

## **CREDENTIALS MANUAL**

**OBTAINING AND RETAINING  
MEDICAL STAFF PRIVILEGES:  
A GUIDE TO CREDENTIALING PROCEDURES**

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Recent Board Approved Changes June 18, 2025

Recent Appendices Changes June 18, 2025

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**ARTICLE I**  
**GENERAL PROVISIONS**

**1.1 Preamble**

Shady Grove Medical Center seeks to serve its community by providing accessible medical care of consistently high quality. The Hospital thus strives to allow its facilities and equipment to be utilized in a fair and efficient manner by competent health care professionals committed to assisting the Hospital in meeting this objective. The Hospital encourages the application of such professionals to its Medical Staff or Allied Health Professional Staff. Individuals may only provide health care services to Hospital patients if they are members of the Medical Staff and Allied Health Professional Staff or otherwise employed by or under contract to the Hospital.

The Medical Staff of the Hospital, with the approval of the Hospital's Governing Board, has adopted Bylaws, which include certain rules and regulations, in order to provide for governance of the Medical Staff. Subject to the provisions of such Bylaws, and certain State and accreditation requirements, the Hospital has prepared this Manual in order to facilitate the application for and maintenance of privileges on the Hospital's Medical Staff.

This Manual, which has been prepared under the supervision of the Director of Medical Staff Services, is intended to facilitate both the initial application and the biennial reapplication to the Medical Staff of the Hospital.

All members of the Medical Staff, and Allied Health Professional Staff of Shady Grove Medical Center are credentialed to provide care to patients at both the hospital and the Germantown Emergency Center.

**1.2 Definitions**

**Active Candidate Status** means that the Member's specialty board has ruled that the applicant or Member has fulfilled the requirements of the board and is approved for admission to the certification examination.

**Active Staff, Courtesy Staff, Emeritus Staff, Community Staff, and Consulting Staff** shall refer to Members of either the Physician Staff or **Dentists and Podiatrists** as appropriate, unless otherwise specified.

**Allied Health Professional** shall refer to those who provide services as a Physician Assistants, Nurse Practitioners, Nurse Anesthetists, Nurse Midwives, and Psychologists.

**Governing Board** means the Governing Board of the Hospital.

**Bylaws** means the bylaws, rules and regulations of the Medical Staff, including the rules and regulations of the applicable department and section (unless the context requires otherwise), as validly adopted and as amended from time to time. The Bylaws include this Manual, unless the context or text of this Manual provides otherwise.

**Hospital's President** means the individual appointed by the Governing Board to act in its behalf in the overall management of the Hospital.

**Credentials Committee** shall mean the Credentials Committee of the Medical Staff, as convened in accordance with the Bylaws.

**Director of Medical Staff Services** means the individual employed by the Hospital to serve as secretary to the Medical Staff in support of its day-to-day organizational functions.

**Executive Committee** means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Board.

**Hospital** means Shady Grove Medical Center in Rockville, Maryland.

**Hospital's President** means the individual appointed by the Governing Board to act in its behalf in the overall management of the Hospital.

**Medical Staff** means all Physician, Dentist and Podiatrist Members who are privileged to attend patients at the Hospital.

**Medical Staff Services Coordinator** means the individual employed by the Hospital to perform credentialing activities for the Medical Staff.

**Medical Staff Term** shall mean the period for which the Member is appointed to the Medical Staff prior to the next period of reappointment.

**Medical Staff Year** means the first day of January through the thirty-first day of December of each year, inclusive.

**Member** means any health care professional admitted to the Medical Staff, unless the context of this Manual requires otherwise.

## 1.2 Definitions (con't)

**Physician** refers to an appropriately licensed medical physician, osteopathic physician or qualified oral and maxillofacial surgeon.

**Physician Staff** means those Physicians admitted to the Medical Staff.

**Professional Affairs Sub-Committee** means the committee designated by the Governing Board to act on its behalf to approve medical staff, credentialing and quality actions.

**State** means the State of Maryland.

## 1.3 Conformity With Bylaws

This Manual is not intended to replace the Bylaws. It generally describes the rights, privileges and obligations applicable to membership on the Medical Staff of the Hospital, and is a convenient reference document for such provisions. In the event of conflict between this Manual and the Bylaws, the provisions of the Bylaws shall govern.

## 1.4 Adoption and Amendments

This Manual, and any amendments thereto, shall become effective after they have been recommended by the Credentials Committee and the Executive Committee and have been approved by the Governing Board.

## 1.5 Access to Medical Staff Files

- a.) To preserve and protect the confidentiality of credentialing, peer review and disciplinary proceedings, as required by the Bylaws and State law, no applicant, Member, or past Member shall have access to any information in any files maintained by the Medical Staff Coordinator; provided, however, that the applicant or Member shall have access to such information in the event of credentialing, peer review or disciplinary proceedings at the Hospital involving such applicant or Member. If the applicant or Member requests access to his or her Medical Staff files, the applicant or Member shall be permitted to review such file in the presence of the Medical Staff Coordinator and the Chair of the applicant or Member's department or section; however, in such event, all confidential information (e.g., reference letters, peer review information) shall be removed from the file prior to such review.
- b.) The Maryland Board of Physicians or other Regulatory bodies has the legal authority to subpoena copies of a current or past Member's credentialing, peer review and disciplinary proceedings files. The Member will be notified in writing of said subpoena.
- c.) The Maryland Department of Health and Mental Hygiene (including but not limited to the Maryland Board of Physicians), Joint Commission, or other Regulatory bodies has the legal authority to review a current or past Member's credentialing files during a survey process or investigation process. Peer review and disciplinary materials will not be shared unless required by subpoena or law, authorized in writing by the Member, or allowed pursuant to a joint credentialing process with an entity that is afforded the same or similar peer review protections.

## 1.6 Confidentiality & Security Controls

All practitioner files shall be maintained in a safe and secure manner. Electronic files shall be maintained on secure, network shared drives and/or in the credentialing software. Only associates in the Medical Staff Offices shall have full, unrestricted access to the credentialing software and their shared drive folders. Accounts can only be created by system administrators and when an associate leaves the department, their accounts are inactivated.

Password rules are established by AHC IT Security and are required to be changed every 90 days. Every associate is required to sign an annual attestation regarding the correct use of their network ID's and passwords. Misuse will result in termination. All communications via email that are not within the system must be sent securely.

Paper files are maintained in a secure location (a locked room) in the Medical Staff Office. Only medical staff personnel have badge access to this room.

AHC IT performs monthly compliance audits to monitor adherence to security protocols. Network accounts not used in greater than 180 days are inactivated. They also perform random phishing exercises to audit compliance with policy. Those who fail the phishing tests more than 2 times have their accounts inactivated and must attend training prior to having it reactivated.

The credentialing software administrators shall audit the user accounts and access on an annual basis. Appropriate modifications (removal, etc.) shall be made if applicable.

The Medical Staff Director shall perform an audit, no less than semi-annually, of a random sampling of files to audit for credentialing security.

The accuracy of the credentialing information displayed in the practitioner directory is consistent with the credentialing data stored in the medical staff credentialing database.

## ARTICLE II

### CONDITIONS AND DURATION OF APPOINTMENT

- 2.1 Acceptance of Membership:** Acceptance of membership on the Physician Staff shall constitute the Physician's agreement that he or she will strictly abide by the Principles of Medical Ethics of the American Medical Association, American Dental Association, and American Podiatry Association and the Bylaws and as such principles may from time to time be amended or expanded. The Member shall recognize the Executive Committee as the proper authority to interpret any doubtful points of ethics. Each member during initial appointment and reappointment shall sign the Clinical Practice Expectation and agree to abide by them.
- 2.2 Ethical Fees and Services:** Applicants for membership on the Medical Staff shall pledge themselves neither to receive from nor pay to another health care professional, either directly or indirectly, any part of a fee received for professional services except as ethically acceptable.
- 2.3 Action by Governing Board:** Initial appointments and reappointments to the Medical Staff shall be made by the Governing Board. The Governing Board shall take final action on appointments, reappointments, or revocation of appointment only after there has been a recommendation from the Medical Staff as provided in this Manual or in the Bylaws; provided that in the event of unwarranted delay on the part of the Medical Staff, the Governing Board may act without such recommendation on the basis of documented evidence of the applicant's or Member's professional and ethical qualifications obtained from reliable sources and a review of the application.
- 2.4 Term of Appointment:** Initial appointments to the Medical Staff shall be for a period not to exceed three years or until the end of the current Medical Staff Term and shall be active for three years unless the physician only provides consulting services. All new physicians requesting membership only to the hospital will be approved with Community Staff status for three years. Reappointments shall be for a period of three years or less.
- 2.5 Clinical Privileges for Physician Staff:** Appointment to the Physician Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Board, in accordance with the Bylaws.
- 2.6 Application for Appointment:** Every application for staff appointment shall be signed by the applicant (**Practitioners signatures are valid for 120 days, after which forms will have to be re-signed**) and shall contain the applicant's specific acknowledgment of every Member's obligations to provide continuous care and supervision of his or her patients, to abide by the Bylaws, to accept committee assignments, to accept consultation and Medical Staff assignments, to participate in staffing the emergency service area and other special care units, to be loyal to the Hospital, to work harmoniously and respectfully with the Medical Staff, Hospital employees and staff, and Hospital administration, and to cooperate with the Hospital's administration in carrying out its functions. The Medical Staff Office will inform the applicant via e-mail and/or phone when credentialing information obtained from other sources varies substantially from that provided by the practitioner. If, during the credentialing process, information is received that is different than what the applicant originally submitted, the practitioner has the right to review and correct the information. The Medical Staff Coordinator shall notify the practitioner, in writing. The practitioner shall have five (5) business days to respond, in writing, with a response. This information shall be included in the file and provided to the Section and/or Department Chair when the file is ready for review.
- 2.7 Leave of Absence:** Members of the Active Physician Staff may request a leave of absence for a period not to exceed one year. All such requests shall be in writing and include the reason and length of the requested leave. In exceptional circumstances, at the member's written request, the Credentials Committee may recommend that the Governing Board grant up to a one-year extension to the original leave of absence. In the event of military activation, members of the medical staff may request a leave of absence regardless of staff status. Under extraordinary circumstances, such as call to active military duty, such leave may be further extended, but this will again require the member's written request, recommendation of the Credentials Committee and Medical Executive Committee, and Board approval. Upon Member's return, before resuming hospital practice, the member must first request reinstatement of clinical privileges in writing. This reinstatement request must be accompanied by a full written explanation and documentation of member's activities during said leave of absence. If a Member seeks appointment twelve or more months after expiration of said leave of absence, this will be treated as an initial application, pursuant to the Bylaws and Credentials Manuals.
- 2.8 Physician and Allied Health Professionals Health:** (See Appendix D –Health Policy) We abide by, cooperate with, and support the Maryland Physician Health Program as run by the Maryland Board of Physicians in order to provide education about health, address prevention of physical, psychiatric, behavioral or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation of physicians who suffer from a potentially impairing condition.
- 2.9 Death of Member:** Staff membership shall be automatically voluntarily resigned upon death of a Member.
- 2.10 Failure to Maintain Office in Community:**
- a. All Members who take ER call or are on a referral schedule, must maintain their bonafide medical office in Montgomery County or Frederick County; Maryland, limited to 15 miles North of Montgomery County/Frederick

- County borderline.
- b. Failure to do so shall result in automatic resignation of Medical Staff membership without the fair hearing rights set forth in the Bylaws. With the exception of Consulting Staff Members, Emeritus without privileges, telemedicine physicians, and Community Staff.
- c. Members who have their medical practice in the County as of the effective date of this manual must continue to do so.
- d. Providers who bring patients to SGMC from their primary area of practice/own group, may be granted an exception to this requirement. If granted an exception, these providers will be expected to provide follow-up to their patients in their primary area of practice/own group.
- e. Members who utilize their home as an office must submit a certificate from Montgomery or Frederick County indicating approval to use their home as their office.
- f. After the Member has or obtains such an office in Montgomery or Frederick County, failure to continuously maintain his or her practice within Montgomery or Frederick County shall result in automatic resignation of Medical Staff membership without the fair hearing rights set forth in the Bylaws.

**2.11 Voluntary Resignation:** Members who voluntarily resign from the Medical Staff shall submit in writing to the Medical Staff Services Coordinator the reason(s) for such resignation. No Member shall be permitted to resign voluntarily while a corrective action is pending against the Member, or where the Member has been recommended to be denied reappointment "for cause" by the Executive Committee. A Member may not voluntarily resign without complying with all pending peer review and quality assurance inquiries and completion of all patient medical records for which he or she is responsible. A resignation by a Member in lieu of corrective action or during a pending investigation will require a report to the National Practitioner Data Bank and the Maryland Board of Physicians. In case of a Member employed by a Contracted Service, the appropriate Medical Director or Department Chair of the Contracted Service will notify the Medical Staff Office of the resignation of their contracted member. A member who does not submit their reappointment application prior to the end of their medical staff term will have their membership and privileges recommended as a voluntary resignation.

**2.12 Liability and Release:** All acts, communications, reports, recommendations and disclosures performed by or made in good faith to an authorized representative of the Hospital or any other health care facility shall be privileged to the fullest extent permitted under the Bylaws and any State and federal law. All applicants and Members agree to hold harmless any person who acts in good faith and without malice in any activity whose purpose is the achievement and maintenance of quality patient care in the Hospital or any other health care facility or program.

**2.13 Withdrawal of Application:** An applicant for initial appointment or reappointment may withdraw his or her application without prejudice at any time prior to its consideration by the Executive Committee. Further, an applicant for initial appointment or reappointment recommended for denial on the basis of his or her failure to meet minimum objective eligibility criteria (e.g., malpractice insurance, board eligibility or certification) may withdraw his or her application at any time prior to action by the Governing Board. Otherwise, an applicant for initial appointment or reappointment may withdraw his or her application only with the consent of the Executive Committee, which may deem such withdrawal to be with prejudice. "With prejudice" shall invoke the bars to reapplication set forth in the Medical Staff Bylaws

**2.14 Ongoing Responsibilities:** The ongoing responsibilities of each Member of the Medical Staff include:

- A. Providing patients with the quality of care which meets the professional standards of the Medical Staff;
- B. Abiding by the Bylaws;
- C. Completing such reasonable responsibilities and assignments imposed upon the Member by virtue of Medical Staff membership, including committee assignments;
- D. Promptly preparing and completing medical records for all the patients to whom the Member provides care in the Hospital;
- E. Agrees to provide continuous care of his or her patients and making appropriate arrangements for coverage for his or her patients with another Member of the Shady Grove Medical Center Medical Staff; with the exception of referring physicians and consulting physicians; Additionally, contracted groups are also exempt from this responsibility as the group is required to provide continuous care for his or her patients at all times.
- F. Refusing to engage in improper inducements for patient referral;
- G. Participating in continuing education programs, as determined by the Medical Staff;
- H. Participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff or Hospital;
- I. Maintaining professional liability insurance in at least the minimum amount required by the Hospital;
- J. Interacting with the Medical Staff, Hospital employees and staff, and Hospital administration in a harmonious and respectful manner;
- K. Discharging such other Medical Staff obligations as may be lawfully established from time to time by the Executive Committee or Hospital;
- L. Pay initial and reappointment processing fees as well as annual Medical Staff dues and department dues, as required;
- M. Participate in performance improvement activities;
- N. Agrees to abide by Maryland State Law regarding Continuing Medical Education (CME) requirements;
- O. Agrees to cooperatively participate in the Hospital's Case Management (CM) Program;
- P. Agrees to notify the President of the Medical Staff immediately of any change of status to include: licensure, professional liability insurance coverage, DEA or Maryland CDS Certificate, physician coverage, and health status.

## 2.14

### Ongoing Responsibilities (con't)

- Q. Agrees to notify the President of the Medical Staff of any arrests or criminal charges carrying a possible penalty of incarceration in any jurisdiction, including but not limited to DUI and DWI, within 10 days after such arrests are made or charges are filed, and to keep the President of the Medical Staff promptly apprised of any significant developments in such matters, including but not limited to pleas, convictions, and sentencing;
- R. Agrees to notify the President of the Medical Staff within 10 business days of any charges filed by any State or federal licensing or regulatory board, including but not limited to the Maryland Board of Physicians, CDS, DEA, or Medicare, Medicaid and Campus;
- S. Agrees to notify the President of the Medical Staff within 10 business days of any proposed or actual reduction in privileges at any other hospital or institution, whether voluntary or involuntarily imposed;
- T. Agrees to notify the President of the Medical Staff immediately of the provider's exclusion or notification of investigation for exclusion of participation in the Medicare or Medicaid programs. Exclusion from Medicare or Medicaid program participation will result in immediate termination of privileges without rights of hearing and appeal. (See Medical Staff Bylaws, Corrective Action, Section 4. Automatic Termination.);
- U. Agrees to remain free of illegal drug use;
- V. Agrees to fully cooperate with any inquiry or investigation undertaken by the Medical Staff or Hospital in connection with the matters set forth in Sections 2.14 (Q) - (U) above;
- W. Agrees to provide and maintain a working e-mail address to allow for ongoing Hospital and Medical Staff communication and all other correspondence. E-mail is the primary source of communication from the Medical Staff Office and the Hospital;
- X. Agrees to complete all required training, orientation, re-certification, etc., including, but not limited to electronic medical record, HIPAA compliance, initial or continued privileges for fluoroscopy, moderate sedation, or any other privileges that the Hospital or Medical Staff deem necessary. The Applicant/Member is responsible for any fees associated with any training/re-certification required by a regulatory body;
- Y. Agrees to abide by the Conflict of Interest policy of Adventist HealthCare and sign a form during initial appointment and reappointment indicating if you have any potential conflicts;
- Z. Agrees to abide by the Organizational Integrity Policy of Adventist HealthCare and attest to this agreement during initial appointment and reappointment.
- AA. Maintenance of a life support certificate(s) from the American Heart Association or an affiliate of the American Heart Association for those specialties requiring certification (i.e. ACLS, BLS, PALS, NPR, etc) as noted on the delineation of privilege forms.

## 2.15

**Board Certification Status:** Effective May 21, 2000, new MD, DO, DPM, and DMD/DDS (Oral Surgeons only) applicants to the medical staff must be board certified or board admissible.

For those boards that have Maintenance of Certification requirements, they must meet all requirements as per your specialty Board. For those boards that have Maintenance of Certification with Annual re-verification dates, you must be in compliance when re-verification dates are verified. All Members must notify the Medical Staff Office within 10 business days of loss if their Board Certification in their primary specialty.

Effective June 27, 2005, all MD, DO, DPM, and DMD/DDS (Oral Surgeons Only) applicants who completed their residency program after January 1, 1990 must be board certified or board admissible by the appropriate Board recognized by the American Board of Medical Specialties or the American Osteopathic Association Boards or by the American Board of Oral and Maxillofacial Surgery or the American Board of Pediatric Dentistry by the American Board of Podiatric Surgery pertinent to their field of expertise and request for privileges.

Effective August 30, 2006, the American Osteopathic Association Boards (AOA) are considered equivalent to the American Board of Medical Specialties (AMBS) Boards for the purposes of credentialing and are accepted for membership and privileges. All new applicants must be board certified in their primary specialty within 5 years of completion of their residency.

If fellowship trained, the applicant must be board certified in their sub-specialty within 5 years of fellowship completion in order to practice that sub-specialty in this institution.

Effective April 28, 2010, all Dentists coming on staff must be board certified by the American Board of Pediatric Dentistry in their sub-specialty within 5 years of fellowship completion in order to practice that sub-specialty in this institution. If a board certification is not available for their sub-specialty (i.e. General Dentistry), this rule does not apply.

Failure to achieve certification within the 5-year grace period will result in automatic termination of medical staff membership and clinical privileges at reappointment anniversary. Neurosurgeons have a grace period of 6 years as per their board requirement, and Podiatrists have a grace period of 7 years. This termination is not reportable to the National Practitioner Data Bank.

**2.16** **Board Recertification:** Effective January 1, 2006, all new applicants who have completed residency in the year 2005 or after must comply with the re-certification requirements of their Board in their primary area of practice.

**2.17** **Malpractice Insurance Purchase Requirements Upon Loss of Privileges or Change to Non-Clinical Status:** In the following instances, the Hospital may require, at its discretion, that any present or former Member purchase additional adequate malpractice insurance to cover malpractice claims arising out of treatment rendered to patients at the Hospital but not asserted until after the cessation of privileges of the Member at the Hospital (including "tail" and "prior acts" coverage):

- A. Voluntary resignation or leave of absence from the Medical Staff;
- A. Revocation of Medical Staff membership and/or clinical privileges;
- B. Honorary and Community Physician Staff require "tail" or "prior acts" coverage for at least five years from cessation of clinical privileges; or
- C. Other termination of Medical Staff membership and/or clinical privileges.
- D. Such requirement shall be a condition which the Hospital may enforce by not accepting a tendered voluntary resignation, by taking disciplinary action under the Bylaws and/or by judicial process, if necessary.

