Banner Del E. Webb Medical Center

Rules and Regulations, Credentialing and Privileging Policy

Allied Health Professionals and Ancillary Staff Professionals

I. CATEGORIES

The Medical Executive Committee (MEC) and the Banner Board determines the categories of individuals eligible for clinical privileges or scope of care and are referred to in the Medical Staff Bylaws as Allied Health Practitioners or Ancillary Staff Professionals. Allied Health Practitioners and Ancillary Staff Professionals are not members of the Medical Staff and do not have voting privileges at Medical Staff meetings unless the privilege to vote is granted by policy at the time the committee appointment is made.

Allied Health Practitioners (AHPs) are healthcare professionals other than licensed physicians who are granted clinical privileges to provide direct patient care services at Banner Del E. Webb Medical Center under a defined degree of sponsorship by a physician medical staff member who has been granted clinical privileges. These categories are:

- Physician assistants
- Advanced practice nurses (i.e., nurse practitioners)
- Certified Nurse Midwives
- CRNA's
- Audiologists
- Crisis Counselors

Ancillary Staff Professionals (ASPs) are individuals who provide only those clinical services that are consistent with a written scope of care approved by the Medical Staff and who work in a support capacity for members of the Medical Staff. These categories are:

- Certified Surgical Technician First Assistants (CSTFA's)
- Intraoperative Monitoring Techs (IOMT's)
- Orthopedic Assistants
- Pathology Assistants
- Registered Nurse First Assists (RNFA's)
- Surgical Registered Nurses
- Surgical Technicians

II. QUALIFICATIONS

Qualifications shall include:

- Licensure (if applicable to category): Evidence of current valid license issued by the State of Arizona
- Prescriptive Authority (if applicable to category): Evidence of current valid authority to prescribe medications
- DEA (if applicable to category): Evidence of current valid DEA
- Certification: Evidence of current board certification as required by MEC and the Board.
- Professional Liability Insurance: AHPs and ASPs must maintain current professional liability insurance with liability limits in an amount as determined from time to time by the Board and with an insurance company that is acceptable to the Board.
- Professional Education and Training: Such education and training as required by the MEC and the Board.
- Clinical Performance: AHP's and ASP's must have current experience, clinical results and utilization practice

patterns, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency.

- Attitude: AHP's and ASP's must display a willingness and capability to work with others in a cooperative, professional manner appropriate to quality patient care
- Disability: AHP's and ASP's must be free from, or exhibit adequate control of, any significant physical, mental or behavioral impairment that may adversely affect the ability to provide quality patient care.
- Professional Ethics and Conduct: AHP's and ASP's must demonstrate high moral character and adherence to generally recognized standards of professional ethics.
- Communication Skills: AHP's and ASP's must be able to read and understand the English language and to communicate in writing and verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible manner.

IV. BASIC RESPONSIBILITIES OF INDIVIDUAL MEMBERSHIP

Each AHP or ASP shall:

- Present to a Banner Medical Staff Services Department in the Arizona Region and present a government issued form of identification as part of the application process. Approved forms of identification are: a) state issued driver's license, b) state issued identification, c) visa, and d) passport.
- Agree to comply with the Medical Center's Disruptive Conduct Policy.
- Provide patients with quality care at the generally recognized professional level of quality and efficiency in the community—to the extent authorized by his or her license, certification, or other legal credentials—by the terms outlined in the AHP category privileges description and by the privileges granted or ASP scope of care.
- Abide by all applicable state and federal laws regulating healthcare providers, as well as by rules and regulations and all other lawful standards, policies, and rules of the Medical Center.
- Discharge functions assigned by the MEC, including but not limited to quality improvement, peer and professional review, patient care monitoring, utilization review, ASP's management, and other responsibilities.
- Cooperate with and participate in committee activities as requested by MEC.
- Submit to such physical and/or mental examination(s) or provide verification of health status as required to verify the AHP's or ASP's ability to fully meet his or her responsibilities and/or to perform the requested privileges or scope of care.
- Provide evidence of freedom from infectious pulmonary tuberculosis pursuant to R9-10-207.
- Report to the Medical Staff Services Department immediately any action taken affecting licensure, certification, registration, or federal Drug Enforcement Agency registration including but not limited to probation, restriction, suspension, termination, and voluntary or involuntary relinquishment of same.
- Utilize Medical Center resources appropriately.
- Treat all individuals at or associated with the Medical Center courteously, respectfully, and with dignity at all times.
- Comply with policies, procedures, rules, regulations, and requirements that relate to the provision of services by AHP's or ASP's at the Medical Center.
- Write orders and provide care, treatment, and services only as permitted by his or her licensure or certification and as outlined in the AHP privileges description and privileges granted to the AHP or scope of care approved for the ASP.
- Document in patient medical record in a complete and timely fashion to the extent authorized in the privileges granted to the AHP or ASP, if granted authority in the scope of care.
- Seek consultation, supervision, and direction whenever appropriate or necessary and as required in the privileges granted to the AHP, or the ASP if granted authority in the scope of care.
- Abide by the ethical principles of the profession.

