dosage and time of administration of medications and treatment. Route of administration and site of injection shall be recorded, if other than by oral administration.

9. Record of type of restraint, including time of application and removal

10. Vital sign sheet, including weight record

11. Reports of all laboratory tests performed

12. Reports of all X-ray examinations performed

13. Clinical notes including dates and time of the visits

14. Treatment and instructions including notations of written prescriptions, diet instructions (if applicable), self –care instructions,

15. Records of preoperative and postoperative instructions.

16. Operative report on outpatient surgery and any surgery cases should include preoperative and post-operative diagnosis, surgeon name, date of surgery/procedure, anesthesiologist name, type of anesthesia, indications for procedure, description of findings, techniques used, description of procedure, tissue removed or altered, if applicable and estimated blood loss.

17. Anesthesia record including preoperative diagnosis, if anesthesia is administered

18. Pathology report, if tissue or body fluid was removed

19. Clinical data from other providers

20. Referral information from other agencies

21. The delivery of all anatomical parts, tissues and foreign objects removed to a designated pathologist and a report of findings to be filed in the patient's medical record

22. Written preoperative instructions to patients covering: applicable restrictions upon food and drugs before surgery, any special preparations to be made by the patient, any postoperative requirements, an understanding that admission to the hospital may be required in the event of an unforeseen circumstance.

23. Labor record and delivery record if applicable.

24. Discharge Summary for Inpatient visit to briefly recapitulate the significant findings and events of the patient's hospitalization, the patient's condition on discharge and the recommendation and arrangements for future care.

B. Medical Records Include diagnostic imaging, Pathology Slides, Physiologic Recordings & Videotapes: Unless otherwise expressly stated, the term "medical record(s)," as used in this Section, also includes diagnostic imaging, pathology slides, physiologic recordings, photographs and videotapes.

C. For purposes related to patient care and treatment medical record documentation will be created and stored in the hospital information system (Epic). Medical record documentation that is created, finalized and authenticated in other electronic record systems must be interfaced and uploaded into Epic.

D. Paper documentation may be used for downtime or in situations of extreme emergency, such as code or trauma resuscitation. Such records will be scanned and added to the patient's EMR record. The Medical Records Committee will review such documentation on a regular basis and report abuse of this provision to the Medical Executive Committee and Department Chair.

## 11.3 Access to and Removal of Medical Records

Medical information and records are the property of Children's Hospital & Research Center Oakland (Children's) and are maintained to serve the patient, the health care providers and the institution. In general, access to the patient's medical record is limited to those engaged in that patient's care. All use and disclosure of medical information shall be carried out with strict adherence to pertinent regulations, accreditation standards and organizational policies. Paper medical records may be transported to other Children's locations to facilitate coordination of patient care in accordance with organizational policy. Medical records shall not be taken, provided or released in any way from Children's for any other reason, except in response to court order, subpoena or statute. Medical Staff may access patient records from off-site locations through EMR functionality. Such access must meet all patient privacy provisions and legal requirements.

## 11.4 Legibility and Authentication of Entries

11.4-1. Definitions:

A. Authentication: The author of each entry must be identified by name and discipline and sign, date and time his or her entry

B. Countersigning: The medical staff rules and regulations define which entries in the medical record by house staff or non physicians require countersigning by supervisory or attending medical staff members. These entries must be signed by the supervisory or attending medical staff member in addition to the author of the entry.

11.4-2 All entries must be legible and complete, and must be authenticated, dated and timed promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. Legibility of name and discipline/credential may be established by stamp, printing, EMR secure log-in or an identification number.

11.4-3 Authentication may include signatures, written initials or electronic signature.

11.4-4 Countersigning Entries:

A. The attending staff physician is responsible for countersigning the following entries when such entries are made by a member of a residency program:

1. History and physical examination
2. Consultation Report
3. Operative or Procedure Report

B. Discharge and transfer summaries may be completed by the resident but require authentication by the attending physician or his designee.

C. See also Section 11.6

## 11.5 Abbreviations

11.5-1. Abbreviation should be clear and concise and understandable in the context being used.

11.5-2 Abbreviations appearing on the "Unacceptable Abbreviations" list, below, cannot be used in the medical record.

| Do Not Use: | Replace with: |
|---|---|
| **IU** | International unit, Int. unit or Intl. unit. |
| **U** | Unit |
| **Q.D.** | Every day or daily |
| **Q.O.D.** | Every other day or Q other day |
| **Trailing zero (X.0)** | X. mg—(Never write a zero by itself after a decimal point.) |
| **Lack of Leading zero (.X)** | 0.X mg—(Always use a zero before a decimal point ) |
| **MS** | Morphine |
| **MSO4** | Morphine sulfate |
| **MgSO4** | Magnesium sulfate |
| **µg (for microgram)** | Microgram |
| **T.I.W.** | Three times a week or 3x per week |
| **AS/AD/AU** | Right ear, left ear, each ear or both ears |
| **Cc** | Ml or milliliters |

11.5-3 Medication names cannot be abbreviated in the physician orders.

11.5-4 Diagnosis(es) cannot be abbreviated in the Diagnosis section of the Discharge Summary.

11.5-5 Procedures cannot be abbreviated in the Procedure section of the Discharge Summary except where the procedure name is commonly abbreviated. Examples include, but are not limited to CT, MRI, EKG, EEG.

## 11.6 DOCUMENTATION REQUIREMENTS: Inpatient, Observation, Outpatient Surgery are located in the Medical Staff Bylaws Section 17.1.

## 11.7 DOCUMENTATION REQUIREMENTS: Ambulatory (Outpatient Primary Care & Subspecialty Care) are located in the Medical Staff Bylaws Section 17.2.

## 11.8 Record Completion

It is highly desirable that medical records be completed at the time of the patient's discharge. Medical records should be completed, including signatures, within fourteen (14) days of discharge. Medical records are considered delinquent if they are not completed within the timeliness requirement of the specific assigned deficiency or 14 days of discharge or outpatient service date whichever is sooner.

The supervising practitioner, usually the attending physician, becomes responsible for completing deficiencies when a resident assigned to this responsibility fails to complete a portion of the record within 14 days of discharge.

Disputes arising about assignment of the Attending Physician are referred to the Chairman of the Medical Records Committee or, in his/her absence, his/her designee. The Chairman of the Medical Records Committee has the final authority to determine assignment of the Attending Physician.

11.8-1. Timeliness of Record Completion

| Documentation Item | Requirement | Delinquency |
|---|---|---|
| History & Physical (H&P)<br>or Consultation (If used as H&P) | • To be completed within 24 hours of admission.<br>• Surgical H&Ps are to be completed prior to the procedure except for emergency cases | Delinquent after 14-days post discharge. |

| | | |
|---|---|---|
| Operative Report | • Detailed and definitive operative report to be completed within 24 hours procedure/procedure | Delinquent if not completed within 24-hours of the procedure/operation |
| Discharge Summary | • To be completed as part of the patient's discharge process. | Delinquent after 14-days post discharge. |
| Ambulatory Encounters | • To be completed upon conclusion of the encounter | Delinquent after 14-days post conclusion of the encounter |
| Other record deficiencies or questions that impact legal medical record keeping and/or correct coding assignment | • To be completed within 7-days of deficiency assignment.. | Delinquent after 14-days post |

11.8-2 Notification of Incomplete Records: The Health Information Management Department (HIM) is given the responsibility for notifying physicians, residents and Allied Health Professionals about incomplete medical records, for both inpatient and ambulatory records.

The physician, resident or Allied Health Professional will receive notification about delinquent medical records from the HIM Department via inbasket notification in the electronic medical records system in the "Hospital Chart Completion" folder. This process is monitored by the HIM Committee. If the provider has delinquencies after three or more notifications, he or she may be required to attend the next Medical Executive Committee meeting. A provider invited to the Medical Executive Committee due to delinquent records will be expected to explain the reason for the unresolved delinquencies, and present a plan for completion of those and all future Medical Records in a timely manner. The Medical Executive Committee will have the discretion and authority to determine further actions needed for each provider. The further action may include, but not be limited to, suspensions, and FPPE (In accordance with Rules and Regulations section 25,) up to and including other corrective action as described in the Medical Staff Bylaws Articles 7 and 8.

A. Adjustments may be made for a physician, resident or Allied Health Professional who notifies the Health Information Management Department of an absence due to vacation, education leave, illness, or leave of absence.

B. This system is managed by the Health Information Management Department with oversight from the Medical Records Committee.

11.8-3 Grounds for corrective action for Failure to Complete Records

A. medical record is incomplete and correction action may occur in accordance with the table in 11.8-1: Timeliness of Record Completion.

B. The attending physician or provider will be responsible for the completion of records of his/her patients.

C. It is the responsibility of the Medical Staff Division chief of the clinical service to see that medical records are completed by members of their departments according to the established departmental guidelines and policies.

# SECTION 12 Orders

## 12.1 Policy and Purpose

The purpose of these rules is to provide an accurate and consistent format for computer generated written and verbal physicians' orders which is consistent with legal requirements.

## 12.2 Responsibilities of the Practitioner

All orders for patient care are to be in entered in the EMR and electronically signed. Exceptions will be made in emergency situations.

## 12.3 General Categories of Orders

12.3-1. Computer Generated Orders

Practitioners must be logged into the computer with their own log-in and password. Orders entered using the order entry system must be validated by reentering the practitioner's password.

12.3-2 Verbal Orders

A. Physicians' Orders shall be transmitted orally only to a Registered Nurse (RN), an authorized Respiratory Care Practitioner (RCP), a Registered Pharmacist, (RPh), a Physician's Assistant, (PA), a Clinical Laboratory Scientist (CLS), or a Registered Dietitian (RD), in those circumstances described below. The verbal order must be transcribed into the EMR by the RN, RCP, PA, RPh, CLS, or RD who accepted it and must include the following:
   1. Date and Time;
   2. Practitioner's Name;
   3. Registered person's name taking the order

B. The verbal order must be repeated back to the practitioner to insure accuracy.

C. Verbal orders shall be accepted only when failure to do so would be detrimental to patient care and shall not be routine practice.

D. Verbal orders must be signed , timed, and dated either by the ordering physician, the physician covering his practice, or an attending physician directly involved in the care of the patient as soon as possible and always within forty-eight (48) hours of their issuance. Verbal orders may also be signed by the covering senior resident.

E. Verbal orders for medications may only be received and recorded by a registered nurse or licensed pharmacist, or in the case of respiratory medications only, by Respiratory Care Practitioners (RCPs).

F. The only RCP's who are authorized to accept verbal orders from physicians are qualified regular CHRCO RCP's approved by the Respiratory Care Department Director. These RCP's can only accept orders for respiratory care procedures, respiratory treatments, respiratory medications, and ventilator settings. The RCP is responsible for:
1. Transcribing the order onto the order sheet in the patient's chart;
2. Carrying out the order; and
3. Informing the patient's nurse about the procedure performed pursuant to the order.

G. Licensed Medical Technologists can accept verbal orders only for lab work or blood products. The verbal order must be followed by a formal note in the EMR.

H. Registered Dieticians may accept verbal orders only for nutrition consultation and all forms of enteral nutrition. They may not take verbal orders regarding parenteral nutrition or vitamin and mineral supplements.

I. The verbal order must be repeated back to the practitioner to ensure accuracy.

12.3-3 Automatic Stop Orders

Orders that are automatically discontinued in accordance with the policy must be rewritten to be continued.

A. Transfer of patient location or responsibility. All prior orders shall be automatically discontinued:
1. After surgery;
2. Upon transfer of a patient to a new unit where the patient will receive a different intensity of care (e.g. transfer from ICU to one of the floors); or
3. Upon transfer of attending responsibility for the patient from one physician within a division to another physician within another division.

B. The following medications must be reordered every twenty-four (24) hours:
1. Parenteral Nutrition
2. Intravenous lipids

C. All other medications as well as intravenous solutions must be re-recorded or discontinued every seven days. Medications ordered with a specific stop date less than one week later need not be reordered before that stop date.

D. All renewed orders must be reentered or reauthorized through the EMR Med. Reconciliation process.

12.3-4 No Code Orders

All No Code orders must adhere to End of Life Care Policy (IPM Policy 5.2)

## 12.4 Standard Procedure for Writing Orders

Except in emergency situations or during EMR downtime, all orders will be entered directly into the EMR. During emergency situations or during EMR Downtime, the following rules will apply:

12.4-1 All orders must include the date, time, practitioner's signature and patient's identifications. If the patient's nameplate cannot be used, at minimum, the patient's full name and medical record number must be written on the order form.

12.4-2 All handwritten orders must be written in ink with blue or black ballpoint pens.

12.4-3 Each new series of orders must be written in an unused section of the order sheet.

12.4-4 Admission Orders must include the attending practitioner's name, patient's weight, diagnosis and known allergies.

12.4-5 Abbreviations: Refer to Section 11 of these Rules and Regulations. There are no exceptions.

12.4-6 The metric system is the approved system of measurement.

12.4-7 Canceling and/or changing orders:

A. An order is canceled by writing a new order canceling the specific item to be discontinued.

B. To change or modify an order, you must cancel the previous order and then write a new order. If you are modifying a part of an order, write the entire order to avoid confusion (as in IV fluid orders).

C. Errors:

1. When an error is made in writing an order, the writer must draw a line through the order, write "mistaken entry," list the date and time, and initial it rewrite the complete correct order.
7. Do not erase or write over the error because such corrections are not legible on the copies.
8. When an error is made while placing an order, the order should be corrected in the EHR.

12.4-8 Hold orders are not permitted. Discontinue the order and re-write it as appropriate. Cancel the order and rewrite it as appropriate.

12.4-9 The RN, RCP, RPh, PA, CLS, or RD shall ask for clarification of any order which seems unclear. They may request re-writing of any unclear physician's orders.

12.4-10 Orders for medications for a parent must be written on an outpatient prescription form. They shall not be written on the child's chart.

## 12.5 Requirements for Specific Orders

12.5-1. Medications

Requirements and format for prescriptions, including inpatient chart orders and controlled substances:

A. All physician orders for medications must contain the following components:
  1. Date and time of order
  2. Name of medication
  3. Dose in appropriate units. It is recommended that the amount per kilogram or amount per meter-squared is given when appropriate. A zero (0) must be written before decimals less than 1, such as 0.9 rather than .9. Trailing zeros after the decimal point must be omitted, such that 1.0 will be written as 1.
  4. Dose ranges are not acceptable.
  5. Route of administration
  6. Schedule of frequency of administration: Frequency ranges are not acceptable.
  7. Signature or computer authentication by physician.
  8. Patient name plate information

B. Digoxin:
All inpatient orders for Digoxin must be done using the Digoxin-specific computer medication order entry screen. Free text entries would not be acceptable.

C. Potassium Chloride:
All inpatient orders for Potassium Chloride must be done using the Potassium Chloride-specific computerized medication order entry screen. Free text entries would not be acceptable.

D. Chemotherapy Drugs:
Must include the patient's height, weight, and surface area. All initial chemotherapy plans must be signed by an attending oncologist. Orders for continuous chemotherapy following an attending's road map may be signed by an NP or PA working under the approved Standardized Procedure.

E. Procedural Sedation: See IPM 16.10 for the Sedation Policy

F. PRN medications: must specify clinical indications.

A. Source of medications: Inpatients shall receive only medications dispensed by the CHRCO Pharmacy, unless specifically ordered by the physician.

B. Take-Home medications: Each take-home medication requires a physician's order. The labeling of each such medication shall indicate, by notation of specific dosage, quantity and directions for use, that it meets all the legal requirements of regular prescriptions.

C. Formulary or Approved Medications: There shall be a formulary of medications approved by the Pharmacy and Therapeutics Committee and the Executive Committee of the Medical Staff. The Pharmacy and Therapeutics Committee shall review these medications at least annually. All suggested changes require approval by the Executive Committee. The most recently approved formulary shall be on file in the Pharmacy.

D. Use of Unlisted Medications: Any desired medication not on the approved formulary (see subsection (I), above) shall require approval of Pharmacist on duty. Disagreements will be referred to the administrator on call. A non-formulary request form must be signed by the attending practitioner before the medication is dispensed. The Pharmacy and Therapeutics Committee will review all such requests monthly. This committee will report any inappropriate uses of non- formulary medications to the Executive Committee and the practitioner's Division or Department Chief, as appropriate.

E. Use of Experimental Medications: Experimental medications shall not be used without prior written approval of the Institutional Review Board (IRB). Emergency use shall be subject to consultation with the Chairperson of the IRB. In the absence of the Chairperson, any of the following may be substituted: the Chair of the Department, the President of the Medical Staff, or the Medical Director. Experimental medications shall be so designated on the order sheet.

F. New Uses of Drugs: When orders for medication require a dosage, route or frequency that conflict or are not supported by references available to the nursing unit/pharmacy staff, the prescribing physician will be required to document the rationale for the order in the progress note.

The practitioner who prescribes a drug is responsible for deciding which drug and dosing regimen the patient will receive and for what purpose.

a. This decision should be made on the basis of the information contained in the drugs labeling (when available) or other data available to the prescriber.

b. The use of a drug, whether off or on label, should be based on sound scientific evidence, expert medical judgement, or published literature whenever possible

c. Off label use is neither incorrect nor investigational if based on sound scientific evidence, expert medical judgement, or published literature.

d. The attending of record must write or cosign any such order.