**2.18** **Reinstatements:** Reinstatement to the Medical or AHP Staff may be requested in writing with an explanation of what the provider has been doing since they left the Medical or AHP staff. A reinstatement may be requested within one year of leaving the Medical and AHP staff and will require a full reappointment application process for the following reasons:

- a) Due to personal/family illness or injury. A \$100 fee may be assessed.
- b) Reappointment non-compliance. Fee of \$300 will be assessed.
- c) Administrative Delay of reappointment. No fee will be assessed.
- d) Leave of Absence. No fee will be assessed.
- e) Moved out of Area with Reappointment within last twelve months. Fee of \$100 will be assessed.
- f) When Medicaid or Medicare program exclusion or investigation is cleared, participant may request reinstatement within twelve months and no fee will be assessed.

**2.19** **Credentialing Physicians and AHPs in the Event of a Disaster:** During a disaster, when the Hospital Emergency Operations Plan (Code Yellow-Disaster Plan) has been activated and Shady Grove Medical Center (SGAH) is unable to handle the immediate patient needs, the Hospital President, the President of the Medical Staff or their designee (s) at the time the disaster is implemented has the option to grant disaster privileges to physicians and allied health professionals who volunteer their services but are not members of the hospital's medical staff. On a case by case basis at his/her discretion following review of the volunteer's application for disaster privileges. The Hospital's Chief Medical Officer will determine the type (s) of medical and technical staff needed to assist with the disaster. The procedures to follow can be found in the Disaster Policy Appendix H of the Bylaws.

**2.20** **Annual Orientation**

Annual orientation is provided to practitioners for the following areas. Practitioners must review the orientation and sign an attestation stating that they have read and understand the content or the materials. This attestation is kept in the practitioners credentialing file.

- Assessment and Management of Pain
- Conflict of Interest
- Illness and Impairment recognition issues specific to licenses independent practitioners
- How to report Environment of Care Risks
- Actions to take in the event of an Environment of Care incident (including Fire Plan, Infection Control Plan, etc.)
- Hospital's Mission, Vision and Values
- Hospital's Patient Safety, Quality Goals and Evidence-Based Practice and Use of Core Measures
- Potentially Preventable Complications (PPCs)
- Situational Briefing Model (SBAR)
- Electronic Incident Reporting (RL Solutions)
- Use of Restraints
- Life Safety
- Code Alerts

- Responsibility in the Event of a Disaster
- I.T. Downtime Procedures
- Internal and External Reporting of Safety and Quality Concerns
- Infection Prevention and Control re: TB Exposure Control Plan, Contact Precautions
- Influenza
- Hand Hygiene
- Pharmacy Information and Anticoagulants
- Multi-Drug Resistant Organisms
- Hospital and Community Acquired Infections
- Hybrid Medical Record Information
- Hospital Department information, ie. Case Management, Security, Health Information Management (formerly Medical Records), Patient Relations, Medical Staff Services, Bed Control and Information Technology
- Patient Safety
- Universal Protocols
- Any other regulatory required education

### **2.21 Review and Action for Sanction Reports**

The Medical Staff Office receives monthly reports of the results AHC's Organizational Integrity Departments run of multiple sanction, exclusion and opt-outs including, Medicare and Medicaid. These results are taken to our monthly Credentials, Medical Executive and Professional Affairs Sub-Committee of the Governing Board for review, action if needed and approval. Practitioners are allowed to determine if they wish to participate in specific programs such as Medicare and Medicaid. If a practitioner decides not to participate, they will show up on the opt-out list and no further action is necessary by any of the Committees noted herein. If a practitioner is excluded from a specific program, the Committees follow their Medical Staff Bylaws with regard to actions to be taken for any practitioners.

## **ARTICLE III**

### **DETERMINATION AND CHANGE IN STATUS OR CLINICAL PRIVILEGES**

#### **3.1 Determination of Clinical Privileges**

**3.1-1 Basis for Determination:** The determination of the clinical privileges to be granted to applicants approved for membership shall be based on the applicant's current licensure, training, experience, references, demonstrated current competence, and where applicable, upon an examination of the records of previous cases treated, and other such information as may be relevant. The Credentials Committee may recommend that current requirements for training be waived for specific physicians who trained prior to such training being readily available, and who demonstrate current clinical competence for the privileges requested. The extent of the clinical privileges granted and the need for proctoring, if any, of an applicant or Member who requests new clinical privileges shall be determined by the appropriate department and the Credentials Committee, subject to the concurrence of the Executive Committee and the Governing Board. Each Member shall be assigned membership in at least one department, and to a section, if any, within such department, but may also be granted membership and/or clinical privileges in other departments or sections consistent with the clinical privileges granted. The exercise of clinical privileges within any department (and section, if any) is subject to the rules and regulations of that department (and section, if any) and is subject to the authority of the Chair of the department (and section, if any).

**3.1-2 Biennial Determination:** The biennial determination of whether a Member's clinical privileges shall be recommended by the appropriate department and section (if any) and shall be based upon direct observation, review of the records, or any portion thereof, of patients treated in this Hospital or other hospitals, review of numbers and types of cases treated and procedures performed, and review of the records of Medical Staff committees, including peer review, Medical Records, continuing medical education credits, and such other statistics/data as may be relevant. If applying for Community Status, the Member must continue to maintain or obtain a current Maryland license, be in good standing with Medicare and Medicaid (if applicable). The department shall make its recommendations to the Credentials Committee, as provided in Article V of the Bylaws, and they shall be subject to the concurrence of the Executive Committee and the Governing Board.

#### **3.2 Change in Staff Category, Clinical Privileges, and Clinical Department or Section**

**3.2-1 Request for Staff Category Change:** Any Member may apply in writing to have his or her Medical Staff category changed to be effective once per year. An application for change in Medical Staff category shall be processed in the same manner as an initial application. Such application may include a request for at least one reference from a practitioner who may, but need not, be a Member of the Medical Staff who is familiar with the Member's work or who has responsibility for assessing the Member's work at this Hospital or another facility. It shall be the responsibility of the Member to ensure that the application and reference form, if any, are completed and promptly returned to the Medical Staff Services Coordinator.

**3.2-2 Request for Change in or Additional Clinical Privileges:** A change in clinical privileges may be requested in writing by the Member or recommended by the appropriate departments at any time. In order to obtain additional

privileges, any Member shall make written request indicating any privileges requested and indicating the justification therefore including any supporting documentation for the requested privileges. Such application or recommendation shall be processed as if it were an initial application. A National Practitioner Data Bank report will be obtained for any Member requesting additional privilege. Request for additional privileges by Practitioners who have not worked clinically over a period of time will be considered on a case-by-case basis. If necessary, a proctoring plan will be developed.

**3.2-3 Request for Change in Clinical Department or Section:** A change in clinical department or section may be requested by the Member or recommended by the appropriate department or section at any time. In order to obtain change in clinical department or section, any Member shall make written request stating the privileges and department or section requested and indicating the justification thereof including any supporting documentation required, i.e. board certification. Such application or recommendation shall be processed as if it were an initial application.

**3.2-4 Triannual Review**

- A. Usual review for recommendations as to change in staff category or clinical privileges shall be made triannually in connection with the Member's application for reappointment.
- B. The triannual review for reappointment and determination of clinical privileges shall be conducted for every Member, regardless of whether a change in staff category or clinical privileges has been granted during the preceding term of appointment.
- C. Members without clinical privileges will complete a demographic update at their triannual review in lieu of a reappointment application.

**ARTICLE IV**

**MEDICO-ADMINISTRATIVE OFFICERS AND LIMITATION OF ADMITTING PRIVILEGES**

**4.1 Medico-Administrative Officers**

**4.1-1 Responsibilities:** A medico-administrative officer is a Member employed by the Hospital on either a full- or part-time basis in an administratively responsible capacity. The officer's activities shall include clinical responsibilities such as direct patient care or supervision of the patient care activities of other Members under his or her direction. A medico-administrative officer must achieve and maintain Medical Staff membership and clinical privileges appropriate to his or her clinical responsibilities and discharge staff obligations appropriate to his or her staff category in the same manner applicable to all other Members.

**4.1-2 Removal from Office:** The effect of the removal from his or her medico-administrative office on the officer's Medical Staff membership status and clinical privileges is governed solely by the terms of the contract between the officer and the Hospital. In the absence of a contract or where the contract is silent on the matter, removal from office alone will have no effect on membership status or clinical privileges, except that the removed officer may not thereafter exercise clinical privileges for which exclusive contractual arrangements have been made. Unless the contract provides otherwise, a health care professional who believes that his or her removal from a medico-administrative office has or will have an adverse effect on his or her exercise of clinical privileges in any aspects specified in the Bylaws is entitled to the procedural rights contained in Article VIII of the Bylaws.

**4.1-3 Adverse Change in Clinical Privileges/Membership Status:** The effect of an adverse change in an officer's Medical Staff membership status or clinical privileges on continuance in his or her medico-administrative office is governed solely by the terms of the contract between the officer and the Hospital. If not addressed by the contract, the effect of an adverse change in clinical privileges on continuation as a medico-administrative officer will be as determined by the Governing Board after soliciting and considering the recommendations of the Medical Staff. An adverse change in membership status or clinical privileges as defined in the Bylaws that is not triggered by removal from a medico-administrative office entitles the officer to the procedural rights contained in Article VIII of the Bylaws. Any change in the officer's contract shall in no way affect his or her Medical Staff privileges and responsibility, unless the contract provides otherwise.

**4.2 Limitation on Inpatient Admitting Privileges for Hospital-Based Physicians**

**4.2-1 Anesthesia Department:** Members who are affiliated with the Department of Anesthesia shall not have admitting privileges to the Hospital except for the purposes of managing acute and/or chronic pain and the complications directly arising from such management. Such privileges shall not extend to patients admitted for medical or surgical management of other diseases, unless a written consultation is made for pain management and is accepted by the anesthesiologist, nor shall such privileges extend to patients with anesthesia-related complications of surgical procedures. Applications for such privileges shall conform with the provisions of the Medical Staff Bylaws and shall include a written description of the nature and extent of privileges desired.

**4.2-2 Emergency Medicine Department:** Members who are affiliated with the Department of Emergency Medicine and who have contracts of employment with the hospital shall not have admitting privileges to the Hospital. The Medical Director of the Observation Unit may transfer patients from the Emergency Room to other patient care units within the hospital for observation status.

**4.2-3 Pathology Department:** Members who are affiliated with the Department of Pathology and who have contracts of employment with the Hospital shall not have admitting privileges to the Hospital.

**4.2-4 Radiology Department:** Members who are affiliated with the Department of Radiology and who have contracts of employment with the Hospital shall not have admitting privileges to the Hospital except for Interventional Radiologists and Nuclear Medicine Physicians. Consults with the primary care physician or appropriate specialty physician must be obtained as needed.

## ARTICLE V

### PROCTORING AND MENTORING

- 5.1 Proctoring:** In the event that proctoring of a practitioner is deemed to be appropriate, whether it is for evaluation of granting of new clinical privileges or as part of the Medical Staff's quality assurance functions with respect to any practitioner, the following principles shall apply:
- A. The proctor's purpose is to evaluate the technical and cognitive skills of the practitioner who is the subject of the proctoring requirement. Accordingly, the proctor differs from a consultant or supervising instructor, in that the proctor is not responsible for training the proctored practitioner. Except as provided in Section 'E' below, the proctor does not participate directly in patient care, does not receive a fee from the patient, and is not part of the physician/patient relationship between the proctored practitioner and his/her patient. The proctor represents the Medical Staff and the Hospital in evaluating the proctored practitioner's abilities, and the proctor is responsible only to the Medical Staff and Hospital in completing all proctoring functions. The proctor is not responsible for providing patient care. The proctor's presence need not be noted in the patient's medical record unless the proctor provides services to the patient.
  - B. Only those individuals already admitted to the Medical Staff are appropriately the subject of proctoring. Proctoring may only be done by well-qualified practitioners who are in the same specialty as the proctored Member and who hold clinical privileges in the proctored procedure or area. It is preferable that the proctor be a Medical Staff Member, although if an appropriately qualified Medical Staff Member is not available, an appropriately qualified non-Member with appropriate privileges at another hospital may serve. Insofar as practicable, the proctor should be free of actual or perceived conflicts of interest with or bias (whether in favor of or against) the proctored practitioner. The member to be proctored for new clinical privileges must submit a written request along with a current CV for the proctor. The proctor's Maryland State license will be verified and a current or new CQ NPDB report will be utilized prior to NPDB report will be run prior to proctoring.
  - C. The review procedure (concurrent, prospective, and/or retrospective) and duration shall be determined by the body that institutes the proctoring requirement. If concurrent proctoring is required, the proctor must engage in direct observation of the proctored practitioner's performance. All observation shall be for a specified time or number of procedures. It is the responsibility of the proctored practitioner to make any necessary scheduling arrangements and to pay any fees or expenses that may be associated with the proctoring.
  - D. All proctoring shall be done at the direction of the Credentials Committee, with the concurrence of the Executive Committee, although if the proctoring is due to the practitioner's request for new clinical privileges, the protocol set forth in Section 3.2-1 shall govern. The proctor shall prepare a written report on the prescribed form within five business days of the proctored practitioner's performance which describes the number and types of cases observed and the practitioner's performance in such cases; the proctor shall promptly forward such report to the Credentials Committee. The proctor's report shall be made a part of the practitioner's Medical Staff file and shall be utilized during the credentialing process.
  - E. A proctoring Physician is empowered to intervene as necessary to ensure patient safety. If the proctor intervenes and/or otherwise becomes directly involved in the patient's care, his/her name and actions with regard to the patient shall be noted in the medical record, as it would be for any other treating practitioner.
  - F. All records relating to the proctoring process shall be kept confidential.

## 5.2 Mentoring

- A. An appropriately licensed practitioner with special expertise in a particular procedure/treatment modality who is not an applicant for Membership may be granted Clinical Privileges in that particular procedure/treatment modality. Such Privileges shall be granted on a patient-specific basis, or for a specific period of time, for purposes of training Hospital staff regarding the procedure/treatment modality. The practitioner will not be permitted to admit, write orders, or otherwise act as a treating practitioner and shall act at all times under the oversight of a Medical Staff Member.
- B. To be granted mentor privileges, the practitioner must complete an application on a form that has been prescribed by the Governing Board after consultation with the Executive Committee. Verification of education, training, board certification, current State licensure, and primary hospital affiliation(s) will occur in the same manner as set forth in the Medical Staff Bylaws. If the practitioner is not licensed to practice in the State of Maryland, either the Maryland Board of Physician Quality Assurance (or other applicable agency) must grant approval for an exception from licensing if the practitioner is to provide any patient care services, or the Hospital administration, in its sole determination, shall have determined the practitioner to be exempt from Maryland licensing requirements.
- C. The practitioner's application must be approved by the section and department chairs, the Credentials Committee, the Executive Committee, and the Hospital's Governing Board, provided that the provisions of the Medical Staff Bylaws regarding interim privileges will apply to the granting of mentor privileges. The practitioner shall not be entitled to any procedural rights under the Bylaws for any failure to approve his/her application or termination of his/her Privileges as a mentor.

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# APPENDIX A

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY MANUAL

### NEW PROCEDURES, CREDENTIALING FOR:

<b>Effective Date:</b>	<b>9/28/94</b>	<b>Policy No:</b>	<b>#001</b>
<b>Cross Referenced:</b>	<b>n/a</b>	<b>Origin:</b>	<b>Credentials Comm.</b>
<b>Reviewed:</b>	<b>8/2000; 11/4/2003; 6/27/07; 7/25/07; 10/19/16</b>	<b>Authority:</b>	<b>Med. Exec. Comm.</b>
<b>Revised:</b>	<b>7/25/07; 10/30/08; 11/30/11</b>	<b>Page:</b>	<b>1 of 1</b>
<b>Approved:</b>	<b>10/30/08; 11/30/11; 10/19/16</b>		

#### POLICY:

It is the policy of Shady Grove Medical Center to ensure patient safety through proper training of physicians and support staff (nurses, techs, etc.) on new and improved procedures as they become available.

#### DEFINITIONS/GUIDELINES:

- 1) Enhancement to current procedures should be encouraged. The hospital staff, working with individual departments and physicians, should continue to add and upgrade equipment without impediment. Physicians should not be inhibited from offering enhancements to current procedures/technologies as soon as they become available.
- 2) New procedures are defined as those requiring a unique technical approach, an innovative treatment of a disease (not previously seen in the community and/or hospital), or an application of new technology, such as laparoscopic surgery. Physicians and their specialty peers are best able to define which procedures require privileging. This process should occur through the organized Medical Staff structure before a new procedure is scheduled and is facilitated through the Medical Staff Services Department.
- 3) Privileging requirements can take a variety of forms. These include but are not limited to specialty courses or technical training, proctoring by physicians who are already credentialed, instruction by visiting physicians, and manufacturer required training. Again, physicians and their specialty peers are best able to define which procedures require privileging. In turn, they should also define the criteria for the new procedure.
- 4) The hospital departments will continually monitor their schedules for new procedures. When questions arise with regard to privileging for new procedures, the Medical Staff Services Department will be notified and appropriate investigation undertaken.

#### PROCEDURE:

The development of separate privileging criteria should be considered if any of the following conditions exist:

1. If additional training is required; OR
2. If nationally published privileging criteria exists; OR
3. If the equipment manufacturer requires privileging and/or training; OR
4. If the procedure is considered to be experimental.

#### CRITERIA:

The proposed criteria may include: 1) basic education requirements; 2) number of years of formal training required and the field of formal training; 3) if the procedure is learned outside of residency or fellowship, a specific number of hours of postgraduate CME training and in what venue; 4) the amount of recent, direct, or indirect experience needed. All experience must be within the past 12 months and must occur within an institution with formal quality improvement programs; and 5) number and type of required references, and from where they must come.

#### APPROVAL PROCESS:

Once the proposed privileging criteria is developed by the applicant requesting the new procedure with input from his or her peers and approved at the service line level, it is then forwarded to the appropriate medical staff department and/or section for review. Once approved by the department and/or section, the criteria are then forwarded to Credentials Committee. (If there is more than one specialty/department or service line affected by the privileges, each specialty/department or service line must have provided input into the criteria and have signed off on recommendation of the final proposed criteria.) The proposed criteria is then forwarded on to the Medical Executive Committee for review and recommendation before being routed to the Hospital's Governing Board for final action. Only after final action by the Governing Board may the implementation of a new procedure (i.e., budgeting, acquisition, training of staff, etc.) begin.

#### RATIONALE:

The pace of development of new procedures continues to expand exponentially. Physicians often schedule or wish to schedule new procedures without formal privileging criteria being established or approved. New procedures are sometimes scheduled without adequate OR and other hospital staff preparation, such as training, without adequate budgeting and without input from peers on the medical staff. The hospital faces serious liability issues when physicians proceed on the premises with procedures for which no privileging criteria exist. On the other hand, enhancements to existing procedures for which no new privileging is necessary also occur. Industry and surgical innovators are continuously enhancing existing equipment for improved safety and efficiency. Common procedures are frequently enhanced with added nuances to allow improvements in cost and efficacy. These enhancements to existing procedures should not require additional privileging.

The medical products industry can form alliances to perform new procedures. Physicians may wish to be viewed as innovators in their fields and wish to be the first at Shady Grove Medical Center to perform new procedures. While most of these new procedures will benefit patients, the potential exists for ethical compromise on the part of the physician. Procedures are marketed to the public through media, creating increased pressure on physicians to perform a procedure.

# APPENDIX B

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY MANUAL

### Advanced Practice Professionals

<b>Effective Date:</b>	6/25/01	<b>Policy No:</b>	#006
<b>Cross Referenced:</b>	n/a	<b>Origin:</b>	Credentials Comm.
<b>Reviewed:</b>	11/30/11	<b>Authority:</b>	Med. Exec. Comm.
<b>Revised:</b>	6/24/02; 4/21/04; 6/22/05; 6/28/06; 8/27/08; 10/30/08; 07/21/10; 01/26/11; 04/25/12; 05/23/12; 10/29/12; 10/19/16; 10/18/23;6/18/25	<b>Page:</b>	1 of 6
<b>Approved:</b>	10/30/08; 07/21/10; 01/26/11; 11/30/11; 04/25/12; 05/23/12; 11/28/12; 2/11/13; 10/19/16; 10/18/23;6/18/25		

#### **POLICY:**

This policy addresses those Advanced Practice Professionals who are permitted to practice or provide services in Shady Grove Medical Center and its facilities. Advanced Practice Professionals practice under supervisory agreement with a licensed physician on the Hospital Staff or by direct consultation of a staff physician.

#### **PROCEDURE:**

Only those classes of Advanced Practice Professionals that have been approved by the Governing Board shall be permitted to practice at Shady Grove Medical Center. When the Governing Board determines there is a need for the services a particular type of Advanced Practice Professionals it shall establish the minimum qualifications that must be demonstrated by such individuals. The Board shall also determine the scope of practice and supervision requirements for these practitioners in the hospital. This listing may be modified or supplemental by action of the Governing Board.

This Policy contains the credentialing processes for Advanced Practice Professionals at Shady Grove Medical Center.

Advanced Practice Professionals shall include:

- Psychologists
- Certified Registered Nurse Practitioners
- Certified Registered Physician Assistants
- Certified Nurse Midwives
- Certified Registered First Nurse Assistants
- Certified Registered Nurse Anesthetists

#### **APPLICATION:**

An application to provide specific services may be submitted via MSONet (our online credentialing module) and on such forms as approved by the Medical Executive Committee and the Governing Board to the Medical Staff Office at Shady Grove Medical Center. Information required in the application will be the following, but not limited to:

**NO ENTITLEMENT TO MEDICAL STAFF APPOINTMENT:**

Individuals applying for permission to provide clinical services as Advanced Practice Professionals are not eligible for appointment to the Medical Staff of Shady Grove Medical Center, or entitled to the rights, privileges and/or prerogatives attendant to Medical Staff appointment.

