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PREAMBLE

This Advanced Practice Professionals (APP) Policy is adopted in recognition of the University of California San Diego Health Medical Staff’s responsibility for overseeing, on behalf of the Governing Body, the quality of patient care, treatment, and services provided by APPs privileged by the Medical Staff at UCSDH. Through this Policy, the Medical Staff provides a delineation of the qualifications, status, clinical duties, and responsibilities of APPs who are granted Privileges through the Medical Staff.

This Policy is only applicable to Advanced Practice Professionals (APPs) and their supervising physicians, as defined in the Bylaws and as set forth below.

DEFINITIONS

The definitions that apply to the terms used in this Policy are set forth in the Bylaws.
ARTICLE 1
QUALIFICATIONS FOR PRIVILEGES

1.1. Designation of Advanced Practice Professionals (APPs)

A. The EGB shall designate which categories of professionals may practice at UCSDH as APPs, and those categories shall be identified in this Policy.

B. Any individual may request that a new category of professional be included in the APP designation. At a minimum, the State of California must recognize the profession through a system of licensure, certification, or registration (as applicable).

C. The request shall be submitted to the MSEC, which may refer it to the Interdisciplinary Practice Committee (IPC) for consideration. The MSEC shall ultimately make a recommendation to the EGB regarding whether the category of professional should be included in the APP Staff.

D. At a minimum, the MSEC and EGB shall consider the following:

1) Any applicable statutory licensing provisions delineating the scope of practice and prescribed mechanisms for governmental oversight (e.g. California Business and Professions Code; California Code of Regulations).

2) Evidence that the new category will improve access to, or quality of care at, UCSDH.

3) The effect of the professional on patient charges.

4) Whether UCSDH and Medical Staff can provide necessary oversight and supervision.

E. The following categories of professionals have been designated as APPs eligible for Privileges:

1) Certified Registered Nurse Anesthetist

2) Certified Nurse-Midwife

3) Nurse Practitioner

4) Physician Assistant

5) Clinical Genetics Counselor
1.2 Basic Qualifications for Privileges

A. Privileges shall be extended only to APPs who are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Bylaws and this Policy.

B. An applicant for Privileges must demonstrate and provide adequate information, as determined by the Medical Staff, to meet all the basic qualifications set forth in this Article in order to have a request for Privileges considered and accepted for review. The applicant must:

1) Qualify to practice as follows:

**Certified Registered Nurse Anesthetist** must meet all of the following requirements: (1) graduate from an accredited nursing program; (2) be licensed in the State of California as a Registered Nurse with designation as a Nurse Anesthetist; (3) graduate from a nurse anesthesia educational program accredited by the AANA Council on Accreditation of Nurse Anesthesia Educational Programs, or its predecessor. This program should consist of a minimum of two-years of clinical and didactic training; (4) be currently certified as a CRNA by the AANA Council on Certification of Nurse Anesthetists or its predecessor (Graduates of an accredited nurse educational program may practice anesthesia for up to one-year after graduating pending completion of the certification examination); and (5) maintain current ACLS certification.

**Nurse Midwife** must meet all of the following requirements: (1) successfully complete a program leading to licensure as a registered nurse; (2) successfully complete a nurse-midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME) Division of Accreditation (DOA); (3) be licensed by the State of California Board of Registered Nursing as a Nurse Midwife; (4) be certified as a Certified Nurse Midwife from the American Midwifery Certification Board (AMCB) - formerly ACNM Certification.

**Nurse Practitioner** must meet all of the following requirements: (1) be licensed by the California Board of Registered Nursing as a Nurse Practitioner; and (2) hold certification by a national or state organization whose standards are equivalent to those set forth in Section 1484 of the Rules and Regulations, Title 16, California Administrative Code, Chapter 12, Registered Nursing. Nurse Practitioners must show proof that he/she is qualified to use the title of “Nurse Practitioner” by the California Board of Registered Nursing.
Physician Assistant must meet all of the following requirements: (1) successfully complete a course of instruction through the California Medical Board’s California Physician Assistant Examining Committee (PAEC); (2) successfully complete a physician assistant training program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA); and (3) provide proof of PA-C designation certification. To attain the PA-C designation, Physician Assistants must pass the Physician Assistant National Certifying Exam (PANCE) administered by the National Commission on Certification of Physician Assistants.

Clinical Genetics Counselors must meet all of the following requirements: (1) be licensed in the State of California; (2) have completed an accredited training program in genetic counseling as recognized by the America Board of Genetic Counseling (ABGC); and (3) be currently certified or an active candidate for the ABGC.

Naturopathic Doctors (ND) must meet all of the following requirements: (1) successfully complete an accredited doctoral program in Naturopathic Medicine approved by the Naturopathic Medicine Committee within the Osteopathic Medical Board of California; and (2) have a minimum of at least one-(1) year of supervised full-time clinical practice. Alternatively, those applying as Naturopathic Doctors may qualify for privileges if he/she presents evidence of five-(5) years of unsupervised clinical practice experience in Naturopathic Medicine.