(Note Reference: Policy Statement: Off label Use of Drugs in Children, AAP)

M. Medication Brought from Home: All medication administered to patients must be issued by the CHRCO Pharmacy. Medications from home may only be used when the medication is not available in the Hospital in a timely manner. Orders for such medications must explicitly state to dispense the medication brought from home.

If the medication from home cannot be identified by a pharmacist, it will not be dispensed, and the ordering physician will be called to discuss alternative medications. Non-allopathic remedies must be ordered using the Medication Brought from Home Policy. (IPM: Medication Management 13.1c)

Medications brought by or with the patient to the hospital shall not be administered to the patient unless all of the following conditions are met:

a. the drugs have been ordered by a person lawfully authorized to give such an order and the order entered in the patient's medical record
b. the medication containers are clearly and properly labeled.
c. the contents of the containers have been examined and positively identified, after arrival at the hospital by the patient's physician or the hospital pharmacist.

N. No drugs supplied by the hospital shall be taken from the hospital unless a prescription or medical record order has been written for the medication and the medication has been properly labeled and prepared by the pharmacist in accordance with state and federal laws, for use outside the hospital.

12.5-2 Titration Orders

Titration orders are defined as orders for a dose adjustment (increase or decrease) of the medication in response to the patient's clinical status.

Titration orders must include a description of the desired physiologic state the prescriber desires for the patient. Specific drug dosage adjustment increments must be stated.
For titrated medications: Orders must include all five elements listed below:
Initial Dose or rate

A. Dose adjustment increments
B. Time interval(s) for evaluation, adjustment of dose, and re-evaluation
C. Maximum (minimum) dose
D. Patient response or goal;

Example – "Dopamine – start at 140 mcg [2 mcg/kg/min]; increase/decrease at 1 mcg/kg/min every 20 minutes until blood pressure equals systolic greater than 90 mmHg or 10 micrograms per kilogram per minute is reached."

12.5-3 Taper Orders

Taper orders are orders where the dose of medications is the progressive decrease in dose or frequency of a medication by established increments. Tapering is predicated on patient improvement or stabilization. If the order states “wean” this is considered Tapering of Medication.

A. Initial Dose
B. Incremental dose
C. Time interval for incremental dose
D. This order must include all the elements of an order plus the duration for each order and the start date of the first order.

12.5-4 Therapeutic Duplication Orders

Therapeutic duplication is the practice of prescribing multiple medications for the same indication without a clear distinction of when one agent should be administered over another – for example, pain, nausea and vomiting, and constipation. If multiple medications from the same therapeutic class are ordered, each medication must include a specific indication or include criteria for which medication to administer first, second, third, etc.

Orders for multiple pain medications:

Orders which include different multiple medication for pain will be specific the level of pain

A. Mild pain: Pain rated as 1 to 3.
B. Moderate pain: Pain rated as 4 to 6.
C. Severe pain: Pain rated as 7 to 10.

Orders for multiple antiemetic medications:

Orders which include multiple antiemetic medications will include what medication is to be administered first. Effectiveness of the antiemetic must be documented prior to administering the next ordered choice.

12.5-5 Standing Orders

Standing orders for drugs may be used for specified patents when authorized by a person licensed to prescribe. A copy of standing orders for a specific patient shall be dated, promptly signed by the prescriber and included in the patient's medical record. These standing orders shall:

A. Specify the circumstances under which the drug is to be administered.
B. Specify the types of medical conditions of patients for whom the standing orders are intended.
C. Be initially approved by the pharmacy and therapeutics committee and be reviewed at least annually by that committee.

D. Be specific as to the drug, dosage, route and frequency of administration.

12.5-6. Fluid Orders

Orders for intravenous fluids, blood products and parenteral nutrition orders must contain the following components:

Solution to be administered.

A. Rate in ml/hour, with total volume specified if known. For continuously infused medications, dosage must be specified in appropriate units per unit time, or kilogram per unit time.
B. Orders for medications or electrolytes to be added to an ongoing IV should follow the medication format with special emphasis on the volume of IV fluid in which the medication is placed and the rate of administration.
C. When changes are made in IV solutions, the IV order must be completely rewritten.
D. Orders for specific fluid intake should include the route.
E. IV solution orders must be rewritten every week as described in the automatic stop order section 12.3-3.
F. IV narcotic orders for continuous or intermittent infusion must contain: dilution, rate of infusion, continuous/intermittent, and parameters for vital signs. Initial orders for Patient Controlled Analgesic (PCA) devices shall always be shall be written on the standard PCA Order Set. Generally all patients on PCA will be on the Pain Service with orders written by an anesthesiologist or a Pediatric Nurse Practitioner (PNP) or Physician Assistant (PA) supervised by an anesthesiologist with two exceptions:
    1. Hematology/Oncology patients who are not immediate post-operative may have PCA orders written by Hematology/Oncology attendings, fellows, or residents.
    2. Patients admitted to the PICU who are not on the Pain Service and may have PCA orders written by the PICU attendings, fellows, and residents.

12.5-7 Blood Product Orders

Blood product orders must be entered using the Blood Product Order Set and include:
A. Type of blood product.
B. Any special preparation (e.g. washed cells).
C. Amount and rate of administration.
D. Indication for transfusion.

12.5-8 Treatment and Procedures Performed by the Nurse

A. Indicate procedure to be performed
B. Indicate solutions and equipment to be used (especially if there is only one specific material which you want to be used).
C. Indicate frequency of treatment.

12.5-9 Diagnostic tests
A. Indicate test to be obtained.
B. Indicate date and time of test.

C. Indicate any preparations required.

12.5-10 Restraints and Seclusion (See Restraint Management Protocol: Located on the Novell Drive within Patient Management Protocols)

A. Patients shall be placed in restraint only on the written order of the physician. This order shall:
1. be patient, episode and time specific;
2. specify the starting and ending times; and shall include:
3. the reason for restraining; and
4. type of restraint to be used.

B. In an emergent situation, if a physician is not available to issue a restraint order, restraint use can be initiated by a registered nurse after he completes an appropriate assessment of the patient. A verbal order from a physician can be accepted but the physician must see the patient within one (1) hour and sign the order.

12.5-11 Ordering High Risk Infant Formulas

High risk infant formulas must be ordered using the Computerized Order Entry System.

12.5-12 Ordering of Drugs and Devices for Advanced Practice Providers

NP's and PA's may prescribe in accordance with the Ordering of Drugs and Devises Standardized Procedure for Advanced Practice Providers, and if granted the privilege to do so. It is understood that no medications will be ordered outside of the scope of the AHP's specialty area. Exceptions to prescribing medications included on the hospital drug formulary will be noted and acknowledged by both the AHP provider and the delegated supervisor on the privilege request form. Any exceptions will be available for review by provider, on the privilege portal.

# SECTION 13 Departmental Rules, Procedures and Policies

Departments and Divisions may develop rules, procedures, policies, and privilege request forms concerning matters of particular interest to the Department or Division. These rules, procedures, policies and privilege request forms may contain criteria for the granting of privileges within the Department or Division. Such rules, procedures, and policies shall be effective when incorporated into the Medical Staff Rules and Regulations.

## 13.1 Policy and Procedures of the Department of Surgery

13.1-1. Pre- and Post operative: Documentation Requirements

All Operative and procedure documentation requirements are described in Section 11 of the Rules and Regulations.

A. Consent to Surgery: Refer to Section 8 of these Rules and Regulations.

B. Dental or Podiatric Surgery
Prior to any dental or podiatric surgery performed in the Children's Hospital operating room, there must be a history and physical exam by a physician member of the Medical Staff, or nurse practitioner credentialed in histories and physicals by the Interdisciplinary Practice Committee, recorded in the patient's chart. Obtaining such a record is the responsibility of the operating dentist or podiatrist.

C. Pathological Examinations
Tissues or other material removed at the operation shall be sent to the pathologist for examination.

13.1-2 Assistant Surgeon Requirements

The use of an assistant surgeon will be determined by the attending surgeon or division chief on a case by case basis, while adhering to existing law or standard of care. Safety of the patient is always paramount. A surgeon undertaking a complex procedure should have a qualified assistant.

13.1-3 Temporary Privileges for Assisting Practitioners

Temporary Privileges must be requested and approved for all surgical practitioners and assistants who are not members of Children's Hospital and Research Center at Oakland (see Bylaws Article 5.5).

13.1-4 Policy and Procedure for Procedural Sedation (Refer to IPM Policy 16.10 Procedural Sedation)

13.1-5 Transfusion Policy is available as a separate policy.(See Policy IPM 20.0)

# SECTION 14 Infection Control

## 14.1 Annual Review of Plan and Protocols

The Infection Control Plan and protocols shall be reviewed at least annually by the Infection Control Committee. Suggested changes require approval of the Executive Committee of the Medical Staff.

## 14.2 Current Infection Control Plan and Protocols

Copies of the plan and protocols shall reflect the most recently approved version and shall be available at the Medical Staff Office and at all applicable nursing and special care units in their respective policies and procedures books.

# SECTION 15 Emergency Services

## 15.1 Policies and Procedures

A copy of the current policies and procedures of the Emergency Department, as approved by the Executive Committee and the Board of Directors of CHRCO shall be available to interested staff members from the Chief of the Division of Emergency Medicine.

## 15.2 On-Call Specialty Coverage

It shall be the responsibility of the Chief of each Division within each Department to provide a list of members of the Medical Staff in their subspecialty who will be available on an on-call basis to provide emergency back-up coverage for patients. Response time either by telephone or in person to a request for consultation by the attending physician in the Emergency Department shall be no longer than one hour. Coverage by Medical Divisions with only one member is subject to review by the Hospital Medical Director and the Chief of the Division of Emergency Medicine.

## 15.3 Medical Screening Exam

It is the duty of the hospital, including the Emergency Department to provide a medical screening examination for each patient who comes to the hospital seeking emergency care for any medical or surgical condition. The purpose of the Medical Screening Exam is to determine if an Emergency Medical Condition exists. An emergency medical condition is defined as any serious illness or injury including active labor or psychiatric/substance abuse.

15.3-1 The Medical Screening Exam shall be performed by qualified medical personnel. Qualified medical personnel include physician members of the Medical Staff; Resident Physicians under

the direct supervision of the Attending Physician in the Emergency Department; and physician assistants, nurse practitioners, registered nurses or others functioning under standardized procedures approved by the Interdisciplinary Practice Committee.

15.3-2 The scope of a Medical Screening Exam depends on the patient's presenting symptoms. The exam may include any lab test, x-ray, procedure or consultation deemed necessary by the examining provider to exclude an Emergency Medical Condition.

15.3-3 If an Emergency Medical Condition is found, it is the duty of the provider to undertake the care, treatment and surgery, if determined to be necessary, to relieve or eliminate the Emergency Medical Condition within the capability of the facility. In the event of the lack of hospital capability or capacity to relieve the emergency medical condition, the

Emergency Department or any other Hospital clinic will attempt to stabilize and then safely transfer the patient to an appropriate facility using an appropriate level of transport and completing formal transfer paperwork as required by EMTALA

15.3-4 It is acceptable for a Medical Screening Exam initiated by the Emergency Department to be completed by a specialist or other physician in contiguous areas of the Hospital so long as there is appropriate communication between the physicians in the two areas.

## 15.4 Transfer of Patients

Members of the Medical Staff when arranging an inter-facility transfer from the Hospital Emergency Department, or any other Hospital clinic will comply with the Hospital's policy (IPM Policy 16.3 Patient Flow Policy) regarding the transfer of patients, and with the Medical Staff Rules and Regulations Section 6, Admission, Discharge and Transfer of Patient

# SECTION 16 Allied Health Professionals

GUIDELINES FOR ELIGIBILITY AND APPOINTMENTS

## 16.1 Allied Health Professional Status

Allied Health Professionals include all non-physicians with specialized training in the healing arts. Such individuals may be appointed by the Governing Body to Allied Health Professional status. Appointment to Allied Health Professional status shall confer on the appointee only such rights and clinical privileges as granted by the process outlined in these Guidelines.

## 16.2 Requirements for Appointment to Allied Health Professional Status

16.2-1 No Allied Health Professional shall provide patient care as an Allied Health Professional until fully credentialed and approved by the Board of Directors.

16.2-2 The applicant must possess any and all certificates or current licenses which are required under the laws of the State of California for his/her professional field.

16.2-3 The applicant will have in force professional liability insurance. The limits of which shall be subject to the approval of the Hospital Risk Manager but will not exceed the limits required for physician members of the Medial Staff. The limits set by the Hospital Risk Manager will be subject to approval by the Medical Staff Executive Committee and the Governing Body.

16.2-4 The applicant must be sponsored or supervised by one or more active members of the Medical Staff. If a Division has less than three (3) Active Staff members, and if there is approval of the Division Chief and Department Chairman, a Courtesy Staff member can be a sponsor or supervisor. The sponsor or supervisor is responsible for integrating the applicants practice activities into the Hospital Quality Assurance program.

16.2-5 The applicant must have submitted a completed application on a form provided by the Medical Staff Services Department, along with any information and supporting materials requested demonstrating that he or she meets the criteria for appointment with the privileges requested.

The application must be supported by a minimum of two references. One must come from the sponsor or supervisor and one from a licensed physician, member of the Allied Health Professional's category, or fully trained professional in the appropriate field, who is familiar with the applicant's professional work and demonstrated competency.

16.2-6 The applicant must agree to strictly abide by the Principles of Medical Ethics of the American Medical Association, and any other appropriate Code of Ethics insofar as applicable to his or her profession. The applicant must agree to be bound by these Guidelines, by all other applicable Rules and Regulations of Children's Hospital and Research Center at Oakland and its Medical Staff, and by all applicable local, state and federal laws and standards.

16.2-7 The applicant must complete EMR Training and successfully complete the required competency exam(s).

## 16.3 Appointment Process

16.3-1 The credentialing and privileging process for appointment to Allied Health Professional status is outlined below:

A. Dentists, psychologists and podiatrists will be credentialed and privileged through the Medical Staff pathway.

B. All other healing arts practitioners requesting clinical privileges will be credentialed and privileged by the Interdisciplinary Practice Committee subject to the approval of the Medical Staff Executive Committee and the Governing Body.

C. Applications for an appointment to Allied Health Professional status are obtained from the Medical Staff Office and upon completion are submitted to that office.

D. Once the application is complete, the Medical Staff Services Department will perform the credentials verification process for both Hospital and non-Hospital employees.

E. Upon completion of the credentials verification process the application will be submitted to the Interdisciplinary Practice Committee for review. The Interdisciplinary Practice Committee will review all pertinent information, including protocols and recommendations of a Department or Division, and then make a recommendation to the Medical Staff Executive Committee. At the next regular meeting after receiving the Interdisciplinary Practice Committee recommendation, the Medical Staff Executive Committee shall either make a recommendation to the Governing Body, recommend a period of observation (Section 16.6 below) or alternatively, defer action for further investigation and/or consideration of specific questions by the Interdisciplinary Practice Committee. If the recommendation of the Medical Staff Executive Committee includes any of the “Grounds for Review” contained in Section 16.10-1 of these Guidelines, the Allied Health Professional shall be notified of the recommendation and shall be afforded the opportunity to request review under Section 16.10-1 below. The Governing Body shall not act on the matter until the Allied Health Professional has waived or exhausted his review rights.

F. The Governing Body’s decision on the application shall constitute the final action of the Hospital. If the Governing Body’s decision includes a “Grounds for Review” as defined in Section 16.10-1 below and the Allied Health Professional has not previously been afforded the right to review as described in Section 16.10 below, the Governing Body shall offer the Allied Health Professional a reconsideration process generally patterned after that process described in Section 16.10 below.

## 16.4 Duties and Prerogatives

An Allied Health Professional shall be expected to perform his/her professional tasks in a manner which exhibits a standard of care which is acceptable to the Hospital, its Medical Staff and those having responsibility for the activities of the Allied Health Professional. In addition, an Allied Health Professional shall comply with these Guidelines, with all other applicable rules of the Children's Hospital and Research Center at Oakland and its Medical Staff, and with all applicable local, state and federal laws and standards.

16.4-2 Prerogatives

Upon appointment, an Allied Health Professional may perform in the Hospital those tasks for which the Allied Health Professional has been privileged according to these Guidelines, provided that a physician who is a current member in good standing of the Medical Staff shall retain the ultimate responsibility for the patients care.

## 16.5 Expansion of Privileges, Reappointment and Corrective Action

16.5-1 Expansion of Privileges

Any request to expand existing privileges or add new privileges must be submitted to the Interdisciplinary Practice Committee. The process will follow that outlined in Sections 16.3 (E) and 16.3 (F) above.

16.5-2 Reappointment

Each Allied Health Professional shall be subject to continuing performance review by the sponsoring Medical Staff Department or Division. On a biannual basis each Allied Health Professional shall apply for reappointment. Reappointment will be based on performance review. The reappointment process will follow Sections 16.3 (C), 16.3 (D), 16.3 (E) and 16.3 (F) above.