- (A) The application forms for APP shall require information about the applicant's professional qualifications, including:
- (1) the names and addresses of a minimum of two (2), but preferably three (3) individuals who have had recent experience in observing and working with the applicant and who can provide adequate information pertaining to the applicant's professional competence and character;
  - (2) current curriculum vitae;
  - (3) the names and addresses of the department chairs or any and all other hospitals at which the applicant has worked or trained;
  - (4) current State licensure, Drug Enforcement Administrative Certificate (DEA), Controlled Drug Substance Certificate (CDS), and job-specific certification (if applicable);  
completed delineation of privileges within scope of practice of sponsoring physician;
  - (5) information as to whether the applicant's appointment, clinical privileges, and/or affiliation have ever been voluntarily or involuntarily relinquished, denied, revoked, suspended, reduced, or not renewed at any hospital or health care facility;
  - (6) information as to whether the applicant has ever withdrawn an application for appointment or
  - (7) clinical privileges or resigned such affiliation or privileges before a final decision by the hospital's or health care facility's governing board was rendered;
  - (8) information as to whether the applicant's
    - (a) membership in any local, state, or national professional society,
    - (b) license to practice any profession in any state, or
    - (c) Drug Enforcement Administration certification (if applicable) is, or has ever been, suspended, modified, terminated, restricted, or is currently being challenged;
  - (9) Applicants to the Advanced Practice Professionals shall present written evidence of adequate and continuous professional liability insurance in the required minimum amount of \$1,000,000/\$3,000,000;
  - (10) information concerning the applicant's malpractice litigation experience and/or any professional misconduct or disciplinary proceedings involving the applicant in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the applicant may deem appropriate;
  - (11) information concerning the suspension or termination for any period of time of the right or privilege to participate in Medicare, Medicaid, or any other government sponsored program or any private or public medical insurance program;
  - (12) current information regarding the applicant's physical and mental health status;
  - (13) information as to whether the applicant has ever been a defendant in a criminal action or convicted of a felony which details about any such instance;
  - (14) information on the citizenship and/or visa status of the applicant;
  - (15) complete on-line orientation within required timeframe;
  - (16) New physician assistants coming on staff, must submit a copy of the e-mail received from the Maryland Board of Physicians (Board) verifying that their delegation agreement has been received by the Board. After 90 days of submitting delegation agreement to the Board, the new physician assistant must sign an Attestation that they have not received a disapproval from the Board regarding their delegation agreement;
  - (18) Current physician assistants on staff, must submit their current written delegation agreement as approved by the Maryland Board of Physicians;
  - (19) a letter from the primary supervising physician(s) listing alternate supervising physicians;
  - (20) documentation of annual PPD testing as well as flu vaccine documentation (during seasonal requirement).;

**NO ENTITLEMENT TO MEDICAL STAFF APPOINTMENT (con't):**

- (21) All nurse practitioners must submit a copy of the attestation filed with the State of Maryland Nursing Board declaring and affirming that they have a named collaborator and will adhere to the Nurse Practice Act and all rules governing the scope of practice for their certification;
- (22) Agreement to follow AHC's Conflict of Interest Policy;
- (23) Agreement to follow AHC's Electronic Health Record Policy;
- (24) Agreement to follow Medical Staff Bylaws, Credentials Manual and respective Department Rules and Regulations;
- (25) Agreement to follow AHC's organizational integrity program;
- (26) Must obtain Hospital I.D. badge;
- (27) the applicant's signature; and
- (28) such other information as the hospital may require.

**BURDEN OF PROVIDING INFORMATION:**

- (a) The applicant shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of competence, character, ethics and other qualifications and of resolving any doubts about such qualifications.
- (b) The applicant shall have the burden of proving that all the statements made and information given on the application are true and correct.

**RELEASE AND IMMUNITY:**

- (a) The applicant specifically authorizes the hospital and its authorized representatives to consult with any third party who may have information bearing on the applicant's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the applicant's qualifications for clinical privileges as an Allied Health Professional. This authorization includes the right to inspect or obtain any and all communications; reports, records, and documents from said third parties. The applicant also specifically authorizes said third parties to release said information to the hospital and its authorized representatives upon request.
- (b) To the fullest extent permitted by law, the applicant releases from any and all liability, extends absolute immunity to, and agrees not to sue the hospital, its authorized representatives, and any third parties with respect to any acts, communications or documents, recommendations, or disclosures involving the applicant.

**SUBMISSION OF APPLICATION:**

Completed applications to practice as Advanced Practice Professionals shall be submitted to the Medical Staff Office via MSONet (our online credentialing module) and must be accompanied by the designated processing fee. After reviewing the application to determine that all questions have been answered, reviewing all references and other information or materials deemed pertinent, and verifying the information provided in the application with the primary sources, the Medical Staff Office shall transmit the completed application along with all supporting materials to the Credentials Committee, via the Fast Track Criteria or Regular Track Criteria.

**FAST TRACKING CREDENTIAL FILES**

**POLICY:** In order to increase efficiency of the Advanced Practice Professionals credentialing process, all applications will be categorized into a fast track category or a regular track category. Those applicants classified into the fast track will be processed in an expeditious manner once the file is deemed to be complete by the Medical Staff Office. Applications classified into the regular track will be processed separately.

A fast track application will be associated with a recently trained practitioner in practice for whom there was absolutely no difficulty in verifying information on the application and the application meets all of the criteria for fast track.

A regular track application will be processed for a practitioner in accordance with the criteria described below.

Fast Track Criteria

1. Recently trained applicant within five years of appropriate training program, i.e., nursing school, PA, ARNP training, etc.
2. Three or fewer prior hospital appointments.
3. No references suggesting potential problems.
4. No prior malpractice actions including notice of intent over the past five years.
5. No reports of disciplinary action, licensure restrictions or investigations.
6. Requests standard services consistent with specialty and training.

**FAST TRACKING CREDENTIAL FILES (con't)**

7. Meets criteria for all requested specific privileges.
8. No unexplained chronological gaps.

Regular Track Criteria

1. Letters of reference suggest applicant may have problems in behavior, ethics or patient care.
2. Report of malpractice event, either open case(s) or closed case(s) with awards during the past five years.
3. Report of challenge, limitation or revocation of license, DEA Certificate, membership or privileges voluntarily or involuntary relinquished.
4. Requests privileges varying from that expected of specialty.
5. Unexplained chronological gaps.

**CREDENTIALING PROCEDURE:**

- (a) If the application has not been fast tracked, the Credentials Committee shall examine the application and all supporting information and documentation, evaluate the applicant's education, training and experience, and make a recommendations to the Executive Committee regarding the applicant's qualifications for affiliation and clinical privileges as an Advanced Practice Professionals. The Credentials Committee may use the expertise of any individual on the Medical Staff, or an outside consultant, if additional information is required regarding the applicant's qualifications. In evaluating the application, the Credentials Committee may also meet with the applicant.
- (b) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:
  - (1) adopt the findings and recommendation of the Credentials Committee;
  - (2) refer the matter back to the Credentials Committee for further consideration and preparation of responses to specific questions raised by the Medical Executive Committee prior to its recommendation to the Governing Board; or
  - (3) set forth in its report and recommendation specific reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation. Thereafter, the Medical Executive Committee's recommendation shall be forwarded together with the Credentials Committee's findings and recommendation, through the Hospital President to the Governing Board.

**PROCEDURAL RIGHTS FOR ADVANCED PRACTICE PROFESSIONALS:**

Advanced Practice Professionals are entitled to a fair hearing process. Each practitioner may be subject to discipline and remedial action, and his or her privilege to provide selected clinical services may be denied, restricted, reduced, suspended or revoked. In the event an action is taken that is adverse to the practitioner as defined below, the practitioner may request an appeal consistent with this policy.

**APPEAL OF ADVERSE ACTION**

- A. The following recommendations or actions shall, if deemed adverse as noted below, entitle the practitioner to an appeal under timely and proper request:
- Denial or restriction of requested clinical privileges
  - Reduction of clinical privileges
  - Suspension of clinical privileges
  - Revocation of clinical privileges
- B. A recommendation or action listed above in section 'A' is adverse only when it has been:
- recommended by the Medical Executive Committee to the Governing Board approved by the Governing Board
- C. The Vice President of Quality and Medical Staff Services shall promptly give the practitioner special notice of an adverse recommendation or action taken pursuant to section 'B' above. The notice shall do the following:
- Advise the practitioner of the recommendation or action and of his or her right to request an appeal pursuant to the provisions of this policy
  - Specify that the practitioner has thirty (30) days after receiving the notice within which to submit a request for an appeal
  - Indicate that the right to appeal may be forfeited if the practitioner fails, without good cause, to appear at the scheduled appeal
  - State that as part of the appeal the practitioner involved has the right to receive an explanation of the decision made and to submit any additional information the practitioner deems relevant to the review and appeal of this decision
  - State that upon completion of the appeal, the practitioner involved has the right to receive a written decision of the hospital, including a statement of the basis of the decision
- D. The practitioner has thirty (30) days after receiving notice under section 'C' to file a request for an appeal. The request must be delivered to the Director of Medical Staff Services and Hospital President either in person or by certified or registered mail.
- E. A practitioner who fails to request an appeal within the time, and in the manner specified in section 'D', waives his or her right to an appeal to which he or she might otherwise have been entitled.
- F. When a practitioner requests an appeal, the appeal shall consist of a single meeting attended by the practitioner, the Hospital President or designee and the President of the Medical Staff or designee. During this meeting, the basis of the decision adverse to the practitioner which gave rise to the appeal will be reviewed with the practitioner, and the practitioner will have the opportunity to present any additional information the practitioner deems relevant to the review and appeal of the decision. Following this meeting, the Hospital President or designee and the President of the Medical Staff or designee will make a recommendation to the Board, which will then determine whether the adverse decision will stand, be modified, or be reversed. The practitioner will receive a written decision of the hospital stating the result of the appeal and the basis of the decision.
- G. The appeal process will be the sole remedy available to a practitioner who qualifies for this appeal who experiences an adverse decision in section 'B' above.
- H. Nothing in this policy shall be deemed to deny a practitioner the right to engage or be advised by legal counsel. However, participation by legal counsel at the appeal meeting shall be at the sole discretion of the hospital.

**AUTOMATIC TERMINATION OF PRIVILEGES**

A physician who has privileges of Shady Grove Medical Center may apply on behalf of the Advanced Practice Professionals (APP) for APP privileges. Such APP privileges shall be contingent upon the supervising/sponsoring physician's privileges. When a physician loses privileges or resigns, the AHPs whom he or she has supervised/sponsored automatically lose their privileges. They are not entitled to fair hearing procedures enumerated in the medical staff bylaws, collective bargaining agreements, or elsewhere. Additionally, employed APPs who have their employment terminated will automatically have their privileges terminated. This termination will be reported to the National Practitioner Data Bank and the respective Maryland Board.

**NO ENTITLEMENT TO MEDICAL STAFF APPOINTMENT:**

Individuals applying to serve as Advanced Practice Professionals are not eligible for appointment to the Medical Staff of Shady Grove Medical Center, nor entitled to the rights, privileges, and/or prerogatives relevant to Medical Staff appointment.

**APPLICATION FOR RENEWED SCOPE OF PRACTICE:**

- (a) Permission to practice at Shady Grove Medical Center as an Advanced Practice Professionals shall be granted for a period not to exceed three years. In seeking renewed permission and scope of practice, AHPs shall be required to complete an appropriate re-application form.
- (b) These re-applications shall be evaluated in the same manner and follow the same procedures as initial applications.

**HOSPITAL EMPLOYEES:**

Individuals who are employees of Shady Grove Medical Center shall not function in the hospital as Advanced Practice Professionals but shall be governed by such hospital policies, manuals, and descriptions as may be established from time to time by the Hospital President or other appropriate designees. Where applicable, the Hospital President (or designee) shall consult with appropriate Medical Staff appointees and/or committees regarding the qualifications of those hospital employees whose responsibilities require the delineation of clinical privileges or scope of practice.

**AMENDMENTS:**

This Policy may be amended by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists, provided the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the MEC and upon approval by the Governing Board.

# APPENDIX C

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY MANUAL

### SEDATION/ANALGESIA

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#### PURPOSE

To optimize patient safety by establishing consistent hospital-wide processes for the management of patients receiving procedural sedation by non-anesthesiologists. In general, non-anesthesiologists will administer sedative medications in doses intended to produce moderate levels of sedation.\*

#### Related Policies

Discharge Criteria from PACU #101-08-002, Fast-Track Policy for PACU #101-08-003, Propofol Sedation Policy #019, Surgical/Invasive Procedure Site Verification Process #101-10-131, Advanced Procedural Sedation #022

#### POLICY

Moderate sedation is intended to reduce patients' pain and awareness during diagnostic or therapeutic procedures. The sedative medication dosages are not intended to result in loss of protective airway reflexes, significantly depress ventilation, or cause cardiovascular compromise. However, because sedation is a continuum and because there is wide variation in patient response to sedative agents, it is not always possible to predict how an individual patient will respond. Occasionally a patient who receives sedation medication in doses that typically produce moderate sedation will slip into a deeper level of sedation. The deeper level of sedation may be associated with potentially catastrophic airway obstruction, hypoventilation, or cardiovascular instability. At Shady Grove Medical Center medical staff and nurses who participate in moderate sedation will have the skills and equipment necessary to recognize the different levels of sedation and then "rescue" patients who slip into deeper-than-intended levels of sedation. Pre-sedation evaluation will be designed to identify appropriate candidates for sedation by non-anesthesiologists and then optimize these patients prior to sedation. Intra-procedure monitoring and post-sedation care will insure that adverse physiologic changes are rapidly recognized and corrected. The processes included in this policy are based upon standards and guidelines developed by the American Society of Anesthesiologists, the American Academy of Pediatrics, and the Joint Commission on Accreditation of Healthcare Organizations.

\*Only specially-credentialed emergency medicine physicians may administer sedation in doses intended to produce deep sedation. Please see Shady Grove Hospital policy on the advanced procedural sedation by non-anesthesiologists for specific requirements.

**Exceptions.** The moderate sedation policy applies only when sedation is given under the direction of a non-anesthesiologist for patients undergoing diagnostic or therapeutic procedures. The policy specifically excludes the following:

1. Sedation/Analgesia for the control of pain, anxiety, seizures or insomnia.
2. Sedation of patients on ventilators.
3. Sedation/Analgesia used in obstetrical labor.
4. Patients requiring urgent intubation.
5. Sedation/Analgesia given by an anesthesiologist's order in the pre-operative or PACU areas.
6. Sedation/Analgesia administered in the NICU under the direction of a neonatologist.

**Locations.** This policy applies to moderate sedation in all locations within Shady Grove Medical Center and the Germantown Emergency Center. This includes the Cardiovascular/Interventional Radiology Labs, Emergency Department, Critical Care areas, Surgical Services, GI endoscopy, and any other area at the discretion of the supervising physician where appropriate staff and equipment are available.

**Staff.** A physician and registered nurse must be involved in the care of each patient undergoing moderate sedation during the entire procedure:

1. A qualified physician who performs the diagnostic or therapeutic procedure supervises the administration of sedation. The physician must remain immediately available from the time of the first dose of sedation until the patient is accepted by a recovery room nurse.
2. A Registered Nurse with special training is responsible for administering sedation and monitoring the patient at the direction of the physician. The nurse should remain at the head of the bed whenever possible to facilitate direct observation of the airway.
3. If assistance is required with the procedure, then additional personnel (>2) must be utilized. The nurse monitoring the patient may not assist with the procedure.

**Essential Equipment.** The following equipment and supplies must be available wherever sedation is to be used:

1. Minimal monitoring equipment includes non-invasive blood pressure, continuous EKG, pulse oximeter, and end-tidal CO2 monitor. Whenever possible the monitor alarms will be set to indicate oxygen saturation less than 90% and apnea  $\geq$  30 seconds. In addition, when available, the pulse oximeter will be set to have a variable-pitch tone that is audible to the supervising physician. When audible alarms are not available the sedation nurse will remain at the head of bed in continuous visual contact with both the patient and display of vital signs.
2. Resuscitation equipment for management of the airway (including ambu-bag and intubation tray) along with a fully assembled and functioning suction apparatus must be immediately available. Airway equipment must be of appropriate size for the patient.
3. A defibrillator and cardiac resuscitation drugs in accordance with ACLS standards must be readily available.
4. Reversal agents must be immediately available.
5. Wall oxygen source must be present and at least one full oxygen E-cylinder with regulator as back-up must be readily available.
6. Appropriate equipment to administer intravenous fluids and drugs must be immediately available.

## **DEFINITIONS**

Definitions of four levels of sedation and anesthesia include the following:

1. Minimal sedation (anxiolysis)  
A drug- induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.
2. Moderate sedation/analgesia (formerly conscious sedation)  
A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Note: reflex withdrawal from a painful stimulus is not considered a purposeful response). No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
3. Deep Sedation  
A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation

may be inadequate. Cardiovascular function is usually maintained. Deep sedation is restricted for use by anesthesiologists and specially-credentialed emergency medicine physicians.

4. Anesthesia

Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired. Anesthesia is restricted for use by anesthesia providers.

5. Aldrete Score

Physiologic assessment scoring system used to evaluate patients' recovery from sedation or anesthesia (Appendix 1).

6. ASA Score

American Society of Anesthesiologists physical status classification system (Appendix 2).

7. Mallampati Classification

Airway evaluation technique that predicts difficult intubation using direct laryngoscopy (Appendix 3).

8. Motor Activity Assessment Scale

Scale used to assess level of sedation (Appendix 4)

9. Fasting Protocol

Nationally recognized guidelines that establish the safe length of time from intake of food or liquid until administration of sedation. It represents the time necessary to ensure gastric emptying and is intended to reduce the risk of catastrophic aspiration of gastric contents (Appendix 5)

10. Recommended Doses of Sedative Medications

Institution specific guidelines for drug dosages intended to produce a moderate level of sedation (Appendix 6)

11. Immediately available

Located at the bedside and obtainable within seconds.

12. Readily available

Located within the same suite and obtainable within one to two minutes.

### **CREDENTIALING REQUIREMENTS**

Only physicians are qualified by specialized training will be permitted to supervise the administration of moderate sedation. Physicians must demonstrate competency in: (1) the safe administration of sedative and analgesic drugs used to establish a moderate level of sedation, (2) rescue of patients who exhibit adverse physiologic consequences of a deeper-than-intended level of sedation, and (3) awareness of the patient care processes outlined in this policy. The Chairman of the Department of Anesthesia is responsible for reviewing each application for privileges in moderate sedation and making a recommendation to the Credentials Committee regarding competency

**Physician Adult Sedation Privileges.** Physicians with adult sedation privileges may provide sedation care to patients fifteen years of age and older. Adult moderate sedation privileges are part of core privileges for the Department of Emergency Medicine. Physicians who are not members of the Department of Emergency Medicine must fulfill the following requirements:

1. Initial Competency Requirements.
  - a. Current ACLS certificate.
  - b. Completion of a residency/fellowship training program within the last two (2) years that includes a formalized education component on the safe administration of sedative drugs. (letter from the residency director required).

**OR**

Review of the Shady Grove self-education module on moderate sedation including:

- a) ASA Guidelines on Preoperative Fasting
    - b) ASA Guidelines for Administration of Moderate Sedation
    - c) ASA Video on Sedation and Analgesia by Non-Anesthesiologists
  - c. Review of the Shady Grove Medical Center Policy on Moderate Sedation.
  - d. Score of  $\geq 80\%$  on the Shady Grove Medical Center Moderate Sedation Competency Test.
2. Ongoing Competency Requirements. Recredentialing of sedation privileges will be evaluated on the same three year cycle as staff appointments.
  - a. Current ACLS certificate.
  - b. Review of the most recent revision of the Shady Grove Medical Center Hospital Policy on Moderate Sedation.
  - c. Evidence of at least eight (8) sedations during the previous three years submitted by the requesting physician.

**OR**

Completion of the above Initial Competency Requirements in Moderate Sedation.

**Pediatric Sedation Privileges.** Only physicians with pediatric moderate sedation privileges may administer moderate sedation to patients less than fifteen (15) years of age, Pediatric moderate sedation privileges are part of core privileges for the Department of Emergency Medicine. Privileges to administer moderate and deep sedation to patients admitted to the NICU are part of core privileges for the Neonatology Subsection.

**Competency Requirements for Nurses.**

1. Only Registered Nurses who have completed the Shady Grove sedation competency module may assist in the administration of sedation.
2. Current ACLS certification or PALS certification (for those nurses who assist in the administration of sedation to patients less than fifteen years of age).

### Special Considerations for Pediatric Sedation

Sedation of pediatric patients has serious associated risks such as hypoventilation, apnea, airway obstruction, laryngospasm, and cardiopulmonary impairment. Because pediatric patients have less physiologic reserve than adult patients, a more rapid deterioration in vital signs usually follows an adverse respiratory event. Therefore the presence of appropriate resuscitation equipment as well as a physician with advanced pediatric airway skills are essential. Younger children (less than six years of age) and those with developmental delays frequently require deep levels of sedation in order to cooperate with even relatively minor procedures.