Provide accurate information, to the satisfaction of the Medical Staff, to assess initial or continued qualifications for Privileges, which include all of the following:

i. Validation of the APP’s current professional license to practice in any state or other professional registration/license;

ii. Be employed or contracted by UCSDH or the UCSDH Clinical Practice Organization;

iii. Adhere to the ethics of his/her respective profession;

iv. Provide current information regarding federal or state criminal charges and convictions. Notification must occur within fifteen (15) calendar days of the charges. Failure to provide such notification is cause to discontinue processing a request for privileges, or if warranted and applicable, automatic suspension or corrective action by the MSEC if previously granted.
v. Agree to work cooperatively and harmoniously with other members of the care team, and comply with all Codes of Conduct and policies of the Medical Staff and UCSDH;

vi. Agree to comply with the Health Insurance Portability and Accountability Act ("HIPAA") and California Confidentiality of Medical Information Act ("CMIA"), and otherwise keep confidential, as required by law, all protected patient information, medical information, or medical records;

vii. Agree to participate in peer review activities in a confidential manner;

viii. DEA registration, if applicable to the APP’s practice, (DEA Certificate must include schedules 2, 2N, 3, 3N, 4 and 5) issued with a State of California local address;

ix. Proof of continuous professional liability insurance with minimum limits as required by the EGB, to include an explanation of endorsements and any limitations;

x. Regardless of the APP’s status, timely and sufficiently respond to any and all questions, inquiries, and requests to document his/her adequate experience, education, and training in the requested Privileges; current professional competence; adherence to professional ethics; and adequate physical and mental health status (subject to any necessary reasonable accommodation) required to perform the requested Privileges; and

xi. Adequate documentation of background, education, experience, training, and current competence sufficient to assure, in the judgment of the appointing authorities, that any patient treated at UCSDH shall be treated with quality professional care and skill.

3) Identify a Medical Staff Member In Good Standing as a supervising practitioner.

i. The supervising practitioner shall assure that the APP complies with the Medical Staff Bylaws, Policies, Plans, and Rules. Supervising practitioners and the APPs they supervise are also responsible for ensuring that the APP complies with the direction and/or supervision requirements detailed in the standardized procedures, supervision agreement, practice protocols, and/or Bylaws, Policies, Plans, and Rules, as applicable.
ii. A supervising practitioner’s failure to supervise an APP in a manner consistent with the standardized procedures, supervision agreement, practice protocols, and/or Bylaws, Policies, Plans, and Rules, as applicable, shall be grounds for corrective action against the supervising practitioner.

iii. As it relates to Physician Assistants, pursuant to California law, a supervising practitioner shall not supervise more than four (4) Physician Assistants at any one time.

1.3 Waiver of Qualifications

Any qualification requirement in this Article or any other Article of the Bylaws or this Policy not required by law or governmental regulation may be waived at the discretion of the EGB upon recommendation of the MSEC, upon determination that such waiver will serve the best interests of the patients of UCSDH.

1.4 No Automatic Privileges

No individual shall be entitled to Privileges merely because he/she holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization or because he/she had, or presently has, privileges at another health care facility. Employment and/or affiliation with UCSDH shall not automatically result in conferral of Privileges.

1.5 Nondiscrimination

Privileges shall be determined by uniformly applied professional criteria. Privileges shall not be denied on the basis of race, color, national origin, religion, creed, gender, medical condition, ancestry, marital status, age, sexual orientation, gender identity, sex, genetic information, citizenship or status as a covered veteran, or physical or mental disability if, after any necessary reasonable accommodation, the APP complies with the requirements as set forth in the Medical Staff Bylaws, Policies, Plans, and Rules.

1.6 Basic Responsibilities for APPs

APPs shall provide services pursuant to approved supervision agreements, standardized procedures, and/or job descriptions delineated by the Service and approved by the IPC, Credentials Committee, MSEC, and EGB, and pursuant to the Privileges granted by the Medical Staff. Supervision requirements shall be specifically defined in applicable standardized procedures, Privilege forms, supervision agreements, and/or job descriptions.

APPs are not members of the Medical Staff and are not eligible to hold office or vote. APPs may participate in the activities of the Medical Staff, may be appointed to committees with voting rights if specified at the time of committee appointment, and
may chair the Interdisciplinary Practices Committee. No APP may admit patients to UCSDH.

Each APP shall continuously meet all of the following responsibilities:

A. Agree to provide timely and continuous care to his/her patients according to the principles established in the Bylaws, Policies, Plans, and Rules, and in accordance with the criteria established by his/her Service, which shall include but not be limited to responding promptly when contacted, identifying acceptable and appropriate coverage for his/her patients when he/she is unavailable, and exercising independent judgment within his/her approved areas of competence, Privileges, applicable standardized procedures, supervision agreements, and job description, provided that a supervising physician shall retain the ultimate responsibility for the patient’s care.

B. Know the Bylaws, Policies, Plans, and Rules, and be bound by them as may reasonably be construed to apply in the context of the limited role and scope of services of the APP.

C. Treat patients in accordance with the APP’s delineated Privileges, standardized procedures, supervision agreements, and/or job descriptions.

D. Abide by the policies and processes of UCSDH and the policies of the University of California.

E. Comply with all applicable laws and regulations of governmental agencies, and comply with applicable standards of The Joint Commission (TJC).

F. Discharge such Medical Staff, Service, and committee functions for which he/she is responsible by appointment, election, or otherwise.

G. Prepare and complete in a timely manner, according to the Bylaws, Policies, Plans, and Rules, including the Medical Records Policy, medical records and other required records for all patients for whom the APP in any way provides services.