- AHP's and ASP's must at all times maintain the confidentiality of patient identifiable information and peer review activities and may make no voluntary disclosures of information except to persons authorized to receive it. AHP's and ASP's must abide by HIPAA guidelines and policies.
- Maintain all other qualifications for privileges set forth in this policy or the applicable AHP privileges description or ASP's scope of care.
- Report to Medical Staff Services Department immediately denial or loss of ability to provide services at another hospital or healthcare institution, any adverse determination by a peer review organization or denial or loss of right to participate in any federal or state program, including Medicare/State program.
- Report to Medical Staff Services Department any loss of employment by medical center or sponsoring physician.
- Wear photo identification badge above waist present for all to see.
- Pay dues as assessed by Medical Staff.

V. SPONSORING PROCEDURES

AHP's and ASP's must have a designated sponsoring physician medical staff member acceptable to and in good standing on the medical staff. A copy of the sponsoring agreement will be submitted with the AHP and ASP's application and will be signed by both parties.

The primary sponsoring physician must sign the privileges of the AHP, or scope of care for ASP's, that he or she sponsors, in which he or she accepts responsibility for the services provided by each AHP or ASP under his or her sponsorship and agrees that the AHP or ASP will not exceed the scope of practice defined by law (within his or her licensing agreement - i.e., sponsoring agreement).

VI. APPLICATION PROCESS

AHP's employed by the Medical Center: Employment by Banner as an AHP is contingent upon successful completion of the credentialing and privileging processes administered by the medical staff organization of the Medical Center.

If the AHP begins employment prior to completion of the credentialing process, the AHP cannot exercise the requested clinical privileges (including functioning under standardized protocols/procedures) until the credentialing process has been successfully completed. During this interim period, the AHP may function as a registered nurse (for advanced practice registered nurses). The applicant will be informed by the Medical Staff Services Department as soon as possible if an unfavorable recommendation is made by the department chair, the Credentials Committee, the MEC or the Banner Board. It will be the responsibility of the employed AHP to notify the Human Resources Department.

AHP's or ASP's employed or sponsored by a physician member of the medical staff organization: AHP's or ASP's will be instructed to obtain application materials from the MSSD. Exercise of privileges or scope of care may not begin until the credentialing process has been successfully completed. The applicant will be informed by the Medical Staff Services Department as soon as possible if an unfavorable recommendation is made by the department chair, the Credentials Committee, the MEC or the Banner Board.

VII. STAFF DUES

The Medical Executive Committee shall establish the amount of annual Allied Health Professional and Ancillary Staff dues. Applicants will be required to pay dues at the time of application. Notice of dues shall be given at the time of reappointment at which time two years must be paid. A practitioner's reappointment will not be considered complete unless dues are paid in full. All new staff members must pay one year's worth of dues with the

application. Failure to render payment shall result in automatic suspension as provided in Section XIV(f) or non-processing of a new application. Provider Staff dues are non-refundable.

VIII. VERIFICATION PROCEDURES AND EVALUATION AND DECISION-MAKING PROCESS

Verification procedures will be carried out by the Medical Staff Services Department, or designated centralized verification organization, in accordance with the Medical Center's procedure. The applicant has the burden of producing adequate information for a proper evaluation of qualifications and to resolve any doubts about any qualification required for staff membership. Applications not demonstrating compliance with the requirements for Allied Health Staff membership and privileges will be deemed to be incomplete. Incomplete applications will not be processed. If information is not obtained from the applicant within ninety (90) days after a written request has been made, the application will be deemed withdrawn.