**Equipment.** Locations where pediatric sedation is administered must be equipped with resuscitation equipment of appropriate age-specific sizes. This includes laryngoscope blades, endotracheal tubes, oral/nasal airways, suction catheters, yankauer tips, defibrillator and pads, monitoring equipment and resuscitation drugs. Typically airway supplies (airways, endotracheal tubes) of the patient's size and one size smaller should be immediately available.

**Pre-procedure Evaluation.** The pre-procedure evaluation must include the patient's weight, history of reactive airway disease, symptoms of upper respiratory infection (if present), and family history of anesthetic complications.

**Consent.** A responsible adult must understand and sign a consent form for patients less than eighteen (18) years of age unless the patient is an emancipated minor.

**Monitoring.** It is recognized that some children will not tolerate placement of routine sedation monitors without becoming agitated. In this circumstance, it is acceptable to administer sedation under careful observation until the child shows clinical signs such as drowsiness or spontaneous eye closure. At this point, monitors should be placed and the child should be monitored according to the standards detailed in this policy.

### Patient Care Process

#### Pre-procedure Care.

RN Responsibilities. Nursing is responsible for collecting pertinent data and preparing the patient for the physician pre-sedation assessment. The nurse performs this task by completing The standard Pre-procedure Checklist which includes:

- a. Confirmation that a valid history and physical exam is part of the medical record (the H&P must be performed within 30 days with updated heart and lung assessment within 7 days). The history and physical must be signed or co-signed by a credentialed member of the Shady Grove medical staff.
- b. Most recent laboratory values.
- c. Pregnancy tests should be considered for females greater than 12 years of age.
- d. Point of care blood glucose measurement is performed for diabetic patients.
- e. Consent signed by the performing physician and patient. The consent must include The name of the procedure, the side (for procedures that involve laterality), and designate that moderate sedation will be used.
- f. Completed nursing assessment.
- g. DNR status documented, if applicable
- h. Up-to-date medication administration record.
- i. Pre-procedure vital signs.
- j. NPO status. The physician should be notified whenever a patient does not Meet the criteria set forth in the fasting protocol.
- k. Confirmation that the anatomical site is marked by the physician.

#### 2. Physician Responsibilities

- a. **Informed Consent.** The physician performing the procedure and supervising the sedation must inform the patient/guardian about the risks, possible complications benefits and alternatives to sedation as a component of the planned procedure. Patients or their authorized representatives should agree to the administration of moderate sedation before the procedure begins.
- b. The physician orders and reviews the results of pertinent laboratory testing. Pre-sedation testing should be guided by the patient's underlying medical condition and the likelihood that the results will affect the management of sedation.

- c. The physician conducts and documents a pre-sedation assessment within 24 hours of the start of the procedure. The assessment may be documented on the standard "Pre-sedation Assessment Form" (appendix 6) and must include the following:
  - i. Physical Status Classification.
  - ii. Focused history documenting any interim changes in health or previous adverse reaction to sedation/anesthesia.
  - iii. Airway Examination.
  - iv. NPO status\*.
  - v. Review of pertinent lab values (patients with end-stage renal disease must have a basic metabolic panel within 24 hours of sedation).
  - vi. Plan for sedation.
  - vii. Re-evaluation of the patient (including vital signs and mental status) just prior to sedation.
- d. The physician conducts a "Time-Out" according to the Shady Grove Policy# 101-10131 just prior to starting the procedure.
- e. For outpatients, the physician will confirm that appropriate arrangements have been made for a responsible adult to drive the patient home.
- f. The physician will consider consultation with an anesthesiologist for high-risk patients. The criteria listed in Appendix 7 may be used as guide to help determine when consultation is indicated.

\*The NPO protocol should be observed whenever a delay will not jeopardize the well being of the patient. Emergent and urgent clinical situations are expected to arise that preclude strict adherence to these guidelines. In these cases the amount of sedation should be minimized and carefully titrated in order to prevent the loss of protective airway reflexes. The risk of aspiration pneumonitis may be further reduced by the use of a non-particulate antacid (bicitra), H2-blockers and/or metoclopramide prior to sedation.

#### **Intra-Procedure Care.**

1. RN responsibilities. The nurse is responsible for administering sedation at the order of the physician while continuously assessing the patient's physiologic status.
  - a.
    - i. Vital signs including blood pressure, heart rate, respiratory rate, oxygen saturation and mental status level will be assessed and recorded prior to initiation of the procedure and on arrival to the recovery area.
    - ii. Blood pressure and heart rate will be assessed and documented every five minutes during the procedure. Cardiac rhythm, respiratory rate, level of consciousness, presence of EtCO<sub>2</sub> and oxygen saturation will be continuously monitored and recorded at least every fifteen minutes.
    - iii. Medication administration, including dose, route, and times.
    - iv. EtCO<sub>2</sub>- Adequacy of ventilation will be monitored by observing the contours of the EtCO<sub>2</sub> waveform.
  - b. The nurse will be positioned at the head of the bed and assess the patient continuously for changes in condition or appearance. The nurse will report any of these changes to the responsible physician immediately and initiate the appropriate intervention.
  - c. Administer oxygen as needed. Typically oxygen via nasal cannula will be administered in order to maintain oxygen saturation above 92% with the following considerations:
    - i. The application of oxygen reduces the incidence and severity of hypoxemia during moderate sedation. However, it must be remembered that the use of supplemental oxygen will delay the detection of apnea by the pulse oximeter. This emphasizes the importance of monitoring respiratory function by observation of chest excursion and EtCO<sub>2</sub> detection.

- ii. **Fire Safety:** If electrocautery is to be used near the airway, then oxygen flow should be minimized to the lowest amount necessary to maintain acceptable hemoglobin saturation. Sedation providers must minimize the build-up of oxygen beneath drapes and in oropharynx and position drapes so that gases will not collect. If possible, supplemental oxygen should be stopped at least one minute before and during the activation of the electro-surgical unit.

2. Physician Responsibilities. The physician orders sedative medication, determines dosage, and responds to adverse physiologic effects.

- a. The responsible physician selects and orders all sedative medication.
- b. The physician is responsible for airway interventions, if necessary.
- c. The physician orders the administration of reversal agents when indicated.

Note: Because reversal agents may have serious side-effects their use should be minimized and their dose titrated to effect (see recommended drug doses). Naloxone is relatively contraindicated in patients with a history of narcotic tolerance. Flumazenil is relatively contraindicated in patients with a history of alcohol abuse or long-standing benzodiazepine use.

### **Post-Procedure Care**

- 1. RN Responsibilities. Nursing is responsible for collecting pertinent data and preparing the patient for the physician pre-sedation assessment. The nurse performs this task by completing the standard Pre-procedure Checklist which includes:
  - a. Confirmation that a valid history and physical exam is part of the medical record (the H&P must be performed within 30 days with updated heart and lung assessment within 7 days). The history and physical must be signed or co-signed by a credentialed member of the Shady Grove medical staff.
  - b. Most recent laboratory values.
  - c. Pregnancy tests should be considered for females greater than 10 years of age.
  - d. Point of care blood glucose measurement is performed for diabetic patients.
  - e. Consent signed by the performing physician and patient. The consent must include the name of the procedure, the side (for procedures that involve laterality), and designate that moderate sedation will be used.
  - f. Completed nursing assessment.
  - g. DNR status documented, if applicable
  - h. Up-to-date medication administration record.
  - i. Pre-procedure vital signs.
  - j. NPO status. The physician should be notified whenever a patient does not meet the criteria set forth in the fasting protocol.
  - k. Confirmation that the anatomical site is marked by the physician.
- 2. Physician Responsibilities
  - a. **Informed Consent.** The physician performing the procedure and supervising the sedation must inform the patient/guardian about the risks, possible complications, benefits and alternatives to sedation as a component of the planned procedure. Patients or their authorized representatives should agree to the administration of moderate sedation before the procedure begins.
  - b. The physician orders and reviews the results of pertinent laboratory testing. Pre-sedation testing should be guided by the patient's underlying medical condition and the likelihood that the results will affect the management of sedation.
  - c. The physician conducts and documents a pre-sedation assessment within 24 hours of the start of the procedure. The assessment may be documented in the EMR or on the standard "Pre-sedation Assessment Form" (appendix 6) and must include the following:
    - i. Physical Status Classification.
    - ii. Focused history documenting any interim changes in health or previous adverse reaction to sedation/anesthesia.
    - iii. Airway Examination.
    - iv. NPO status\*.

- v. Review of pertinent lab values (patients with end-stage renal disease must have a basic metabolic panel within 24 hours of sedation).
  - vi. Plan for sedation.
  - vii. Re-evaluation of the patient (including vital signs and mental status) just prior to sedation.
- d. The physician conducts a "Time-Out" according to the Shady Grove Policy# 101-10-131 just prior to starting the procedure.
  - e. For outpatients, the physician will confirm that appropriate arrangements have been made for a responsible adult to drive the patient home.
  - f. The physician will consider consultation with an anesthesiologist for high-risk patients. The criteria listed in Appendix 7 may be used as guide to help determine when consultation is indicated.

*\*The NPO protocol should be observed whenever a delay will not jeopardize the well being of the patient. Emergent and urgent clinical situations are expected to arise that preclude strict adherence to these guidelines. In these cases the amount of sedation should be minimized and carefully titrated in order to prevent the loss of protective airway reflexes. The risk of aspiration pneumonia may be further reduced by the use of a non-particulate antacid (bicitra), H2-blockers and/or metoclopramide prior to sedation.*

### **Intra-Procedure Care**

1. RN responsibilities. The nurse is responsible for administering sedation at the order of the physician while continuously assessing the patient's physiologic status.
  - a. Documentation of the physiologic status of the patient may be in the EMR or on the Shady Grove Sedation and Analgesia Flowsheet (Appendix 9).
    - i. Vital signs including blood pressure, heart rate, respiratory rate, oxygen saturation, and level of consciousness will be assessed and recorded prior to initiation of the procedure and on arrival to the recovery area.
    - ii. Blood pressure and heart rate will be assessed and documented every five minutes during the procedure. Cardiac rhythm, respiratory rate, level of consciousness, presence of EtCO<sub>2</sub> and oxygen saturation will be continuously monitored and recorded at least every fifteen minutes.
    - iii. Medication administration, including dose, route, and times.
    - iv. IV fluid replacement.
  - b. Whenever possible the nurse will be positioned at the head of the bed and assess the patient continuously for changes in condition or appearance. The nurse will report any of these changes to the responsible physician immediately and initiate the appropriate intervention.
  - c. Administer oxygen. Typically oxygen via nasal cannula will be administered in order to maintain oxygen saturation above 92% with the following considerations:
    - i. The application of oxygen reduces the incidence and severity of hypoxemia during moderate sedation. However, it must be remembered that the use of supplemental oxygen will delay the detection of apnea by the pulse oximeter. This emphasizes the importance of monitoring respiratory function by observation of chest excursion and EtCO<sub>2</sub> detection.
    - ii. Fire Safety: If electrocautery is to be used near the airway, then oxygen flow should be minimized to the lowest amount necessary to maintain acceptable hemoglobin saturation. Sedation providers must minimize the build-up of oxygen beneath drapes and in oropharynx and position drapes so that gases will not collect. If possible, supplemental oxygen should be stopped at least one minute before and during the activation of the electrosurgical unit.
2. Physician Responsibilities. The physician orders sedative medication, determines dosage, and responds to adverse physiologic effects.
  - a. The responsible physician selects and orders all sedative medication.
  - b. The physician is responsible for airway interventions, if necessary.
  - c. The physician orders the administration of reversal agents when indicated.

*Note: Because reversal agents may have serious side-effects their use should be minimized and their dose titrated to effect (see recommended drug doses). Naloxone is relatively contraindicated in patients with a history of narcotic tolerance. Flumazenil is relatively contraindicated in patients with a history of alcohol abuse or long-standing benzodiazepine use.*

**Post-Procedure Care**

1. RN Responsibilities. Nursing is responsible for monitoring the patient until their physiologic status has returned to a level at or close to their baseline. The following standards for monitoring and discharge criteria will be used:
  - a. Oxygen saturation and EKG will be continuously monitored. Vital signs including blood pressure, heart rate, oxygen saturation, level of consciousness and respiratory rate will be documented on arrival to the recovery area and every fifteen (15) minutes thereafter.
  - b. Significant changes in the patient's condition are reported to the physician immediately. These include:
    - i. Symptomatic changes in blood pressure.
    - ii. Oxygen saturation less than 90% with supplemental oxygen.
    - iii. Heart rate <45 or >110.
    - iv. Dyspnea, apnea, diaphoresis.
    - v. Inability to arouse.
    - vi. Need for mechanical airway support.
    - vii. Any other unexpected patient response
  - c. Pain level will be assessed every fifteen (15) minutes using a visual analog scale. Pain score greater than five (5) not easily controlled with ordered post-procedure analgesics will be reported to the responsible physician.
  - d. The nurse will assess the Aldrete score every fifteen minutes and discharge the patient according to the below criteria as approved by the Medical Staff.
  - e. Those patients who meet the criteria for the SGMC Fast-Track Protocol at the conclusion of the procedure may be admitted directly to Phase II PACU and be advanced immediately to the Phase II care guidelines
2. Physician Responsibilities.
  - a. The procedural physician is responsible for all orders in the recovery phase including but not limited to: analgesics, oxygen therapy, hemodynamic medications and reversal agents.
  - b. The procedural physician signs the discharge order.
  - c. The procedural physician documents a post-procedure/sedation progress note immediately following the procedure.
3. Discharge Criteria.
  - a. Inpatients will be discharged from the recovery area to other inpatient areas when they have met the following criteria and after SBAR report is given to the receiving nurse. Inpatients will be transported via stretcher or wheelchair accompanied by a staff member. Patients will be instructed regarding post-procedure status and activities.
    - i. Aldrete score of ten (10). Patients with an Aldrete score less than ten may be discharged only by physician order.
    - ii. If reversal agents are used then the patient must be observed for two hours after the last dose of an antagonist to insure that respiratory depression does not recur.
    - ii. Stable vital signs over a period of at least fifteen minutes.
    - iv. Adequate ventilation and oxygenation as evidenced by a stable respiratory rate and oxygen saturation appropriate for the patient. (Patients with room air oxygen saturation of less than 90 percent will be transported with supplemental oxygen).
    - v. Ability to maintain/protect airway with level of alertness and orientation appropriate to pre-procedure status.

- b. Outpatients will be discharged to home from the recovery area when they have met the following criteria:
- i. All discharge criteria listed above for inpatients have been met.
  - ii. Patients who have received sedation are discharged in the company of a responsible adult. The patient will have arrangements for transportation home. Patients who have received sedation will not be allowed to drive themselves home.
  - iii. The patient has received written discharge instructions that have been reviewed with the patient and/or escort.

### **Performance Improvement**

#### **Data Collection.**

1. Peer Review. Each Department will review adverse sedation related events as part of their peer review process. Cases that receive a standard of care score of III or IV will be forwarded to the multidisciplinary Professional Peer Evaluation Committee for action.
2. Performance Improvement Indicators. The following adverse sedation-related events will be reported through the hospital's incident reporting system.

#### Reportable adverse events:

- i. Sustained SpO<sub>2</sub> < 88% (>3 minutes) with supplemental oxygen.
- ii. Prolonged unresponsiveness (>30 minutes).
- iii. Sedation related death.
- iv. Sedation related cardiac/respiratory arrest.
- v. Aspiration pneumonia.
- vi. Sedation related rapid response or "Anesthesia stat" call

### **References**

#### American Society of Anesthesiologists Standards and Guidelines:

1. Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation, October 2014
2. Statement on Granting Privileges for Administration of Moderate Sedation to Non-Anesthesiologists, October 2011
3. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, March 2002
4. Standards for Basic Anesthesia Monitoring, October 2015
5. Standards for Postanesthesia Care, October 2014
6. Practice Guidelines for Post-Anesthesia Care, October 2012
7. Basic Standards for Preanesthesia Care, October 2015
8. Practice Guidelines for Preop Fasting, October 2010

Appendix 1.

Aldrete Scoring System

<u>Activity</u>	<u>Score</u>
Able to move four extremities voluntarily or on command	2
Able to move two extremities voluntarily or on command	1
Unable to move extremities voluntarily or on command	0
<u>Respiration</u>	
Able to breathe freely and cough deeply	2
Dyspnea or limited breathing	1
Apneic	0
<u>Circulation</u>	
BP within 20% of pre-sedation level	2
BP within 21 to 49% of pre-sedation level	1
BP more than 50% different from pre-sedation level	0
<u>Consciousness</u>	
Fully awake	2
Arousable on calling	1
No response	0
<u>Oxygen saturation</u>	
Able to maintain O2 saturation greater than 92% on room air	2
Needs O2 inhalation to maintain O2 saturation greater than 90%	1
O2 saturation 90% or less even with O2 supplementation	0

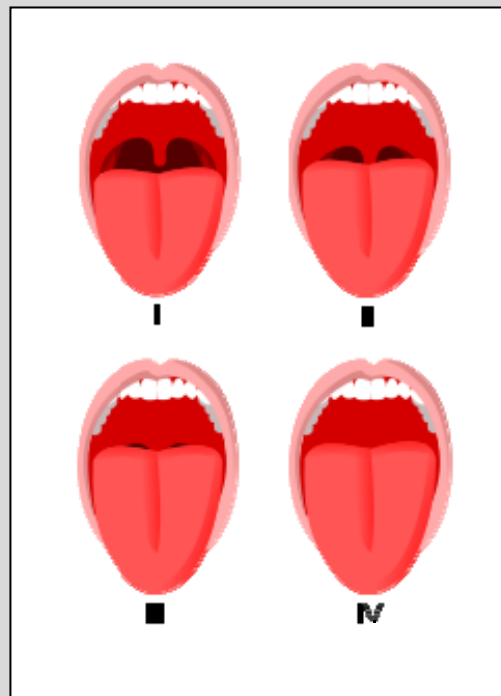
**Appendix 2.**

**ASA Physical Status Classification**

Status I	Normal healthy patient
Status II	Mild systemic disease
Status III	Severe systemic disease with definite functional impairment
Status IV	Severe systemic disease that is a constant threat to life
Status V	Moribund patient, not expected to survive

Appendix 3.

Mallampati Classification



The Mallampati classification is a tool used to predict the ease or difficulty of intubation. It is determined by looking at the anatomy of the oral cavity. A high classification score (class 3 or 4) is predictive of difficult intubation and sleep apnea.

Technique:

The patient sits upright with head tipped back, mouth opened and tongue protruded. Classifications are described below.

- Class I: Can visualize soft palate, all of uvula, tonsillar pillars
- Class II: Can visualize soft palate, tip of uvula is obscured
- Class III: Can visualize soft palate
- Class IV: Can visualize hard palate only

**Appendix 4.**

**Motor Activity Assessment Scale**

The MAAS is a standardized method for describing level of sedation. Target MAAS scores for patients under moderate sedation are 2 to 3.

<b>Clinical Score</b>	<b>MAAS – Level of Sedation Achieved</b>
0	Unresponsive - Does not move with noxious stimuli
1	Responsive only to noxious stimuli - Opens eyes, OR raises eyebrows, OR turns head toward stimulus, OR moves limbs with noxious stimuli
2	Responsive only to touch - Opens eyes, OR raises eyebrows, OR turns head toward stimulus, OR moves limbs when touched, OR when name loudly spoken
3	Calm & cooperative - No external stimulus required to elicit movement AND patient adjusts sheets or clothes purposefully and follows Commands
4	Restless & cooperative - No external stimulus required to elicit Movement AND patient picks at sheets or tubes uncovering self AND follows command
5	Agitated - No external stimulus required to elicit movement AND patient attempts to sit up or move limbs out of bed AND does not consistently follow commands
6	Dangerously agitated - No external stimulus required to elicit movement AND patient pulls at tubes or catheters, OR thrashes side to side, OR strikes at staff, OR tries to climb out of bed and does not calm down when asked

**Appendix 5.**  
**Fasting Protocol**

The following is a summary of American Society of Anesthesiologists Pre-procedure Fasting Guidelines:

<b>Ingested Material</b>	<b>Minimum Fasting Period</b>
Clear liquids	2 hours
Breast milk	4 hours
Infant formula	6 hours
Non-human milk	6 hours
Light meal	6 hours
Full meal	8 hours

Please note:

1. These recommendations apply to healthy patients who are undergoing elective procedures. Following these guidelines does not guarantee that complete gastric emptying has occurred.
2. In emergency situations, when following the guidelines might result in patient harm, the physician providing sedation may proceed with the procedure while using precautions to minimize the risk of pulmonary aspiration.
3. Examples of clear liquids include water, fruit juices without pulp, carbonated beverages, clear tea, and black coffee.
4. A light meal typically consists of toast and clear liquids.
5. Full meals include fried, fatty foods, or meats.