H. Abide by the ethical principles of his/her profession.

I. Abide by any Medical Staff and/or UCSDH Code of Conduct, and any other Medical Staff Policies, Plans, and Rules that address conduct.

J. Refrain from unlawful fee splitting or unlawful inducements relating to patient referral.

K. Refrain from any unlawful discrimination against any person, including, but not limited to, any patient, UCSDH employee, UCSDH independent contractor, Member, Practitioner, House Staff, volunteer, or UCSDH visitor, based upon
the person’s race, color, national origin, religion, creed, gender, physical or mental disability, medical condition, ancestry, marital status, age, sexual orientation, gender identity, sex, genetic information, citizenship or status as a covered veteran, or by source of payment, subject to state and federal laws, and regulations.

L. Refrain from any harassment, including sexual harassment, against any person, including but not limited to, any patient, UCSDH employee, UCSDH independent contractor, Member, Practitioner, House Staff, volunteer, or UCSDH visitor. “Harassment” includes any unwelcome conduct that has the purpose or effect of creating a hostile or intimidating environment that is sufficiently severe or pervasive to alter the working conditions of a reasonable person. "Sexual harassment" includes unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters.)

M. Seek consultation whenever specialty expertise is warranted by the patient’s clinical condition, by UCSDH policies and procedures, or by the APP’s Privileges, applicable standardized procedures, supervision agreements, and/or job description.

N. Actively participate in and cooperate as requested with the Medical Staff in assisting UCSDH to fulfill its obligations related to patient care, including, but not limited to, continuous quality improvement, peer review, utilization management, quality evaluation, and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.

O. Communicate with the appropriate Medical Staff Service Chief, Officer, or Chief Medical Officer when he/she obtains credible information indicating that a fellow Practitioner may have engaged in unprofessional or unethical conduct or may have a health or other condition that poses a significant risk to the well-being or care of patients, and to cooperate as reasonably necessary toward the appropriate resolution of any such matter.

P. Participate in Medical Staff proctoring in accordance with the Bylaws, Policies, Plans, and Rules and/or UCSDH policies and procedures.

Q. Work cooperatively with Members, APPs, nurses, UCSDH administrative staff and others in a respectful and professional manner so as not to adversely affect patient care or UCSDH operations.

R. Participate in emergency service coverage as requested.
S. Continuously meet the qualifications for Privileges as set forth in this Policy and the Bylaws.

T. Cooperate with the Medical Staff in its efforts to comply with accreditation, reimbursement, and legal requirements.

U. Supply requested information, and cooperate and appear for interviews with regard to his/her Privileges or in connection with peer review activities.

V. Provide complete and accurate information on requests for Privileges and to immediately notify Medical Staff Administration of any changes in such information at the time the changes or events occur.

W. Authorize the Medical Staff to consult with members of medical staffs of other medical centers/hospitals/healthcare entities with whom the APP trained, has been associated with, or with others who may have information bearing on his/her health status, training, experience, competence, skill, ethics, professionalism, and other qualifications.

X. Consent to the Medical Staff’s inspection of all records and documents that may be material to an evaluation of his/her professional qualifications for the Privileges he/she requested.

Y. Release from liability, to the full extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the APP. He/She also releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the APP, including otherwise confidential information.

Z. Agree to inform the Chief of the Medical Staff and the Chief Medical Officer in writing promptly, but no later than fifteen (15) calendar days, following any notice of malpractice claims, any criminal charges, pleas of nolo contendere, or criminal convictions, any limitations or sanctions imposed or proposed by any other healthcare entity, licensing Board or drug control authority, or state and/or federally funded programs and any voluntary or involuntary relinquishment of any license, registration, privileges, or any report filed with the NPDB, the applicable licensing Board, or any other action against his/her privileges at any institution.

AA. Agree to conduct clinical research in accordance with all applicable laws and University policies regarding human subjects’ research. Prior to conducting any clinical studies involving any patient at UCSDH, the APP must: (a) receive approval from the UCSD IRB to conduct and/or participate in the study; and (b) be granted those Privileges necessary to conduct the procedures involved in the study. He/She also agrees to inform the Chief of the Medical Staff and the Chief Medical Officer in writing promptly, but no later than fifteen (15) calendar days, following notice by any IRB and/or the UCSD Research
Compliance & Integrity Office that he/she is suspended from conducting clinical trials, enrolling patients, serving as Primary Investigator, and/or serving as a sub-Investigator.

**BB.** Agree to inform the Chief of the Medical Staff and the Chief Medical Officer in writing promptly, but no later than fifteen (15) calendar days, following (a) the substantiation of an allegation of sexual misconduct following a formal investigation by any educational institution, employer, regulatory or law enforcement agency, or other organization or entity, or through any other administrative or judicial proceeding; (b) any disciplinary action (e.g., no-contact order, reprimand, probation, suspension), termination, dismissal, or involuntary separation from a post-secondary educational institution (college, university), medical staff, medical group, or employer related to allegations of sexual misconduct; (c) any administrative action (e.g., investigatory leave, or voluntary or involuntary separation) by a post-secondary educational institution (college, university), medical staff, medical group, or employer exceeding thirty (30) calendar days related to allegations of sexual misconduct; (d) any administrative or disciplinary action by a health professional licensing authority related to allegations of sexual misconduct; or (e) the imposition of any requirement that the APP is required to be accompanied by a chaperone when examining, diagnosing, or treating patients as a result of an allegation of sexual misconduct made against him/her.

