Banner Gateway
Medical Center

ALLIED HEALTH PROFESSIONALS
RULES & REGULATIONS

ARTICLE I Definition & Categories

Section I Definition

Allied health professionals (AHPs) are individuals who:

(a) are qualified by training, experience, and current competence in a discipline permitted to practice in the hospital; and

(b) function in a medical support role to physicians who have agreed to be responsible for such AHPs. AHPs are not members of the medical staff.

Section II Categories

The following are the only categories of AHPs currently authorized to provide services in the Medical Center:

Nurse practitioners, non-physician first assistants, certified nurse anesthetists, pathology assistants, private scrubs/surgical technologist and physician assistants. The Executive Committee may recommend for Board approval other categories of AHPs to be given authorization to provide services in the Medical Center.

ARTICLE II Qualifications

A statement of qualifications for each category of allied health professionals shall be developed by the department to which the AHP would be assigned, subject to approval by the Executive Committee and the Board. Each statement must:

(a) Be developed with input, as applicable, from the physician director of the clinical unit or service involved, the physician supervisor of the AHP, and other representatives of the medical staff, Medical Center management, and other professional staff;

(b) Require the individual AHP to hold a current license, Drug Enforcement Administration (DEA) registration (when applicable) or such other credential, if any, as may be required by state law; and

(c) Satisfy the qualifications as are set forth for allied health staff appointment, including appropriate professional liability insurance coverage, or for Medical Center employment, as applicable.

ARTICLE III Prerogatives, Obligations, Terms and Conditions

Section I Prerogatives

The prerogatives of an AHP are to:

(a) provide such specifically designated patient care services as are granted by the Board

upon recommendation of the Executive Committee and consistent with any limitations stated in the Bylaws, the policies governing the AHPs practice in the Medical Center, and other applicable medical staff or Medical Center policies;

(b) serve on committees when so appointed;

(c) attend open meetings of the staff or the department; and

(d) exercise such other prerogatives as the Executive Committee with the approval of the Board may accord AHPs in general or to a specific category of AHPs.

Section II Obligations

Each AHP shall:

(a) meet the basic responsibilities required by Section 3.3 of the Medical Staff Bylaws for medical staff members;

(b) meet the general qualifications required by Section 3.1-5 Cooperativeness and Section 3.1-8 Professional Ethics and Conduct of the Medical Staff Bylaws for medical staff members;

(c) retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the Medical Center for whom services are provided;

(d) participate when requested in quality review program activities and in discharging such other functions as may be required from time to time;

(e) when requested, attend meetings of the staff, the department, and the section;

(f) refrain from any conduct or acts that could be reasonably interpreted as being beyond the scope of practice authorized by the Board.

(g) Prior to practicing at BGMC each AHP is required to present to the ~~Security~~ HR Department to obtain a BGMC photo identification badge which has been verified by legible photo identification.

(1) The AHP is required to present legible Federal/State government issued photo identification (i.e. driver's license, passport, etc.)

(2) ~~An AHP must obtain photo identification within 90 days of notification to Security (or prior to practicing at BGMC, whichever comes first). The names of AHP's who have not obtained photo identification from Security will be provided to Medical Staff Services. Membership and permission to practice for these AHP's will automatically expire per Section III m. of the Allied Health Rules & Regulations~~.

Section III Terms and Conditions

An AHP shall be individually assigned appointment to the clinical department appropriate to his or her professional training.

Any questions concerning the function of an Allied Health Professional at Banner Gateway Medical Center should be referred to the department of the sponsoring physician.

ARTICLE IV Adverse Action Review and Appellate Review, Automatic and Nonreviewable Actions

Section I Adverse Action Review and Appellate Process
Initiation of Adverse Action Review and Appeal Process

Allied Health Professionals ("AHPs") 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 Scope of Practice or revocation, suspension, reduction, limitation or termination of permission to provide any patient care services within the applicable Scope of Practice. AHPs 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, the AHP shall be notified in writing of the specific reasons for the Adverse Action and the AHPs rights per these Rules & Regulations**.**

Request for Review of Adverse Recommendation or Action

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

Composition of the Review Committee

The Medical Staff Department to which the AHP is assigned or departmental committee consisting of at least three members of the Department and a Nursing Administration representative will consider the request and serve as the Review Committee.