16.5-3 Corrective Action

The Allied Health Professional may be subject to corrective action as follows:

A. After considering a recommendation from any of the following – the Interdisciplinary Practice Committee, the President of the Medical Staff, the Department/Division Chief, or the Chief Executive Officer – the Medical Staff Executive Committee may recommend to the Governing Body the restriction, suspension, or termination of the privileges or status of an Allied Health Professional. The Allied Health Professional shall have the right to obtain a review of such recommendation, as set forth in Section 14.10 below.

B. In the event immediate action is necessary to prevent harm to any person or to forestall an immediate threat to the operations of the Hospital, the Medical Staff Executive Committee, the Interdisciplinary Practice Committee, the President of the Medical Staff,

the Chief Executive Officer or the Governing Body may summarily suspend or restrict the privileges of the Allied Health Professional. Such action to take effect immediately.

The Medical Staff Executive Committee must be notified of the suspension within two weeks of its next regularly scheduled meeting to allow for its placement on the agenda. The Committee shall have the authority to continue, modify, or terminate the restriction. In the event the Medial Staff Executive Committee decides to continue the restriction, the Allied Health Professional shall have the right to obtain review under Section 14.10 below. The restriction shall remain in effect pending any such review.

C. At the appropriate juncture, the matter shall be forwarded to the Governing Body for final decision.

## 16.6 Observation

16.6-1 The Medical Staff Executive Committee, the Interdisciplinary Practice Committee, the appropriate Department or Division Chief, the President of the Medical Staff, or the Governing Body shall have the authority at any time to require that an Allied Health Professional be subject to a period of observation, to last as long as deemed appropriate, and shall have the authority to adopt any rules or procedures considered necessary to implement this requirement.

16.6-2 Observation may consist of any of the methods customarily used at hospitals, including concurrent or retrospective chart review, proctoring, or the requirement of consultation. However, a single individual, “the observer”, will be responsible for submitting in writing to the body requesting the period of observation the results of that observation.

16.6-3 The observer shall be a member in good standing of the Medical Staff who exercises appropriate clinical privileges. The observer shall not be a Medical Staff member who sponsors or supervises the Allied Health Professional under Section 16.2 (C) above.

## 16.7 Relationship to Medical Staff

Because they are not Medical Staff members, Allied Health Professionals shall not be entitled to vote on Medical Staff matters, nor shall they be required to pay Medical Staff dues or to satisfy any Medical Staff attendance requirements. They shall, however, be expected to attend and participate actively in the clinical meetings of their respective medical staff Departments/Divisions to the extent requested by the Department/Division Chief.

## 16.8 Confidentiality

Allied Health Professionals shall at all times respect the confidentiality of patient and Medical Staff information obtained in the course of their practice at the Hospital, and shall, in addition, abide by any written rules or policies pertaining to the confidentiality of Medical Staff committee information, proceedings, and records.

## 16.9 Informed Consent

The Allied Health Professional shall comply with all Hospital and Medical Staff rules applicable to informed consent.

## 16.10 Review Procedure

16.10-1 Grounds for Review

An Allied Health Professional shall be given the opportunity to have any of the following actions reviewed as described below, before it becomes final and effective (except for a summary suspension– Section 16.5-3, B, above - which shall be effective immediately):

A. Denial of an application for appointment or reappointment to Allied Health Professional status;
B. Denial of a request for initial or additional privileges;
C. Reduction in existing privileges (except temporary privileges – Section 16.13 below)
D. Suspension or expulsion from Allied Health Professional status.

16.10-2 No Grounds for Review

Notwithstanding Section 16.10-1, above, an Allied Health Professional shall have no right to obtain review in the following instances:

A. When an application is denied because it is incomplete;
B. When the action is taken because the physician who is required by law and by these Guidelines to act as the sponsor or supervisor of the Allied Health Professional has lost or withdrawn such sponsorship or supervision, or has lost or resigned his/her Medical Staff membership or necessary privileges;
C When the action is taken because of the existence of a contractual, employment, or other relationship between the Hospital and one or more Allied Health Professionals in the affected category which limits the number of Allied Health Professionals in that class who may practice at the Hospital.

16.10-3 Request for Review

To obtain review, the Allied Health Professional must submit a written request to the Chief Executive Officer of the Hospital. Such request must be received within fourteen (14) days of the notice to the Allied Health Professional that his/her application and/or privileges have been denied or reduced. If the Allied Health Professional does not request review in this manner, he/she shall be deemed to have waived any review rights.

16.10-4 Notice of Hearing

Review shall be in the form of a hearing before a panel, to be selected in accordance with Section 16.10-6, below. Within a reasonable time in advance of the hearing, the Chief Executive Officer shall give the Allied Health Professional written notice of the time and date of the hearing and a

written summary of the reasons for the action. If possible, this summary should include reference to representative patient care situations or to relevant events.

16.10-5 Composition of Panel

The hearing shall be before an ad hoc panel consisting of at least three (3) persons appointed by the Medical Staff Executive Committee. The Executive Committee shall ensure that panel members have not participated earlier in the formal consideration of the case. The Executive Committee shall designate one member of the panel as its chairperson and may include an Allied Health Professional in the appropriate category as a panel member.

16.10-6 Conduct of Hearing

The panel shall have discretion about how to conduct the hearing, subject to the rules provided in these Guidelines. The panel shall consult with the Hospital administration prior to making major decisions regarding the conduct of the hearing. The person or entity responsible for the action or recommendation shall have the opportunity to present evidence in the presence of the Allied Health Professional, and the Allied Health Professional shall have the opportunity to present evidence in rebuttal. Evidence presented may include documentary or physical evidence or testimony by witnesses. Each party shall have the opportunity to cross-examine adverse witnesses. The panel shall determine the order in which the evidence is presented and the relevance or appropriateness of the evidence offered. Formal rules of evidence shall not apply. The panel shall permit any evidence, which in its view is relevant and which reasonable persons are accustomed to rely upon in the conduct of serious affairs. The panel may in its discretion allow both sides to be represented by legal counsel. The panel itself may choose to be advised by legal counsel, who may also serve as a hearing officer, without regard to whether the parties are represented by counsel.

16.10-7 Record of Hearing

The panel shall maintain a record of the hearing by means of a tape recording or a certified shorthand reporter. The parties shall bear equally the costs of the appearance of the certified shorthand reporter. The party requesting the original of the transcript shall bear the cost of the preparation of the transcript.

16.10-8 Decision of Panel

Within fourteen (14) days of the conclusion of the hearing, the panel shall decide, on the basis of the evidence presented at the hearing, whether to affirm, modify, or overturn the action that led to the hearing. The panel shall uphold the action unless it finds that it was arbitrary and unreasonable. The panel shall render its decision in writing.

16.10-9 Final Decision

The decision shall be forwarded to the Governing Body. The Governing Body shall decide whether to affirm, modify, or overturn the decision of the panel. The decision of the Governing Body shall be the final decision of the Hospital.

## 16.11 Individual Categories – Requirements and Scope of Practice

Each applicant for or appointee to Allied Health Professional status shall abide by all additional requirements and restrictions pertinent to his/her individual category.

## 16.12 Approval for adding a new AHP Category

16.12-1 A request may be made to the IDPC Committee by the Department to add an AHP Category.

16.12-2 In order to be considered for approval, the request for approval for a new AHP category must at least include:

A. The education, training and experience criteria required for individual AHP's applying to be admitted to the category
B. A copy of the scope of practice and/or Job Description, approved by the Department/Section
C. A written plan for monitoring performance of the AHP, including specific criteria to be monitored and the frequency of the monitoring.
D. Plan for appropriate oversight of the AHP.
E. Explanation of proposed role of AHP staff approved in this category within the organization and anticipated initial number of applicants who may initially be applying for this category.

The IDPC will review the request and a recommendation for approval or denial of the AHP category

16.12-2 Once the IDPC Approves the category, the fully vetted proposal, including the plan for professional practice oversight and competencies will be submitted to the MEC for further review and approval. The MEC may or may not request that the sponsoring Medical Staff Member attend the MEC to provide any clarifications regarding the category.

The MEC will review the recommendation of the IDPC and forward any affirmative recommendations to the Board of Directors.

16.12-3 The Board of Directors will review the MEC recommendation and render a decision.

16.12-4 A new AHP provider may not request Allied Health Professional Status until the new category has been approved by the Board of Directors.

## 16.13 Temporary Privileges

16.13-1. The Chief Executive Officer, upon the recommendation of the Department or Division Chief and any supervising physician, may grant an Allied Health Professional temporary privileges if he/she

submits a completed application for Allied Health Professional privileges and, in addition, presents satisfactory evidence of licensure, compliance with any other conditions for exercising the privileges requested, including professional liability insurance coverage, and sufficient additional information concerning the ability to exercise the privileges requested. Temporary privileges may be granted in any of the following circumstances:

A. Temporary privileges may be granted upon preliminary review of an application for initial appointment to Allied Health Professional status, to last as long as the application is pending.

B. Temporary privileges may be granted for the care of a specific patient in the Hospital, up to a maximum limit of one (1) patient in any calendar year.

16.13-2 An Allied Health Professional who is granted temporary privileges shall be subject to observation by a member or members of the Medical Staff.

16.13-3 The Chief Executive Officer or the Medical Staff President may at any time terminate an Allied Health Professional’s temporary privileges.

16.13-4 Except as may be otherwise explicitly required by California law, an Allied Health Professional shall not be entitled to any of the review rights set forth in these Rules and Regulations in the event that a request for temporary privileges are denied or terminated.

16.13-5 The applicant must complete EMR training and successfully complete the required competency exam.

# SECTION 17 Utilization Review

## 17.1 Development and Review of Plan

A utilization review plan shall be developed and reviewed at least annually by the Utilization Management Committee. The original plan and revisions require approval of the Executive Committee of the Medical Staff.

## 17.2 Current Utilization Review Plan

The most recently approved revision of the CHRCO Utilization Review Plan is found in the Interdisciplinary Policy Manual, Policy number 21.2.

# SECTION 18 Performance Improvement

## 18.1 Annual Review of Plan

The Performance Improvement Plan shall be reviewed at least annually by the Continuous Quality Improvement Committee. Recommended changes require approval by the Executive Committee and the Governing Body.

## 18.2 Current Performance Improvement Plan

The current Performance Improvement Plan is located in the Interdisciplinary Policy Manual Policy number 16.7.

## 18.3 Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE)

The current Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) Policy is located in Section 25 of these Rules and Regulations. The Professional Practice Oversight Committee (See section 23.4-16) provides oversight to and monitors the OPPE/Peer Review processes.

## 18.4 Medical Staff Disruptive Behavior Policy/Procedure

The current Professional Conduct Policy is located in Section 27 of these Rules and Regulations.

## 18.5 Patient Safety Program

The current Patient Safety Program is located in the Interdisciplinary Policy Manual Policy Number 16.6

# SECTION 19 Impaired Physician Policy

## 19.1 Report

19.1-1. If a hospital employee or Medical Staff member has reason to believe that a medical staff member may be impaired, due to substance abuse, mental or physical illness, or any condition rendering the member incapable of giving appropriate care to patients, he must report such concern to the President of the Medical Staff or the Chairperson of the Medical Staff Well-Being Committee. The report should state the facts that led to the suspicions. The Medical Staff President and the Well-Being Committee Chair should all be made aware of all such reports. The report should be reduced to writing and contents thereof affirmed by the person originally making the report, though failure of the person to reduce the report to writing shall not preclude appropriate action taken in the matter under the Bylaws or these Rules & Regulations. The identification of the reporting person shall be kept confidential, and shall not be disclosed to the person about whom the report pertains unless otherwise required by law. However, nothing shall preclude the Medical Staff President from investigating and/or taking appropriate action to protect patient safety and quality of care.

19.1-2 A Member of the Medical Staff who recognizes he has a behavioral, substance abuse, or other problem which may be impairing his ability to care for patients or get along acceptably with co-workers should report himself to the Chair of the Medical Staff Well-Being Committee.

## 19.2 Intervention Process

19.2-1 For either 19.1-1 or 19.1-2, The Chair or designee shall discuss the matter thoroughly with the Member to obtain as much information as possible. The Chair of the Committee, or his designee, shall report immediately to the President of the Medical Staff, or if unavailable, another Medical Staff Officer or the Executive Committee, all facts which he or any member of the Committee discovers, or which are conveyed to the Committee in any report or complaint it receives (whether written or verbal), about a Medical Staff member that indicates the Member is

A. providing unsafe treatment,

B. engaging in conduct or behavior such that the physical or psychological well-being of patients or any other person in the hospital may become threatened, or

C. suffering from an impairment or other condition which is likely to cause the Member to be unable to safely perform the privileges he has been granted, or otherwise causes the Member to present an unreasonable risk of harm to patients or others.

The President shall take all necessary steps to protect patients as provided in the Medical Staff Bylaws. If it is determined that no report need be made about the Member as set forth above, the Chair of the Medical Staff Well-being Committee shall then immediately report the referral to the Medical Staff Well-Being Committee, and the Committee shall investigate the matter further as necessary. The Committee may require the medical staff member, as appropriate, to obtain for the Committee's review any physical or psychological evaluation(s) to determine the degree and nature of any impairment or other problem. The Committee may



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utilize any appropriate consultants internal or external to the hospital to accomplish this goal. The report of the evaluation(s) shall be transmitted in confidence by the Committee.

19.2-2 If, based on the Committee's evaluation, the Committee determines the medical staff member is impaired but does not pose a threat of danger to patients, the Committee may require the medical staff member to obtain any and all necessary treatment, therapy and or rehabilitation, and shall monitor the member's progress therein, including arranging for random urine samples or other appropriate testing. The Committee shall report to the MEC the fact that it is monitoring the progress of a Medical Staff Member, giving only general information, and without identifying the person who has self-referred, unless the Committee Chair deems it appropriate to do otherwise under the circumstances. The Committee shall include such information in every regular report to the MEC thereafter as long as it continues to monitor the progress of the Member.

19.2-3 If, based on the evaluative reports, the Committee determines that the medical staff member may pose a threat of danger to patients, all information and evaluative report(s) shall be reported fully and immediately to the President of the Medical Staff to take any necessary corrective action to protect patients. Subsequently, the President shall report the case to the Medical Executive Committee sitting in Executive Session for any further investigation and corrective action authorized by MEC under the Medical Staff Bylaws.

19.2-4 Failure of the medical staff member under this subsection to cooperate with the Well-Being Committee at any time shall result in a full report by the Committee to the MEC for appropriate action.

19.2-5 In the case of a report under this section, the report should be discussed between the Medical Staff President and the Medical Staff Well-Being Committee Chair within 24 hours of receipt of the report. If after such discussion, an investigation of the matter is felt to be necessary, the Medical Staff Well-Being Committee may be directed to undertake it by the Medical Staff President.

19.2-6 The investigation of a report described under this section may:

A. Show there is clearly no merit to the report, or that the report is otherwise false or based on mistaken facts or impressions. In this case the report shall be expunged from any and all written and electronic files of both the hospital and medical staff, and immediately destroyed.

B. Show there is some merit to the report but not enough to warrant immediate action, or that the report cannot be substantiated one way or the other with any certainty.

19.2-7 The report shall be included in a confidential portion of the medical staff member's personnel file and the member's activities and practice shall be monitored until it can be established whether there is an impairment problem. The Medical Staff President and the Well-Being Committee Chair must meet with the member to inform him of this situation and the mechanism for further monitoring. The filer of the report should remain unknown to the member.

19.2-8 Well-Being Committee Chair must meet with the member to inform him of the results of the investigation. The filer of the report should remain unknown to the member. The report shall

be filed in a confidential portion of the credentials file, the member shall have full and appropriate provision of rights to notice of charges and opportunity for hearing as may otherwise be required by the Medical Staff Bylaws depending on the severity of the problem, the medical staff may:

A. Require the member to undertake a rehabilitation program or psychiatric therapy as a condition for continued appointment and privileges.
B. Require such program or therapy, and in addition impose appropriate and immediate restrictions on the member's practice.
C. Immediately suspend any or all of the member's privileges in the hospital until rehabilitation has been accomplished or the member has otherwise been certified to be fit for practice during the rehabilitation process.(In some cases, such as cognitive impairment due to untreatable disease, rehabilitation is not appropriate)

19.2-9 If at any time a member under this section continues practicing in the hospital or clinics and subsequently becomes unable to safely perform the privileges he or she has been granted, the appropriate corrective action shall be taken under the Medical Staff Bylaws.

19.2-10 If at any time a member under subsection 19.8-2 B or C of this section continues practicing in the hospital or clinics and fails to satisfy the requirements of any therapy or rehabilitative program, the matter must be reported immediately to the President of the Medical Staff for immediate corrective action as appropriate.

19.2-11. Regardless of any other provision in this Section 19 of the Rules & Regulations, if it is reasonably believed that a member is unable to safely exercise the privileges that he has been granted, or is otherwise engaging in behavior or conduct that violates policies of the medical staff or may post a threat to the physical or psychological well-being of patients or any other person in the hospital, the matter shall be reported immediately to the President of the Medical Staff for appropriate action.

19.2-12 The hospital and Medical Staff shall seek the advice of counsel to determine whether any conduct must be reported to law enforcement authorities or other government agencies.

19.2-13 The Medical Staff President should inform the individual who filed the report that follow up action was taken.