**SHADY GROVE MEDICAL CENTER MODERATE SEDATION  
ADULT DOSING SCHEDULE**

Generic Name (Trade Name)	Use	Dosing Guidelines	Onset, Peak, Duration of Action	Adverse Effects	Reversal
<b>BENZODIAZEPINES</b>					
Midazolam (Versed)	Sedation Amnesia Anxiolysis	<p><i>Adults &lt;60 years old:</i>  IV: 0.5mg to 2.5mg over  2 to 3 minutes.  <i>Wait 2 minutes to evaluate sedative  effect before giving  additional doses.</i>  IM: 0.07 to 0.08mg/kg as  one time dose</p> <p align="center">Total Dose- 7.5 mg IV</p> <p><i>Adults ≥60 years old:</i>  IV: 0.5 to 1.5mg IV over 2  to 3 minutes.  <i>Titrate as above.</i>  IM: 0.02 to 0.05mg/kg</p> <p align="center">Total Dose- 5mg IV</p>	<p>Onset:  IV: 1-5 min  IM: 15 min</p> <p>Peak:  IV: 20-60 min  IM: 30-60 min</p> <p>Duration:  IV: 1-2 hours  IM: 6 hours</p>	Respiratory depression Paradoxical agitation Hypotension (especially with opioid) Arrhythmias Nausea/emesis/ Headache Hallucinations Hiccoughs	Flumazenil (Watch for rebound sedation)
Lorazepam (Ativan)	Sedation Amnesia	<p>IV: 2-3 mg over 2-5 min  IM: 0.025 to 0.05mg/kg  PO: 2 to 4mg</p> <p><u>Total Dose- 4mg</u></p>	<p>Onset:  IV: 1-5 min  IM: 15 min  PO: 30-60 minutes</p> <p>Peak:  IV: 15-20 min  IM: 2-3 hours  PO: 2 hours</p> <p>Duration: 4-8 hours</p>	See Midazolam	Flumazenil

**SHADY GROVE MEDICAL CENTER MODERATE SEDATION  
ADULT DOSING SCHEDULE (CON'T)**

**OPIOIDS**

<b>Generic Name (Trade Name)</b>	<b>Use</b>	<b>Dosing Guidelines</b>	<b>Onset, Peak, Duration of Action</b>	<b>Adverse Effects</b>	<b>Reversal</b>
Fentanyl (Sublimaze)	Sedation Analgesia	0.5-1.0 mcg/kg/dose IV/IM <b>Administer slowly over 1-2 minutes</b> Total Dose 3mcg/kg	Onset: IV: 1 minutes IM: 7-8 minutes  Peak: IV: 3-5 minutes IM: No data  Duration: IV: 30-60 minutes IM: 1-2 hours	Respiratory depression Hypotension Bradycardia Chest wall rigidity with rapid dosing	Naloxone
Morphine Sulfate	Sedation Analgesia	<b>Adults &lt;60 years old:</b> 2-5 mg/dose IV Total dose- 15 mg  <b>Adults &gt;= 60 years old:</b> 2-3 mg/dose IV <u>Total dose- 10 mg</u>	Onset: IV: 5-10 minutes  Peak: IV: 20 minutes  Duration: IV: 4-5 hours	Respiratory depression Hypotension Bradycardia Nausea Pruritis Urinary retention	Naloxone
Dexmedetomidine	Sedation	Moderate Sedation IV Bolus: 1-2 mcg/kg once Infusion: 0.6-1 mcg/kg/hr Max Dose: 1 mcg/kg/hr  For elderly reduce to 0.5 mcg/kg/hr	Onset: IV: 5 minutes Peak: 15 minutes	Bradycardia Hypotension Atrial Fibrillation  Contraindicated in the presence of heart block severe renal/hepatic impairment & use of beta blockers	N/A
Hydromorphone (Diauid)	Sedation Analgesia	Adults <60 years old: 0.5-1.0 mg IV Total dose- 2mg Adults >60 years old: 0.25-0.5 mg IV Total dose- 1mg			

**SHADY GROVE MEDICAL CENTER MODERATE SEDATION  
ADULT DOSING SCHEDULE (CON'T)**

**REVERSAL AGENTS**

Generic Name (Trade Name)	Use	Dosing Guidelines	Onset, Peak Duration of Action	Adverse Effects	Reversal
Naloxone (Narcan)	Reverses opioid induced analgesia & sedation	<p>For Respiratory Depression:  0.1 mg IV every 2-3 minutes with 0.1 mg increments</p> <p><u>Total dose- 1 mg in 5 min</u></p> <p>For Apnea/Arrest:  0.4 to 2mg IV/IM every 2-3 minutes</p> <p><u>Total dose- 10 mg</u></p>	<p>Onset:  IV: 1-2 minutes  IM: 2-4 minutes</p> <p>Peak: No data</p> <p>Duration:  IV: &lt;45 minutes  IM: 60 minutes</p> <p>The duration of opioid may be longer than the duration of the antagonist</p>	<p>Nausea/Vomiting  Diaphoresis  Seizures  Severe pain  Excitement  Hypertension  Tachycardia  Ventricular arrhythmia  Pulmonary edema  Myocardial ischemia</p> <p>Watch for return of respiratory depression</p>	N/A
Flumazeil (Romazicon)	Complete or partial reversal of benzodiazepine sedation	<p>0.3 mg IV followed in one minute by 0.3 mg then 0.5 mg IV q 1 min</p> <p><u>Total dose- 3 mg IV</u></p>	<p>Onset:IV: 1-2 minutes</p> <p>Peak:  IV: 6-10 minutes</p> <p>Duration  IV: 60 minutes</p>	May precipitate seizures	N/A

**SHADY GROVE MEDICAL CENTER MODERATE SEDATION  
PEDIATRIC DOSING SCHEDULE**

Generic Name	Use	Dosing Guidelines	Onset and Duration of Action	Adverse Effects	Reversals	Comments
Dexmedtomidine	Sedation	<p>Moderate Sedation</p> <p>IV: Bolus 0.5-1.5 mcg/kg (over 10min) infusion 1-2 mcg/kg/hr</p> <p>IN: 3-4 mcg/kg per dose Mac Cum Dose 100mcg</p> <p>IM: 2-3 mcg/kg/dose</p> <p>Minimal Sedation IN: 1-2 mcg/kg per dose Max Cum Dose 100 mcg</p>	<p>IV:</p> <p>Onset: 5 to 10 minutes</p> <p>Duration:60-120 min</p> <p>IN: Onset: 15-25 min</p> <p>Duration: 85 minutes</p>	Bradycardia Hypotension	None	Contraindications : Age <6 months Heart block Severe renal/hepatic impairment Use of beta blockers

**BENZODIAZEPINES**

Generic Name	Use	Dosing Guidelines	Onset and Duration of Action	Adverse Effects	Reversals	Comments
Midazolam (Versed)  Versed syrup (10 mg/2 cc)	Sedation Amnesia Anxiolytic	<p>Moderate Sedation</p> <p>IV: 0.05-0.1 mg/kg/dose IV</p> <p>Max Cum IV Dose: 0.2 mg/kg</p> <p>PO 0.5-0.75 mg/kg</p> <p>Max Cum dose: 15 mg PO</p> <p>IM 0.1-0.2 mg/kg/dose</p> <p>IN: 0.5 mg/kg/dose Max Cum Dose 10mg</p> <p>Minimal Sedation PO: 0.25-0.4 mg/kg</p>	<p>Onset :</p> <p>IV: 1-5 min IN: 10-15 min PO: 15 min</p> <p>Duration: 20-60 min</p> <p>PO: up to 2 hours</p>	<p>Resp Depression</p> <p>Paradoxical agitation Hypotension (esp w opioid) Arrhythmias Nausea/ vomiting Headache Hallucinations Hiccoughs</p>	Flumazenil:	Reduce dose by 25-50% when giving with narcotic (e.g Fentanyl) and wait 10 min for desired effect

		Max Cum Dose 20 mg  IN: 0.2-0.4 mg/kg/dose Max Cum Dose 10mg (5mg/nare)				
Lorazepam (Ativan)	Sedation Amnesia	Moderate Sedation  IV: 0.05-0.1 mg/kg Max Cum Dose: 4 mg IV  IM:0.1-0.2 mg/kg one time dose  PO: 0.05-0.2 mg/kg	Onset: IV: 1-5 min Duration: 4-6 hours	See Midazolam	Flumazenil	Midazolam a better choice unless desire a long duration of action

**MEDICAL STAFF POLICY**  
**SEDATION/ ANALGESIA**

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**SHADY GROVE MEDICAL CENTER MODERATE SEDATION  
PEDIATRIC DOSING SCHEDULE (con't)**

**OPIOIDS**

- Avoid repeat IM dosing
- If titrating to response, IV route is recommended

<b>Generic Name (Trade Name)</b>	<b>Use</b>	<b>Dosing Guidelines</b>	<b>Onset and Duration of Action</b>	<b>Adverse Effects</b>	<b>Reversals</b>	<b>Comments</b>
Fentanyl (Sublimaze)	Sedation Analgesia	Moderate Sedation  IV: 0.7-1.0 mcg/kg/dose May repeat in 2-3 min Total dose:5 mcg/kg IN: 1.5-2mcg/kg (50mcg/nare)  Minimal Sedation: (Analgesia) 1-1.4 mg/kg Max 50mcg	Onset: 1 min IV Duration 30-60 min IV	Respiratory depression Hypotension Bradycardia Chest wall rigidity w/ rapid admin. Facial pruritis Nasal irritation	Naloxone	Do NOT exceed rate of admin of 1 mcg/kg/min IV  Reduce max dose by 50% if used with benzodiazepines
Morphine sulfate	Sedation Analgesia	0.05-0.15 mg/kg/dose IV 0.1 mg/kg IM or SC  Total dose: 0.2 mg/kg	Onset: 5 min IV 15-30 min IM or SC  Duration: 1-5 hr	Resp depression Hypotension Bradycardia Nausea Pruritis Urinary retention Epileptogenic	Naloxone	Reduce dose by 50% if given with Benzodiazepine

**SHADY GROVE MEDICAL CENTER MODERATE SEDATION  
PEDIATRIC DOSING SCHEDULE (con't)**

**REVERSAL AGENTS**

<b>Generic name (Trade name)</b>	<b>Use</b>	<b>Dosing Guidelines</b>	<b>Onset and Duration of Action</b>	<b>Adverse Effects</b>	<b>Comments</b>
Naloxone (Narcan)	Reverses opioid induced analgesia & sedation  May reverse chest wall rigidity	Apnea or arrest: 0.01-0.1 mg/kg; redose at 2 min intervals to effect  Resp depression: 0.001 mg/kg/dose  OR Narcan drip: 1-30 ug/kg/hour	IV: 1-2 min IM/ETT: 2-5 min  Duration: < 45 min  <i>The duration of the opioid may be longer than the duration of the antagonist</i>	Severe pain Excitement Hypertension Tachycardia Ventricular arrhythmia Pulmonary edema Myocardial Ischemia	<i>Watch for return of respiratory depression</i>
Flumazenil (Romazicon)	Complete or partial reversal of benzodiazepine Sedation	0.01 mg/kg IV q 1 min Total dose: 0.2 mg	Onset 1-3 min IV  Duration: 45-60 min	May precipitate seizures	<i>Use with extreme caution</i>  <i>Watch for return of sedation/ respiratory depression</i>

### **Guidelines for Determining Need for Anesthesia Consultation**

This document is intended to serve as a guide for physicians when deciding on the need for consultation with an anesthesiologist prior to sedation. These recommendations have been developed by consensus opinion of the Department of Anesthesia and are based on the best available medical evidence. The incidence of adverse outcomes related to sedation is increased in the presence of multiple risk factors and is especially high when risk factors from multiple categories (medical, behavioral, procedure- related) are present. In general, consultation is usually only necessary for the highest risk patients.

#### **Patient related medical risk factors:**

- ASA status  $\geq 3$  (especially due to end-stage renal/liver disease, severe pulmonary disease, obstructive sleep apnea, morbid obesity, ejection fraction  $< 25\%$ )
- History of drug reaction to sedative agent
- History of drug or alcohol abuse/dependence
- Orthopnea
- Pregnancy
- Difficult airway by history or exam (Mallampati score  $\geq 3$ , rigid c-spine, mouth opening  $< 3\text{cm}$ , prominent incisors)

#### **Patient behavioral risk factors:**

- Dementia
- Highly anxious
- Uncooperative/hostile
- Altered mental status/delirium
- Significant mental illness (schizophrenia, bipolar)
- Autism

#### **Procedure related risk factors:**

- Procedures with the potential for causing significant pain
- Prolonged procedures ( $> 2$  hours)
- Procedures requiring unusual positioning (prone)

Anesthesia consultation should be considered whenever one of the above risk factors is present. Consultation is recommended whenever risk factors from more than one category are present. For emergency procedures the physician should weigh the risk of proceeding immediately against the risk of delay associated with obtaining consultation.

Appendix 8.



This supplemental form must be completed by the procedural physician in addition to the History and Physical examination prior to implementation of sedation.

**Pre-sedation Assessment:**

- Morbid obesity\*
- History adverse reaction to sedation\*
- History of alcohol or narcotic dependence\*
- End stage renal/liver disease\*
- Other: \_\_\_\_\_
- Changes present since H&P. Explain: \_\_\_\_\_
- Orthopnea\*
- Pregnancy\*
- Obstructive sleep apnea\*
- Severe pulmonary disease (O2 sat < 92% on room air)\*

**Airway Assessment:**

1. Circle patient's Mallampati classification:



Class 1   Class 2   Class 3\*   Class 4\*

2. Check appropriate box(es):

- Neck:  limited range of motion\*
- circumference > 43cm (17 inches)\*
- short neck
- Mouth:  Prominent incisors\*    Loose teeth\*
- Broken teeth\*    Mouth opening <3cm\*
- Dentures    Capped teeth

**ASA Classification:**

- Status I   Normal healthy patient
- Status II   Mild systemic disease
- Status III\*   Severe organic disease with functional impairment
- Status IV\*   Severe systemic disease that is a constant threat to life
- Status V\*   Moribund patient, not expected to survive

**NPO Status:**   Last solid food intake: \_\_\_\_\_   Last clear liquid intake: \_\_\_\_\_

*\*Associated with increased risk of an adverse sedation related event. Anesthesia consult should be considered when one or more of the above risk factors are present. Consult is recommended when risk factors exist and patient is uncooperative or undergoing high risk procedure.*

In light of the above evaluation, I believe this patient is an acceptable candidate for sedation/analgesia and have discussed the sedation/anesthesia alternatives, indications for, and risks of sedation with the patient/parent/guardian, who understands and consents.    Yes    No

Comments: \_\_\_\_\_

Signature of MD \_\_\_\_\_ ID # \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

**\*IMMEDIATE PREOPERATIVE ASSESSMENT\***

I have re-evaluated the patient immediately prior to the administration of sedation/analgesia medication and: (check appropriate box)

- The status is unchanged and I consider the patient an acceptable candidate for the procedure/sedation.
- Status has changed but still consider the patient to be an appropriate candidate for the procedure/sedation.

Comment: \_\_\_\_\_

- Due to a change in status the procedure will be canceled at the current time.

Comment: \_\_\_\_\_

Signature of MD \_\_\_\_\_ ID # \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_



S6600188

**PRE-SEDATION/  
ANALGESIA  
ASSESSMENT FORM**

6600-188 (11/10)

Patient Identification



# APPENDIX D

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY

### HEALTH POLICY

<b>Effective Date:</b>	<b>January 14, 2002</b>	<b>Policy No:</b>	<b>#006</b>
<b>Cross Reference:</b>	<b>n/a</b>	<b>Origin:</b>	<b>Credentials Comm.</b>
<b>Reviewed:</b>	<b>11/30/11</b>	<b>Authority:</b>	<b>Med. Exec. Comm.</b>
<b>Revised:</b>	<b>June 28, 2006; 10/30/08; 08/26/09</b>	<b>Page:</b>	<b>1 of 7</b>
	<b>09/23/09</b>		
<b>Approved:</b>	<b>09/23/09; 11/30/11</b>		

#### Policy Statement

1. The hospital and its medical staff are committed to providing patients with quality care. The delivery of quality care can be compromised if a member of the medical staff is suffering from impairment. Impairment may result from a physical, psychiatric or emotional condition.
2. Impairment is defined as one whose ability to practice medicine with reasonable skill and safety, is impaired because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol.
3. The Health Committee shall consist of the President of the Medical Staff, Credentials Committee, Vice President/President/Chief Medical Officer and Hospital President.
4. Medical Staff Members who are suffering from an impairment that affects their ability to practice are encouraged to voluntarily bring the issue to the Health Committee so that appropriate steps can be taken to protect patients and to help the individual to practice safely and competently.
5. To the extent possible, and consistent with quality of care concerns, the Health Committee will handle impairment matters in a confidential fashion. The Health Committee shall keep the Hospital President, apprised of matters under review.
6. Presentation at Grand Rounds or other meetings by the Maryland Board of Physicians Professional Rehabilitation Program will provide education to Medical and Administration staff.

#### Mechanism for Reporting and Reviewing Potential Impairment

1. If any individual has a concern that a member of the medical staff may be impaired in any way that may affect his or her practice at the hospital, a written report shall be given to the Hospital President, the President of the Medical Staff, the Chairperson of the Credentials Committee, or any member of the Health Committee or via RL Solutions (incident reporting software) and forward to the respective staff noted here. The report shall include a factual description of the incident(s) that led to the concern.
  - **Signs and Symptoms (examples):**
    - Slurred speech, tremors, impaired coordination
    - Unusual smells on breath, body or clothing
    - Deterioration of physical appearance and personal grooming habits
    - Bloodshot eyes or pupils that are larger or smaller than usual
    - Constant Irritability or Anxiety
    - Aggression
    - Reduced performance or cognitive skills
    - Reduced judgment, perception or reasoning skills
    - Memory deficiency
2. If, after discussing the incident(s) with the individual who filed the report, the Hospital President, the President of the Medical Staff, the Chairperson of the Credentials Committee, and/or any member of the Health Committee believes there is enough information to warrant a review, the matter shall be referred to the Health Committee.
3. The Health Committee shall act expeditiously in reviewing concerns of potential impairment that are brought to its attention.

4. As part of its review, the Health Committee may meet with the individual(s) who prepared the report.
  1. If the Health Committee has reason to believe that the staff member is or might be impaired, it shall meet with the individual. At this meeting, the staff member should be told that there is a concern that he or she might be suffering from an impairment that affects his or her practice. The staff member should not be told who filed the initial report, but should be advised of the nature of the concern.
  2. As part of its review, the Health Committee may request that the staff member be evaluated by an outside organization or person and have the results of the evaluation provided to it. A consent for the release of information to the Health Committee is attached as Appendix A. The Health Committee also has the ability to request that the staff member obtain drug, alcohol, physical and/or psychiatric/psychological testing by an institution or individual. The staff member's failure to cooperate with such evaluation and testing may be considered by the Health Committee as it evaluates the situation.
  3. Depending upon the severity of the problem, the information available to the Health Committee, and the nature of the impairment, the Health Committee has the following options available to it:
    - a. recommend that the staff member voluntarily take a leave of absence, during which time he or she would participate in a rehabilitation or treatment program to address and resolve the impairment;
    - b. recommend that appropriate conditions or limitations be placed on the staff member's practice;
    - c. recommend that the staff member voluntarily agree to refrain from exercising some or all privileges in the hospital until rehabilitation or treatment has been completed or an accommodation has been made to ensure that the individual is able to practice safely and competently;
    - d. recommend that some or all of the staff member's privileges be suspended if he/she does not voluntarily agree to refrain from practicing in the hospital.;
    - e. recommend that the staff member consent to and complete an immediate and/or ongoing alcohol and/or drug testing; and
    - f. recommend that the staff member consent to and complete ongoing psychological and/or psychiatric therapy and/or rehabilitation.
  4. If the Health Committee recommends that the staff member participate in a rehabilitation or treatment program, it will assist the individual in locating a suitable program. Shady Grove Medical Center participates with the Maryland Board of Physicians Professional Physician Rehabilitation Program.
  5. If the staff member agrees to abide by the recommendation of the Health Committee, then a confidential report will be made to the Hospital President, the President of the Medical Staff, and the Chairperson of the staff member's department.
  6. If any individual has a reasonable concern that a member of the medical staff may be impaired while on hospital premises and the individual believes that an immediate response is necessary in order to protect the health and safety of patients or the orderly operation of the hospital, the individual shall immediately notify the relevant department chair and/or Hospital President or their designee. The department chair (or designee) shall assess the staff member and determine whether it appears that an impairment exists that may immediately affect the ability to safely practice medicine in the Hospital. The department chair (or designee) may relieve the staff member of responsibility for the patient or patients and assign to another individual with appropriate clinical privileges responsibility for care of the affected staff member's hospitalized patients. The wishes of the patient shall be considered, to the extent practicable, in the selection of a covering medical staff member. Patients may be assigned to the physician on call. The affected patients shall be informed that the staff member is unable to proceed with their care due to illness.
  7. Following the immediate response, the individual and the department chair shall file formal reports as described in this Policy in order for the question of impairment to be more fully assessed and addressed.