Notice of Time and Place for Review

The AHP 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, that will be called to support the Adverse Action.

Statements in Support

The Medical Staff Representative and the AHP 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 Office at least five (5) 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, Hospital nor the Medical Staff Representative shall be entitled to legal counsel at the Adverse Action Review or Appellate Review.

Burden Of Proof

The Medical Staff Representative has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the AHP 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 and the Medical Staff Representative shall be provided with a copy of the Committee's recommendation.

Duty To Notify Of Noncompliance

If the AHP believes that there has been a deviation from the procedures required by this Adverse Action Review Plan or applicable law, the AHP must promptly notify the Chief of Staff of such deviation, including the Adverse Action Review Plan/Allied Health Professionals 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 is dissatisfied with the Committee's recommendation, such party 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'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 shall be given an interview with the Medical Executive Committee or a subcommittee thereof consisting of at least three (3) members. The AHP 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 Medical Executive Committee shall make a final determination on the Adverse Action, which shall be provided to the parties. The decision of the Medical Executive Committee shall not be subject to further appeal.

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

Section II Automatic Suspension or Limitation

Automatic suspension shall be immediately imposed under the conditions contained in this section. In addition, further corrective action may be recommended in accordance with the provisions contained within these Rules & Regulations whenever any of the following actions occur:

(a) **License**
Whenever a practitioner's license is revoked, restricted, expired or suspended, the practitioner's scope of practice is similarly revoked, restricted, expired or suspended.

(b) **Controlled Substances Registration**
Whenever a practitioner's DEA or other controlled substances registration is revoked, restricted, or suspended, the practitioner's right to prescribe medications covered by the registration is similarly revoked, restricted, or suspended.

(c) **Professional Liability Insurance**
A practitioner's appointment shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required by the BHS Board. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension, upon presentation of proof of adequate insurance. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for AHP membership.

(d) **Exclusion From Medicare/State Programs**
The CEO with notice to the Chief of Staff will immediately and automatically suspend an Excluded Practitioner. An "Excluded Practitioner" is a practitioner whose name is listed on the then current "list of Excluded Individuals/Entities" maintained by the Office of 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 CHAMPUS program.

(e) **Failure To Satisfy Special Appearance Requirement**
A practitioner who fails without good cause to appear at a meeting where his or her special appearance is required, shall automatically be suspended. Failure to appear within 3 months of the request to appear shall result in revocation of staff membership. Thereafter, the affected practitioner must reapply for staff membership.

(f) **Failure To Pay Staff Dues**
A practitioner who fails to pay staff dues shall automatically be suspended from the AHP staff. If the dues are paid within 30 calendar days of notification of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership.

(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 a term of appointment when requested by the Chief of Staff, department chairman, section chief, or designee shall automatically be suspended. If the release is executed and/or documents 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 from the staff and must reapply for staff membership.

(h) **Failure To Establish Freedom From Infectious TB**
A practitioner's staff membership and scope of practice shall be immediately suspended for failure to establish freedom from infectious TB whenever such evidence is requested. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension, upon presentation of proof of freedom from infectious TB. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership.

Section III Nonreviewable Actions

Not every action entitles the practitioner to rights pursuant to the Adverse Action Review and Appellate Review. Those types of corrective action giving rise to automatic suspension as set forth in Section 6.6 are not reviewable under the Adverse Action Review and Appellate Review. In addition, the following occurrences are also nonreviewable under the Adverse Action Review and Appellate Review:

(a) Imposition of supervision pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
(b) Issuance of a warning or a letter of admonition or reprimand.
(c) Imposition of monitoring of professional practices, other than direct supervision, for a period of 6 months or less.
(d) Termination or limitation of temporary permission to provide patient care services.
(e) Any recommendation voluntarily imposed or accepted by a practitioner.
(f) Denial of membership for failure to complete an application for membership or permission to provide patient care services.
(g) Removal of membership for failure to complete the minimum supervisory requirements.
(h) Removal of membership and permission to provide patient care services for failure to submit an application for reappointment within the allowable time period.
(i) Any requirement to complete an educational assessment or training program.
(j) Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.
(k) Retrospective chart review.
(l) Removal of permission to provide patient care services for lack of a sponsoring physician.
(m) ~~Failure to verify identification and obtain a badge through the Security Department within 90 days of original notification~~.
(n) Termination of any contact with or employment by the medical center(s).