19.2-14 All reports, records, proceedings or other information generated or obtained by a medical staff member or other person in the course of supporting, implementing or enforcing the provisions of this section 19 are confidential and protected from compelled disclosure under the law. For that reason, section 4 : Confidentiality of Meetings and Meeting Records of these Rules and Regulations and section 12.1-9: Breach of Confidentiality of Peer Review Records of the Medical Staff Bylaws, and any other relevant provisions of the Medical Staff Bylaws, shall be enforced to protect the confidentiality of such information.

19.2-15 In the event there is an apparent or actual conflict between this policy and policies of the hospital or Medical Staff other than provisions of the Medical Staff Bylaws, the provisions of this section shall take precedence.

# SECTION 20 Mass Casualty Plan

## 20.1 Current Mass Casualty Plan

The plan set forth in the Disaster Manual for the care of mass casualties at the time of any major disaster is approved. Copies of the plan shall be available in the Emergency Room, the Office of the Medical Director, The Medical Staff Office, and every nursing and other major unit of the hospital.

## 20.2 Annual Review of Plan

The Mass Casualty Plan shall be reviewed at least annually and updated when necessary by the Disaster Committee. Any changes in the plan must be approved by the Executive Committee of the Medical Staff and the Board of Directors.

# SECTION 21 Medical Education

## 21.1 Commitment to Education

Incorporated into the mission statement of CHRCO is a commitment to medical education. This includes medical students, graduate medical training programs, pre and post doctoral training programs in psychology and the continuing medical education of the Medical Staff. For the purposes of this Section all educational activities involving medical students, residents, fellows and pre and post doctoral psychology trainees will be referred to as graduate medical education (GME).

## 21.2 Supervision of Medical Education

Administratively the designated Institutional Official (DIO) / Director of Graduate Medical Education and/or his designee is accountable for both the supervision and management of all GME programs. Accountability to the Governing Body for GME is through both the Hospital Chief Medical Officer and through the GME Committee of the Medical Staff reporting up through the Medical Staff Executive Committee. It is expected that the DIO/Director of Graduate Medical Education and/or his designee will report to the GME Committee and the Governing Body upon request, on the program content and needs, resident performance and evaluation, and the status of accreditation by the appropriate accrediting agencies.

## 21.3 Compliance with Medical Staff Rules and Regulations

Programs in GME shall not impose requirements which conflict with the Medical Staff Bylaws and Rules and Regulations.

## 21.4 Supervision of Trainees in GME Programs

21.4-1 The term "trainee" in GME refers collectively to medical students, residents, fellows and pre and post doctoral students in psychology.

21.4-2 All patients seen at or admitted to CHRCO will have a designated Attending Physician who is a member of the Medical Staff

21.4-3 Trainees may participate in the evaluation and/or management of patients at CHRCO but only under the supervision of and concurrence by the Attending Physician who is ultimately responsible for all decisions related to the patient's diagnostic and treatment plans, and outcomes.

21.4-4 Trainees must discuss the diagnostic and treatment plan with the attending physician at the time of admission and subsequently on a daily basis. Ideally, "discussion" will be by verbal communication but may, as circumstances dictate, be by entries into the Progress Note

section of the Medical Record. Any change in the diagnostic or treatment plan must be communicated to and be approved by the Attending Physician, unless a delay in intervention

might compromise the patient's course. Such changes and the subsequent approval should be documented in the patient's chart. Under such circumstances, the proposed changes must be discussed and approved by the appropriate senior resident who may consult with any available member of the Medical Staff. This applies to the time of admission as well.

21.4-5 Upon approval by the Attending Physician, a diagnostic procedure may be performed under the direct supervision of a senior resident or fellow who has documented competency in that procedure, or under the direct supervision of a Medical Staff member with privileges to perform that procedure.

21.4-6 Trainees may participate in the provision of consultative services but only under the supervision of a member of the Medical Staff with privileges in the consulting specialty or subspecialty. All consultations must be documented in the Medical Record and countersigned by the responsible Medical Staff member within 24 hours of the request or as otherwise specified in the Medical Staff Rules and Regulations.

## 21.5 Responsibilities of Documentation in the Medical Records.

21.5-1 Trainees assigned to participate in the care of a patient will be expected to document and incorporate into the patient's Medical Record all of the data elements required of an Attending Physician

21.5-2 Trainees assigned to participate in the care of a patient will be expected to document and incorporate into the patient's Medical Record all of the data elements required of an Attending Physician

21.5-3 Attending physicians involved in the supervision of trainees will comply with all of the provisions of the Medical Staff Rules and Regulations.

## 21.6 Demonstration of Competency by Trainees

21.6-1 The DIO/Director of Graduate Medical Education and/or his/her designee is responsible for evaluating the performance and academic progress of all trainees. Evaluation procedures must be in accordance with accreditation body standards. Trainees in CHRCO accredited programs will have a formal evaluation session in accordance to requirements set forth by the Accreditation Council of Graduate Medical Education (ACGME) and the GME Committee will be apprised of the results.

21.6-2 Procedure competencies for trainees will be developed by the specific training programs and in accordance with accreditation body standards. Until a trainee has been certified competent to perform a procedure, he must be supervised by a Medical Staff member credentialed to perform that procedure or by a senior resident or fellow with demonstrated competency in that procedure.

21.6-3 The GME Committee will be apprised of and have the opportunity to comment upon all decisions related to the matriculation of trainees in CHRCO accredited programs.

## 21.7 Quality of Care Provided by Trainees

The GME Committee will be apprised of all significant quality, performance and safety issues related to care provided by trainees.

## 21.8 Disciplinary Actions Involving Trainees

The GME Committee will be informed of, have the opportunity to comment upon, and become involved with as necessary, any disciplinary actions involving trainees.

## 21.9 Organization of the Hospital Units for Teaching Purposes

Hospital units, for the purposes of teaching, are organized into “teams”. Each team is supervised by an Attending Physician who is a member of the Active Medical Staff.

# SECTION 22 Fellowship Programs

## 22.1 Guidelines for Fellowship Program

22.1-1 All Fellowship Programs are the responsibility of the respective Medical Staff Division.

22.1-2 A Division wishing to establish a program will present to the Hospital Medical Director the reasons for doing so along with documentation that the division has the necessary resources to meet the requirements set forth by the American Council on Graduate Medical Education and the American Board of Pediatrics.

22.1-3 The Division Director and the Hospital Medical Director will present to the Graduate Medical Education Committee a formal request for approval of the fellowship program. This request will include written hospital administrative approval.

22.1-4 The Graduate Medical Education Committee will then send their recommendation to the Executive Committee for final approval.

22.1-5 All fellowship programs at CHRCO must abide by the following:

A. Meet all requirements set forth by the American Council on Graduate Medical Education and formally apply for accreditation;

B. Develop Hospital job descriptions for Fellows, which are reviewed and approved by the Medical Director;

C. Make every effort to adhere to the CHRCO salary scale and provide the same benefits given to the residents as the division's budget, including grants and other outside support, will allow;

D. Have a formal evaluation process in place with two feedback sessions a year for each Fellow. Performance Review and Criteria will be maintained in the Division in which the Fellowship was performed.

E. Adhere to the guidelines regarding working hours and working conditions for residents in the State of California; and

F. Use the Graduate Medical Education Committee as an Appeal Board when there are unresolved differences between a Fellow and the Director of the Fellowship Program.

G. Maintain records of Fellowships and the participants in said Fellowships. These records will be available in the Medical Education Department.

# SECTION 23 Medical Staff Committees

## 23.1 Committee Organization

The organization of Medical Staff Committees is defined in the Medical Staff Bylaws Section 12.1. Included therein are methods of appointment, numbers constituting a quorum, ex-officio members, minutes, policies and procedures, the use of consultants and issues surrounding confidentiality. With the exception of the Executive, Bylaws, Credentials and Joint Conference Committees, a description of each Medical Staff committee will be set forth in this Section of the Rules and Regulations. The description for each committee will include the composition, duties and meeting frequency and, when appropriate, subcommittee(s) and/or ad hoc committee(s) that have a reporting responsibility to the subject committee.

## 23.2 Committee Chairperson

Each Medical Staff Committee shall have a Chairperson (Chair) appointed annually by the Medical Staff President (Medical Staff Bylaws, Section 10.6-1). The duties of the Chair include but are not limited to the scheduling of meetings as prescribed in the Rules and Regulations of the Medical Staff; the preparation of the agenda for each meeting; the taking of attendance at the meeting; and the submission of minutes summarizing the business conducted. Approved minutes must be submitted to the Medical Staff Office for the purpose of maintaining a permanent record.

## 23.3 Committee Membership

Unless otherwise specified in the Medical Staff Bylaws, Committee members for each Medical Staff Committee shall be appointed annually by the Medical Staff President in consultation with the committee Chair (Medical Staff Bylaws, Article 10.6-1).

## 23.4 Committees of the Medical Staff

### 23.4-1 Executive Committee

Refer to Article 12, Section 12.2-1, of the Medical Staff Bylaws

### 23.4-2 Bylaws Committee

Refer to Article 12, Section 12.2-2, of the Medical Staff Bylaws

### 23.4-3 Credentials Committee

Refer to Article 12, Section 12.2-3, of the Medical Staff Bylaws

## 23.4-4 Joint Conference Committee

Refer to Article 12, Section 12.2-4, of the Medical Staff Bylaws

## 23.4-5 Continuing Medical Education Committee

A. Composition

This Committee shall consist of:

1. At least six (6) representatives from the Medical Staff from both the Departments of Medicine and Surgery
2. A Medical Staff member who is a current member of the Best Practice (or IQF) Committee
3. Chief Medical Officer and the Director of Graduate Medical Education
4. A Chair appointed by the President of the Medical Staff

B. Duties

This Committee will be responsible for:

1. Postgraduate medical education for the Medical Staff;
2. Continuing medical education for community practitioners;
3. Responding to continuing medical education needs identified through the quality improvement program;
4. Promotion of hospital-based physician subspecialty care.

C. Meeting Frequency

The Committee shall meet at least quarterly or more often if needed.

## 23.4-6 Diversity Awareness Committee

A. Composition

This Committee shall consist of:

1. At least eight (8) members of the Medical Staff representing the cultural diversity of that body.
2. At least two (2) Pediatric Residents
3. A Chair appointed by the President of the Medical Staff

B. Duties

1. To insure that the Medical Staff understands and appreciates the cultural differences of the population we serve.

2. To advise the - Chief Medical Officer and Administration on issues related to cultural diversity as they may impact on the mission of CHRCO.
3. To act in an advisory role to the Director of the Multicultural Program on issues related to both the educational goals and operation of that Program.
4. Additional responsibilities as may be assigned by the Executive Committee.

C. Meeting Frequency:

The Committee shall meet ad hoc or more often if needed.

### 23.4-7 Department of Diagnostic Imaging Professional Practice Review Committee

A. Composition:

This Committee shall consist of: Department members.
The Chairperson of the Committee shall be appointed by the Committee.

B. Duties:

The committee will perform multidisciplinary peer review for Department of Diagnostic Imaging as described in the Ongoing Professional Practice Evaluation and Peer Review Plan.

C. . Meeting Frequency:

The Committee shall meet upon request of the Executive Committee or the Chairperson of Department of Diagnostic Imaging or as needed for peer review (at least quarterly and as often as monthly).

### 23.4-8 Department of Pathology Professional Practice Review Committee

A. Composition:

This Committee shall consist of:
Department members
The Chairperson of Pathology will serve as Chair.

B. Duties:

The committee will perform multidisciplinary peer review for the Department of Pathology as described in the Ongoing Professional Practice Evaluation and Peer Review Plan.

C. Meeting Frequency:

The Committee shall meet upon request of the Executive Committee or the Chairperson of Department of Pathology or as needed for peer review (at least quarterly and as often as monthly).

### 23.4-9 Graduate Medical Education Committee

A. Composition

This Committee shall consist of:

1. The Chief Medical Officer
2. Director of Medical Education
3. Assistant Director of Medical Education
4. Directors or designee of subspecialty fellowship programs
5. The Director of Graduate Medical Education
6. At least five (5) members of the Medical Staff who are actively involved in the graduate medical education training program.
7. At least three (3) Pediatric Residents or Fellows
8. A Chair appointed by the President of the Medical Staff

B. Duties

1. The Committee shall serve as a forum in which communication between House Staff officers, Fellows and Fellowship Directors, the Medical Staff, the Director of Medical Education, the Medical Director and/or Administration shall be furthered
2. The Committee shall assist and advise the Director of Graduate Medical Education regarding issues impacting the education of the House Staff
3. The Committee shall have such other responsibilities as may be assigned to it by the Executive Committee
4. The Director of Medical Education provides oversight to the organization Graduate Medical Education (GME) Program. The GME Medical Director reports to the President and CEO. The GME Committee provides periodic report to the Medical Executive Committee (MEC). The program maintains accreditation through the ACGME. The Residency Program maintains policies, procedures, and files relating to the program.

C. Meeting Frequency

The Committee shall meet at least quarterly or more often if needed.

### 23.4-10 Infection Control Committee

A. Composition

This Multidisciplinary Committee shall consist of:

1. At least five (5) representatives of the Medical Staff
2. The Chief of the Division of Infectious Diseases and/or the Infection Control Officer,
3. The Nurse Epidemiologist certified in infection control
4. At least one (1) representative each from Hospital Administration, Employee Health and/or Safety, Clinical Laboratory, Nursing Services, Central Processing and Quality Improvement
5. A Chair appointed by the President of the Medical Staff

B. Duties

1. The Committee determines policies for the prevention of the transmission of infectious diseases to patients, employees, visitors and the community.
   a) These policies compose the hospital infection control manual which is distributed to all hospital departments including patient care areas. The Infection Control Manual is revised and updated every three years or as necessary.

2. The Committee evaluates monthly nosocomial infection reports and surveillance data at each meeting and recommends preventive measures. The Committee evaluates the investigation of exposures, outbreaks and unusual occurrences of infectious diseases and recommends appropriate control measures.

a) The Committee oversees the reports to the regulatory agencies such as the State and County Health departments of incidents and occurrences required by law.
3. The Committee provides expertise and guidance to the Nurse Epidemiologist which enhances the practice of infection control.
4. The Chairperson may institute appropriate emergency control measures or studies when it is reasonably perceived that an infectious disease danger exists to patients, personnel or the community.

B. Meeting Frequency

The Committee will meet no less than nine (9) times per year.

## 23.4-11 Interdisciplinary Practice Committee (IDPC)

The Interdisciplinary Practice Committee is established in accordance with Section 70706 of Title 22. Specifically, in any facility where registered nurses will perform functions requiring standardized procedures pursuant to Section 2725 of the Business and Professions Code, or in which licensed or certified healing arts professionals who are not members of the medical staff will be granted privileges pursuant to Section 70706.1 of Title 22, there shall be an Interdisciplinary Practice Committee established by and accountable to the Governing Body.

A. Composition

This Committee shall consist of:

1. The Vice President for Nursing and Clinical Support Services or his/her designee
2. An equal number of physicians and registered nurses.
3. Licensed or certified health professionals other than registered nurses who are performing or will perform functions described in Section 70706(a) of Title 22.
4. A Chair appointed by the President of the Medical Staff.

B. Duties

1. To oversee the practice of Allied Health Professionals at the Hospital
2. To develop formats for standardizing procedures
3. To establish policies and procedures for interdisciplinary medical practice
4. Additional responsibilities as may be assigned by the Executive Committee

Duties of the Committee may be further defined in the Allied Health Professional Guidelines set forth in the Rules and Regulations of Medical Staff (Section 14).

C. Meeting Frequency

The Committee shall meet at least quarterly or more often if needed.

## 23.4-12 Medical Ethics Committee

A. Composition

This Committee shall consist of:

1. At least six (6) members of the Medical Staff, including one (1) physician from the Division of Critical Care Medicine and one (1) from the Division of Neonatology
2. At least one (1) member from Nursing
3. At least one (1) member from Hospital Administration
4. At least one (1) member from the Department of Social Services
5. At least one (1) Pediatric Resident
6. A Chair appointed by the President of the Medical Staff

B. Duties

1. Provide consultation at the request of attending physicians and others regarding the appropriate treatment or management in cases involving seriously ill or terminal patients. When providing such consultation, the Committee shall utilize, as

needed, expert consultants in the fields of medicine, ethics and law. The Committee shall act in an advisory capacity only and its recommendations or suggestions are not binding.

2. Retrospectively review cases that raise bioethical issues in order to identify areas in which patient care may be improved.
3. Additional responsibilities as may be assigned by the Executive Committee.

C. Meeting Frequency

The Committee shall meet quarterly or more often if needed.

## 23.4-13 Medical Records Committee

A. Composition

This Committee shall consist of:

1. At least five (5) members of the Medical Staff
2. A representative from Nursing
3. A representative from the Medical Record Department
4. A Chair appointed by the President of the Medical Staff

B. Duties

1. Through review of a representative number of medical records, assure that medical records reflect the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient, and condition of the patient at discharge.
2. Monitor the timeliness with which members of the Staff complete medical records and recommend corrective action when warranted.
3. Periodically review the medical record and forms used therein and review and approve any changes in proposed new forms for the medical record.
4. Periodically review those rules and regulations pertaining to the medical record, including accepted abbreviations, and the confidentiality of the contents thereof, and as appropriate, recommend changes.
5. Additional responsibilities as may be assigned by the Executive Committee.
6. Provide oversight for the EMR and its use.