**CC.** Agree to participate in patient and family education activities, as determined by the Clinical Service, UCSDH, Medical Staff, and/or the MSEC.

**DD.** Agrees to abide by other responsibilities as may be lawfully established from time to time by the Medical Staff and/or MSEC as may reasonably be construed to apply in the context of the limited role and scope of services of the APP.

### 1.7 Standards of Conduct

APPs are required to adhere to the Standards of Conduct set forth in Section 1.6 of the Credentialing Policy.

### 1.8 Fitness for Practice Evaluations

Fitness for Practice Evaluations may be requested by the MSEC as it relates to an APP through the process set forth in Section 1.7 of the Credentialing Policy.
ARTICLE 2
PROCEDURES FOR REQUESTING CLINICAL PRIVILEGES

2.1. General

The Medical Staff shall consider each request for Privileges using the procedure and the criteria and standards for Privileges in the Bylaws and this Policy. The Medical Staff shall also perform this function for individuals who seek Temporary Privileges. The Medical Staff shall review each APP’s qualifications before recommending action to the Executive Governing Body. By requesting Privileges from the Medical Staff, the APP agrees that regardless of whether he/she is granted the requested Privileges, to comply with the Bylaws, Policies, Plans, and Rules as they exist and as they may be modified from time to time.

2.2. APP’s Burden

A. An APP requesting Privileges shall have the burden of producing information deemed adequate by the Medical Staff for the proper evaluation of competence, ethics, and other qualifications, and of resolving any doubts about such qualifications.

B. The APP requesting Privileges shall have the burden of providing evidence that all the statements made and information provided on the request for Privileges are true and correct.

C. Until the APP requesting Privileges has provided all information requested by the Medical Staff, the request for Privileges will be deemed incomplete and will not be further processed.

D. Should information provided in the initial request for Privileges change during the course of an appointment year, the APP has the burden to timely provide information about such change to Medical Staff Administration sufficient for the Medical Staff’s review and assessment.

E. Any committee or individual charged under the Bylaws and/or this Policy with the responsibility for reviewing the request for Privileges may request further documentation or clarification. If the APP fails to adequately respond to such request within thirty (30) days, the request will be deemed incomplete, shall be deemed voluntarily withdrawn, and the processing of the request will then be discontinued.

F. Any committee or individual charged under the Bylaws with the responsibility for reviewing the request for Privileges shall have the authority to require the APP to submit evidence of current health status, evidence of the ability to perform the Privileges being requested, and that the privileging criteria for
appointment has been met. A failure to comply with such a request will result in the request being deemed incomplete and it will be deemed withdrawn.

2.3. Exercise of Privileges

Except as otherwise provided in the Bylaws or this Policy, every APP providing direct clinical services at UCSDH shall be entitled to exercise only those specific Privileges approved for him/her by the MSEC and EGB.

2.4. Criteria for Privileges

Subject to the approval of the MSEC and EGB, each Service will be responsible for developing criteria for granting specific Privileges. These criteria endeavor to assure uniform quality of patient care, treatment, and services. For criteria that apply to APPs, the Services shall work with the IPC in developing these criteria. All criteria shall be subject to approval by the MSEC and the EGB.

Documentation of each APP’s current Privileges (granted, modified, or rescinded) shall be available electronically through Medical Staff Administration.

2.5. Delineation of Clinical Privileges

A. Application Form

An APP requesting Privileges shall complete an application form that requests information regarding the APP and attests to the APP’s agreement to abide by the Bylaws (including the standards and procedures for evaluating APPs contained therein) and releases all persons and entities from any liability that might arise from their review and/or acting on the request for Privileges. The information shall be verified and evaluated by the Medical Staff using the procedure and standards set forth in this Policy and supporting policies of the Medical Staff. No APP has the right to a two (2) year appointment, and appointments may be for periods of less than two (2) years.

B. Basis for Privilege Determinations

1) A request for Privileges or a modification of Privileges must be supported by documentation of training and/or experience supportive of the request.

2) Recommendations for granting Privileges shall be based upon the APP’s training, experience, current professional performance, professionalism, qualifications, reputation, and his/her physical and mental ability to carry out all of the responsibilities specified in the Bylaws, Policies, Plans, and Rules. Recommendations from peers in the same professional discipline as the APP and who have personal
knowledge of the APP’s professional skills, are to be included in the evaluation of the qualifications of the APP’s qualifications.

3) UCSDH shall verify that the APP requesting Privileges is the same individual identified in the credentialing documents by viewing a valid picture ID issued by a state or federal agency (i.e. driver’s license or passport).

4) UCSDH shall verify in writing from the primary source whenever feasible the following information:
   i. The APP’s current licensure at the time of initial granting, and upon renewal and revision of Privileges, and at the time of license expiration;
   ii. The APP’s relevant training; and
   iii. The APP’s current clinical competence.

5) An APP who does not meet the basic qualifications for Privileges as outlined herein, is ineligible to apply for Privileges, and the request for Privileges shall not be accepted for review. If it is determined during the processing of a request for Privileges that the APP does not meet all of the qualifications for Privileges, the processing of the request shall be discontinued. An APP who does not meet the basic qualifications, for which the request process is discontinued, is not entitled to the procedural rights set forth in the Bylaws and this Policy, regardless of whether the review process was initiated.