After review by the department chair, the application of AHP's is forwarded to the Credentials Committee and MEC. Application of ASP is reviewed by the Department Chairman and the CEO or his/her designee.

IX. TEMPORARY PERMISSION TO PROVIDE PATIENT CARE SERVICES

Upon recommendation of the Department Chair or designee, the Chief of Staff and the CEO or their respective designee, temporary privileges may be granted in the following circumstances:

- an applicant's complete and verified credentials file has been reviewed and recommended for approval by the IPC. Temporary permission may be granted for 90 days. Temporary permission may be terminated by the CEO or Chief of Staff if it is discovered that any information or action raises a question about a practitioner's professional qualifications or ability to perform privileges or scope of care requested.
- for the purpose of fulfilling an important patient care need. The Medical Staff Services Department will verify current licensure/and or certification, current competency, evidence of malpractice insurance coverage, results of NPDB has been queried and receipt of sponsoring physician statement.

X. AHP REAPPOINTMENT PROCESS

All AHP's shall be reappointed to the AHP staff at least every 24 months. The Medical Staff Services Department or their designee shall send an application for reappointment and notice of the date on which privileges or scope of care expires. Failure to return the satisfactorily completed forms shall be deemed a voluntary resignation. Inadequacies or verification problems shall be reported to the reapplicant who will have the burden of producing adequate information and resolve any concerns.

Relevant findings from quality review, timely and accurate completion of medical records, cooperativeness in working with practitioners and hospital personnel, general attitude towards patients and the Medical Center and compliance with Rules and Regulations, policies and procedures of the medical staff and Medical Center will be considered in the reappointment process.

During the reappointment process, the department chair or his or her designee is permitted access to performance evaluations (maintained in Human Resources files) that occurred during the previous two-year period of time immediately preceding the reappointment (applicable to Medical Center–employed AHP's only). Copies of employment-related performance evaluations are not maintained in credentials files. Peer review data maintained in credentials files (e.g., NPDB query) is not available for individuals performing employment-related performance evaluations.

After review by the Department Chair, the reapplication of AHP's is reviewed by the Credentials Committee, the MEC and the Banner Board.

XI. LEAVE OF ABSENCE

AHP's or ASP's may request a leave of absence for up to one year by giving written notice to the Medical Staff Services Department. During the leave, the privileges or scope of care, and requirement of sponsoring physician, and payment of dues are suspended. The Department Chair will consider the request and forward its recommendation to the Credentials Committee, MEC and the Banner Board for final action.

Reinstatement must be requested in writing. A written summary of his/her relevant activities during the leave must be provided and if the term of appointment has expired during the leave of absence, the reappointment process must be completed. AHP or ASP must provide evidence of current clinical competency, sponsoring physician member of the medical staff, licensure, DEA registration and professional liability insurance. The Department Chair will consider the request and forward its recommendation to the Credentials Committee, MEC and the Banner Board for final action.

XII. PROCEDURES FOR ANNUAL EVALUATION OF PERFORMANCE

The performance of all AHP's and ASP's will be evaluated on a yearly basis as part of the medical staff's routine performance improvement processes. All AHP's yearly annual competency evaluation will occur at the time of reappointment and on the year in between his/her regular reappointment. The assessment will consist of a competency evaluation by the sponsoring physician(s). Any concerns regarding the quality or appropriateness of care provided by an AHP or ASP identified during such review processes shall be referred to the Professional Review Committee (PRC). Any concerns regarding the sponsorship of an AHP or ASP by a physician shall be referred to the appropriate medical staff department. In addition, the quality of care provided by AHP's or ASP's employed by the Medical Center will also be reviewed on an ongoing basis through the employment performance evaluation process of the Medical Center.

The annual competency evaluation of all AHP's and ASP's will be evaluated by the Department Chair and CEO. Any concerns regarding the sponsorship of an AHP or ASP by a physician shall be referred to the appropriate medical staff department or review committee.