C. Meeting Frequency

The Committee shall meet at least quarterly or more often if needed.

## 23.4-14 OR Committee

A. Composition

The Co-Medical Directors of Perioperative Services shall serve as Co-Chairs of the OR Committee. The Division Chief of Surgery, Chair of the Department of of Anesthesia and Director of Surgical Services shall serve as members of the committee. Other members shall include but not limited to:

Representatives from Department of Surgery, Department of Anesthesia, Division of Orthopedics, Division of Neurosurgery, and Division of Gastroenterology, representative from Outpatient Surgery-Walnut Creek, Clinical Administrator Outpatient Surgery-Walnut Creek, Surgical Services Educator, PACU Assistant Head Nurse, OR Assistant Director, Nursing, Inpatient Surgical Nursing Manager, Operating Room Business
Manager/CPD and representative from Administration. In addition representatives from Finance and Planning and/or others may be invited to attend meetings as guests.

B. Oversight

The Operating Room Committee will report jointly through the Medical Staff and Hospital Administration.

C. Duties

The Committee is charged with responsibilities to recommend to the governing body (Medical Staff and Hospital Administration) steps to improve quality of care in the operating rooms, including safety, effectiveness, efficiency, and timeliness. In addition, the committee is charged with taking actions, when appropriate, to resolve issues in the operating rooms. Topics for committee review include, but are not limited to the following:

- Safety measures consistent with the National Patient Safety Goals, including Universal Protocol
- Development, implementation, and maintenance of policies promoting effective surgical care based on clinical evidence
- Efficiency in the use of space, staff, equipment, and other resources
- Timeliness in care to achieve the best possible patient satisfaction and outcome
- Utilization management
- Benchmarking
- Capital Expenditure recommendations, including the determination of emergency equipment and supplies in the OR
- Training and education of staff
- Organization of operating room services
- Oversight of the process of determining which procedures require as assistant surgeon or assistants to the surgeon. (Also see Rules and Regulations 13.1-2)

Day to day management of the operating rooms and block assignments are functions assigned to the Director of Surgical Services. The committee may advise the Director, but is not charged with these responsibilities.

D. Meeting Frequency

The Committee shall meet at least 10 times per year

## 23.4-15 Pharmacy and Therapeutics Committee

A. Composition

This Committee shall consist of:

1. At least five (5) members of the Medical Staff
2. A Chief Resident
3. One (1) member each from the Pharmacy, Nursing and Hospital Administration
4. Director of the Pharmacy
5. A Chair appointed by the President of the Medical Staff

B. Duties

This Committee shall be responsible for the development and surveillance of the pharmacy and therapeutic policies and practices, particularly drug utilization within CHRCO. The functions of this Committee include:

1. The review of the appropriateness, safety and effectiveness of prophylactic, empiric and therapeutic use of drugs, including antibiotics, through the analysis of individual or aggregate patterns of drug practices;
2. The development or approval of policies and procedures relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials;
3. The review of all significant untoward drug reactions; and
4. The maintenance of a formulary or drug list.
5. Provide oversight for medication utilization and the ordering process within the EMR.

Additional responsibilities as may be assigned by the Executive Committee.

C. Meeting Frequency
The Committee shall meet quarterly or more often if needed.

### 23.4-16 Professional Practice Oversight Committee

A. Composition

1. Medical Staff President
2. Medical Staff President-Elect
3. Department of Medicine Chair
4. Department of Surgery Chair
5. Department of Pathology Chair
6. Department of Radiology Chair
7. Department of Anesthesiology, Chair
8. Chief Medical Officer, non voting
9. Vice President, Medical Affairs, non-voting
10. Medical Director, Clinical Quality Improvement, non-voting

B. Duties

1. Provides oversight to and monitors the Ongoing Professional Practice Evaluation (OPPE)/ Peer Review

Processes. .

2. Reviews defined indicators and/or criteria of each clinical division at least annually and assures the OPPE process is criteria based. The process includes Departments and/or Divisions each identifying appropriate indicators/criteria to be used to evaluate practitioner specific clinical performance. Division Chiefs shall review performance indicators and reports annually.

3. Receives results of peer review/OPPE evaluation of each practitioner's professional practice evaluation completed by the clinical Department and/or Division at least every nine months.

4. Communicates any OPPE/peer review issues or concerns back to the Department Chair(s) and/or Division Chief(s) for review. This may also include praise and observations regarding practitioner specific clinical performance.

5. Monitors and may initiate Focused Professional Practice Evaluation (FPPE) processes in accordance with the Medical Staff Rules and Regulations.

6. Through OPPE and/or Focused Professional Practice Evaluation (FPPE) assures processes are in place within the Medical Staff structure to identify professional practice trends that may impact quality of care and patient safety.

7. Provides summary reports of OPPE and peer review activities to the Medical Executive Committee (MEC) at least quarterly.

8. Recommends relevant information obtained from OPPE be integrated into performance improvement activities.

9. Works with the Medical Staff President to insure that the Multidisciplinary Peer Review Committee is appointed annually. Provides oversight to the Multidisciplinary Peer Review Committee and receives periodic reports.

C. Meeting Frequency

At least quarterly or more often as needed.

### 23.4-17 Sedation Committee

The Sedation Committee is a multidisciplinary committee responsible for overseeing procedural sedation practice at CHRCO.

A. Composition

Chair- A member of the Department of Anesthesia in good standing shall chair the committee.

The members shall consist of:

1. A representative from each sedation location (Emergency Department, Diagnostic Imaging, Pulmonary Function Lab, Intensive Care Unit, Intensive Care Nursery, Cardiac Catheterization Lab/Cardiology, and the Operating Rooms), a Chief Pediatric Resident, and a representative from Quality Management.
2. Additional members shall serve at the discretion of the committee chair.

B. Duties

1. Develop and revise policy to meet Federal, State, and Accreditation organization requirements
2. Monitor sedation outcomes within the organization
3. Monitor compliance with policy
4. Maintain hospital-wide sedation database
5. Provide feedback to individual sedating locations on their performance

C. Meeting Frequency

This Committee shall meet biannually or more often if needed.

## 23.4-18 Radiation Safety Committee

A. Composition

This Committee shall consist of:

1. A Chair appointed by the President of the Medical Staff
2. The Radiation Safety Officer
3. A representative from Administration
4. A representative from Nursing
5. At least four (4) members of the Medical Staff who use radiation in their routine practice

B. Duties

1. Under the terms of the Radioactive Material License issued to Children's Hospital Oakland, the Radiation Safety Committee shall assure that the requirements for State licensure are satisfied and shall assure compliance with the policies and procedures established by the Radiation Safety Committee.
2. Additional responsibilities as may be assigned by the Executive Committee.

C. Meeting Frequency

This Committee shall meet at least annually or more often if needed.

## 23.4-19 Research Committee

A. Composition

This Committee shall consist of:

1. At least six (6) members of the Medical Staff
2. At least two (2) research scientists from the Children's Hospital Oakland Research Institute
3. Director of Research at Children's Hospital Oakland Research Institute
4. A Chair appointed by the President of the Medical Staff

B. Duties

1. This Committee shall review all clinical research projects to be performed at CHRCO, and shall report on said projects to the Executive Committee. These projects and projects involving human subjects must also be reviewed by the Institutional Review Board.
2. Additional responsibilities as may be assigned by the Executive Committee.

A. Meeting Frequency

This Committee shall meet quarterly or more often if needed.

### 23.4-20 Transfusion Committee

A. Composition

This Committee shall consist of:

1. At least five (5) members of the Medical Staff, including one (1) hematologist and one (1) pathologist
2. A Chair appointed by the President of the Medial Staff

B. Duties

This Committee shall be responsible for oversight, measurement and improvement of blood product utilization, especially as it pertains to patient safety. The review carried out by the Transfusion Committee shall include the following:

1. Monitoring the appropriate use of blood products
2. Evaluating actual and suspected transfusion reactions
3. Measuring the amount of blood products requested and amount used
4. Monitoring the effects of blood products on patients
5. Monitoring distribution and administration procedures for blood products.

When blood usage review consistently supports justification and appropriateness of blood product use, the review of an adequate sample of cases is acceptable.

The Committee will consider issues of transfusion safety and will promote safe transfusion practices. The Committee has the responsibility for developing and recommending policies to the Medical Staff to ensure appropriate, safe and cost-effective transfusion practices.

C. Meeting Frequency

The Committee shall meet at least quarterly or more often if needed.

## 23.4-21 Utilization Management Committee

A. Composition

The Utilization Management Committee shall consist of:

1. At least five (5) members of the Medical Staff, including representatives from both the Departments of Medicine and Surgery.
2. The Chief Operating Officer or his/her designee
3. Vice President for Nursing and Clinical Support Services
4. The Chief Medical Officer
5. Chief Financial Officer or his designee
6. A Chair appointed by the President of the Medical Staff

B. Duties

The Utilization Management Committee shall establish standards relating to the efficient delivery of quality care and shall monitor and attempt to promote adherence from the Medical Staff to such standards through the following measures.

1. It shall review the appropriateness of admissions to the Hospital, use of Hospital resources, and patient outcomes pertinent to specific Hospital admissions, and Clinical Practice Guidelines. Aggregate data for specific diagnoses and physician profiles utilization will be reviewed. The Committee also may conduct other reviews it deems appropriate using accepted methodologies to discharge this function.
2. The Committee shall be concerned that quality of care is not sacrificed for efficiency and, through those measures described herein and in the Utilization Management Plan, safeguard against over-utilization or under-utilization of hospital resources.
3. The Committee shall evaluate the necessity for continuing education in the area of utilization management. To the extent necessary, the Committee may conduct educational programs and require attendance by specified members of the Medical Staff who are experiencing difficulties in this area.
4. It shall be able to require the attendance of individual members of the Medical Staff at meetings of the Committee in the event the Committee determines that such attendance would be helpful in promoting the Committee's objectives.
5. Additional responsibilities as may be assigned by the Executive Committee.

C. Meeting Frequency

The Committee shall at least six (6) times per year or more often if needed.

## 23.4-22 Medical Staff Well Being Committee

A. Medical Staff Well Being Committee Composition

a) This Committee shall consist of:

No fewer than five (5) persons, a majority of whom shall be physician members of the Active Staff
At least one clinical psychologist
A Chair appointed by the President of the Medical Staff.

b) Each member of this committee shall serve a term of 3years. There shall be no term limits.

c) Insofar as possible, members of this committee shall not serve as active participants on other standing peer review or quality assessment and improvement committees or the MEC while serving on this committee. Members serving on other committees that have the potential to review the care or conduct of a practitioner receiving advice, support, evaluation, or monitoring from the Well Being Committee must choose either to be recused from the Well Being Committee's activities relative to the practitioner, or be recused from the committee reviewing the practitioner's care, whichever is appropriate under the circumstances.

d) Participation on a time-limited focused review committee evaluating the care or conduct of a practitioner shall not alone serve as grounds for conflict of interest or recusal of a committee member as long as the practitioner being reviewed by the focused review committee is not the subject of Well Being Committee activities. Examples of such time-limited review committees include an ad hoc investigative committee constituted by the MEC, or a Focused Professional Practice Evaluation committee.

e) All members of the Well Being Committee must disclose all potential conflicts of interest before participating in any Well Being Committee activity regarding a practitioner. A conflict of interest may require recusal of the committee member as determined by the Chair of the committee or by vote of the committee.

B. Duties:

a) The Committee shall design and implement a process for identifying and managing physician health issues of medical staff members that is separate from actions taken for disciplinary purposes.

b) Physician-specific issues addressed by the Committee shall be separate from Medical Staff disciplinary functions outlined in the Medical Staff Bylaws. If the Committee's activities as to a specific physician were based in whole or in part on a referral by the Executive

Committee, however, then its activities as to that physician may be integrated into a program of discipline and monitoring that is overseen by the Executive Committee.

c) The Committee shall serve as a resource for Medical Staff members who voluntarily seek assistance related to substance abuse or other health matters. In addition, this Committee shall receive reports regarding Medical Staff members and, as it deems appropriate, shall further investigate ~~such~~ reports. However, the Chair of the Committee, or his designee, shall report immediately to the President of the Medical Staff, or if unavailable, another Medical Staff Officer or the Executive Committee, all facts which he or any member of the Committee discovers, or which are conveyed to the Committee in any report or complaint it receives (whether written or verbal), about a Medical Staff member that indicates the Member is [1] providing unsafe treatment, [2] engaging in conduct or behavior such that the physical or psychological well-being of patients or any other person in the hospital may become threatened, or [3] suffering from an impairment or other condition which is likely to cause the Member to be unable to safely perform the privileges he has been granted, or otherwise causes the Member to present an unreasonable risk of harm to patients or others.

d) In addition to complying with the requirements under subsection (c) of this section, and with respect to Medical Staff members who voluntarily seek assistance, the Committee shall offer advice, counseling and referral to the appropriate internal or external resources for confidential diagnosis, treatment and rehabilitation of the condition or concern.

e) In addition to all the foregoing, the Committee shall:

1. Coordinate and/or provide education for the Medical Staff and other Hospital staff about physician health and wellness as well as illness prevention.
2. Educate the Medical Staff and hospital Staff about illness and impairment recognition issues specific to licensed independent practitioners
3. Educate the Medical Staff at large about options for Member self referral and/or referral of a Member by other Hospital staff
4. Receive referrals from the MEC, department chairs, division chiefs and others regarding potential individual physician health and/or impairment issues; evaluate the credibility of a complaint, allegation, or concern, subject to subsection (c) of this section.
5. In conjunction with existing Medical Staff mechanisms, monitor the affected Member and the safety of patients until the rehabilitation or any disciplinary process is complete.
6. Review Medical Staff Member behavioral occurrence trends to determine needs for education of the general medical staff, and possible intervention in physician-specific cases.

f)

1. Any member of the Well Being Committee may be called upon to provide peer to peer psychosocial support, or ongoing monitoring of any condition that impacts, or may impact, the ability of a medical staff member to care for patients. If the total monthly hours of such participation go beyond four (4) hours for any Committee member, the member will be paid a specified sum hourly for the total number of hours of participation at a rate, and up to a maximum amount, predetermined during the Medical Staff annual budgeting process.
2. In the case that the Well Being Committee is being called upon to implement the intervention provisions under Section 19 of the MS R&R, the Well Being Committee chair shall discuss the potential for conflict of interest with the President of the Medical Staff, and if appropriate under the circumstances, the

President shall delegate the peer support activities of subsection f.1 to another qualified Medical Staff Member.

g) The information and records kept by the Committee with respect to such Medical Staff members shall be confidential and shall not be disclosed outside the Committee unless the Committee determines, on the basis of information received, that the health or impairment of the Medical Staff member presents an unreasonable risk of harm to patients or others. In that event, the Chairperson of the Committee shall report pertinent information to the President of the Medical Staff.

C. Meeting Frequency & Reports to the MEC

The Committee shall meet quarterly or as needed. A report of its activities shall be made to the Executive Committee at least quarterly, though a report must be made at the next monthly Executive Committee meeting following each Well-being Committee meeting. Such regular reports shall not reveal the identity of particular Medical Staff members who have sought assistance or have been referred to the Committee for health impairment or other reasons, unless the Member was referred to the Committee by the Executive Committee itself. In such case, the report shall fully identify the physician and provide a general statement as to the progress of the Committee's evaluation(s) and/or monitoring of the physician, and any other specific details the Well-being Committee Chair deems appropriate.

## 23.4-23 Scholarship Oversight Committee (a Subcommittee of the GME Committee)

A. Composition

This Committee shall consist of:
1. At least three (3) Medical Staff representatives comprised of the department of Medicine, four (4) subspecialties of the department of Medicine;
2. At least three (3) representatives from CHORI;
3. Program Directors will be ad hoc members (non-voting);
4. All sub-specialty fellows will be ad hoc members (non-voting).

B. Duties

This Committee will be responsible for:
1. Evaluating the progress of each sub-specialty fellow's scholarly work;
2. Determining a course of preparation or remediation to ensure successful completion of a fellow work product;
3. Advise program directors, mentors, and fellows with respect to completion of a successful work product that will meet ABP guidelines of competence in research;
4. Ensure completion of documentation for the ABP of a work product for each sub-specialty fellow.

C. Meeting Frequency

The committee meets quarterly at the CHORI Little Theater. Additional meetings may be called to assist individual fellows, program directors, and mentors in assuring the success of their research.

D. Structure

The Scholarship Oversight Committee shall be a subcommittee of the Graduate Medical Education Committee (GMEC). The committee shall provide a report to the GMEC Committee at least twice a year.

### 23.4-24 Multidisciplinary Peer Review Committee

A. Members shall be appointed by the Medical Staff President.

Composition:
1. Medical Staff President-Elect who shall serve as Chair
2. Department of Surgery representative
3. Department of Medicine representative
4. Department of Pathology representative
5. Department of Diagnostic Imaging representative
6. Department of Anesthesiology Representative
7. At least five additional physician members to assure the Committee membership represents a broad range of clinical specialties, one which shall be a community physician.
8. Medical Director, Clinical Quality Improvement, non-voting

Division Chiefs shall not serve on the Multidisciplinary Peer Review Committee (MDPRC). The appropriate Division Chief(s) and Department Chair(s) shall be called upon to present case review to the committee.