6) There will be a determination by the applicable Service as to whether a sufficient number of procedures each year are performed to develop and maintain the APP’s skills and knowledge, and compliance with any specific criteria. The Medical Staff shall conduct adequate privileging activities. This may include querying the NPDB, the applicable licensing body, and other relevant agencies.

C. Basis for Subsequent Requests to Renew Privileges

Recommendation for renewal of Privileges shall be based upon a reappraisal of the APP’s performance, including but not limited to clinical and professional conduct at UCSDH and in other settings. The reappraisal shall include confirmation of adherence to requirements as stated in the Bylaws, Policies, Plans, and Rules, and the applicable Service expectations. Such reappraisal should also include relevant APP-specific information from performance improvement activities and, where appropriate, comparisons to aggregate information about performance, judgment, professionalism, and clinical or technical skills. The results of peer review activities, including OPPE and any
FPPE, shall also be considered. Recommendations from peers in the same professional discipline as the APP and who have personal knowledge of the APP’s professional skills, are to be included in the evaluation of the APP’s qualifications.

D. Failure to File Request to Renew Privileges

Failure by the APP to file a completed request for Privileges within the time specified pursuant to the Bylaws and this Policy, shall be considered a voluntary resignation at the end of the current appointment period. In the event Privileges terminate for failure to timely file a request for Privileges, the APP shall not be entitled to any procedural rights as set forth in the Bylaws and this Policy.

In the event of an untimely, incomplete, or withdrawn request, the APP who wishes to request Privileges may submit a new request for Privileges based on the qualifications for Privileges in effect at the time of the new request. The APP will not be permitted to perform any clinical activity at UCSDH until the new request has been fully processed and approved by the MSEC and the EGB.

E. Misstatement or Omission of Relevant Information

If an APP misrepresents or omits relevant information regarding his/her training, experience, and/or qualifications during the request process, the request will be denied and his/her Privileges will be immediately and automatically terminated, unless otherwise determined by the MSEC. Denial of a request for Privileges for reason of misstatement or omission does not give the APP due process as outlined in the Bylaws and this Policy.

2.6 Approval Process for Requests for Privileges

A. Recommendations and Approvals

As set forth in the Bylaws, the Medical Staff Service Chief of the Service in which the APP seeks Privileges shall review requests, together with supporting documentation obtained during the credentialing process, and make a written recommendation to the IPC regarding whether the APP qualifies for the Privileges requested. The IPC shall then review the request and make a written recommendation to the Credentials Committee. The Credentials Committee shall make a recommendation to the MSEC that is either favorable, adverse, or defers the recommendation, along with the reason(s) for its recommendation. Following receipt of the Credentials Committee’s recommendation, the MSEC shall make a recommendation to the EGB that is either favorable, adverse, or defers the recommendation, along with the reason(s) for its recommendation.
If the APP seeks Privileges from multiple Services, each Service shall determine whether the APP qualifies for the Privileges requested within that Service.

B. The Executive Governing Body's Action

The EGB shall review the recommendation from the MSEC and take action by adopting, rejecting, modifying, or sending the recommendation back for further consideration. After notice, the EGB may also take action on its own initiative if more than forty-five (45) calendar days have expired since the Credentials Committee's recommendation and the MSEC has not acted upon the request.

Requests for modification of privileges may also be approved by a delegated committee of the EGB so long as the following criteria is met: (1) the request is complete; and (2) the request has received a favorable recommendation from the Credentials Committee and the MSEC. The process for Expedited Credentialing is further set forth in MSP-23, Expedited Credentialing.

C. Notice of Final Action on Requests for Privileges

When the EGB makes a final determination on requests for Privileges, notice will be given to the APP, and, if the decision differs from the recommendation of the MSEC, notice shall also be given to the MSEC.

2.7 Scope of Practice

A. Nurse Midwife

Nurse Midwifes must practice under the supervision of a licensed physician and surgeon who has current Privileges in obstetrics. The physical presence of the supervising physician is not required at the time the Nurse Midwife is engaged in practice. The Nurse Midwife is authorized to provide care pursuant to his/her Privileges, which may include triaging patients and attending cases of normal childbirth. Nurse Midwifes may provide prenatal, intrapartal, postpartal, and interconceptional care including family-planning for the mother and immediate care for the newborn. The Nurse Midwife shall function within medically approved guidelines set forth in the standardized procedures approved by the IPC, Credentials Committee, MSEC, and EGB.

B. Certified Registered Nurse Anesthetist

Certified Registered Nurse Anesthetists shall practice under the direct supervision of a board certified or board eligible Anesthesiologist who has current Privileges in Anesthesia.

C. Nurse Practitioner
Nurse Practitioners must practice under the supervision of a licensed physician. The physical presence of the supervising physician is not required at the time the Nurse Practitioner is engaged in practice, but he/she must be available in person or by electronic communication at all times when the Nurse Practitioner is caring for patients. A supervising physician shall delegate to a Nurse Practitioner only those tasks and procedures consistent with the supervising physician's specially or usual and customary practice, and with the patients' health and condition. The Nurse Practitioner shall function within medically approved guidelines set forth in the standardized procedures approved by the IPC, Credentials Committee, MSEC, and EGB. Categories of specialization include, but are not limited to, adult nurse practitioner, pediatric nurse practitioner, neonatal nurse practitioner, obstetrical-gynecological nurse practitioner, and family nurse practitioner.