XIII. FAST TRACKING NEW APPLICANTS, REAPPOINTMENTS & NEW AND/OR REVISED PRIVILEGES

In order to increase efficiency of the credentialing process, all applications will be categorized into a Category One or Category Two. Applications deemed as Category One will be eligible for "fast-track" and will be processed in an expeditious manner once the file is determined to be complete. Applications deemed as Category Two will be processed through the traditional process.

New Applicant Files & Reappointments: All credentials files will be analyzed for completeness by the Medical Staff Office and categorized as a Category One eligible for fast-tracking or Category Two non-eligible for fast-tracking requiring full review by the Credentials Committee.

(a) Category One: Any appointment or reappointment application can be fast tracked through the Credentials Committee Chairman and the Department Chairman and onto MEC if the applicant meets the qualifications for membership and privileges as outlined in the Bylaws and all information contained within the application is found to be current and complete, identification has been verified and there are no suggestions in the verified materials of potential problems or issues to resolve; no significant malpractice actions; no reports of disciplinary action; and no license restrictions or any type of investigation. If at any time during the process there are concerns raised, the application will be referred to the traditional credentialing process.

(b) Category Two: Any appointment or reappointment application not meeting Category One criteria will be classified as Category Two. Files classified as Category Two require the file be processed through the Department Chairman, Credentials Committee, Medical Executive Committee and Board of Directors.

Additional Privilege Requests and/or Revision of Clinical Privileges (including completion of routine concurrent observation or retrospective review requirements): All new privilege requests, revision of clinical privileges, and completion of routine concurrent observation or retrospective review requirements will be analyzed for completeness by the Medical Staff Office and categorized as a Category One eligible for fast-tracking or Category Two non-eligible for fast-tracking.

(a) Category One: Any request for additional privileges or revision to clinical privileges may be "fast tracked" through the Credentials Committee Chairman and the Department Chairman if a) all eligibility criteria has been met for the procedure, b) there are no suggestions in the verified materials of potential problems or issues to resolve; c) there are no significant malpractice actions; d) there are no reports of disciplinary action; and e) there are no license restrictions or any type of investigation. Any request for a change in observation status may be "fast-tracked" through the Department Chairman and the Credentials Chairman if the applicant has successfully completed all observation or retrospective review requirements and provided documentation of this completion If at any time during the process there are concerns raised, the application will be referred to the traditional credentialing process.

(b) Category Two: Any request for additional privileges, revision to clinical privileges or change in observation status not meeting Category One criteria will be classified as Category Two. Files classified as Category Two require the file be processed through the Department Chairman, Credentials Committee, Medical Executive Committee and Board of Directors.

XIV. REVIEW OF SPECIFIC CONDUCT OR CARE/CORRECTIVE ACTION

Whenever the activities or professional conduct of an AHP or ASP adversely affect or are reasonably likely to adversely affect patient safety or the delivery of quality patient care or are disruptive to the organization's operations, the matter will be reviewed by the PRC. The review and/or investigation may involve an interview of the AHP or ASP involved the sponsoring physician medical staff member and other individuals or groups.

If additional review is necessary, the PRC may designate an ad hoc or external body to investigate the matter. Additionally, the matter may be handled by the employing organization as described in organization-specific policies and procedures (applicable only to AHP's or ASP's employed by the Medical Center).

Automatic relinquishment of privileges

The privileges or scope of care and status as an AHP or ASP shall terminate immediately, without right to due process, in the event that the employment of the AHP or ASP with the Medical Center is terminated for any reason. If the AHP or ASP loses his/her sponsoring physician, privileges will be suspended immediately until the AHP or ASP can provide documentation of new sponsorship by another physician who is credentialed and in good standing at the Medical Center. If documentation of a new sponsoring physician is not provided within 30 days following suspension, the practitioner shall be deemed to have voluntarily resigned from staff and must reapply.