B. Duties

1. Reviews cases referred for peer review from any source.

2. Receives reports of the results of peer review activities (preliminary case evaluations) conducted by Division and/or Department Chairs and determines the final case assessment.

3. Reports to and works in cooperation with the Professional Practice Oversight Committee to, maintain, monitor and as needed recommend changes and/or modifications to the Medical Staff peer review processes.

4. Provides summary reports of peer review activities to the Professional Practice Oversight Committee and Medical Executive Committee (MEC) at least quarterly.

C. Case Review Processes: Referrals for peer review may be received from Medical Staff Officers, Department Chairs and/or Divisions Chiefs, Medical Staff Leadership, Administration Leadership, Root Cause Analysis (RCA) Determination Team, the Event Reporting and Response System (ERRS) and other sources as appropriate.

Types of cases to be reviewed: Cases that will be automatically screened by the Committee

Chair for review by the Committee include but are not limited to the following:

Unexpected death
Unexpected major loss of function
All "Never Events"
Cases that have been reviewed by an RCA Determination Team and have been referred to the Medical Staff for review through the medical staff peer review process. Such cases may involve practitioner specific clinical performance issues or concerns.
Peer review cases involving multiple divisions

Other cases may be reviewed by the Committee Chair and/or members which may be referred from various referral sources including staff and/or patient/family complaints.

C. Meeting Frequency

The Multidisciplinary Peer Review Committee shall meet at least every other month.

## 23.4-25 Trauma Services Committee

**A. Composition**

The Trauma Services Committee shall consist of:

1. A Chairperson who shall serve to direct and oversee all trauma care services, and who is appointed by the President of the Medical Staff in consultation with the Chair of the Department of Surgery.
2. A medical staff representative from each of the following specialties who regularly takes trauma call, nominated by the Chair in consultation with the Chair of the Department of Surgery, for consideration and appointment by the President of the Medical Staff:
   a. General Surgery;
   b. Orthopedic Surgery;
   c. Neurosurgery;
   d. Emergency Medicine;
   e. Critical Care Medicine;
   f. Anesthesia; and
   g. Diagnostic Imaging;
3. The Chair of the Department of Surgery;
4. The Trauma Program Manager, *ex officio* without vote;
5. The Trauma Registrar, *ex officio* without vote.

**B. Duties Of The Trauma Services Committee**

The Trauma Services Committee shall administer the trauma service's Performance Improvement and Patient Safety Program. In carrying out this function, the Committee shall:

1. Serve as the multidisciplinary peer review committee for Children's Hospital trauma services, whose goal is to improve trauma care by reviewing selected deaths, complications, and sentinel events with objective identification of issues and appropriate responses. When meeting to perform this peer review function, the Chairperson shall determine the attendance and participation of any other medical staff members or hospital personnel as may be beneficial to the Committee's purposes in carrying out this function to assure that there are vigorous provider discussions regarding peer review;
2. Review trauma cases according to the Committee's protocol for the Performance Improvement Plan;
3. Monitor all events that occur during a trauma-related episode of care when admitted to the institution;
4. Make recommendations and action plans with associated reevaluation when areas needing improvement are determined;
5. Serve as the Trauma Program's Operational Process Performance Committee, to identify all patient care issues that are not provider-related, and to review, address, assess and correct global trauma program and system issues. When meeting to perform this systems analysis function, the Chairperson determines the additional attendance and participation of appropriate members of the medical staff, hospital administration and hospital staff in order to assure a broad based venue for systems issues;
6. Provide monthly summary reports of its activities, findings, recommendations and conclusions to the Chair of the Department of Surgery, the Multidisciplinary Peer Review Committee, and the Patient Safety Committee. The Committee shall forward reports to such other Committees of the Medical Staff as necessary and relevant to those Committee's scope of activities and oversight;
7. Provide informational reports regarding trauma PI issues as appropriate to Institutional Quality.

**C. Qualifications and Duties of the Trauma Services Committee Chairperson**

1. The Chairperson of the Trauma Services Committee shall be:

   a. board certified in general surgery, and board-eligible or board certified in pediatric surgery;
   b. current in Advanced Trauma Life Support;
   c. a member of, and an active participant in, national or regional trauma organizations;
   d. document completion of verifiable, external trauma-related CME in the amount of 16 hours in a year, or 48 hours in three years.

2. The Chairperson of the Trauma Services Committee shall:

   a. Identify and define, in consultation with the Committee, and subject to the approval of the Chair of the Department of Surgery, Credentials Committee, and the Medical Executive Committee, as applicable:

i. inclusion criteria for the trauma registry and PIPS review;
ii. quality of care standards for delivery of trauma services;
iii. audit filters and indicators (including complications), including, but not limited to, those as may be defined by the regional trauma system and the American College of Surgeons Committee on Trauma;
iv. the structure of the PI review process;
v. appropriate measures and implement them within his/her authority in order to ensure compliance with verification requirements of the American College of Surgeons for a Level I Pediatric Trauma Center;
vi. the bypass protocol, known as the Critical Patient Overload protocol, as it pertains to trauma services.
vii. recommend additional privileging and/or credentialing criteria to the Chair of the Department of Surgery for surgical specialists taking trauma call;

b. Provide oversight of all aspects of trauma care, and of the Trauma Performance Improvement and Patient Safety (PIPS) program, including monitoring compliance with trauma treatment guidelines, policies and protocols.

c. In cooperation with Division Chiefs and the Chair of the Department of Surgery, and as a required step in the credentials-approval process, perform initial and annual review and evaluation of each trauma surgeon's prior performance and current ability to participate in emergency trauma call. The Chairperson shall report any deficits identified in the function of trauma call panel, or any of its members, along with recommendations for correction to the Chief of the Department of Surgery, who shall take such action as appropriate and/or required to assure quality of care and patient safety for emergency call services.

d. Participate in trauma call.

e. Be actively engaged in the trauma services role in providing surgical critical care, and promoting a cooperative environment that provides coordinated care in the intensive care unit.

f. Document the dissemination of information from the Trauma Services Committee to other core and non-core trauma practitioners.

g. Report all performance improvement activity of the Committee to the Chair of the Department of Surgery, who shall report same to the MEC.

**D. Qualifications and Duties of the Voting Committee Members**

1. All Committee members with right to vote must attend at least 50% of the Committee's meetings;
2. Committee members representing Neurosurgery, Orthopedic Surgery, Emergency Medicine, and Critical Care Medicine must each complete verifiable external CME averaging 16 hours annually, or 48 hours in 3 years, of which at least 12 hours over 3 years must be related to clinical pediatric trauma care. Failure to meet these attendance requirements shall result in

removal of the member, and appointment of a new member in compliance with the requirements of section A.2.

3. Specialty Representatives on the Committee shall provide to their Division colleagues a summary of Trauma Services Committee activities after each of its meetings, and shall coordinate trauma-related education in their Division with support and guidance from the Chair and Trauma Program Manager

## 23.4-26 BCH Quality Improvement Committee

The BCH Quality Improvement Committee is a joint committee established by this Medical Staff and the Medical Staff of UCSF Medical Center to provide oversight of quality improvement activities and quality-related subcommittees and programs at this Hospital and Benioff Children's Hospital – San Francisco. The BCH Quality Improvement Committee Policy and Procedure which has been jointly adopted by this Medical Staff and the Medical Staff of UCSF Medical Center, describes the committee's composition and duties. To the extent the BCH Quality Improvement Committee Policy and Procedure conflicts with the BCHO Medical Staff Bylaws and Rules with respect to conduct of meetings (e.g., quorums and voting), the Policy and Procedure shall control.

## 23.4-27 BCH Patient Safety Committee

The BCH Patient Safety Committee is a joint committee established by this Medical Staff and the Medical Staff of UCSF Medical Center to provide leadership, direction, and oversight for safety initiatives to reduce medical errors and health acquired incidents and to foster a culture of safety and excellence in patient safety at this Hospital and Benioff Children's Hospital – San Francisco. The BCH Patient Safety Committee Policy and Procedure which has been jointly adopted by this Medical Staff and the Medical Staff of UCSF Medical Center, describes the committee's composition and duties. To the extent the BCH Patient Safety Committee Policy and Procedure conflicts with the BCHO Medical Staff Bylaws and Rules with respect to conduct of meetings (e.g., quorums and voting), the Policy and Procedure shall control.

## 23.4-28 BCH Quality and Safety Executive Committee

The BCH Quality and Safety Executive Committee is a joint committee established by this Medical Staff and the Medical Staff of UCSF Medical Center to provide executive leadership and strategic oversight for the quality and safety of care provided at this Hospital and Benioff Children's Hospital – San Francisco. The BCH Quality and Safety Executive Committee oversees activities of the BCH Quality Improvement Committee and BCH Patient Safety Committee and helps prioritize and direct the implementation of BCH-wide performance improvement activities and strategic initiatives. The BCH Quality and Safety Executive Committee Policy and Procedure which has been jointly adopted by this Medical Staff and the Medical Staff of UCSF Medical Center, describes the committee's composition and duties. To the extent the BCH Quality and Safety Executive Committee Policy and Procedure conflicts with the BCHO Medical Staff Bylaws and Rules with respect to conduct of meetings (e.g., quorums and voting), the Policy and Procedure shall control.

# SECTION 24 Initial Focused Professional Practice Evaluation Departmental Guidelines

## 24.1 Policy for all Departments:

All Initial Focused Professional Practice Evaluations (FPPE) will take place in accordance with the Medical Staff Bylaws Section 3.7: Period of Observation for Medical Staff Members. The FPPE is an evaluation of privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges' at UBCHO. The criteria for initial FPPE are developed and approved by the appropriate Division/Department, approved by the Credentials Committee, MEC, and the Board of Directors, and are consistently implemented. Specific policies and criteria for FPPE are listed below for each department, and are further defined on the approved Privilege Request Form for each Division/Department. FPPE in response to competency concerns are discussed in Section 18.

## 24.2 Department of Pathology

Guidelines:

The Department of Pathology shall provide FPPE in accordance with the above section. The results of said FPPE will be recorded on the approved FPPE form.

FPPE Reviewers for new Pathology Department members will be chosen by the Department Chairperson. It is the responsibility of the reviewer to contact the new member to make arrangements for the FPPE Review.

Initial FPPE in surgical pathology will include observation for successful completion of the following types of cases:

Two frozen section examinations
1. Two neoplasms
2. Two gastroenterology cases
3. Two infectious disease cases
4. At least five routine general surgical cases

Autopsy proctoring will require observation of the successful completion of one autopsy.

Clinical pathology FPPE will require successful discussion and evaluation of at least five patients with abnormal laboratory tests, chosen by the reviewer.

## 24.3 Department of Diagnostic Imaging

Guidelines

The Department of Diagnostic Imaging shall proctor in accordance with the above section and with the criteria developed on the approved privilege request form

## 24.4 Departments of Surgery ,Medicine, and Anesthesia

24.4-1 Guidelines

A. The Chief of each Division or the Chief of the Department of Anesthesia, shall be authorized to designate or appoint one or more members of their Department to serve in the role of FPPE reviewer. Said reviewer(s) will have established expertise or competence within that field of practice, including the specific procedure, and will hold unsupervised privileges for the privileges being reviewed. Close personal or professional associations with the initially privileged provider Is discouraged.

B. It is the responsibility of the individual members of each division/Department to serve as a reviewer when requested to do so, and to convey a complete and accurate report to the Chief of the Department on an approved form. Any member unable or unwilling to comply with said request shall, in writing, submit reasons for same to the Executive Committee. The Executive Committee may concur or not and its decision shall be binding.

24.4-2 Types of Routine FPPE

A. Initial Appointment:
Physicians receiving their initial appointment to the Medical Staff shall undergoes FPPE until at least six (6) cases, admissions, consultations, or induction of General Anesthesia, appropriate to his/her specialty have been observed or reviewed and approved by the reviewing physician or physicians. The number of cases/admissions/consultations may, by recommendation of the division chief and with concurrence of the Department Chair, be shortened or extended for individual specific types of cases based on the proctoree's demonstration of competence

B. New Privileges:
Physicians who have been granted new privileges shall undergo FPPE on each newly granted privilege a minimum of two (2) times, or as defined in the applicable Divisions approved Privilege Request Form. The designated reviewer may have the option of acting as an observer or as an assistant or consultant.

24.4-3 Each Division shall adopt a written format which the proctor will use in transmitting reports via the Chief of the Department of Surgery, Medicine or Anesthesia to the Credentials Committee for evaluation. Such reports will indicate the type and number of cases with an

evaluation of each case and a recommendation. Such reports will be absolutely privileged and be incorporated in the proctoree's Medical Staff credentials file.

24.4-4 The FPPE Reviewer must indicate in writing, on an approved FPPE review form that:

A. FPPE is no longer necessary;

B. FPPE should be continued; or

C. FPPE of core privileges is no longer necessary but that direct supervision of specific requested procedure privileges is still necessary. The privileges for which FPPE is no longer needed will be specifically identified by the assigned reviewer.

# SECTION 25 Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) Policy

## 25.1 Purpose

To define the medical staff mechanism to conduct patient care review and Ongoing Professional Practice Evaluation (OPPE) for the purpose of analyzing and evaluating the quality and appropriateness of care provided to patients at Children's Hospital & Research Center Oakland (CHRCO).

To establish the mechanism for incorporating relevant information from peer review and OPPE activities into the medical staff reappointment and clinical privileging processes.

To define when Focused Professional Practice Evaluation (FPPE) and/or corrective action, pursuant to Article 7 of the Medical Staff Bylaws, may be indicated.

To define the reporting of medical staff peer review, FPPE and OPPE activities to the Medical Executive Committee and Board of Directors.

## 25.2 Policy

25.2-1 It is the policy of the Medical Staff of CHRCO that all licensed clinical services of the hospital provided by Medical Staff practitioners holding clinical privileges and providing clinical care at CHRCO are reviewed as part of the ongoing Medical Staff Performance Improvement Process.

25.2-2 The Medical Staff shall monitor a variety of elements relating to the clinical care delivered to patients, data which shall be made available from the Institutional Quality Program. These elements may include ongoing monitoring of the following:

A. clinical functions such as medication use, blood use, operative and invasive procedure review, etc.;
B. important clinical outcomes, such as complications;
C. undesirable or unexpected events that may occur in the hospital and may be related to the clinical performance of those who hold clinical privileges;
D. disruptive or other behavioral issues on the part of medical staff members privileged by CHRCO.

25.2-3 All Medical Staff professional practice evaluations will be carried out by one of the following:

A. A Medical Staff Professional Practice Review Committee (PPRC). In the departments of Medicine and Surgery these will be implemented at the division level. In the

departments of Diagnostic Imaging, Anesthesia, and Pathology and Laboratory Medicine, these will be implemented at the department level.

B. Division Chief or Department Chair

C. The Multidisciplinary Peer Review Committee

D. The Medical Executive Committee; or

E. An ad hoc practitioner or committee appointed by the MEC.

25.2-4 Each division in the case of Medicine and Surgery, or department in the Case of Diagnostic Imaging, Anesthesia and Pathology and Laboratory Medicine, is required to evaluate its review plan at least annually which describes those outcomes, care processes, and events, which should be measured and assessed. The measurement and assessment program outlined in each plan may include the following elements:

A. Hospital-wide generic indicators.

B. Medical staff division/department-specific indicators or performance measures determined by the division/department.

C. Definition of triggers that indicate consideration of in-depth review

## 25.3 Procedures

25.3-1 Ongoing Professional Practice Evaluation (OPPE)

A. Routine Review

Information regarding a practitioner's practice is evaluated on an ongoing basis, referred to herein as Ongoing Professional Practice Evaluation (OPPE). The types of information included in the OPPE may include review of operative and/or clinical procedures, blood usage, length of stay patterns, morbidity and mortality data, and other relevant data as determined by the individual department's PPRC and approved by the MEC. Information for OPPE may be acquired through

1. chart review;
2. direct observation;
3. case screening using predetermined criteria;
4. monitoring of diagnostic and treatment techniques;
5. discussion with other individuals involved in the care of patients including consulting physicians, assistants at surgery, nursing, and administrative personnel;
6. data abstracting reports;
7. referral from other medical staff committees
8. performance measures determined by the division;
9. the unusual occurrence system, and
10. The complaints system.

Information obtained through OPPE is used to improve patient care and continue, limit, or revoke existing Medical Staff privileges.

The Institutional Quality Department staff, acting solely as an agent of the Medical Staff, reports OPPE data to each division chief at intervals at least as frequently as every 9 months for use in trend analysis. A summary of OPPE data is reported at least annually to MEC, Departmental Chairpersons and the Quality Committee of the Board.

Additionally, OPPE information related to members of the medical staff who serve on the Trauma Call Panel will have a trauma specific supplemental review and report conducted by the Trauma Medical Director and reviewed with designated Division Chiefs and Department Chairs in accordance with Medical Staff OPPE policy.

Peer review is performed when specific criteria are met, for example, mortality, complication, or adverse outcome, or when there is a concern regarding quality of care. Concerns regarding a privileged practitioner's professional practice, competence, or behavior are uniformly forwarded to the Institutional Quality Department as an agent of the Medical Staff for appropriate professional practice review.