## **Reinstatement**

1. Upon sufficient proof that a staff member who has an impairment has successfully completed a rehabilitation or treatment program, the Health Committee may recommend that the individual's clinical privileges be reinstated. In making a recommendation that an impaired staff member be reinstated, the Health Committee must consider patient care interests as paramount.
2. Prior to recommending reinstatement, the Health Committee must obtain a letter from the physician overseeing the rehabilitation or treatment program. (A copy of a release from the Medical Staff Member authorizing this letter is attached as Appendix B.) The letter should address the following:
  - a. the nature of the staff member's condition;
  - b. whether the staff member is participating in a rehabilitation or treatment program and a description of the program;
  - c. whether the staff member is in compliance with all of the terms of the program;
  - d. to what extent the staff member's behavior and conduct need to be monitored;
  - e. whether the staff member is rehabilitated;
  - f. whether an after-care program has been recommended to the staff member and, if so, a description of the after-care program; and
  - g. whether the staff member is capable of resuming medical practice and providing continuous, competent care to patients.
3. Before recommending reinstatement, the Health Committee may request a second opinion on the above issues from a physician of its choice.
4. Assuming that all of the information received indicates that the physician is capable of resuming care of patients, the following additional precautions shall be taken before the staff member's clinical privileges are reinstated:
  - a. the staff member must identify at least one practitioner who is willing to assume responsibility for the care of his or her patients in the event of the staff member's inability or unavailability; and
  - b. the staff member shall be required to provide periodic reports to the Health Committee from his or her attending physician, for a period of time specified by the Committee, stating that the staff member is continuing rehabilitation or treatment, as appropriate, and that his or her ability to treat and care for patients in the hospital is not impaired. Additional conditions may also be recommended for the staff member's reinstatement.
5. The final decision to reinstate a staff member's clinical privileges must be approved by the Hospital President in consultation with the President of the Medical Staff and/or the Chairperson of the Credentials Committee.
6. The staff member's exercise of clinical privileges in the hospital shall be monitored by the department chief or by a physician appointed by the department chief. The nature of that monitoring shall be recommended by the Health Committee in consultation with the President of the Medical Staff.
7. In the event of any apparent or actual conflict between this policy and the bylaws, rules and regulations, or other policies of the hospital or its medical staff, including the investigation, hearing and appeal sections of those bylaws and policies, the provisions of this policy shall control.

### **Documentation And Confidentiality**

1. The original report and a description of any recommendations made by the Health Committee shall be included in the staff member's credentials file. If, however, the review reveals that there was no merit to the report, the report should be destroyed. If the review reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in the staff member's credentials file and the staff member's activities and practice may be monitored until it can be established whether there is an impairment that might affect the staff member's practice. The staff member shall have an opportunity to provide a written response to the concern about the potential impairment and this shall also be included in his or her credentials file.
2. The Hospital President or the President of the Medical Staff shall inform the individual who filed the report that follow-up action was taken.
3. Throughout this process, all parties should avoid speculation, conclusions, gossip, and any discussions of this matter with anyone other than those described in this policy.
4. If at any time it becomes apparent that the matter cannot be handled internally, or jeopardizes the safety of the staff member or others, the Hospital President may contact law enforcement authorities or other governmental agencies.
5. All requests for information concerning the impaired staff member shall be forwarded to the Health Committee.
6. Nothing in this policy precludes immediate referral to the Executive Committee (or to the Board) or the elimination of any particular step in the policy in dealing with conduct that may compromise patient care.

APPENDIX A  
CONSENT FOR RELEASE OF INFORMATION PERTAINING TO EVALUATION

I hereby request that \_\_\_\_\_ [the facility/**practitioner**] provide Shady Grove Medical Center ("the Hospital") and its Health Committee with all information relevant to your evaluation of my ability to care for patients safely, to competently fulfil the responsibilities of medical staff appointment and to relate cooperatively to others in the Hospital.

I also request that the Hospital and Health Committee provide \_\_\_\_\_ [the facility/**practitioner**] with a copy of any information which it believes supports the need for the evaluation and any other information that \_\_\_\_\_ [the facility/**practitioner**] might request.

I release from liability and grant absolute immunity to, and agree not to sue, \_\_\_\_\_ [the facility/**practitioner**] and the Hospital and its Health Committee (and any physician on the Hospital's medical staff who is involved in reviewing my practice) for providing the information set forth above.

I wish  do not wish to have information about HIV/AIDS status released under this authorization.

I wish  do not wish to have information about mental health treatment released under this authorization.

I wish  do not wish to have information about drug/alcohol abuse treatment released under this authorization.

This authorization will expire one year from the date of its signature.

I understand that:

- This authorization is voluntary.
- My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this authorization form.
- I may receive a copy of this form.
- I may inspect my protected health information without signing this form.
- This authorization to disclose information may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation. To revoke the authorization, I understand that I must notify the facility/practitioner in writing.
- I understand that once information covered by this authorization has been disclosed, redisclosure of the information by the recipient is possible and the information may no longer be protected by the federal regulations referenced above but may be protected by Maryland law.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Member

**APPENDIX B**  
**CONSENT FOR RELEASE OF INFORMATION**

I hereby request that Dr. \_\_\_\_\_ [physician overseeing treatment] provide Shady Grove Adventist Hospital (“the Hospital”) and its Health Committee with information pertaining to my rehabilitation or treatment program. Specifically, this information should include:

- (a) the nature of my condition;
- (b) whether I am participating in a rehabilitation or treatment program;
- (c) whether I am in compliance with all of the terms of the program;
- (d) to what extent my behavior and/or conduct needs to be monitored;
- (e) whether I am rehabilitated;
- (f) whether an after-care program has been recommended for me and, if so, a description of the after-care program; and
- (g) whether I am capable of resuming medical practice and providing continuous, competent care to patients.

I also request that Dr. \_\_\_\_\_ provide the Hospital and its Health Committee with periodic reports relating to my ongoing rehabilitation or treatment and my ability to treat and care for patients in the Hospital.

I release from liability, grant absolute immunity to and agree not to sue Dr. \_\_\_\_\_ for providing the information set forth above.

I wish  do not wish to have information about HIV/AIDS status released under this authorization.

I wish  do not wish to have information about mental health treatment released under this authorization.

I wish  do not wish to have information about drug/alcohol abuse treatment released under this authorization.

This authorization will expire one year from the date of its signature.

I understand that:

- This authorization is voluntary.
- My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this authorization form.
- I may receive a copy of this form.
- I may inspect my protected health information without signing this form.
- This authorization to disclose information may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation. To revoke the authorization, I understand that I must notify the facility/practitioner in writing.
- I understand that once information covered by this authorization has been disclosed, redisclosure of the information by the recipient is possible and the information may no longer be protected by the federal regulations referenced above but may be protected by Maryland law.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Member

APPENDIX C  
HEALTH STATUS ASSESSMENT

CONFIDENTIAL PEER REVIEW DOCUMENT

HEALTH STATUS ASSESSMENT

Please respond to the following questions based upon your assessment of Dr. \_\_\_\_\_'s current health status (if additional space is required, please attach separate sheet):

1. Does Dr. \_\_\_\_\_ have any physical, psychiatric, or emotional condition that could affect his/her ability safely to exercise the clinical privileges set forth on the attached list and/or perform the duties of appointment, including response to emergency call?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please provide the diagnosis/diagnoses and prognosis: \_\_\_\_\_  
\_\_\_\_\_

2. Is Dr. \_\_\_\_\_ currently taking any medication that may affect either clinical judgment or motor skills?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please specify medications and any side effects: \_\_\_\_\_  
\_\_\_\_\_

3. Is Dr. \_\_\_\_\_ currently under any limitations concerning activities or work load?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please specify: \_\_\_\_\_  
\_\_\_\_\_

4. Is Dr. \_\_\_\_\_ currently under the care of a physician? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please identify: \_\_\_\_\_  
\_\_\_\_\_

5. In your opinion, is any accommodation necessary to permit Dr. \_\_\_\_\_ to exercise privileges safely and/or to fulfill medical staff responsibilities appropriately? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain any such accommodation: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Physician Evaluator

# APPENDIX E

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY

### INSTITUTIONAL REVIEW BOARD & PHYSICIAN PRIVILEGES POLICY

<b>Effective Date:</b>	<b>February 11, 2002</b>	<b>Policy No:</b>	<b>#007</b>
<b>Cross Reference:</b>	<b>n/a</b>	<b>Origin:</b>	<b>Credentials Comm.</b>
<b>Reviewed:</b>	<b>11/30/11; 10/19/16; 6/26/19</b>	<b>Authority:</b>	<b>Med. Exec. Comm.</b>
<b>Revised:</b>	<b>April 25, 2007; 10/30/08</b>	<b>Page:</b>	<b>1 of 1</b>
<b>Approved:</b>	<b>10/30/08; 11/30/11, 6/26/19</b>		

#### PURPOSE:

To provide a mechanism to assure that physicians participating in research protocols approved by Institutional Review Board (IRB) also obtain appropriate privileges through the Medical Staff credentialing process.

#### POLICY:

1. When a research trial involving invasive procedures is submitted to the Institutional Review Board, an IRB Staff Member is responsible to access the Medical Staff Information On-Line system for Shady Grove Medical Center and document that the physicians involved with each study possess the appropriate privileges to perform the invasive procedure. Appropriate documentation is kept in the IRB protocol file.
2. If it is found that a physician does not possess the appropriate privileges, the IRB Administrator or IRB Staff member will be responsible for notifying Medical Staff Services.
3. Privileges to perform any procedure must be specifically granted by the Credentials Committee, either through core privileges or specialty privileges.
4. Physicians are not authorized to begin performance of any invasive procedure involved in a research trial until the privileging process has been successfully completed.
5. Final IRB approval will not be granted until all physicians associated with a research trial have obtained the necessary privileges.

# APPENDIX F

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY

### MANDATORY TB TESTING POLICY

<b>Effective Date:</b>	<b>November 19, 2003</b>	<b>Policy No:</b>	<b>#013</b>
<b>Cross Reference:</b>	<b>n/a</b>	<b>Origin:</b>	<b>Credentials Comm.</b>
<b>Reviewed:</b>	<b>May 27, 2004; 8/22/07; 11/30/11</b>	<b>Authority:</b>	<b>Med. Exec. Comm.</b>
<b>Revised:</b>	<b>2/24/05; 8/22/07; 10/30/08; 10/19/16; 6/28/17</b>	<b>Page:</b>	<b>1 of 1</b>
<b>Approved:</b>	<b>10/30/08; 11/30/11; 10/19/16; 6/28/17</b>		

#### PURPOSE:

The Centers for Disease Control and Prevention (CDC) has determined that Shady Grove Medical Center and Washington Adventist Hospital are in the high risk category for nosocomial tuberculosis infection. As such, all Health Care Providers are required to undergo an Annual evaluation for newly acquired tuberculosis infection. This change in risk category requires some changes in how Medical Staff Members are assessed for new tuberculosis infection.

#### POLICY:

1) Medical Staff Services will send your reappointment application via MSONet (our on-line credentialing module), the form to complete PPD testing/or TB questionnaire, whichever applies as well as annually via e-mail request to those with clinical privileges.

#### 2) Documentation accepted:

**Providers must provide the following based on the recommendation of the Centers of Disease Control (CDC) for positive and negative TB:**

- a) Newly credentialed providers with a history of Negative Tuberculosis Skin Test (TST) will receive a TST at the Adventist HealthCare entity accordingly (or) provide proof of a TST (or) provide proof of T-Spot test within 1 year of the application date.
- b) Current Providers with a known Negative Tuberculosis Skin Test will receive a TST or T-Spot test every other year and will complete a Tuberculosis Symptom Screening Survey every other year (opposite the TST).
- c) Newly credentialed providers with a history of Positive Tuberculosis Skin Test will receive baseline Interferon Gamma Release Assay and will receive baseline chest x-ray or provide a chest x-ray within 90 days of the application date. Only a one-time baseline chest x-ray is required.
- d) Current providers with a history of Positive Tuberculosis Skin Test will receive baseline Interferon Gamma Release Assay if not already on file and will complete a Tuberculosis Symptom Screening Survey annually.
- e) Testing is provided by the hospital's Occupational Health Department.
- f) Occupational Health does not obtain copies of test results. Please keep copies for your file and future reference.



## APPENDIX G

<b>PRIMARY SOURCE VERIFICATIONS</b>	
<b>Physician – Initial Appointment &amp; Reappointment (MD, DO, DMD)</b>	<b>Physician Assistant – Initial Appointment &amp; Reappointment (PA)</b>
<p><b><u>MDs</u></b></p> <ul style="list-style-type: none"> <li>- AMA (for MDs - Residency, Fellowship, Board Certification, State Licensures, Federal DEA, State Licensures)***</li> <li>- MBoP (Maryland State License)***</li> <li>- Certifax – Board Certification only if not on AMA</li> </ul> <p><b><u>DOs</u></b></p> <ul style="list-style-type: none"> <li>- AOA (for DOs - Residency, Fellowship, Board Certification, State Licensures, Federal DEA, State Licensures)***</li> <li>- MBoP (Maryland State License)***</li> <li>- Certifax – Board Certification only if not on AOA</li> </ul> <p><b><u>DMDs</u></b></p> <ul style="list-style-type: none"> <li>- American Board of Maxillofacial Surgery (Board Certification)</li> <li>- State Board of Dental Examiners (State Licensures)</li> </ul> <p><b><u>ALL</u></b></p> <ul style="list-style-type: none"> <li>- DHMH (CDS)</li> <li>- NTIS (DEA with Maryland address including active-duty military)</li> <li>- NPDB (Malpractice Claims Info/Settlements/Amount of Monies Paid Out/State Licensure Adverse Actions)</li> <li>- ECFMG (if applicable – Education of Foreign Graduate)</li> <li>- Sanction Check (Medicaid/Medicare Sanctions and Disciplinary Actions)**</li> <li>- Malpractice Claims History for any cases indicated on application and not on NPDB; request explanation from applicant</li> <li>- *Affiliation/Privileges with Other Facilities (Most current 5 years for initial applicants only)*</li> <li>- Peer and Professional References – (<u>Initial</u> – 3 required on application of which one must be a professional reference from most recent dept. chair, program director, etc. Two must be received to move forward – one peer and one professional.) (<u>Reappointment</u> – Only required for low/no volume providers then 2 required with one being a professional reference)</li> <li>- Work History – Initial applicants only – Verify most current 5 years for healthcare related employment or locations with privileges. Additionally, review application and CV with month/year dates to look for gaps and request explanation for all gaps of 30 days or more from applicant.</li> </ul>	<ul style="list-style-type: none"> <li>- AMA (Training, State Licensures)</li> <li>- National Commission of Certification of Physician Assistants (Certification)</li> <li>- DHMH (CDS)</li> <li>- NTIS (DEA with Maryland address including active-duty military)</li> <li>- NPDB (Malpractice Claims Info/Settlements/Amount of Monies Paid Out/State Licensure Adverse Actions)</li> <li>- Sanction Check (Medicaid/Medicare Sanctions and Disciplinary Action)**</li> <li>- Malpractice Claims History for any cases indicated on application and not on NPDB; request explanation from applicant</li> <li>- *Affiliation/Privileges with Other Facilities (Most current 5 years for initial applicants only)</li> <li>- MBoP (Maryland State License)</li> <li>- National Student Clearinghouse (Education and Training - Last Training only if not on AMA)</li> <li>- Peer and Professional References – (<u>Initial</u> – 3 required on application of which one must be a professional reference from most recent dept. chair, program director, etc. Two must be received to move forward – one peer and one professional.) (<u>Reappointment</u> – Only required for low/no volume providers then 2 required with one being a professional reference)</li> <li>- Work History – Initial applicants only – Verify most current 5 years for healthcare related employment or locations with privileges. Additionally, review application and CV with month/year dates to look for gaps and request explanation for all gaps of 30 days or more from applicant.</li> </ul>

<p><b>Podiatrist – Initial Appointment &amp; Reappointment (DPM)</b></p> <ul style="list-style-type: none"> <li>- American Board of Podiatric Surgery and/or American Board of Foot and Ankle Surgery (Board Certification)</li> <li>- State Board of Podiatric Medical Examiners (State Licensures)</li> <li>- NTIS (DEA with Maryland Address including active-duty military)</li> <li>- DHMH (CDS)</li> <li>- NPDB (Malpractice Claims Info/Settlements/Amount of Monies Paid Out/State Licensure Adverse Actions)</li> <li>- Sanction Check (Medicaid/Medicare Sanctions and Disciplinary Action)**</li> <li>- Malpractice Claims History (available online) for any cases indicated on application and not on NPDB; request explanation from applicant</li> <li>- *Affiliation/Privileges with Other Facilities (Most current 5 years for initial applicants only)</li> <li>- Education and Training via Schools (via mail for initial applicants only)</li> <li>- Peer and Professional References – (<u>Initial</u> – 3 required on application of which one must be a professional reference from most recent dept. chair, program director, etc. Two must be received to move forward – one peer and one professional.) (<u>Reappointment</u> – Only required for low/no volume providers then 2 required with one being a professional reference)</li> <li>- Work History – Initial applicants only – Verify most current 5 years for healthcare related employment or locations with privileges. Additionally, review application and CV with month/year dates to look for gaps and request explanation for all gaps of 30 days or more from applicant.</li> </ul>	<p><b>Nurse Practitioner – Initial Appointment &amp; Reappointment (NP)</b></p> <ul style="list-style-type: none"> <li>- Maryland State Board of Nursing (RN &amp; NP State Licensures and Disciplinary Actions)</li> <li>- American Academy of Nurse Practitioners or American Nurses Credentialing Center (Certification)</li> <li>- NTIS (DEA with Maryland Address including active-duty military)</li> <li>- DHMH (CDS)</li> <li>- NPDB (Malpractice Claims Info/Settlements/Amount of Monies Paid Out/State Licensure Adverse Actions)</li> <li>- Sanction Check (Medicaid/Medicare Sanctions and Disciplinary Action)**</li> <li>- Malpractice Claims History (available online) for any cases indicated on application and not on NPDB; request explanation from applicant</li> <li>- *Affiliation/Privileges with Other Facilities (Most current 5 years for initial applicants only)</li> <li>- National Student Clearinghouse (Education and Training - Last training only)</li> <li>- Peer and Professional References – (<u>Initial</u> – 3 required on application of which one must be a professional reference from most recent dept. chair, program director, etc. Two must be received to move forward – one peer and one professional.) (<u>Reappointment</u> – Only required for low/no volume providers then 2 required with one being a professional reference)</li> <li>- Work History – Initial applicants only – Verify most current 5 years for healthcare related employment or locations with privileges. Additionally, review application and CV with month/year dates to look for gaps and request explanation for all gaps of 30 days or more from applicant.</li> </ul> <p><b><u>Pediatric Nurse Practitioner</u></b></p> <ul style="list-style-type: none"> <li>- Pediatric Nursing Certification Board (Certification)</li> </ul>
<p><b>Dentist – Initial Appointment &amp; Reappointment (DDS)</b></p> <ul style="list-style-type: none"> <li>- State Board of Dental Examiners (licensures)</li> <li>- NTIS (DEA)</li> <li>- DHMH (CDS with Maryland Address)</li> <li>- NPDB (Malpractice Claims Info/Settlements/Amount of Monies Paid Out/State Licensure Adverse Actions)</li> <li>- Sanction Check (Medicaid/Medicare Sanctions and Disciplinary Action)**</li> <li>- Malpractice Claims History for any cases indicated on application and not on NPDB; request explanation from applicant</li> <li>- Affiliation/Privileges with Other Facilities (Most current 5 years for initial applicants only)</li> <li>- Education and Training via Schools</li> <li>- <u>Note:</u> There is no current Accredited Board Certification.</li> <li>- Peer and Professional References – (<u>Initial</u> – 3 required on application of which one must be a professional reference from</li> </ul>	<p><b>Nurse Midwife – Initial Appointment &amp; Reappointment (CNM)</b></p> <ul style="list-style-type: none"> <li>- Maryland Board of Nursing (RN &amp; CNM Licensures and Disciplinary Actions)</li> <li>- American College of Nurse Midwives Certification Council (Certification)</li> <li>- NTIS (DEA)</li> <li>- DHMH (CDS with Maryland Address)</li> <li>- NPDB (Malpractice Claims Info/Settlements/Amount of Monies Paid Out/State Licensure Adverse Actions)</li> <li>- Sanction Check (Medicaid/Medicare Sanctions and Disciplinary Action)**</li> <li>- Malpractice Claims History for any cases indicated on application and not on NPDB; request explanation from applicant</li> <li>- *Affiliation/Privileges with Other Facilities (Most current 5 years for initial applicants only)</li> </ul>