Automatic suspensions

Automatic suspension shall be immediately imposed whenever any of the following actions occur:

a) **License** – when license is revoked, restricted, or suspended, privileges or scope is similarly revoked, restricted or suspended. Reinstatement may be requested during a period of 30 calendar days following suspension if evidence of reinstatement is provided. Thereafter, practitioners shall be deemed to have voluntarily resigned from staff and must reapply.

b) **DEA or Controlled Substance Registration** – when DEA or other controlled substance registration was revoked, restricted, or suspended, right to prescribe medications covered by the registration is similarly revoked, restricted, or suspended.

c) **Professional Liability Insurance** – for failure to maintain the minimum amount of professional liability insurance required by the Banner Board. Reinstatement may be requested during a period of 30 calendar days following suspension upon proof of adequate insurance. Thereafter, practitioners shall be deemed to have voluntarily resigned from staff and must reapply.

d) **Exclusion from Federal (Medicare) /State Programs** – The CEO with notice to the Chief of Staff will immediately and automatically suspend privileges of an Excluded Practitioner. The CEO may restore limited privileges to an Excluded Practitioner upon his/her signing an agreement whereby he/she agrees (a) not to provide items or services to patients enrolled in Medicare/State Programs and (b) to indemnify the Medical Center and the Medical Staff for any liability they might have solely as a result of a breach of this agreement. An "Excluded Provider" is a practitioner whose name is on the then current "list of Excluded Individuals/Entries" maintained by the Office of the Inspector General, Department of Health and Human Services or who has been barred from participation in any Medicare/State Program. A "Medicare/State Program" is any federal or state program, including Medicare, Medicaid, AHCCCS, Indian Health Service, or TriCare program.

e) **Failure to satisfy special appearance requirements** - failure, without good cause, to appear at a meeting where his/her special appearance is required. A practitioner who fails without good cause to appear at a meeting where his or her special appearance is required shall automatically be suspended from exercising all clinical privileges. Failure to appear within 3 months of the request to appear shall result in revocation of staff membership and privileges. Thereafter, the practitioner must reapply for membership and privileges.

f) **Failure to pay staff dues** – A practitioner who fails to pay staff dues shall automatically be suspended. If the dues are paid within 30 calendar days of notification of suspension, the practitioner shall be reinstated. Thereafter, the AHP or ASP shall be deemed to have resigned voluntarily from the staff and must reapply.

g) **Failure to execute releases and/or provide documents** – A practitioner who fails to execute a general or specific release and/or provide documents during term of appointment when requested by the Chief of Staff, Department Chairman or designee or the Professional Review Committee shall automatically be suspended. If the release is executed and/or documents provided within 30 calendar days of the notice of suspension, the practitioner will be reinstated. Thereafter, such practitioner shall be deemed to have voluntarily resigned from staff and must reapply.

h) **Failure to establish freedom from infectious TB** - failure to provide evidence of freedom from infectious TB. Reinstatement may be requested during a period of 30 calendar days following suspension if evidence of freedom from infectious TB is provided. Thereafter, practitioners shall be deemed to have voluntarily resigned from staff and must reapply.

i) **Certification** – failure to maintain certification as required. Reinstatement may be requested during a period of 30 calendar days following suspension if evidence of certification is provided. Thereafter, practitioners shall be deemed to have voluntarily resigned from staff and must reapply.

j) **Eligibility criteria** - Failure to meet eligibility criteria for the applicable category. Reinstatement may be requested during a period of 30 calendar days following suspension if evidence of meeting eligibility

criteria for the applicable category is provided. Thereafter, practitioners shall be deemed to have voluntarily resigned from staff and must reapply.

k) **Failure to Participate in an Evaluation** – A practitioner who fails to participate in an evaluation of his/her qualifications for Allied Health or Ancillary Staff membership and/or privileges shall automatically be suspended. If, within 30 days of the suspension, the practitioner agrees in writing to participate in the evaluation and does participate constructively, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for membership and privileges.

l) **Failure to Complete Assessments and Provide Results** – A practitioner who fails to complete a required educational assessment and/or training program and//or health (including psychiatric/psychological health) assessment and follow-up treatment or to provide a report of such findings shall automatically be suspended. If the report is provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily resigned and must reapply for membership and privileges.

m) **Failure to complete CPOE training** - For categories that are required to complete CPOE training, failure to complete CPOE training will result in the automatic suspension of privileges and failure to complete training within 6 months of appointment to the staff will result in automatic relinquishment of membership and privileges.

n) **Failure to provide evidence of flu vaccine or exemption** - The clinical privileges of a practitioner who provides care services at the Medical Center shall be immediately suspended for failure to provide evidence of annual influenza vaccination or of an exemption. When granted an exemption, failure to wear a protective mask as required by Banner Policy will result in immediate suspension. The practitioner will be reinstated once the flu season has officially ended.