D. Physician Assistant

In compliance with State, and Federal prescribing laws, Physician Assistants are authorized to: (a) perform the medical functions set forth in Business and Professions Code ("BPC"), § 3502.3; (b) to supervise medical assistants pursuant to BPC, § 2069; (c) to provide care and sign forms under the workers' compensation program pursuant to Labor Code, § 3209.10; and (d) any other services or activities authorized under California law.

In further compliance with State, and Federal prescribing laws, the Physician Assistant may order and furnish those drugs and devices, including Schedule II through V controlled substances, as indicated by the patient's condition, the applicable standard of care, and in accordance with the Physician Assistant's Privileges.

Physician Assistants must practice under the supervision of an Active Staff Member. Physician Assistants may only provide those services that he/she is competent to perform and which are consistent with the Physician Assistant’s education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that Physician Assistant. A Physician Assistant shall consult with a physician regarding any task, procedure, or diagnostic problem that the Physician Assistant determines exceeds his/her level of competence or shall refer such cases to a physician.

A supervising physician shall be available in person or by electronic communication at all times when the Physician Assistant is caring for patients. A Physician Assistant and his/her supervising physician shall establish in writing guidelines for the adequate supervision of the Physician Assistant which shall include acknowledgment by the supervising physician that he/she oversees and accepts responsibility for the activities of the Physician Assistant. The supervising physician has continuing responsibility to follow
the progress of the patient and to make sure that the Physician Assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a Physician Assistant under his/her supervision.

E. Clinical Genetics Counselor

Clinical Genetics Counselors shall practice under the supervision of an Active Staff Member.

F. Naturopathic Doctor

Naturopathic Doctors provide consultative services to self-referred patients and/or patients referred to them by other physicians. Naturopathic Doctors do not serve as the patients’ primary care provider. Naturopathic Doctors shall practice under the supervision of an Active Staff Member. Treatments recommended by Naturopathic Doctors often include: dietary and lifestyle counseling; recommendation for appropriate nutritional supplements or herbal medicines; mind-body interventions in the form of behavior change counseling, meditation, breathing exercises; mindfulness training; and/or psychological counseling.

2.8 Disaster Privileges

Disaster Privileges may be granted to an APP through the process set forth in Section 3.5 of the Credentialing Policy.

2.9 Emergency Privileges

For the purpose of this Section, “emergency” is defined as a condition in which serious or permanent harm would result to a patient or other individual or in which the life of a patient or other individual is in immediate danger and any delay in administering treatment would add to that danger. In an emergency, any APP who has been granted Privileges is permitted to do everything possible, within the scope of their license, to save a life or to save an individual from serious harm.

2.10 Temporary Clinical Privileges

Temporary Clinical Privileges may be granted to an APP through the process set forth in Section 3.7 of the Credentialing Policy.

2.11 Proctoring

A. Routine FPPE Proctoring Requirements

1) Except as otherwise determined by the MSEC and EGB, all initially granted Privileges shall be subject to a period of FPPE pursuant to the
standards and procedures set forth in this Policy and the criteria established by the Service in which the APPs will be exercising Privileges.

i. **Initial Request for Privileges:** All initially granted privileges shall be subject to a period of FPPE not to exceed ninety (90) calendar days. APPs who are practicing for the first time at UCSDH are required to complete a minimum of ten (10) proctored procedures.

ii. **Request for Additional Privileges:** When new Privileges are requested by an APP who currently holds other Privileges, he/she will be required to undergo initial FPPE/proctoring for those specific new Privileges. This includes completion of the number of procedures identified by the Medical Staff Service Chief and procedure-specific credentialing criteria for initial proctoring.

2) The APP will be proctored by his/her supervising physician. Proctoring requirements are referenced in the APP’s Privilege form(s).

3) Proctoring pursuant to this Section is routine and generally applied to all APPs. No action taken pursuant to this section shall constitute an Investigation.

B. **Completion of Routine Proctoring**

Completed proctoring reports must be submitted to Medical Staff Administration as soon as practicable after the procedure/case has been proctored. Medical Staff Administration will forward the completed forms to the Medical Staff Service Chief. The Medical Staff Service Chief will review all proctoring forms to assure standard of care has been met. The Medical Staff Service Chief will forward his/her recommendation when the minimum required number of cases has been submitted. The recommendation of the Medical Staff Service Chief will be forwarded to the IPC and Credentials Committee for review, and to the MSEC for final recommendation.

Proctoring shall be deemed successfully completed when (i) the APP satisfactorily completes the required number of proctored cases within the time frame established in this Policy; and (ii) the APP’s professional performance in the cases meets the standard of care of UCSDH, as determined by the Medical Staff Service Chief.

C. **Effect of Failure to Complete Routine FPPE Proctoring Requirement**

1) Failure to Complete Necessary Volume
An APP who has not had adequate volume or opportunity to perform procedures required for proctoring within the ninety (90) calendar day time frame may request a one-time, thirty (30) calendar day extension through the appropriate Medical Staff Service Chief. The Medical Staff Service Chief will be required to appeal for approval of the extension to the MSEC. As part of the appeal, the supervising physician is required to review and agree to the extension. The supervising physician must also provide an explanation regarding the reasons for the extension.