At time of reappointment to the Medical Staff, the Institutional Quality Department, acting solely as an agent of the Medical Staff, will compile a 2-year summary of the individual's OPPE evaluation data to be used by the Credentials Committee in consideration of the medical staff member's reappointment.

Review of cases and other OPPE performance measures, may result in the following determinations:

1. That care provided by the individual medical staff member met the minimum standard of care;
2. That care provided met minimum standards but information should be provided to the practitioner regarding methods to improve clinical services, communication or documentation;
3. That the practitioner failed to meet minimum patient care standards;
4. That the practitioner exhibited unprofessional behavior

When care and/or behavior are deemed to meet minimum standards, no further action is required of the Professional Practice Review Committee or notice to the practitioner when care and behavior is deemed to meet minimum standards.

B. Reports Concerning Questionable Clinical Practice, Competence and/or Behavior

Reported concerns regarding a privileged practitioner's professional practice, competence or behavior are uniformly forwarded to the Institutional Quality Department as an agent to the Medical Staff for appropriate professional practice review. Concerns are uniformly collected, investigated, and addressed.

C. Further Review of Cases or Performance Measures Possibly Not Meeting the Standard of Care

When a Professional Practice Review Committee determines that a practitioner failed to meet minimum patient care standards, the committee shall notify the involved practitioner in writing. The practitioner will be afforded the opportunity to provide additional information that may not have been considered or known by the committee. The practitioner will be given an opportunity to respond to the results of the professional practice review, either in person or in writing, at the committee's discretion. If the Professional Practice Review Committee requests that the practitioner reply in writing, the practitioner shall be given a deadline of 14 days by which a reply is required.

Whether or not a practitioner has responded in writing, the practitioner under review may be mandated by the committee to appear before the committee and respond to questions regarding his or her conduct or practice. The practitioner must be provided with no less than 14 days notice of the mandate to appear. Failure to respond either in writing or by appearance will be deemed to be acceptance of the Professional Practice Review Committee findings and forfeiture of the right to appeal.

The Professional Practice Review Committee, by majority opinion, will determine its findings and recommendations. Minority opinions and views of the practitioner are considered and recorded in the committee minutes. The practitioner will be informed of the final outcome of the review in writing, to include the committee's findings, review result and recommendations.

The Professional Practice Review Committee may recommend FPPE if ongoing professional practice evaluation (OPPE) shows a variation that cannot be explained without a focused review, or if there is a concern regarding the practitioner's ability to provide safe, high quality patient care.

If, at any time during the implementation of this policy, it is determined that failure to take immediate action regarding the conduct of or care provided by a medical staff member may result in an imminent danger to the health, life, or safety of any individual, the President of the Medical Staff (or if unavailable other officer of the Medical Staff) and the Department/Division chief shall be immediately informed, and article VII of the Medical Staff Bylaws shall be implemented as appropriate for the circumstances.

25.3-2 For Cause Focused Professional Practice Evaluation (FPPE)

For Cause Focused Professional Practice Evaluation (FPPE) may be initiated when ongoing professional practice evaluation shows a variation that cannot be explained without a focused review or when there is a concern regarding a practitioner's ability to provide safe, high quality patient care. FPPE is a time-limited period during which the medical staff evaluates the practitioner's performance. FPPE is not an investigation as defined under Article VII of the medical staff bylaws, and shall not be performed when an investigation is

warranted under that Article. The results of an FPPE may be utilized, however, in a preliminary investigation of a practitioner under that Article.

A. If concerns are identified through OPPE or at time of reappointment regarding the behavior or clinical performance of a practitioner holding clinical privileges, that concern will be forwarded to the appropriate Professional Practice Review Committee or Medical Staff Leadership.

B. The Medical Executive Committee may initiate a FPPE of practitioner performance based on its own review of data, reports and/or events.

C. If a Professional Practice Review Committee determines that a practitioner-specific intensified assessment is indicated, the Committee shall initiate a Focused Professional Practice Evaluation (FPPE). Circumstances that require consideration by a Professional Practice Review Committee in whether to initiate a FPPE include:

   1. 2 assessment codings of PR4 or PR5 within any 24 month period (i.e. second occurrence triggers consideration of FPPE)
   2. 3 or more assessment codings of PR3 or higher within any 12 month period, or
   3. Any single egregious case or sentinel event.

D. When a FPPE of a practitioner's performance is initiated by the Professional Practice Review Committee or Medical Executive Committee:

   1. The medical staff office shall provide the involved practitioner written notice regarding the specific concerns that have been identified and which serve as the basis for the Focused Professional Practice Evaluation.

   2. The composition of the Committee performing the FPPE shall be determined by the PPRC or the MEC depending on which body initiated the FPPE.

   3. The FPPE Committee shall include no less than 3 physician members of the medical staff.

   4. When the concerns being reviewed include clinical or technical issues related to a specific specialty treatment or procedure, the FPPE Committee shall include, if feasible, at least one practitioner currently qualified and competent in the clinical area, specific treatment or procedure under review. The practitioner must be unbiased, and may not be a financial competitor or otherwise hold any conflict of interest in the matter.

   5. As part of the FPPE process, the FPPE Committee shall ask the involved practitioner to respond to the Committee's concerns in writing. It shall be the obligation of the practitioner being reviewed to fulfill this request within 14 days, unless the practitioner chooses to respond to the Committee in person. If the involved practitioner does not respond to the concerns of the FPPE Committee, either in writing or in person, the practitioner then forfeits the right to appeal the FPPE Committee's decision.

6. The FPPE Committee will determine the type of performance monitoring to be conducted. Types of performance monitoring that can be instituted include, but are not limited to:
   a. internal sample chart audit
   b. internal observational proctoring
   c. external peer review of charts, subject to the requirements of subsection F.
   d. observational proctoring by a qualified practitioner not on the medical staff, and who is granted temporary membership on the medical staff without privileges for this sole purpose;

7. The professional practice monitoring process in each case will be clearly defined by the FPPE Committee and will include each of the following elements:
   a. Criteria for conducting performance monitoring;
   b. Establishing a monitoring plan specific to the requested privilege(s) or to the clinical area(s) of concern;
   c. Determining the duration of performance monitoring not to exceed 90 days.

8. A report of the conclusions of the FPPE Committee will be sent to the Professional Practice Review Committee and the MEC.

9. MEC shall notify the practitioner of the summary of findings

E. When conducting a FPPE, the FPPE Committee should consider the following principles:

   1. Assuring that the individual whose performance is being reviewed is allowed to provide input and feedback regarding the review process.
   2. Utilizing objective standards, relevant medical literature, and relevant clinical practice guidelines in the FPPE process whenever possible.
   3. Considering and recording minority opinions and the views of the reviewed physician in its report.

F. The chairperson of the FPPE Committee shall consider the use of external expert consultation when either there are no practitioners available to serve on the FPPE Committee who have appropriate clinical or technical skills, or when there is a potential conflict of interest relevant to a specific practitioner or practitioners who may otherwise be appropriate members of a FPPE Committee. When external expert consultation appears to be needed, the chairperson of the committee performing FPPE shall inform the President of the Medical Staff. Only the Medical Staff President or designee can authorize a request (and payment if needed) for external expert consultation.

G. The FPPE shall be concluded within 90 days of initiation. If the FPPE Committee is not able to complete the review within 90 days of initiation, a report will be submitted to the Medical Executive Committee regarding the status of the FPPE and reasons the FPPE was not completed, along with any recommendation, if appropriate, for an

extension of the FPPE performance monitoring to a date certain, and the reasons for the recommendation.

H. If the MEC determines that corrective action, as defined in the medical staff bylaws, is necessary based on the FPPE report or any part thereof, the involved practitioner shall have hearing rights as set forth in the medical staff bylaws. The Medical Executive Committee has no obligation to implement the recommendations of the FPPE Committee and can conduct its own investigation pursuant to the Medical Staff Bylaws.

I. The conclusions of the FPPE Committee shall be recorded in writing and shall include a record of any medical record reviews, interviews, reports, medical literature information, or relevant clinical practice guidelines which have been used in arriving at the FPPE Committee's recommendation.

J. The results any FPPE performance review and all supporting records and information provided to, generated by, and sent to and from the FPPE committee constitute confidential medical staff peer review information.

25.3-3 Implementation

Administrative implementation of this policy shall be the responsibility of the Medical Staff Office with assistance from the Institutional Quality Department, both as noted herein and as convenient and necessary in assisting with the Medical Staff Office workload, and also acting solely as an agent of the Medical Staff.

Additional, specific and/or detailed procedures needed to carry out this protocol may be developed as needed and will be kept on file in the Medical Staff Office.

In all professional practice review documents (peer review forms, committee minutes, etc.), Medical Staff QM code numbers, issued by the IQ Department on behalf of the medical staff and which permit the identities of practitioners under review to be kept confidential, will be used when referencing individual Medical Staff Members.

25.3-4 Reference
Comprehensive Accreditation Manual for Hospitals, 2016

# SECTION 26 Professional Conduct Policy

## 26.1 Purpose

This policy is adopted by the Medical Staff to address those situations where Medical Staff Members exhibit behavior which is disruptive, intimidating or otherwise inappropriate, and which could compromise the quality and safety of patient care services. Such behavior can have either a direct negative effect on the ability of other professionals to provide quality patient care, or an indirect effect by, for example, adversely affecting teamwork, communication and morale. The result can be increased medical errors, increased preventable adverse outcomes, poor patient satisfaction, increased costs of care, and good health care providers leaving the medical staff to seek a more professional environment. These behaviors, therefore, pose a serious threat to the culture of safety so critical to good patient care. This Professional Conduct policy is an expression of the medical staff's goal of "zero tolerance" for these damaging behaviors.

This Policy is intended to [1] encourage reporting of the disruptive, intimidating and inappropriate behaviors described herein, [2] enhance the ability of the medical staff to address and resolve these problems, and [3] raise consciousness of these issues among everyone in the hospital through open discussion and regular educational programs on these topics.

This Professional Conduct Policy will be the exclusive means for review and disciplining medical staff members for inappropriate or disruptive behavior.

## 26.2 Groups and Persons Affected

Those bound by this Policy include all members of the Medical Staff and Allied Health Professionals holding privileges or providing care under the direction of the Medical Staff including those with temporary privileges.

## 26.3 Policy Summary

It is the policy of the Medical Staff of Children's Hospital & Research Center at Oakland (CHRCO) that all individuals within the hospital facility be treated courteously, respectfully and with dignity. To that end, the Medical Staff requires that Medical Staff Members conduct themselves in a professional and cooperative manner while in the hospital in addition to signing the CHRCO Code of Professional Conduct at the time of applying to the Medical Staff with reaffirmation at the time of reappointment.

## 26.4 Definitions

26.1-1 "Appropriate behavior" means any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized medical staff, or to engage in professional practice including practice that may be in competition with the hospital. Appropriate behavior is not subject to discipline under these bylaws.

26.4-2 "Disruptive behavior" means any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.

26.4-3 "Harassment" means conduct toward others based on their race, religion, gender, gender identity, sexual orientation, nationality or ethnicity, which has the purpose or direct effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating or otherwise hostile work environment.

26.4-4 "Inappropriate behavior" means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become

A. disruptive behavior because its repeated nature raises it to the level of being abusive, harmful or intimidating, or
B. a form of harassment and thereby become disruptive, and subject to treatment as "disruptive behavior."

26.4-5 "Sexual harassment" means unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person's work performance or which creates an offensive intimidating or otherwise hostile work environment.

26.4-6 "Medical staff member" or "member" as used in this policy, means members of the medical staff and Allied Health Professionals holding privileges or providing care under the direction of the Medical Staff including those with temporary privileges.

## 26.5 Types of Conduct

26.5-1 Appropriate Behavior

A. Medical staff members cannot be subject to discipline for appropriate behavior. Appropriate behavior is desirable behavior and, in fact, should be modeled regularly by medical staff leaders and all medical staff members.

B. Appropriate behavior that is accompanied by inappropriate or disruptive behavior is not acceptable behavior. For example, communicating a valid and significant criticism regarding patient care by yelling or engaging in condescending or insulting remarks is never justified and is prohibited by this policy. All such communications must be delivered professionally and respectfully.

C. Examples of appropriate behavior include, but are not limited to, the following:

1. Criticism communicated in a reasonable and respectful manner, and offered in good faith with the aim of improving patient care and safety;
2. Encouraging clear and respectful communication;
3. Expressions of concern about a patient's care and safety;
4. Expressions of dissatisfaction with policies through appropriate grievance channels or other civil and non-personal means of communication;
5. U s e of cooperative approach to problem resolution;
6. Constructive criticism conveyed in a respectful and professional manner, without shaming or asserting blame for adverse outcomes;
7. Professional and respectful comments to any professional, managerial, supervisory, or administrative staff, or members of the Board of Directors about patient safety or patient care provided by others;
8. Active and respectful participation in medical staff and hospital meetings. Comments which fall under the definition of "appropriate behavior" made during or resulting from such meetings cannot be used as the basis for a complaint or action taken under this Professional Conduct Policy, referral to the Health and Wellbeing Committee or economic sanctions;
9. Membership on other medical staffs;
10. Seeking enforcement of any provision of the Medical Staff Bylaws, Rules & Regulations, Medical Staff Policy, or any other formally adopted rule or policy of the medical staff or hospital; and
11. Seeking legal advice or the initiation of legal action for cause.

26.5-2 Inappropriate Behavior

Inappropriate behavior by medical staff members is discouraged. Persistent inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to scrutiny as "disruptive behavior" under this Policy. Examples of inappropriate behavior include, but are not limited to, the following:

A. Belittling or berating statements;

B Name calling;

C. Use of profanity or disrespectful language;

D. Inappropriate comments written in the medical record;

E. Intentional failure to respond to patient care needs or staff requests – this category of behavior may also constitute violations of law, e.g., EMTALA regulations or Medicare Conditions of Participation;

F. Personal sarcasm, insults or cynicism when these are directed at another person;

G. Deliberate lack of cooperation without good cause;

H. Deliberate refusal to return phone calls, pages, or other messages concerning patient care or safety;

I. Intentionally condescending language and/or voice intonation; and

J. Intentionally degrading or demeaning comments regarding patients and their families; nurses, physicians or hospital personnel.

26.5-3 Disruptive Behavior

Disruptive behavior by medical staff members is prohibited. Examples of disruptive behavior include, but are not limited to, the following:

A. Physically threatening language directed at anyone in the hospital including patients or their friends and family members, physicians, nurses, other medical staff members, or any hospital employee, administrator or member of the Board of Directors;

B. Physical contact, or threatened physical contact, with another individual that is threatening or intimidating;

C. Throwing instruments, charts or other things;

D. Threats of violence or retribution;

E. Shouting in an intimidating, menacing or threatening fashion;

F. Sexual harassment; and,

G. Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation.

## 26.6. Procedure

26.6-1 Reporting Behavioral Issues.

A. If a Medical Staff Member is observed to exhibit actions that may represent either inappropriate or disruptive behavior, then such actions may be recorded by a hospital observer in event report as soon as possible. A member of the medical staff may instead choose to complete a Confidential Peer Review Referral Form and promptly deliver it to the Medical Staff Office. The Medical Staff Office shall promptly notify the President of the Medical Staff of the delivery of the report. Upon receipt of

information regarding a behavioral issue, the Medical Staff Quality Specialist will assess the severity of the reported event, refer for review to the Division Chief, and, if deemed appropriate, consult with VP of Quality, Department Chair, and President of the Medical Staff. A Division Chief or Department Chair may directly report a Medical Staff Behavioral event to the Medical Staff President.

B. Complaints or reports of disruptive and inappropriate conduct by medical staff members are subject to review under this Policy whether or not a complainant or witness reduces the events to writing, and whether or not he or she requests or desires action to be taken.

C. The event report or peer review referral shall include to the extent possible:

1. Date and time of the alleged behavior or incident.
2. The medical record number of any patient present or involved with the occurrence which is being reported.
3. A detailed factual description of the events observed. The description should include the names of all persons involved and those who witnessed the events,
    a. a description of the behavior observed,
    b. the circumstances which precipitated the incident, and
    c. a description of any observed or potential effects on the quality of patient care services or on hospital operations.
    d. The reporter should also note, if feasible, whether the events observed affect medical or hospital staff members' ability, directly or indirectly, to provide quality patient care services.
    e. A description of any actions taken to remedy the situation, including the date, time and place of actions taken and the names of those intervening.

D. The completed unusual occurrence report and/or the peer review referral form will be submitted to the Institutional Quality Department.

E. The Institutional Quality Department will review the report that has been submitted.

F. The Vice President for Institutional Quality (VPIQ) or designee shall immediately report all cases of potential inappropriate or disruptive behavior involving Medical Staff Members to the President of the Medical Staff or designee, to include a copy of the event report or peer review referral form received.