Where an action that is not reviewable (automatic or nonreviewable action) has been taken against a practitioner, the affected practitioner may request that the action be reviewed and may submit information demonstrating why the action is unwarranted. The Executive Committee, in its sole discretion, shall decide whether to review the submission and whether to take or recommend any action. The affected practitioner shall have no appeal or other rights in connection with the Executive Committee's decision.

ARTICLE V Scope of Service

Section 1 Description

The scope of service that may be provided by any group of AHPs shall be developed by the appropriate department and representatives of management, if applicable, and subject to the recommendation of the Executive Committee and the approval of the Board. For each group, guidelines must include at least:

(a) specifications of categories of patients to whom services may be provided.
(b) a description of the services to be provided and procedures to be performed, including any special equipment, procedures, or protocols that specific tasks may involve, and responsibility for documenting the services provided in the medical record.
(c) a description of the scope of assistance that may be provided to a physician and any limitations thereon, including the degree of physician supervision required.

ARTICLE VI Credentialing

Section I General

The procedures for processing individual applications from AHPs, for reviewing performance during the probationary period, for periodic reappraisal, and for disciplinary action shall be established by the department, the Executive Committee, and the Board.

A physician assistant, nurse practitioner or certified nurse anesthetist who is or who will be providing professional direct patient care services pursuant to a contract or employment with the Medical Center, must meet the same appointment qualifications, must be evaluated for appointment, reappointment, and clinical privileges in the same manner, and must fulfill all of the obligations of the assigned category as a non contracted/employed AHP staff member. Neonatal nurse practitioners are a closed service which is not open to non contracted practitioners.

Section II Processing the Application

(a) **Applicant's Burden**

The applicant has the burden of producing adequate information for a proper evaluation of his or her qualifications and of resolving any doubts about any of the qualifications required for staff membership, department or section assignment, or scope of service requested, and of satisfying any requests for information or clarification (health status including freedom from infectious TB). Applications not demonstrating compliance with the requirements for allied health staff membership and scope of service will be deemed to be incomplete. Incomplete applications will not be processed.

(b) **Verification of Information**

Applications shall be submitted to the Medical Staff Office. Representatives of the Medical Staff Office or its agent as approved by the Executive Committee and BH Board, working with the Credentials Committee shall collect and verify the references, licensure, and other qualification evidence submitted and notify the applicant of any problems in obtaining the required information. Upon such notification, it is the applicant's obligation to obtain the required information. When collection and verification is accomplished, the application shall be deemed to be complete and shall be transmitted with all supporting materials to the chairman of the

Credentials Committee and to the chairman of each department and the chief of each section in which the applicant seeks permission to provide patient care services.

(c) **Credentials Review**

Nurse Practitioners, Non-Physician First Assistants, Certified Nurse Anesthetists

Nursing Administration in cooperation with the Senior Administrator shall review the completed application, the supporting documentation, and any other relevant information and determine if the applicant meets all of the necessary qualifications for staff membership and department and section requested. Nursing Administration shall transmit its recommendation(s) regarding staff appointment and prerogatives to Medical Staff Services for committee review.

Physician Assistants

Upon receipt of all necessary documentation**,** The Credentials Committee at its next regularly scheduled meeting shall review the completed application, the supporting documentation, and any other relevant information and determine if the applicant meets all of the necessary qualifications for staff membership and department and section requested. The Credentials Committee shall transmit its recommendations regarding staff appointment and prerogatives to the clinical department or section in which permission to provide patient care services has been requested.

(d) **Department and Section Action**

The chairman of the respective department and chief of the section (if applicable) in which the applicant seeks permission to provide patient care services shall review the application and its supporting documentation and forward to the Executive Committee the recommendation as to the scope of permission to provide patient care services to be granted.

Prior to submitting a recommendation to the Executive Committee, the chairman of the department and section chief (if applicable) shall determine whether an application is expedited or routine. Applications meeting any of the following criteria may not be eligible for expedited review:

- Application is incomplete
- Where there is a current challenge or previously successful challenge to an applicant's licensure or registration
- Where the applicant has received an involuntary termination of allied health staff membership at another organization
- Where the applicant has received involuntary limitation, reduction, denial or loss of clinical scope of practice
- Where the Credentials Review determines that there has been either an unusual pattern of liability actions brought against the applicant, or an excessive number of professional liability actions resulting in a final judgment against the applicant
- Any felony criminal conviction or any conviction involving healthcare.
- Adverse information on reference letters or comments suggesting potential problems

An application not forwarded directly to the Executive Committee shall be reviewed at the next regularly scheduled meeting of the department prior to being forwarded to the Executive Committee.