XV. NON-REVIEWABLE ACTIONS

a) Imposition of supervision pending completion of an investigation to determine if corrective action is warranted.
b) Issuance of a warning or letter of admonition or reprimand.
c) Termination or limitation of temporary permission to provide patient care services.
d) Any recommendation voluntarily imposed or accepted by an AHP or ASP.
e) Denial of membership for failure to complete an application for membership or permission to provide patient care services.
f) Removal of membership for failure to complete the minimum supervisory requirements.
g) Removal of membership and permission to provide patient care services for failure to submit an application for reappointment within the allowable time period.
h) Any requirement to complete an educational assessment or training program.
i) Any requirement to complete a health and/or psychiatric psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.
j) Removal of permission to provide patient care services for lack of a sponsoring physician.
k) Temporary suspension for failure to timely complete medical records.
l) Any limitation imposed by employer.

XVI. ADVERSE ACTION REVIEW AND APPELLATE REVIEW

An AHP or ASP shall have the right to dispute any action that revokes, suspends, terminates, restricts, or reduces the clinical privileges or scope of care that the AHP or ASP has been given permission to provide at the Medical

Center unless the action revokes, suspends, terminates, restricts, or reduces the clinical privileges of an entire classification of AHP's or ASP's rather than being focused on an individual AHP or ASP. If the AHP or ASP is a hospital employee and a limitation is imposed by the Medical Center, Human Resources will provide a review pursuant to hospital policy; a review will not be provided pursuant to this policy.

The AHP or ASP's rights of hearing and appeal are as follows:

AHP's or ASP's who are subject to Adverse Action (other than Nonreviewable or Automatic Actions defined in Sections II & III) shall be afforded an Adverse Action Review and appeal process in accordance with these Rules & Regulations. Adverse Action includes: denial of a request to provide any patient care services within the applicable privileges or scope of care or revocation, suspension, reduction, limitation or termination of permission to provide any patient care services within the applicable privileges or scope of care. AHP's or ASPs are not entitled to due process rights set forth in the Medical Staff Bylaws, and none of the procedural rules set forth therein shall apply.

Notice of Adverse Recommendation or Action

Within fifteen (15) days after Adverse Action is taken against an AHP or ASP, the AHP or ASP shall be notified in writing of the specific reasons for the Adverse Action and the AHP or ASP's rights per these Rules & Regulations.

Request for Review of Adverse Recommendation or Action

The AHP or ASP may request an Adverse Action Review following the procedure set forth in these Rules & Regulations. If the AHP or ASP does not deliver a written request for an Adverse Action Review to the Chief Executive Officer within ten (10) days following the AHP or ASP's notice of the Adverse Action, the Adverse Action shall be final and non-appealable.

Composition of the Review Committee

A committee consisting of the Chief Nursing Officer, the Chief of the applicable Medical Staff Department and Professional Practice Director, or their respective designees, will consider the request and serve as the Review Committee.

Notice of Time and Place for Review

The AHP or ASP shall be given ten (10) days prior written notice of the time, place and date of the Adverse Action Review and a list of witnesses, if any, who will be called to support the Adverse Action.

Statements in Support

The sponsoring Medical Staff member and the AHP or ASP shall be entitled to submit a written statement in support and/or to introduce all relevant documentation by supplying two (2) copies of the statement and/or documentation to the Medical Staff Services Department at least three (3) days prior to the review.

Rights of Parties

During the Adverse Action Review, the parties will be given an opportunity to present relevant evidence, call witnesses and make arguments in support of their positions. Neither the AHP or ASP, Medical Center, nor the sponsoring Medical Staff member shall be entitled to legal counsel at the Adverse Action Review or Appellate Review.

Burden Of Proof

The Medical Staff has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the AHP or ASP has the burden of demonstrating, by a preponderance of the evidence, that the adverse

action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

Action on Committee Review

Upon completion of the review, the Review Committee shall consider the information and evidence presented, make a recommendation, which shall include the basis therefore, and forward it to the Chief of Staff. The AHP or ASP and the Medical Staff shall be provided with a copy of the Committee's recommendation.