G. The complainant shall be provided a written acknowledgement of receipt the complaint.

26.6-2 Addressing Reports and Complaints about Behavior

A. The President of the Medical Staff (or designee) and at least one other member of the Medical Executive Committee selected by the President shall contact the medical staff member whose behavior is discussed in the report and describe to the

affected practitioner the nature of the event that has been reported. The President of the Medical Staff and MEC member(s) selected shall:

1. Request the affected practitioner to describe his/her account of the reported event;
2. Allow the affected practitioner the opportunity to provide a written response to the alleged incident or behavior within a reasonable time specified, but no later than 48 hours from the time of the request. The practitioner's written response to the report shall be attached to a summary of the occurrence and investigation and placed in a confidential reference file in the Medical Staff Office.
3. Provided a copy of the Medical Staff Standards of Professional Conduct C and a transcribed copy of the complaint to the member in a timely fashion (with names of witnesses or the complainant removed as appropriate) and shall inform the member that attempts to confront, intimidate, or otherwise retaliate against the complainant(s) is a violation of this Policy and may result in corrective action against the medical staff member.
4. Attempt to the greatest extent possible under the circumstances to protect the identity of those individuals reporting the occurrence and those individuals providing additional information regarding the occurrence. If anonymity is not possible, every effort will be made to ensure that those individuals, whether or not they are hospital employees, members of the Medical Staff, or others, are treated respectfully and protected from retaliation;

B. Following discussion with the involved practitioner, and at any other point in the process of implementation of this behavioral policy, the President of the Medical Staff shall determine if there is a potential for imminent harm to patient safety or welfare related to the described behavior. If such potential harm exists, then the President of the Medical Staff shall initiate corrective action pursuant to the Medical Staff Bylaws. Such corrective action may include summary suspension.

C. If the President of the Medical Staff, in consultation with the MEC member(s) selected to assist in evaluating the matter, determines there is no imminent threat to patient safety and welfare, then the President of the Medical Staff shall take one or more of the following actions, as appropriate:

1. Determine that no further action or evaluation is required. In this case, the report/referral would be entered into the confidential peer review database for routine tracking and trending. Further, the President must report this fact at the next Medical Executive Committee in executive session, which report may be subject to discussion and further action as determined by that Committee;
2. Refer the practitioner to the Chairman of the Medical Staff Well Being Committee immediately for evaluation of the concern. The Chairman shall determine whether treatment and monitoring are indicated and will provide oversight of practitioner's physical and/or psychological evaluation and treatment. The involved practitioner, however, must agree to such

consultation. The Chairman of the Medical Staff Well Being Committee shall be available to provide consultation to the President of the Medical Staff, as needed;

3. Refer the report/referral to the appropriate Department peer review committee for evaluation.
4. If the occurrence is the first incident of inappropriate behavior, the appropriate department chair, shall discuss the matter with the offending medical staff member, and emphasize that the behavior is inappropriate and must cease. The offending medical staff member may be asked to apologize to the complainant or others known to be the targets of, or adversely affected by, the offending behavior. The approach during this initial intervention should be collegial and helpful. The department chair shall provide to the Medical Executive Committee at its next regularly scheduled meeting a summary of this discussion and any action requested of, and subsequently taken by, the member.

D. If the offending medical staff member has demonstrated persistent, repeated inappropriate behavior which taken together constitutes harassment (a form of disruptive behavior), or has engaged in an episode of disruptive behavior on the first offense, as determined by the medical executive committee, the medical executive committee shall issue a letter of admonition to the offending medical staff member, and, as appropriate, a rehabilitation action plan developed by the medical executive committee, or by its delegate, with the advice and counsel of the medical executive committee.

E. If, in spite of the admonition and intervention discussed in the previous subsection, disruptive behavior recurs, the President shall appoint an ad hoc committee of no less than three persons from the Medical Executive Committee who shall meet with the member to discuss the matter fully, and advise the offending medical staff member that such behavior must immediately cease and never recur or corrective action will be initiated. This “final warning” shall be summarized in writing and sent to the offending member, and a copy of the letter shall be placed in the member’s credential file.

F. If after the “final warning” discussed in the previous subsection the disruptive behavior recurs, and the President of the Medical Staff determines the report and information regarding the recurrence is likely to be credible, the President may take any action authorized under the medical staff bylaws if he determines the member poses a threat of imminent harm. In any case, the President shall immediately initiate an investigation under Article VII of the medical staff bylaws. The Medical Executive Committee shall receive the report of the ad hoc committee appointed thereunder, and immediately evaluate the matter for initiation of corrective action pursuant to the medical staff bylaws.

G. The Medical Director on the advice of the Risk Manager may independently determine that the reported occurrence requires administrative review. This

administrative review, pursuant to administrative and human resources policies and procedures, may be carried out independently of any Medical Staff evaluation.

H. If any practitioner receives three (3) or more unusual occurrence report/referrals directly related to disruptive behavior within any rotating six-month period, this will be considered a trend of concern and may require a focused review. Following review by the President of the Medical Staff and the Department Chair to determine if immediate action is required, the total reports/referrals will be automatically referred to the Medical Executive Committee to determine the need for a focused review or other intervention.

I. The Medical Staff Member being reviewed as a result of the occurrence report/referral may not in any way subject the reporting individual(s) to retaliatory treatment, threats or harassment related to the reporting or review of the occurrence. The Medical Staff Member, or his/her designee, shall not attempt to contact the reporting individuals regarding the reported events and may not discuss the events with the reporting individuals except as may occur as part of the formal Medical Staff or administrative review process. Any harassment type activities, such as those described above, which are carried out by the Medical Staff Member being reviewed should be immediately reported to the Institutional Quality Department/Risk Manager, the President of the Medical Staff and/or the Medical Director. If found to be accurate, such activity may be the basis of additional corrective action by the Medical Staff.

J. If a Medical Staff review is indicated, then the Peer Review Protocol should be followed. Further actions may include discussion of the event with the involved practitioner, the performance of a more in- depth Medical Staff review, initiation of an investigation or the initiation of corrective action. The results of the peer review process shall be placed in the peer review protected file/database along with any written response received from the practitioner and will be considered at the time of reappointment.

26.6-3 Actions to Enforce the Behavioral Policy

Action taken by the medical staff leadership to enforce this policy should initially be non-adversarial in nature, if possible, with the focus on restoring trust, placing accountability on and rehabilitating the offending medical staff member, while always protecting patient care and safety. The medical staff shall endeavor to implement tiered, non-confrontational intervention strategies, starting with informal discussion of the matter with the appropriate section chief or department chairperson. Further interventions can include a request for an apology from the medical staff member directly addressing the problem, or a letter of admonition to the member, a final written warning, anger management or other educational efforts, or corrective action pursuant to the medical staff bylaws, if the behavior is or becomes disruptive. The use of summary suspension should be considered only where the physician's disruptive behavior presents an imminent danger to the health of any individual. At any time rehabilitation may be recommended. If there is reason to believe inappropriate or disruptive behavior is due to illness or impairment, the matter may be evaluated and managed confidentially according to the established procedures of the medical staff's Well-being Committee.

## 26.7 Addressing Complaints' of Patients And Family

This policy shall apply equally with regard to any complaint from a patient, patient's friend(s) or family member(s), except that the Patient Advocate shall contact and/or meet with the complainant to discuss the matter. The Patient Advocate shall generally explain the procedures for handling these complaints, provide empathy and understanding, thank the complainant for sharing his concerns and assure the complainant that such behavior is not tolerated and shall be addressed.

## 26.8 Disruptive Behavior Against a Medical Staff Member

Disruptive behavior which is directed *against* a Medical Staff member by a hospital employee, contractor, board member, or other member of the hospital community shall be reported by the member to the hospital pursuant to the hospital policy governing conduct.

# SECTION 27 Medical Staff Policy on Disclosure of Interests and Resolution of Conflicts of Interest

## 27.1 Disclosure of Interest and Conflict of Interest Resolution

27.1-1 A conflict of interest policy serves the objective of improving the internal decision- making processes of the medical staff. The objective of this conflict of interest policy is to encourage unbiased, responsible medical staff management and decision-making, all of which is in furtherance of quality of care and patient safety. This conflict of interest policy shall be applied equally to all medical staff members.

27.1-2 Conflicts of interests among the members of the medical staff are not completely avoidable. The presence of a conflict of interest is often indicative of the broad experience, accomplishments and diversity of those who are granted decision-making authority in any organization. The goal of this conflict of interest policy is to identify potential conflicts of interest and manage those conflicts of interest which are actual and material. Therefore, the potential consequences of conflicts of interest shall be kept in mind by those charged with making decisions, and, in case of doubt, interests that may potentially lead to a conflict shall be disclosed.

27.1-3 Neither the disclosure or existence of financial or personal interests, nor the disclosure or existence of a conflict of interest, shall affect medical staff membership or privileges. Membership and privileges on the medical staff shall be granted, revoked or otherwise restricted or modified based only on the professional training, competence, experience and conduct criteria set forth in the medical staff Bylaws and these Rules.

27.1-4 For the purposes of these Rules, CONFLICT OF INTEREST means a personal or financial interest or conflicting fiduciary obligation that makes it extremely unlikely, as a practical matter, for the individual to act in the best interests of the medical staff without regard to the individual's private or personal interest. Such an interest may also be held by an immediate family member of that individual, including that individual's spouse, domestic partner, child or parent.

27.1-4 The disclosure of an interest, as set forth in these Rules, does not automatically mean that a conflict of interest exists. Whether a disclosed interest constitutes a conflict depends on other factors, as set forth below.

## 27.2 Application

27.2-1 In order to encourage unbiased, responsible management and decision making, all medical staff leaders, including officers, department chairs, division chiefs, medical staff representatives at-large, committee chairs, medical staff members serving on committees, and any other medical staff members acting in a decision-making capacity regarding medical staff affairs and activities, shall comply with the disclosure of interest and conflict of interest requirements as relevant to the position held and the circumstances, consistent with these Rules. These positions include, but are not limited to:

A. Medical staff members serving as a medical director;
B. Medical staff members of a hospital contracted group or other organization affiliated, or under contract with, the hospital;
C. Medical staff members serving in a hospital-appointed or elected position, including as a hospital board member, whether ex-officio or otherwise;
D. members of the board of directors of primary insurance groups;
E. members receiving payment from other hospitals.

27.2-2 These Rules, in conjunction with Bylaws section 3.10, shall be the unique and exclusive mechanism for discerning and acting upon conflicts of interest applicable to medical staff members. Only those medical staff members who also serve on the governing body may be required to adhere to a disclosure and conflict of interest policy, if any, of the governing body.

## 27.3 Medical Staff Form for Disclosure of Interests

27.3-1 No member may exercise any leadership, committee, or peer review role, or any medical staff investigative or other decision-making role on behalf of the medical staff unless the member timely completes the Medical Staff Disclosure of Interest Form ("DIF") approved by the Medical Executive Committee, and discloses the form, as consistent with these Rules. The DIF shall be used to record and disclose the personal, financial and professional interests of the member, as set forth more fully elsewhere in this Rule. The member shall update the DIF within thirty (30) days of the occurrence of any changes relating to statements on that form.

27.3-2 The member's completed DIF shall be available for viewing only by with those who need the information to make an informed decision about the member's role as a decision maker. These circumstances include disclosure in at least the following situations:

A. to those who have the right to vote for the member for election or appointment to a leadership position within the medical staff;
B. to those who have the right to vote or determine whether the member should abstain, or be recused, from participation in any particular decision(s) or recommendations to be made by a committee of the medical staff;
C. to fellow committee members and reviewers at the inception of, or at any time in carrying out, the duties as a committee member, investigator or peer reviewer;
D. to leaders who may appoint the member to serve on a medical staff committee, or in a peer review or other investigative or decision-making capacity within the medical staff;

27.3-3 Aside from the foregoing, a DIF, and the information contained within it, shall be used only for bona fide medical staff purposes and not for individual personal use or hospital administration or board use without the written consent of the member to whom it pertains. No DIF information may be shared with any person who is not a medical staff members. A violation of this subdivision shall be grounds for medical staff discipline.

27.2-4 Members holding any leadership or committee role must disclose their potential conflict of interest relevant to the subject under discussion when they address a medical staff body or prior to voting upon the subject where a potential conflict of interest exists.

## 27.4 Information to be Disclosed on the Medical Staff Disclosure of Interest Form at the Time of the Members' Candidacy for a Leadership Position

27.4-1 Members subject to this Policy have a duty to disclose, at the time of candidacy, any actual or potential personal or financial interest that a reasonable person would believe may have the potential to create a conflict in representing, advocating for or otherwise serving in the medical staff position or role at issue. These include, but are not limited to current or impending:

A. Competitive or personal relationships, activities, or interests that may reasonably perceived to have the potential to influence a member's decisions or actions;
B. Grants or other financial, academic or professional relationships involving research relating to decisions under review;
C. Ownership or investment interests in excess of $5,000 or 5% of the whole, whichever is less, in any hospital, hospital system, and/or ambulatory health facility;
D. Ownership or investment interests in excess of $5,000 or 5% of the whole, whichever is less, in any company that furnishes goods or services to the hospital or is seeking to provide goods or services to the hospital;
E. Employment, consulting or other personal compensation agreement with any hospital or ambulatory health facility;
F. Ownership or investment interests in excess of $5,000 or 5% of the whole, whichever is less, or holding a director, trustee, officer or key employee position in a managed care company that contracts with or could contract with the hospital;
G. Receipt of gifts including goods, services, or honoraria from the hospital or any company or person who contracts with or otherwise sells to the hospital, in excess of$100;
H. Employment, consulting or other personal compensation agreement with any quality assurance, credentialing, and/or utilization review entity, including but not limited to any third party payer, quality improvement organization, or the Medical Board of California.
I. Individually held material financial interests of a spouse, or domestic partner, parent or child.
J. Any other personal or financial interest or conflicting fiduciary obligation that may raise a conflict of interest.

## 27.5 Subsequent Disclosures of Interest

Subsequent written disclosures on the medical staff DIF shall be required from each member-leader at the time of re-election, re-appointment, at any change in appointed or elected position or at any material change in the member's interests. Written disclosures of interests, other than those submitted at time of reappointment which show no changes from the prior written disclosure form, shall be submitted to the medical executive committee, and shall be available to any member who has a direct interest in election or selection of the leader making the disclosure.

## 27.6 Verbal Disclosures Required

At each meeting of a medical staff committee or other medical staff event where such a disclosure may be relevant to the immediate proceeding, medical staff members shall verbally disclose all interests that could potentially constitute a conflict of interest relative to the member's role or authority at the meeting or event. Disclosures of such interests shall be made to the entire medical staff body or medical staff committee in attendance, as appropriate. Verbal disclosures shall be recorded in the minutes of proceedings, as shall abstentions and recusals based on conflicts of interest.

Each disclosed interest shall be assessed by the pertinent medical staff body or committee on a case-by-case basis.

## 27.7 Member's Abstention or Recusal

27.7-1 Least Disruptive Measures Required.

In the event a conflict of interest is determined to exist, this policy requires application of least disruptive remedial action available and necessary in order to preserve, to the maximum extent feasible, the ability of an involved member to carry out the responsibilities of the leadership role to which he/she has been elected or appointed.

27.7-2 Voluntary Abstention and/or Recusal.

Abstention is the act of withholding one's vote on a matter. Recusal is the disqualification of a person from participating in the decision-making on an issue, including leaving the meeting room, due to the members' conflict of interest. Sometimes, it is appropriate for a recused member to present his or her views or perspectives on a matter, but no more.

Not all disclosures of a potential conflict of interest require a member's abstention or recusal. However, a member may voluntarily abstain from voting, or self-recuse, on any issue based on a perceived or actual conflict of interest. A member *shall* recuse himself/herself if the member reasonably believes that his/her ability to render a fair and independent decision is or may be affected by a conflict of interest. A recused member shall not be counted in determining the quorum for the vote on the matter, but may answer questions or otherwise provide information about the matter after disclosing the conflict. Otherwise, a recused member is disqualified from attending, or involvement in, any further participation in the matter so long as the matter remains under consideration. Voluntary abstention or recusal does not excuse the member from making the disclosures required by this policy.

27.7-3 Involuntary Recusal for Conflicts of Interest.

A. Where an individual has failed to [a] voluntarily disclose a potential conflict of interest, [b] abstain from voting, or [c] recuse himself/herself, from the decision-making process and/or participation, the medical staff committee or body involved may vote whether to involuntarily recuse, and thereby disqualify, the individual from any further participation in the matter so long as the matter remains under consideration.

B. A majority vote is required for involuntary recusal. Votes to involuntarily recuse an involved individual may be based upon information obtained through disclosure by the involved individual and/or credible information provided by others. Before a vote is taken on whether involuntary recusal is appropriate, the involved individual shall be notified of this possibility and permitted an opportunity to explain to the medical staff committee or body why he/she should be allowed to participate in the matter at hand. The individual shall be excused from the room for the discussion and vote regarding the recusal.

C. A recused individual shall cease all participation in the matter to which the conflict relates. Further, for as long as the matter remains under consideration, the individual shall receive no further information upon which the committee or body relies in its consideration of the matter. The individual shall be informed of that fact.

D. The minutes of medical staff meetings shall include the names of those who disclosed potential conflicts in the meeting and those who abstained, and/or recused themselves voluntarily, or were recused by a vote of the majority.

## 27.9 Selection of Alternate Committee After Recusal

Medical staff members who fail to comply with all provisions of these bylaws concerning actual or potential conflicts of interest shall be subject to corrective action under these bylaws, including but not limited to removal from the medical staff position.