A department chairman or section chief may conduct an interview with the applicant or designate a committee to conduct such interview.

(e) **Executive Committee Action**

The Executive Committee, at its next regular meeting, shall review the application, the supporting documentation, the reports and recommendations from the department chairmen, section chiefs, and Nursing Administration/Credentials Committee, and any other relevant information available to it. The Executive Committee shall prepare a written report with recommendations as to approval or denial of, or any special limitations on, staff appointment, and prerogatives, department and section affiliation, and scope of permission to provide patient care services, or defer action for further consideration.

Conditional Appointment/Reappointment: The Executive Committee may recommend that the applicant or member be granted conditional appointment for the term of appointment or reappointment. Conditional appointment/reappointment is not a reduction or limitation of membership or privileges, and does not constitute corrective action. Where the Executive Committee recommends conditional appointment/reappointment, the CEO will advise the AHP member of the Executive Committee's expectations for conduct and/or performance and the possible consequences if those expectations are not met.

Limited Period of Appointment: From time to time, the Executive Committee may recommend a period of appointment of less than two years. A limited appointment may be extended without completion of a new application and review required by these Bylaws provided that a reappointment application is completed and processed within two years. The practitioner will submit a supplemental application and any other requested information, which will be reviewed, along with any additional information deemed appropriate, by the Department.

(f) **Board**

At its next regularly scheduled meeting, the Board may adopt or reject, in whole or in part, a recommendation of the Executive Committee or refer the recommendation back to the Executive Committee for further consideration stating the reasons for such referral. Favorable action by the Board is effective as its final decision. If the Board's action is adverse to the applicant in any respect, the CEO shall, by special notice, promptly so inform the applicant who is then entitled to the procedural rights provided in these Rules and Regulations. Board action after completion of the procedural rights provided in the AHP Rules & Regulations or after waiver of these rights is effective as its final decision.

Section III Temporary Permission to Provide Patient Care Services

(a) CONDITIONS

Temporary permission to provide patient care services may be granted only in the circumstance and under the conditions described below, only to an appropriately certified/licensed practitioner, only when the information available substantially supports a favorable determination regarding the requesting practitioner's qualifications, and only after the practitioner has provided evidence of professional liability insurance of a kind and in an amount satisfactory to the Board upon the recommendation of the Executive Committee. Special requirements of supervision and reporting may be imposed by the Chief of Staff, department chairman, or section chief. Under all circumstances, the practitioner requesting temporary permission to provide patient care services must agree to

abide by these Rules and Regulations and the policies of the Medical Center.

(b) CIRCUMSTANCES
Upon recommendation of Nursing Administration, the Chief of staff, department chairman, or section chief, the CEO or his/her designee may grant temporary permission to provide patient care services in the following circumstance:

Pendency of Application: to an applicant for the purpose of fulfilling an important patient care need who has requested temporary permission to provide patient care services only upon verification of such information contained in the application as deemed appropriate but at least the following:

Verification of current licensure/and or certification (if applicable)
Relevant training or experience
Current competence
Ability to perform within the scope of practice requested
Results of the NPDB have been queried and obtained (if applicable)

The applicant has:
A complete application
No current or previously successful challenge to licensure or registration
Not been subject to involuntary termination, limitation, reduction, denial or loss of staff membership at another organization

Temporary permission to provide patient care services may be granted to an applicant for an initial period not to exceed 120 days. Under no circumstances may such permission to provide patient care services be granted if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

Disaster Management: to a practitioner who is volunteering in the event of a disaster (when the hospital disaster plan has been activated) but only after the identity of the practitioner is verified. The minimum acceptable sources of identification for the practitioner providing emergency care include a current license to practice (if applicable) in the state of AZ accompanied by a) a picture ID or b) verification of the practitioner's identity by a current hospital or medical staff member c) identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or d) identification indicating the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity). The medical staff will begin the verification process of the credentials and permission to practice of individuals who receive disaster scope of patient care service as soon as the immediate situation is under control. The verification process will be the same described in Section III(b). Temporary permission to provide patient care services last for the duration of the disaster or 90 days, whichever occurs first.