Any APP who fails to complete the required number of proctored cases within the time frame above shall be deemed to have voluntarily resigned the relevant Privileges, and he/she shall not be afforded the procedural rights provided in the Bylaws and/or this Policy.

2) Failure to Complete Proctoring Satisfactorily

If an APP completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, he/she may be terminated for Medical Disciplinary Cause or Reason (or the relevant Privileges may be revoked), and he or she shall be afforded the procedural rights, if applicable, pursuant to the Bylaws and this Policy.

i. The supervising practitioner shall assure that the APP complies with the Medical Staff Bylaws, Policies, Plans, and Rules. Supervising practitioners and the APPs they supervise are also responsible for ensuring that the APP complies with the direction and/or supervision requirements detailed in the standardized procedures, supervision agreement, practice protocols, and/or Bylaws, Policies, Plans, and Rules, as applicable.

ii. A supervising practitioner’s failure to supervise an APP in a manner consistent with the standardized procedures, supervision agreement, practice protocols, or Bylaws, Policies, Plans, and Rules, as applicable, shall be grounds for corrective action against the supervising practitioner.

2.12 Ongoing Performance Monitoring

A. OPPE is the process by which all APPs are evaluated against criteria set by their Service so as to identify performance issues and intervene as necessary. FPPE is the process used to evaluate, for a specified time period or number of procedures, an APP’s performance or competency in exercising his/her privileges. OPPE and FPPE are performance monitoring tools and are not considered a disciplinary measure by the Medical Staff, rather, as information-gathering activities. Performance monitoring does not give rise
to the procedural rights described in this Policy, nor is it considered an Investigation for purposes of the Bylaws.

B. The Officers, Medical Staff Service Chiefs, and Medical Staff committees may undertake informal corrective activities to counsel, educate, or institute retrospective or concurrent monitoring in the course of carrying out their duties without initiating formal corrective action as set forth in this Policy. Comments, suggestions, and warnings may be issued to the APP orally or in writing. The APP may be given an opportunity to respond in writing to informal corrective activities and may be given an opportunity to meet with the Officer, Medical Staff Service Chief, or committee issuing the comment, suggestion, or warning.

C. Any informal actions, monitoring, or counseling may be documented in writing in the APP’s credentials file. MSEC approval is not required for such actions, although the actions shall be reported to the MSEC.

2.13 Leave of Absence

An APP shall request a Leave of Absence, as is defined in the Bylaws, through the process set forth in Section 2.5 of the Credentialing Policy. Any reference in Section 2.5 of the Credentialing Policy to “Member”, shall be read for purposes of this Policy as “APP”.

2.14 Waiting Period for Request for Privileges Following Adverse Decision

The waiting period set forth in Section 2.6 of the Credential Policy shall apply to APPs.
ARTICLE 3
INVESTIGATIONS AND CORRECTIVE ACTION

3.1 Investigations

APPs shall be subject to the Expedited Initial Review/Preliminary Investigation and Formal Investigation processes as set forth in Sections 9.5 and 9.6 of the Fair Hearing Plan and the Bylaws.

3.2 Corrective Action

A. APPs are subject to any corrective action processes described within the terms of their employment with UCSDH.

B. By accepting privileges, APPs are also accepting the Medical Staff’s authority to recommend and/or impose corrective action pursuant to the Bylaws and this Policy. Each APP agrees that he/she will comply with any requirements imposed on the APP as corrective action once that action is considered a final action or if the action is a Summary Action. Failure to comply with the requirements of corrective final actions or Summary Actions shall, in and of itself, be grounds for additional corrective action, including termination of APP Privileges or other practice prerogatives. Invoking the processes in this Policy to challenge corrective actions shall not be considered a failure to comply with any corrective action requirement, and no APP shall be penalized for asserting those rights.

1) Corrective action may be imposed on the grounds that the APP has exhibited acts, demeanor, or conduct as described in the Bylaws and Section 9.3 of the Fair Hearing Plan.

2) Restrictive corrective action is defined as an adverse decision by the MSEC or EGB regarding reappointment, or a denial, reduction, suspension, or revocation of Privileges if the decision (i) involves a Medical Disciplinary Cause or Reason, and (ii) would affect the APP’s Privileges for more than thirty (30) calendar days. Restrictive corrective actions are effective and final upon approval by the Governing Body as described in Section 3.3 below.

3) All other corrective action is deemed non-restrictive. Non-restrictive corrective actions are considered final upon imposition. The MSEC, the Chief of Medical Staff, the Medical Staff Service Chief of the Service in which the APP is exercising Privileges, or the EGB may impose non-restrictive corrective action. The APP shall be given notice of the corrective action and a brief description of the reasons for the action.
The MSEC, the Chief of Medical Staff, the Medical Staff Service Chief of the Service in which the APP is exercising Privileges, the Chief Executive Officer, the Medical Officer, or the EGB may impose a summary restriction or suspension (Summary Action) on any APP whenever any of those individuals or bodies determine that such action is necessary. The APP shall be given notice of the Summary Action and a brief description of the reasons for the action.

3.3 Challenging Corrective Actions

A. If a process to challenge a corrective action is available, the APP must exhaust that process before resorting to legal action.

B. Technical, non-prejudicial, or insubstantial deviations from the procedures set forth in this Policy shall not be grounds for invalidating the action taken.