<p>most recent dept. chair, program director, etc. Two must be received to move forward – one peer and one professional.) (<u>Reappointment</u> – Only required for low/no volume providers then 2 required with one being a professional reference)</p> <ul style="list-style-type: none"> <li>- Work History – Initial applicants only – Verify most current 5 years for healthcare related employment or locations with privileges. Additionally, review application and CV with month/year dates to look for gaps and request explanation for all gaps of 30 days or more from applicant.</li> </ul> <p><b><u>Pediatric Dentist</u></b> -American Board of Pediatric Dentistry (Board Certification)</p>	<ul style="list-style-type: none"> <li>- National Student Clearinghouse (Education and Training – last training only)</li> <li>- Peer and Professional References – (<u>Initial</u> – 3 required on application of which one must be a professional reference from most recent dept. chair, program director, etc. Two must be received to move forward – one peer and one professional.) (<u>Reappointment</u> – Only required for low/no volume providers then 2 required with one being a professional reference)</li> <li>- Work History – Initial applicants only – Verify most current 5 years for healthcare related employment or locations with privileges. Additionally, review application and CV with month/year dates to look for gaps and request explanation for all gaps of 30 days or more from applicant.</li> </ul>
<p><b>First Nurse Assistants - Initial Appointment &amp; Reappointment (CRNFA)</b></p>	<p><b>Nurse Anesthetist - Initial Appointment &amp; Reappointment (CRNA)</b></p>
<ul style="list-style-type: none"> <li>- Maryland Board of Nursing (RN &amp; CRNFA Licensures and Disciplinary Actions)</li> <li>- CCI Competency &amp; Training Institute (Certification)</li> <li>- NPDB (Malpractice Claims Info/Settlements/Amount of Monies Paid Out/State Licensure Adverse Actions)</li> <li>- Sanction Check (Medicaid/Medicare Sanctions and Disciplinary Action)**</li> <li>- Malpractice Claims History History for any cases indicated on application and not on NPDB; request explanation from applicant</li> <li>- *Affiliation/Privileges with Other Facilities (Most current 5 years for initial applicants only)</li> <li>- National Student Clearing House (Education and Training – last training only)</li> <li>- Peer and Professional References – (<u>Initial</u> – 3 required on application of which one must be a professional reference from most recent dept. chair, program director, etc. Two must be received to move forward – one peer and one professional.) (<u>Reappointment</u> – Only required for low/no volume providers then 2 required with one being a professional reference)</li> <li>- Work History – Initial applicants only – Verify most current 5 years for healthcare related employment or locations with privileges. Additionally, review application and CV with month/year dates to look for gaps and request explanation for all gaps of 30 days or more from applicant.</li> </ul>	<ul style="list-style-type: none"> <li>- Maryland Board of Nursing (RN &amp; CRNA Licensures and Disciplinary Actions)</li> <li>- National Board of Certification and Recertification for Nurse Anesthetist (Training, Certification)</li> <li>- NPDB (Malpractice Claims Info/Settlements/Amount of Monies Paid Out/State Licensure Adverse Actions)</li> <li>- Sanction Check (Medicaid/Medicare Sanctions and Disciplinary Action)**</li> <li>- Malpractice Claims History for any cases indicated on application and not on NPDB; request explanation from applicant</li> <li>- *Affiliation/Privileges with Other Facilities (Most current 5 years for initial applicants only)</li> <li>- National Student Clearinghouse (Education and Training- last training only)</li> <li>- Peer and Professional References – (<u>Initial</u> – 3 required on application of which one must be a professional reference from most recent dept. chair, program director, etc. Two must be received to move forward – one peer and one professional.) (<u>Reappointment</u> – Only required for low/no volume providers then 2 required with one being a professional reference)</li> <li>- Work History – Initial applicants only – Verify most current 5 years for healthcare related employment or locations with privileges. Additionally, review application and CV with month/year dates to look for gaps and request explanation for all gaps of 30 days or more from applicant.</li> </ul>
<p><b>Psychologist - Initial Appointment &amp; Reappointment</b></p>	<p><b>For Additional Privileges (Any Practitioner/Specialty)</b></p>
<ul style="list-style-type: none"> <li>- Maryland Board of Psychologist (Licensure &amp; Disciplinary Actions)</li> <li>- American Board of Professional Psychology (Certification)</li> <li>- NPDB (Malpractice Claims Info/Settlements/Amount of Monies Paid Out/State License Adverse Actions)</li> </ul>	<ul style="list-style-type: none"> <li>- Training (specific training for additional privilege)</li> <li>- Case logs or other documentation as stated on the delineation for that specific privilege</li> <li>- NPDB (Malpractice Claims Info/Settlements/Amount of Monies Paid Out/State License Adverse Actions)</li> </ul>

<ul style="list-style-type: none"> <li>- Sanction Check (Medicaid/Medicare Sanctions and Disciplinary Action)**</li> <li>- Malpractice Claims History for any cases indicated on application and not on NPDB; request explanation from applicant</li> <li>- *Affiliation/Privileges with Other Facilities (Most current 5 years for initial applicants only)</li> <li>- National Student Clearinghouse (Education and Training – Last Training Only)</li> <li>- Peer and Professional References – (<u>Initial</u> – 3 required on application of which one must be a professional reference from most recent dept. chair, program director, etc. Two must be received to move forward – one peer and one professional.) (<u>Reappointment</u> – Only required for low/no volume providers then 2 required with one being a professional reference)</li> <li>- Work History – Initial applicants only – Verify most current 5 years for healthcare related employment or locations with privileges. Additionally, review application and CV with month/year dates to look for gaps and request explanation for all gaps of 30 days or more from applicant.</li> </ul>	<ul style="list-style-type: none"> <li>- State Licensure</li> </ul>
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**Notes:**

\* For Telemedicine providers who have more than 10 current hospital affiliations, a minimum of 5 must be received. If one hospital affiliation is negative, the medical staff will require receiving one more.

\*\* SAMS – To be performed for every provider (according to NCQA guidelines) on quarterly basis by the corporate compliance office. Monthly opt-out and exclusion reports are reviewed, and action taken as necessary at relevant Medical Staff meetings.

\*\*\*Military License – If working within scope of military work as a Federal employee, then federal license accepted. If moonlighting, then need Maryland State license.

All primary source verifications must be signed and dated by the Medical Staff Coordinator who pulled them from the respective sites or received via other means.

**Board Approved: 10/30/08; 06/22/11; 04/25/12; 06/25/14; 10/19/16; 5/22/19; 6/18/25**

# APPENDIX H

## SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY MANUAL

### PROFESSIONAL PRACTICE EVALUATION (FPPE AND OPPE)

<b>Effective Date:</b>	12/01/08	<b>Policy No:</b>	#016
<b>Cross Referenced:</b>	n/a	<b>Origin:</b>	Credentials Comm.
<b>Reviewed:</b>	11/30/11	<b>Authority:</b>	Med. Exec. Comm.
<b>Revised:</b>	06/01/10; 06/21/10; 08/31/10; 4/25/12; 10/19/16; 5/22/19;	<b>Page:</b>	1 of 3
<b>5/26/21; 10/18/23; 3/20/24</b>			
<b>Approved:</b>	11/19/08; 11/30/11; 04/25/12; 10/19/16; 5/22/19; 5/26/21; 10/18/23; 3/20/24		

#### PURPOSE

To assure that the hospital, through the activities of its medical staff, assesses on an ongoing basis the professional practice and competence of its medical and advanced practice professional staff, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competency, practice, and care.

Throughout this policy, the phrase "Professional Practice Evaluation" (PPE) indicates the FPPE and OPPE processes. The Medical Staff has the responsibility of evaluation and improvement of the quality of care rendered in the Hospital. The records and proceedings of Medical Staff activities that relate to this policy in any way are protected from discovery pursuant to Maryland law. Relevant information resulting from the evaluation process is integrated into performance improvement activities, consistent with the organization's policies and procedures that are intended to preserve confidentiality and privilege of information.

The goals of this policy include to:

1. Determine that individual practitioners are performing well or within expectation and that no further action is warranted.
2. Identify opportunities for practice and performance improvement of individual practitioners.
3. Monitor for significant trends in individual performance by analyzing aggregate data and case findings.
4. Assure that the process for professional practice evaluation is clearly defined, objective, equitable, defensible, timely, and useful.
5. Evaluate the performance of the practitioner when issues are affecting the provisions of safe, high quality patient care.
6. Provide suggested areas for department and system-wide improvement.

#### PEOPLE AFFECTED

All members of the Medical Staff and Advanced Practice Professionals credentialed and privileged through the Medical Staff Services excluding those practitioners with referral only privileges, and Community or Honorary Staff Status.

#### SUPPORTIVE DATA

Joint Commission Standards MS.08.01.01-03

#### DEFINITIONS AND RESPONSIBILITIES

**I. Focused Professional Practice Evaluation (FPPE):** This is a process whereby the Medical Staff evaluates the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege. FPPE may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. FPPE is a time-limited period during which the organization evaluates and determines the practitioners' professional performance. FPPE process will be implemented consistently.

**A. The organized medical staff does the following:**

- Evaluates practitioners without current performance documentation at the organization
- Evaluates practitioners in response to concerns regarding the provision of safe, high quality patient care
- Develops criteria for extending the evaluation period
- Communicates to the appropriate parties the evaluation results and recommendations based on r
- Implements changes to improve performance

**B. Scope of FPPE:**

- All Newly credentialed and privileged practitioners
- All existing practitioners who have been granted new privileges
- Existing practitioners who are identified as requiring more intensive review as determined by OPPE or by some other triggering event or circumstance

**C. Measures and Indicators for Focused Professional Practice Evaluation**

1. Data identified for FPPE will be reviewed by the Department/Section Chair or his/her designee.
2. The Department/Section Chair or his/her designee will review the data and determine if the practitioner meets the departments/sections indicators and can be removed from FPPE for initial applicants or new privileges.
3. After the FPPE is completed, the results are shared with the practitioner and filed in their Credentialing file. If practitioner does not meet the department/section indicators, their FPPE may be extended for a period of time.

**D. Methodology/FPPE Plan may include:**

1. Direct Observation of the required number of procedures/cases as determined by the Department or Section Chair with final review by the Medical Executive Committee.

**DEFINITIONS AND RESPONSIBILITIES (con't)**

2. Chart Review of no fewer than 3 Medical Record Reviews. Medical Record Review Indicators with Satisfactory performance = 100% compliance for **based on department/section specific indicators.**
  3. For low/now volume providers, review of successfully completed FPPE results from a sister hospital within Adventist HealthCare. If applicable, the practitioner may obtain FPPE results from another facility where they maintain like privileges for consideration.
- D. Timeframe for FPPE: will be for the first three to six months and/or until all required methodology has been evaluated. The time period of the evaluation can be extended up to 6 months maximum with total review period not to exceed 9 months. However, for low/no volume providers, the total review period may be extended continually if needed every 3 months until the FPPE evaluation can be completed appropriately. FPPE documents may be accepted for low/no volume providers from other AHC entities and other facilities outside of AHC for review to satisfy FPPE completion. If a provider does not successfully complete FPPE within 9 months of obtaining initial appointment/privileges and/or additional privileges, they may be automatically taken through the recommendation and approval process to be moved to a non-clinical status category.

E. Circumstances under which external review is required: Need for specialty review, when there are a limited number or no medical staff members within the required specialty (or with the appropriate technical expertise) on the medical staff.

F. Focused Professional Practice Evaluations (FPPE) consist of individual practitioner data that are based upon department/section indicators Examples include:

- o RLOccurrence reports
- o Patient/family grievances
- o Sentinel events and events required by regulatory agencies to be reported
- o Department/section Peer Review Cases Scored III or IV
- o Referral from Professional Practice Evaluation Committee
- o Cases identified by patterns or trends noted in rule or rate-based indicators

G. End of review period:

1. Confirmation that the practitioner has been reviewed and that there are no identified concerns with the performance or trends that would impact quality of care.
2. When FPPE is successfully completed; continue existing privileges; enter OPPE phase of credentialing.
3. If FPPE unsuccessfully completed; recommend practitioner for non-clinical status category, or limited or revoked specific privileges.

**II. Ongoing Professional Practice Evaluation (OPPE):** Ongoing professional practice evaluation is a process that allows the Medical Staff to identify professional practice trends that impact on quality of care and patient safety on an ongoing basis. The process includes:

1. The evaluation of an individual practitioner's professional performance and identification of opportunities to improve care based on recognized standards. It differs from other quality improvement processes in that it evaluates the strengths and opportunities of an individual practitioner's performance and competence related to their privileges rather than appraising the quality of care rendered by a group of professionals or by a system.
2. Multiple sources of information are utilized, including but not limited to: direct observation, review of individual cases, aggregate data, compliance with Hospital policies, protocols, and the Bylaws and the Rules and Regulations of the Medical Staff, clinical standards, and the use of rates compared against established benchmarks or norms.
3. Individual evaluation is based on generally recognized standards of care. This process provides practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing medical care.
4. Relevant information obtained from the ongoing professional practice evaluation is integrated into performance improvement activities. Findings from ongoing professional practice evaluation are factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal.
5. For low/no volume providers, successfully completed OPPE results for the same cycle period from a sister hospital within Adventist HealthCare may be utilized to assist with completion of the provider's OPPE at Shady Grove Medical Center. Additionally, OPPE documents may be accepted for low/no volume providers from other facilities outside of AHC for review to satisfy OPPE completion.

A. The organized medical staff does the following:

1. Data identified for OPPE will be reviewed by the Department/Section Chair or his/her designee.
2. The Department/Section Chair or his/her designee will review the data and determine if the practitioner meets the departments/sections indicators.
3. If practitioner does not meet department/section indicators, the department/section chair or designee may initiate a conversation/meeting with the practitioner to review performance and suggest opportunities for improvement. If practitioner is substantially below one or more indicators on OPPE, they may be recommended for Quality FPPE. Additionally, a FPPE for Quality may be initiated if practitioner's performance is only marginally below target over two or more OPPE cycles indicating a trend.

B. Scope of OPPE:

- All existing practitioners with privileges to see patients in the hospital not currently undergoing FPPE for initial appointment, additional privileges or for cause/quality.

C. Methodology/OPPE includes:

- o The indicators are based off of the ACGME six core competencies for the practitioner under review.

- \* Patient-Based Learning
- \* Medical/Clinical Knowledge

- \* Patient Care
- \* Professionalism
- \* System Based Practice

**D. Measures and Indicators for Ongoing Professional Practice Evaluation**

1. Performance measures used for OPPE are selected and recommended in conjunction with the Department/Section Chairs and approved by the Medical Staff, and include the following:
  - a. Rule-based indicators, which identify individual instances of non-compliance with administrative or clinical processes, policies, or other established rules. These occurrences are reviewed by the Department/Section Chair.
    - i. Rate-based indicators, which identify potential performance differences among physicians using aggregated data on outcomes or processes of care, taking into account differences in activity. These indicators are evaluated for evidence of a clinical practice trend and are reviewed at Department/Section meetings.
    - ii. After the Department/Section has finalized any recommendations for follow up actions, the recommendations are forwarded to the Credentials and Medical Executive Committees for any further action.
    - iii. The practitioner is informed of the outcome of the OPPE recommendations and advised of any additional requirements.
    - iv. OPPEs are maintained in the individual practitioner's confidential credentialing file.

D. Timeframe for OPPE: will be conducted at least every twelve months beginning with the January 2022 cycle.

E. Circumstances under which external review is required: Need for specialty review, when there are a limited number or no medical staff members within the required specialty (or with the appropriate technical expertise) on the medical staff.

**Advisors:**

1. Collect specialty, practitioner specific data from subject matter experts.
2. Enters this data on the practitioner's specific OPPE form.
3. Informs the Medical Staff Office when OPPE forms are completed.

**Medical Staff Services:**

1. **Runs report from MSOW database to determine which practitioners are to have OPPE forms completed for the specific cycle.**
2. **Creates individual OPPE forms for each practitioner during each OPPE cycle.**
3. **Enters data on practitioner specific OPPE forms for which they are the subject matter experts.**
4. **After notification Quality Advisors of completion of practitioner OPPE forms, compares results and requirement data to identify red flags. Outliers are red flagged.**
5. **OPPE forms are sent to respective Section and/or Department Chair or designee to review and refer for further action as necessary for any red flags. If no red flags, Chair reviews and signs each practitioners OPPE form.**
6. Maintains individual OPPE/FPPE information in the Medical Staff or Advance Practice Professionals credentials file.

**Credentials Committee:** Considers all professional practice evaluation data at the time of reappointment and privileging. Is notified that practitioner is off of FPPE or recommended for an extension or recommended to move practitioner to non-clinical status if unable to complete FPPE due to low/no volume by first reappointment cycle..

**Confidentiality**

- A. Professional practice evaluation information is privileged and confidential in accordance with Medical Staff and Hospital Bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.
- B. Individuals involved in professional practice evaluation will sign a statement of confidentiality on an annual basis.
- C. Professional practice evaluation is conducted in a manner that is objective, equitable, timely and consistent.

# APPENDIX I

## ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY MANUAL

### ADVANCED PROCEDURAL SEDATION

**Effective Date:** 10/25/17

**Cross Referenced:**

**Reviewed:**

**Revised:** 5/26/21; 6/21/23

**Approved:** 10/25/17; 5/26/21; 6/21/23

**Policy No:** #022

**Origin:** Credentials  
Comm.

**Authority:** Med. Exec.  
Comm.

**Page:** 1 of 5

#### PURPOSE

To establish standards for the preparation, intra-procedure care, and recovery of patients receiving deep sedative agents in the Emergency Department by non-anesthesiologists. This policy is intended to be used in conjunction with the SGMC Policy on Moderate Sedation.

#### PEOPLE AFFECTED

Emergency Medicine Physicians, Pediatric Emergency Physicians, and Emergency Room Registered Nurses

#### Related Policies

Moderate Sedation (Sedation Analgesia) Policy # 005

Low Concentration N2O / Anxiolysis Policy # 021

#### DEFINITIONS

**APP** - Advanced Practice Providers such as nurse practitioners and physician assistants.

**Emergency Medicine Physicians**-Include both General Emergency Medicine Physicians and Pediatric Emergency Physicians.

**Deep Sedation** – A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully after repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

**ASA PS** – American Society of Anesthesiologists Physical Status Classification

**IM** – Intramuscular

**IV** – Intravascular

**NPO** – Nothing by mouth

#### POLICY

This policy applies when Propofol, Ketamine, Etomidate or high concentration (>50%) N2O is used in the Emergency Department for procedural sedation. Each of these medications has a narrow therapeutic index and/or other special property that precludes it from being considered a moderate sedative. When used to produce deep sedation they may result in the inability to maintain a patent airway and independent ventilatory function. In addition, patients may experience abrupt and unpredictable hemodynamic changes. Because of the possible need for advanced airway maneuvers and hemodynamic intervention only specially credentialed Emergency Medicine Physicians may administer the deep sedative agents described in this policy. All procedures, monitoring and documentation required by the moderate sedation policy will be followed for patients receiving Advanced Procedural Sedation. In addition, Emergency Medicine Physicians must be present at the bedside during administration of deep sedative agents and remain with the patient until return of purposeful movements in response to light stimulation. The ED physician is ultimately responsible for assessing and managing the patient's ventilatory status.

More than one deep sedative agent may not be used simultaneously. This policy does not apply when these agents are used to facilitate endotracheal intubation.

**Special Precautions-**

**Procedures.** This policy is appropriate for painful procedures of short duration including but not limited to:

- a. Fracture reduction
- b. Reduction of subluxed / dislocated joint
- c. Cardioversions
- d. Foreign body removal
- e. Complex laceration repairs (notably in children)
- f. Specifically excluded from this policy are GI endoscopy procedures, D&C's, and other procedures usually scheduled in the operating suite.

**Locations.** This policy applies only to procedures performed within the SGMC Emergency Department, the Pediatric Emergency Department, and the Germantown Emergency Center.

**NPO Status.** Deep sedation frequently results in the loss of protective airway reflexes. However, in the Emergency Department the observance of NPO restrictions for elective procedures is frequently impractical or impossible. The Emergency Medicine Physician should weigh the risks and benefits of proceeding expeditiously with those associated with waiting for complete gastric emptying.

**Supplemental Oxygen.** Supplemental oxygen will always be administered during advanced procedural sedation. In the case of nitrous oxide, at least 30% oxygen will be administered.

**Staffing.** In addition to the staff involved in the procedure, a RN will be present to assist with sedation and monitoring of the patient. The ED physician will remain at the bedside from the beginning of sedation until the patient is able to respond purposefully to verbal or light tactile stimulation. Propofol sedation will be administered by an appropriately credentialed physician who is solely responsible for sedation, airway management, and monitoring and not in any way involved in the procedure. When nitrous oxide is administered the physician will remain with the patient for no less than 5 minutes after discontinuation of the gas.

**Equipment.** An ambu-bag, working suction with yankauer tip, intubation tray, and intubation drug pack will be kept at the bedside during the sedation.

**Patient Selection.** ASA I and II patients are the most appropriate candidates for deep sedation by an emergency medicine physician. Anesthesia consultation may be considered for patients ASA III and above.

## **Propofol-**

**Pharmacology.** Following IV administration, propofol is rapidly distributed in the plasma and then well-perfused brain tissue. The effects of propofol are usually seen within 40 seconds, which corresponds to one blood/brain circulation time. It is then rapidly redistributed to other tissues in the body. An adequate period of time (1 to 3 minutes) should be allowed after an initial dose in order to assess the clinical effects of propofol prior to subsequent doses. Although it is primarily eliminated by hepatic conjugation and renal excretion, the dosage of propofol does not need to be adjusted for renal or hepatic insufficiency.

**Administration.** Propofol is available in 20 cc bottles at a concentration of 10mg/cc. For the purpose of procedural sedation in the emergency room, it will be administered in boluses. The initial dose is 0.3 to 1.0 mg/kg followed in 1 to 3 minutes by boluses of 0.3 to 0.5mg/kg, if necessary. The dosage is based on ideal body weight and may need to be decreased in elderly patients or when administered in combination with other sedatives. The maximum total cumulative dose is 2.0 mg/kg. Lidocaine 0.5 to 1 mg/kg may be administered as a bolus just prior to, or mixed with the initial bolus of propofol to decrease pain on injection (unless otherwise contraindicated).