Duty To Notify Of Noncompliance

If the AHP or ASP believes that there has been a deviation from the procedures required by this Adverse Action Review Plan or applicable law, the AHP or ASP must promptly notify the Chief of Staff of such deviation, including the Adverse Action Review Plan, these Rules & Regulations or applicable law citation. If the Chief of Staff agrees that a deviation has occurred and is substantial and has created demonstrable prejudice, he/she shall correct such deviation.

Request for Appellate Review

If the AHP or ASP is dissatisfied with the Committee's recommendation, the AHP or ASP may submit a written request for an Appellate Review, provided that the Chief Executive Officer receives such request within ten (10) days following the AHP or ASP's receipt of the Committee's recommendation. The request must identify the Grounds for Appeal and must include a clear and concise statement of the facts in support of the request. Grounds for Appeal include: that the Adverse Action Review failed to comply with these Rules & Regulations or applicable state law and that such noncompliance created demonstrable prejudice or that the Review Committee's recommendation was not supported by substantial evidence. If the request for an Appellate Review is not requested properly and/or timely, the Committee's recommendation shall become final and non-appealable.

Interview with Medical Executive Committee

Upon a proper and timely request for an Appellate Review, the AHP or ASP shall be given an interview with the MEC or a subcommittee thereof consisting of at least three (3) members. The AHP or ASP shall be given at least five (5) days prior written notice of the time, place and date of the Appellate Review. At the appeal, the parties shall be allowed to present written and/or oral arguments as to why the Committee's recommendation should be reversed or modified.

Final Determination by the Medical Executive Committee

The MEC shall make a final determination on the Adverse Action, which shall be provided to the parties. The decision of the MEC shall not be subject to further appeal.

The final decision will be submitted to the Medical Staff Subcommittee of the Board.

XVII. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

As outlined in the Professional Practice Evaluation Policy. OPPE also includes annual sponsoring physician competency evaluation.

XVIII. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) *Nurse practitioners, audiologists, crisis counselors, certified nurse anesthetists, and physician assistants.*

A retrospective review of three (3) cases, performed at Banner Del E. Webb Medical Center, must be completed. The three cases must be cases which represent privileges granted.

(a) Three to six months after a practitioner's initial appointment or initial granting of privileges, the Medical Staff Office will obtain a list of the practitioner's activity in the hospital. An evaluation form will be generated for three (3) randomly selected cases which will be reviewed and/or assigned for review by the Department Chairman as needed. Results of the review will be reported to the Department Chairman for review and action.

(b) The reviewer's report is confidential and for use of the Department only. The report, however, may be released to other hospitals if requested in writing, by the reviewed physician for privileges at other hospitals.

(c) Active staff members of the Department are eligible to serve as reviewers for the retrospective review process.

(d) The reviewer shall give a candid opinion on the report to the Department Chairman. The reviewer shall immediately notify the Department Chairman should any questions arise concerning a physician's competency or management of a particular case.

(e) Following review of the completed review forms, additional cases may be required if deemed necessary by the Department Chairman.

(f) If the practitioner has no activity within the facility to adequately evaluate his/her performance, the FPPE period will be extended for an additional three (3) month monitoring period(s) not to exceed twenty-four (24) months.

(g) Practitioners must complete FPPE requirements within the first (24) months of appointment. Failure to complete FPPE requirements will result in a voluntary resignation from the Medical or Allied Health Staff.

(h) For those practitioners with minimal activity during the initial FPPE period (practitioners who only provide occasional coverage at the hospital), the Department Chairman may recommend that 100% of his/her cases be reviewed during the initial period.

APPROVED: MEC – 5/6/10
Board – 5/13/10

REVISED: MEC – 12/2/10
Board – 12/9/10

REVISED: Dept of Surgery – 8/9/11 (IOMT scope approved)
MEC – 8/9/11
Board – 8/11/11

REVISED: Medical Executive Committee – 3/1/12
Board – 3/7/12

REVISED: Dept of Surgery – 5/10/12
Dept of Medicine – 5/1/12
Medical Executive Committee – 6/7/12
Communicated to MS – 7/2/12
Board – 7/12/12

REVISED: Bylaws Cmt – 111/19/14
Medical Executive Committee – 12/4/14
Sent to Medical Staff for comment – 12/10/14
Board – 1/8/15