C. No APP is entitled to the hearing and appeals provisions found in the Medical Staff Bylaws and Fair Hearing Plan.

D. An employed APP who is disciplined through UCSDH’s employment processes, including, but not limited to, termination, is not entitled to challenge that action through the hearing processes described in this Policy. This includes actions UCSDH takes that would, if taken by the Medical Staff, entitle the APP to the hearing process in this Policy.

E. Restrictive Corrective Action

1) If an APP is subject to restrictive corrective action by the Medical Staff and a formal mechanism to challenge the corrective action exists for the APP through his/her employment (e.g. nurse practitioners, in accordance with the provisions of the CNA Agreement), the APP is required to challenge any action by the Medical Staff through that process.

2) If an APP is subject to restrictive corrective action by the Medical Staff and no formal mechanism to challenge the corrective action exists for the APP through his/her employment, the APP shall have the right to challenge an action taken by the MSEC or EGB through the following process:

i. The body that imposes the corrective action shall provide notice to the APP of the action and a brief description of the reasons for the action. The notice shall inform the APP that he/she may request a limited hearing under this Policy and that such request must be received by the Medical Staff Administration within fifteen (15) calendar days of the notice. A copy of this Policy shall be included.
ii. If the APP timely requests a limited hearing, the COMS shall create an *ad hoc* committee consisting of at least three (3) Active Staff Members in good standing of the Medical Staff or APPs. If feasible, at least one of the committee members must have the same licensure and/or practice in the same specialty as the APP who requested the hearing. The members of the *ad hoc* committee shall be impartial and not have participated in the process that led to the corrective action. Knowledge of the action does not disqualify anyone from serving on the *ad hoc* committee. The COMS also shall appoint a hearing officer, which may, but is not required to, meet the qualifications of a hearing officer as set forth in the Fair Hearing Plan.

iii. At least forty-five (45) calendar days prior to the limited hearing, the COMS shall provide the APP with the following:

a. Notice of the date, time, and place for the limited hearing;

b. The names of the *ad hoc* committee members;

c. A brief description of the acts and omissions that led to the corrective action, including a list of medical records, if applicable; and

d. A copy of any witness statements or other documents the Medical Staff intends to rely on at the limited hearing.

iv. At least thirty (30) calendar days prior to the limited hearing, the APP must provide the Medical Staff with a copy of any witness statements or other documents the APP intends to rely on at the limited hearing. Failure to do so shall give the Medical Staff the right to move to exclude such statements or documents from the limited hearing.

v. The following hearing procedures shall be followed:

a. Neither party shall be represented by an attorney at the limited hearing; however, each party may be represented by a Medical Staff member or UCSDH APP of his/her choosing.

b. Both parties may submit a written statement to the *ad hoc* committee prior to the limited hearing, subject to any limits that the *ad hoc* committee may impose. Such
statements must be submitted at least ten (10) calendar days before the hearing, with a copy to the other party.

c. No witnesses shall be presented at the limited hearing. The APP and a representative of the Medical Staff are entitled to make oral statements to the ad hoc committee, subject to any limits the ad hoc committee may impose. All other information provided to the ad hoc committee shall be in the form of documents or written witness statements. The ad hoc committee may question the APP and the Medical Staff representative.

d. The limited hearing shall be recorded by a court reporter or by minutes, as determined by the Medical Staff. The cost of any court reporter shall be borne by UCSDH, but the cost of the transcript, if any, shall be borne by the requesting party. The APP is entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record.

e. The APP shall have the burden of demonstrating to the ad hoc committee by a preponderance of the evidence that the corrective action is not reasonable and warranted.

f. After the limited hearing with the ad hoc committee, the committee shall determine whether or not the APP met his/her burden. Within fifteen (15) days after the limited hearing, the ad hoc committee shall issue a report stating, at a minimum, its factual findings and its conclusion. The ad hoc committee shall submit its report to the MSEC and the APP.

vi. The EGB shall affirm the decision if it is supported by substantial evidence.

vii. The decision of the EGB shall be final.

viii. If required by law, the MSEC and/or EGB will report the decision to the appropriate licensing board and/or the NPDB.

3.4 Automatic Suspension Or Limitation Without Hearing Rights

A. An APP’s Privileges may be automatically suspended through the process set forth in Section 9.11 of the Fair Hearing Plan. Any reference in Section 9.11 of
the Fair Hearing Plan to “Member”, shall be read for purposes of this Policy as “APP”.

B. APPs shall also be subject to an automatic suspension if his/her supervising practitioner’s Medical Staff membership or Privileges terminate or are suspended, or if the supervising practitioner declines to continue supervision. In such cases, the APP shall remain on suspension until the supervising practitioner is no longer subject to suspension, until another supervising practitioner is identified, or until the APP accumulates sufficient suspension days to result in an automatic termination, whichever occurs first.
ARTICLE 4
CONFIDENTIALITY, IMMUNITY, RELEASES, AND DEFENSE

To maintain confidentiality and to assure the unbiased performance of appointment and reappointment functions, participants in the credentialing process shall limit their discussion of the matters involved to the formal avenues provided in the Bylaws and/or this Policy for processing requests for Privileges from APPs.

APPs are entitled to the same rights and protections as set forth in Article 4, Confidentiality, Immunity, Releases, and Defense, of the Credentialing Policy. Any reference in Article 4 of the Credentialing Policy to “Member”, shall be read for purposes of this Policy as “APP”.