**Handling.** Propofol injectable emulsion can support the growth of microorganisms as it is not an antimicrobially preserved product under usp standards. Accordingly, strict aseptic technique must be adhered to. Propofol should be prepared for use just prior to initiation of each individual sedation. The rubber vial stopper should be disinfected using 70% isopropyl alcohol. Propofol should be drawn into sterile syringes immediately after vials are opened and the syringe should be labeled with date and time. Administration should commence promptly and be completed within 6 hours after the vials have been opened. Propofol should be prepared for **single –patient use only**. Any unused portion of propofol drawn into a syringe must be discarded at the end of 6 hours.

### **Contraindications.**

1. Morbid obesity
2. Severe OSA
3. Hypotension/low cardiac output
4. Elevated intracranial pressure

**Staff Responsibilities.** Propofol sedation will be administered only by an appropriately credentialed physician who is responsible for sedation, airway management, and monitoring, and not in any way involved in the procedure.

## **Ketamine-**

**Pharmacology.** Ketamine is a phencyclidine derivative which causes a unique sedative state characterized by profound analgesia, amnesia, dissociation and nystagmus. Side effects include a mild tachycardia, elevated blood pressure, increased salivation and heightened airway reflexes. The effects are seen within 40 seconds of an IV dose or 5 minutes with an IM injection.

**Administration.** The dose range for ketamine is 0.2 to 2 mg/kg IV with doses above 1mg/kg IV resulting in deep levels of sedation. In some cases, IM administration (3-4 mg/kg) may be appropriate when IV placement is impractical. When ketamine is used IM, equipment to place an IV line must be immediately available. A one-time dose less than 0.2 mg/kg IV is considered analgesic and does not require special monitoring.

### **Contraindications.**

1. History of airway instability, tracheal surgery, or tracheal stenosis
2. Active pulmonary infection or severe URI with productive cough
3. Acute globe injury
4. Children < 3 month of age

**Staff Responsibilities.** Ketamine may be administered only when an appropriately credentialed emergency medicine physician is present at the bedside. If the physician is involved in the procedure, then a sedation RN must also be present who is responsible only for medication administration and patient monitoring. Ketamine may be administered by the sedating physician or by the RN at the physician's order. The physician is ultimately responsible for knowing the patient's ventilatory status and responding to adverse changes.

**Unique Exception:** On rare occasion, an aggressive patient deemed to be a risk for imminent physical harm to self or others will, in the judgement and discretion of the emergency physician benefit from treatment with Ketamine IM. In these instances, consent signed by the patient/ parent and a pre-sedation assessment will be waived. Vital signs will be taken after the medication has been administered and the patient is no longer deemed a threat for violent behavior.

**Pharmacology.** Etomidate is a short acting intravenous sedative hypnotic agent that primarily affects the cerebral cortex and has very little hemodynamic effect. Side effects include suppression of adrenal steroids, myoclonic movements, and pain on injection. Onset of action is in 30-60 seconds with peak effect in one minute.

**Administration.** The dose of etomidate for procedural sedation is 0.1mg/kg IV bolus every 3 to 5 minutes as needed to a maximum of 3 doses.

**Contraindications.**

1. Septic shock
2. Pregnancy

**Etomidate-**

**Staff Responsibilities.** Etomidate may be administered only when an appropriately credentialed emergency medicine physician is present at the bedside. If the physician is involved in the procedure, then a sedation RN must also be present who is responsible only for medication administration and patient monitoring. Etomidate may be administered by the sedating physician or by the RN at the physician's order. The physician is ultimately responsible for knowing the patient's ventilatory status and responding to adverse changes.

**Pharmacology.** Nitrous oxide is an odorless, colorless gas that has potent anxiolytic and amnestic effects. Unconsciousness is produced when concentrations reach 70%. Adverse effects include nausea, inhibition of methionine synthetase, and diffusion into closed air spaces.

**Administration.** Procedures for administration of N2O in the Emergency Department are described in the Nitrous oxide/minimal sedation Policy. At inhaled concentrations less than 50%, nitrous oxide produces minimal sedative effects. Between 50 and 70% nitrous oxide produces moderate to deep levels of sedation. It is rapidly taken up from the lungs and rapidly reaches equilibrium in the brain. Clinical effects begin in less than 30 seconds and peak in 5 minutes.

**Nitrous Oxide-**  
**Contraindications.**

1. Altered level of consciousness
2. Suspected pneumothorax
3. Respiratory distress
4. Facial or neck injuries that would impair a tight mask seal
5. Recent retinal or brain surgery
6. Suspected bowel obstruction
7. Pregnancy
8. Known Vitamin B12 Deficiency
9. Closed head injury
10. Active nausea and vomiting

**Staff Responsibilities.** Nitrous oxide at inhaled concentrations greater than 50% may be administered only when an appropriately credentialed emergency medicine physician is present at the bedside. If the physician is involved in the procedure, then a sedation RN must also be present who is responsible only for nitrous oxide administration and patient monitoring. The physician is ultimately responsible for knowing the patient's ventilatory status and responding to adverse changes.

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# APPENDIX J

## ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER MEDICAL STAFF POLICY MANUAL

### LOW CONCENTRATION NITROUS OXIDE/MINIMAL SEDATION

Effective Date: 10/25/17

Cross Referenced:

Reviewed: 6/5/2023

Revised:

Approved: 10/25/17

Policy No: #021  
Origin: Credentials

Authority: Med. Exec.  
Comm.

Page: 1 of 4

#### PURPOSE

To establish guidelines for the administration of low concentration Nitrous Oxide (<50%) as minimal sedation/anxiolysis during procedures in the Emergency Department.

#### PEOPLE AFFECTED

Physicians and Emergency Room Registered Nurses

#### Related Policies

Moderate Sedation (Sedation Analgesia) Policy # 005

Patient Identification Policy #101-01-105

Physician Orders Policy #101-01-016

Sedation, Ketamine Policy # 101-01-228

Advanced Procedural Sedation Policy #022

#### DEFINITIONS

APP- Advanced Practice Providers such as nurse practitioners and physician assistants.

Nitrous oxide scavenging system-suction system to remove exhaled gases from the environment.

#### POLICY

**Indications-** 1. Minor procedures of short duration including but not limited to:

- g. Urinary Catheterization
  - h. IV Placement
  - i. Simple Incision and Drainage (e.g. Paronychia drainage)
  - j. Burn or "road rash" cleaning and debridement
  - k. Laceration repair (along with local anesthesia)
  - l. Foreign body removal
  - m. Sexual assault/abuse examinations
2. More complicated and invasive procedures for which >50% N<sub>2</sub>O will likely be administered do not fall under this policy and are considered in the Advanced Procedural Sedation Policy (#?)
3. Recommended patient age is greater than one year.

**Properties-** 1. Odorless, colorless gas with analgesic properties.

2. Has potent anxiolytic and amnestic properties.
3. Rapidly taken up from the lungs and rapidly reaches equilibrium with the brain. Clinical effects begin in less than 30 sec. and peak effects occur in less than 5 min.

4. Unconsciousness is produced when N<sub>2</sub>O concentrations exceed 70%
5. Recovery is rapid. Arterial blood N<sub>2</sub>O concentration is reduced by 70% within 3 minutes of discontinuation.
6. The rapid diffusion of N<sub>2</sub>O from the blood at discontinuation may cause hypoxemia. When N<sub>2</sub>O is discontinued, patients should be placed on 100% oxygen for at least 5 minutes.
7. Has minimal effects on respirations at inhaled concentrations <50%
8. Blunts protective airway reflexes.
9. Is a suspected teratogen and has been associated with fetal wastage and pre-term delivery
10. Can produce a state of general anesthesia when combined with other sedative or analgesic agents.

**Contraindications-**

1. Altered level of consciousness
2. Chest injuries
3. Respiratory distress
4. Suspected or actual pneumothorax
5. Facial or neck injuries where ability to create seal may be impaired
6. Recent retinal or brain surgery
7. Abdominal pain (including known or suspected bowel obstruction)
8. Pregnancy
9. Known Vitamin B12 Deficiency
10. Closed head injury

**Procedural Precautions-**

1. Pregnant family members or healthcare providers may not be present in the room during administration.
2. In general, N<sub>2</sub>O should only be used in conjunction with local/regional anesthesia. N<sub>2</sub>O should not be administered within 20 minutes of a dose of intranasal fentanyl.
3. If Nitrous oxide in oxygen is combined with other sedating medications, such as midazolam, the likelihood for moderate or deep sedation increases. In this situation, the practitioner must institute the guidelines for procedural sedation.
4. Waste gases are scavenged according to institution protocols.
5. Nitrous oxide sedation is ordered and supervised by the Attending Physician on-duty who must remain physically present in the Emergency Department Suite during administration.

**Monitoring-**

1. Baseline vital signs and mental status including NIBP are obtained prior to initiation of N<sub>2</sub>O delivery whenever possible.
2. Pulse oximetry is monitored continuously during administration of N<sub>2</sub>O and until the patient returns to their baseline level of consciousness.
3. The concentration of inspired oxygen in the patient breathing system is measured using a properly calibrated oxygen analyzer.

**Equipment-**

1. Nitrous oxide delivery and scavenging system (Sentry Sedate)
2. Disposable patient circuit/mask of appropriate size
3. Key for administration system from Pyxis
4. Pulse oximeter
5. Bag-valve mask
6. Yankauer suction set-up
7. Emergency cart with airway equipment and resuscitation equipment

**Procedures-**

**Pre-procedure Responsibilities**

1. Review physician's/APP's order.
2. Verify the patient's identity according to policy
3. Provide the patient/parent with educational materials and information regarding the procedure, and potential complications.
4. Check the patient's allergies
5. Equipment set-up
  - a. Attach green oxygen hose and gray vacuum hose to respective wall outlets.
  - b. Ensure that end of gray vacuum hose is hooked to scavenger interface.
  - c. Connect patient circuit to the Sentry Sedate per instructions in circuit. Place mask on circuit.
  - d. Perform fail safe test
7. Use appropriate isolation precautions
8. Baseline vital signs including heart rate, respiratory rate, oxygen saturation, blood pressure are obtained and recorded.

**Intra-procedure Responsibilities**

1. Continuous pulse oximetry is begun and continued until patient returns to their baseline level of consciousness.
2. Turn on the flow of oxygen. Fill the gray breathing bag 2/3 to 3/4 full.
3. Mask is placed on the patient's face and N2O added. The total flow rate is adjusted to maintain the breathing bag 2/3 to 3/4 full. Titrate to effect- not to exceed 50% Nitrous oxide in oxygen.
4. Instruct patient to exhale into the mask to keep exhaled gas collected by scavenger.
5. Allow patient to inhale gas for 3-4 minutes before beginning the procedure.
6. Avoid unnecessary conversation with the patient to prevent breaking the mask seal and exhaling nitrous into the room. Use imagery and distraction techniques to enhance/compliment administration.
7. Monitor the patient's level of consciousness and response to procedure, pain, and signs of side effects such as nausea.
8. Discontinue Nitrous oxide administration if nausea, light-headedness or other side-effects occur, or pain relief has not been achieved.

**Post-Procedure Responsibilities**

1. When procedure is finished turn off Nitrous oxide and increase oxygen flow to keep breathing bag 2/3 to 3/4 full while administering 100% oxygen for 3-5 minutes.
2. Immediately post procedure dispose of circuit/mask, close Nitrous oxide tank, replace empty tank if necessary, and lock Sentry Sedate doors.
3. Clean non-disposable equipment after use and return to designated secure area. Return key to Pyxis.
4. Evaluate patient for discharge criteria including return to baseline cognitive functioning and stable vital signs.

**Documentation-**

1. The patient's chart will contain a time-based record that includes:
  - a. Concentration of administered Nitrous oxide and oxygen
  - b. Oxygen saturation
  - c. Heart Rate
  - d. Respiratory Rate
  - e. Level of consciousness
  - f. Name, route, time, and dosage of any additional medications
2. Any adverse events will be recorded
3. The time and condition of the child at discharge shall be documented; this includes documentation that the child's level of consciousness has returned to baseline.

**Education & Training-**

The Department of Emergency Medicine will maintain competency through departmental in-services and conferences. The department will maintain documentation of competency for all physicians, nurses, and APP's involved in Nitrous oxide sedation. Privileges for the use of Nitrous oxide in concentrations less than or equal to 50% are included in the core privileges for Emergency Medicine.

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# APPENDIX K

## ADVENTIST HEALTHCARE MEDICAL STAFF POLICY MANUAL

### CREENTIALING SYSTEM CONTROLS

**Effective Date:** 07/19/2023  
**Cross Referenced:**  
**Reviewed:**  
**Revised:**

**Policy No:** #023  
**Origin:** Credentials Comm.  
**Authority:** Med. Exec. Comm.  
**Page:** 1 of 4

**Approved:** WOMC – 7/10/2023; SGMC – 7/19/2023; FWMC – 7/27/2023; Rehab – 7/24/2023

#### PURPOSE:

To satisfy the requirements of National Commission Quality Assurance (NCQA) elements regarding Credentialing System Controls.

#### POLICY:

##### 1. How primary source verification information is received, dated and stored.

Receiving verification information from primary or approved sources is completed through a mix of automated and manual processes in MSOW, our Credentialing Software, that are triggered by an action for each document and associated records within an active process. Process verification actions include web crawler, internet grabber, letter (email), letter (fax), letter (print), and document default.

MSOW users are set up by System Administrators with a level of permissions that allow access to provider records. The sending and receiving of verifications is designated by the job responsibilities of each end user.

#### Web Crawls

Many primary or approved sources are sent and received using web crawlers. Web crawls are MSOW's primary source verification tool that is integrated with verifying organizations. Web crawls retrieve primary source (PSV) images or information directly from the verifying organization and the retrieved information posts in the provider's images tab in MSOW as a response image.

#### Subscription Services

There are verifying organizations that require a subscription. The system is setup by a System Administrator to send and receive primary source verification queries through the PSV subscription service. These query results are maintained in the Images tab for each applicable practitioner.

#### Internet Grabber

Medical Staff Coordinators manually query websites, by accessing the URL through the MSOW internet grabber window. Users can copy the web page and paste directly into MSOW. A PDF image will be created and stored as a response image for the verification. This image is maintained in the Images tab for the applicable practitioner record.

#### Email & Fax

A fax service has been set up in MSOW to send and receive faxes. Verifications received as a fax come to the fax service and are viewed as an email with the verification as a PDF attachment.

Email verification requests go out under the MSOW user's email.

## VERIFICATION DATES & STORAGE

### Web Crawls

Primary source verifications received through web crawls post as a response image with the acquired by date and are stored in the Images blue button of the provider's record.

### Websites, Emails, and Fax Queries

Primary source verifications obtained through internet grabber, emails, and faxes are manually uploaded as response images and stored in the Images blue button of the provider's record.

The date a verifying organization attests to the primary source information is entered into the received date. When a verifying organization does not date the verification, the acquired date or the date the verifier reviews the information is used.

MSOW users have options to document verifications.

- I. A designated verifier can sign or initial each credentialing document. The designated verifier adds a verifying signature to the document prior to uploading the verification to the provider's Images blue button.
- II. A verification summary checklist is used showing the verification source, the date of the verification and the signature or initials of the person who verified the information.
- III. A checklist with all verifications listed and a single signature and date with a statement confirming the signer verified all the credentials on that date.

## 2. How modified information is tracked and dated from its initial verification.

All changes to provider data in MSOW are recorded and retained in an Audit table including date, change made and MSOW user ID.

## 3. Titles or roles of staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate.

Security and access to provider record areas is based on system settings and facility record area access. MSOW incorporates User Groups categorized by types of user and access requirements. These role-based groups access and security supports system administrators adding users to groups to inherit access to areas within the platform which includes the ability to view, add, edit, and delete information.

Security groups can include:

- o **Admin Users** – Admin users have access to all areas of the MSOW system. They have access and security to view, add, edit and delete areas within the solution. This level of access is granted to Supervisors, Managers, Directors, and Database Administrators.
- o **Super Users** – Super users are granted core user access and security. Super users receive access to run reports, ability to maintain provider areas and limited access to system administration functions. This level of access is only granted to Medical Staff Coordinators and Medical Staff Admin Assistants.

Some examples of when modifications or deletions need to be made include:

- o When graduating residents who completed a rotation at an AHC hospital and then joins the Medical Staff. Their license # changes at the state licensing board therefore changes need to be made to their ID in MSOW.
- o When a licensing board changes the license # of a Medical Staff member after initial credentialing.

When a practitioner changes their name at with NPPES, their name is changed in MSOW to match. [Note: Our personnel offices are kept locked when the person assigned to the office is not in the office. AHC has equipped our hospitals, including our offices with secure Konica printers which require badge access by the person who sent the document to print therefore no documents are left on the printer for unauthorized access. All staff are provided their own electronic fax accounts for secure sending and receiving of facsimiles. Badge or key access is required outside of normal business hours. All credentials files and credentials information are maintained electronically on secure AHC servers. Custodians are allowed in the suites/offices after hours however all credentials files and information is stored on the AHC servers, therefore they are unable to access them either physically or remotely.

Some examples of when modifications or deletions need to be made include:

- When graduating residents who completed a rotation at an AHC hospital and then joins the Medical Staff. Their license # changes at the state licensing board therefore changes need to be made to their ID in MSOW.
- When a licensing board changes the license # of a Medical Staff member after initial credentialing.
- When a practitioner changes their name at with NPPEs, their name is changed in MSOW to match. [Note: Our business rules at AHC require that the name in MSOW matches their name as listed on the NPPEs website.
- Name change upon marriage, divorce, etc.
- A practitioner moves their office practice, changes their practice name or updates their contact information such as email address or phone or fax numbers.

**4. The security controls in place to protect the information from unauthorized modification.**

In-app modification of the data is governed by system settings, facility record area access, user groups and access requirements by user as referenced above. AHC has subscribed to the cloud version of MSOW. Their infrastructure is protected from un-authorized modification as follows:

Physical Security

- MSOW Hybrid Cloud’s Colocation Deft Data Center is located in Elk Grove Village, Illinois.
- Facility security: Deft maintains risk-based information security and privacy controls and a compliance framework to ensure that their infrastructure meetings client commitments while helping clients meet compliance requirements.
- The Elk Grove Village data center includes:
  - 24/7 Onsite Security Staff Visitor and Equipment screening
  - CCTV with 90-day backup
  - Dual-factor authentication via biometric and proximity sensors
  - Secure shipping and receiving areas

Network Security

- High Availability Citrix Netscalers
- Servers are hidden from public polling using private address or network address translation.
- Access to all data within the data center is abstracted via the application.
- Client web-browser connects to MSOW Cloud service that utilizes a sha256 hash algorithm and a 2048 bit public key, via TLS, over HTTPS.
- Deft continuously monitors servers, networks, and applications to detect threats.
- Deft’s multipronged threat-management approach uses intrusion detection, distributed denial- of-service (DDoS) attack prevention, penetration testing, behavioral analytics, anomaly detection, and machine learning to constantly strengthen its defense and reduce risks

Additionally, the following general security measures have been taken with regards to the MSOW applications:

- User sessions will timeout after defined periods of inactivity
- Session credentials are maintained and validated on each page accessed.
- All Data including sensitive data (PHI, passwords, credit card numbers, etc.) are transmitted between client and server machines, using TLS (1.2) encryption with a 2048 bit key.
- Activity logging is performed and monitored
- Password protection requires that users provide a username/password combination to access the site and incorporates password hardening features.
- Password policy and password reset days are set by the client under System Control Options

**5. The building security that adequately limits physical access to credentials information.**

Each Medical Staff Office is in a secure, locked location inside their individual hospitals. During normal business hours, either a badge is required to enter, or a Medical Staff staffer is there to assist. Medical Staff personnel offices are kept locked when the person assigned to the office is not in the office. AHC has equipped our hospitals, including our offices with secure Konica printers which require badge access by the person who sent the document to print therefore no documents are left on the printer for unauthorized access. All staff are provided their own electronic fax accounts for secure sending and receiving of facsimiles. Badge or key access is required outside of normal business hours. All

credentials files and credentials information are maintained electronically on secure AHC servers. Custodians are allowed in the suites/offices after hours however all credentials files and information is stored on the AHC servers, therefore they are unable to access them either physically or remotely.

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**6. How the organization monitors its compliance with the policies and procedures in factors 1–4 or 5 (depending on certification) at least annually and takes appropriate action when applicable.**

In MSOW there is a standard audit trail detail report that is used to report on all edit and delete changes in MSOW over a given period. The query criteria for this report can be edited to focus on one or more provider sub-area records, to look at changes by specific users, or to focus on specific fields in provider records. When modifications are made, the reasons for modification are tracked in notes related to verification elements. MSOW captures the identity of the individual entering the notes.

At least annually, each medical staff office runs an audit trail detail report and analyzes a sampling of the modifications to determine if the modifications made are in accordance with the Credentials Policies and Procedures. Any modifications that do not meet standard policy are addressed with the MSOW User by the Medical Staff Director to whom they report for appropriate action.

The process for taking actions when modifications are identified that do not meet the established policy is a quarterly monitoring process to assess the effectiveness of its actions on all findings until it demonstrates improvement for one finding over at least three consecutive quarters.