ARTICLE VII Reappointment

Section I Information Collection and Verification

A. From AHP

The Medical Staff Office or its designee shall send each AHP member an application for reappointment and notice of the date on which membership

and permission to provide patient care services will expire. The application for reappointment must be submitted on the form designated by the Executive Committee. The application shall include:

(a) Information to demonstrate the member's continued compliance with the qualifications for allied health membership and to update the member's credentials file.
(b) Imposed or pending sanctions and any other problems.
(c) Information regarding health status (including freedom from infectious TB)

Failure to return the satisfactorily completed forms shall be deemed a voluntary resignation from the AHP staff and shall result in automatic termination of membership at the expiration of the current term unless such term.

The Medical Staff Office or its designee shall verify the information provided on the reappointment form and notify the allied health member of any specific information inadequacies or verification problems. The allied health member has the burden of producing adequate information and resolving any doubts about it.

B. From Internal Sources

The Medical Staff Office shall collect all relevant information regarding the individual's professional and collegial activities, performance, and conduct in the Medical Center. Such information may include:

(a) Findings from the quality review and utilization management activities;
(b) Level of clinical activity at Banner Gateway Medical Center;
(c) Timely and accurate completion of medical records;
(d) Cooperativeness in working with other practitioners and hospital personnel;
(e) General attitude toward patients and the Medical Center; and
(f) Compliance with all applicable Bylaws, rules and regulations, and policies and procedures of the medical staff and Medical Center;

C. From External Sources

(a) Verification of clinical competency from a physician designated on the reappointment application.
(b) Verification of staff status from a primary hospital that the allied health member utilizes.
(c) Information regarding any imposed or pending sanctions and any other problems.

D. Nursing Administration Review
(Nurse Practitioners, Non-Physician First Assistants, Certified Nurse Anesthetists)

The Administrator of Nursing Services shall review the reappointment application and all supporting information and documentation, and evaluate the information for continuing the permission to provide patient care services requested. The recommendation of Nursing Administration shall be forwarded to the appropriate medical staff department/section.

E. Department/Section Evaluation

The chairman of the respective department and chief of the section (if applicable) in which the allied health member requests or has exercised permission to provide patient care services shall review the reappointment application and all supporting information and documentation, and evaluate the information for continuing the permission to provide patient care services requested. See Section II (d) for process of expedited vs. routine reappointments. The recommendation shall be sent to the Executive Committee.

F. Executive Committee Action

The Executive Committee shall review the department and section reports, and any other relevant information available to it and either make a recommendation for reappointment or nonreappointment.

G. Board Action

Final approval of reappointments rests with the Board of Directors.

H. Time Periods for Processing

All recommendations for reappointment should be presented to the Board prior to the expiration of the appointment period.

ARTICLE VIII OPPE/FPPE

Section I General

A. Ongoing Professional Practice Evaluation (OPPE)

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

B. Focused Professional Practice Evaluation (FPPE)

Nurse practitioners, certified nurse anesthetists, and physician assistants.

A retrospective review of three (3) cases, performed at Banner Gateway 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 AHP'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.

1) **Monitoring of physician-specific data for the FPPE shall include, as available, the use of blood and blood products, medication usage, appropriate utilization of resources, timeliness of the completion of patient records, quality of patient records, outcome information related to morbidity and mortality, all available performance improvement data, outcome information pertaining to operative and other invasive procedures and other matters related to the physician's competency.**

2) **Clinical competency, technical skill, judgment, adherence to bylaws, cooperativeness and ability to work with others in a professional manner will be evaluated through the peer review process. Generated variance reports shall be reviewed by the Chair or designee.**

3) **If the practitioner has insufficient activity to adequately evaluate his performance, the FPPE period will be extended for a period not to exceed 12 months in duration.**

4) **For those practitioners with minimal activity during the initial FPPE period (practitioners who only provide occasional coverage at the hospital) the MEC may, on the recommendation of the department chairman, modify the department specific requirements, 100% of his/her cases during the initial period will be reviewed.**

Non-physician first assistants and private scrubs/surgical technologists - **a 6 month competency evaluation will be completed by the sponsoring physician and/or peri-operative director.**

Approved: Executive Committee: 5/6/07
Board: 5/17/07

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