The Department of Radiology is organized to provide accountability for professional performance and ethical conduct of its members to the Summa Health System Board and to strive toward continual improvement of the quality of patient care delivered in the Department consistent with the recognized standards of professional care and resources available; to provide educational opportunities to its members to continually advance professional knowledge; to provide ongoing review of patient care practices; and to provide a means through which the Department may participate in the Hospital's policy-making and planning processes.

The Department of Radiology shall be organized as follows:

I. Officers of the Department
   A. Department Chair
      1. The Department Chair shall be appointed by the Hospital Board and shall meet the qualifications as outlined for a Department Chair in the Summa Health System Medical Staff Bylaws.
      2. Duties of the Department Chair are outlined in the Summa Health System Medical Staff Bylaws.
      3. Removal of a Department Chair is outlined in the Summa Health System Medical Staff Bylaws
   B. Department Vice Chair – as applicable
      1. The Vice Chair shall be a member of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in at least one clinical area within the Department.
      2. The Vice Chair shall be appointed by the Chair of the Department and approved through the Medical Executive Committee.
      3. Duties of the Vice Chair shall be:
         a. Act as presiding officer, or representative, at any meeting as designated by the Chair.
         b. Assist Department Chair in the development, implementation, evaluation and monitoring of the Department quality review programs.
         c. As appropriate, review credentials applications, conduct clinical interviews, and make recommendations to the Department Chair regarding the clinical privileges to be exercised within the Department by members of, or applicants to, the Medical Staff in the Department.
         d. Evaluate the clinical work performed in the Department, as assigned.
         e. Conduct investigations and submit reports and recommendations to the Department Chair regarding clinical privileges to be exercised within the Department by members of, or applicants to, the Medical Staff in the Department.
         f. Perform such other duties commensurate with the office that may be requested by the Department Chair.
      4. Vice Chair shall serve the same term as the Department Chair until his/her successor is chosen, unless he/she resigns or is removed from office.
      5. Removal of a Vice Chair may be initiated by:
         a. Removal of a Vice Chair shall be at the discretion of the Department Chair, and reported to the Medical Executive Committee.
         b. Removal of a Vice Chair does not constitute adverse action and shall not entitle the member removed to any hearing or appeal rights regarding the issue of removal.
   C. Division Chiefs – as applicable
      1. Division Chiefs shall be members of the Active Staff of the Department of Radiology.
      2. Division Chiefs shall be qualified by training, board certification in the appropriate specialty or subspecialty, experience and demonstrated current ability in the clinical area included within their division.
      3. Appointment of Division Chiefs:
         a. By the Department Chair, or
         b. Division members shall select a leader acceptable to the Department Chair, or
         c. Upon acceptance by the Department Chair, the nominee will be presented to the Department membership for their information.
         d. The Department Chair shall notify the Medical Executive Committee, for their information, of the decision of the Department.
4. Each Division Chief shall serve a minimum term of two years unless he/she resigns prior to the end of the term, or is removed from office.

5. Duties of the Division Chief, or designee, shall be:
   a. Act as presiding officer at any division meeting, and keep accurate records of the proceedings.
   b. Assist in the development and implementation, in cooperation with the Department Chair, of a program to carry out the quality review, evaluation and monitoring function assigned to the division.
   c. Review credentials applications, conduct clinical interviews, and make recommendations to the Department Chair regarding the clinical privileges to be exercised within his/her division by members of, or applicants to, the Medical Staff in the Department of Radiology.
   d. Evaluate the clinical work performed in the division.
   e. Conduct investigations and submit reports and recommendations to the Department Chair regarding the clinical privileges to be exercised within his/her division by members of, or applicants to, the Medical Staff in the Department.
   f. Perform such other duties commensurate with the office that may from time to time be requested by the Department Chair.
   g. May serve as education coordinator for the division for education of residents and students and shall coordinate the continuing medical education of attending and ancillary staff.

6. Removal of a Division Chief may be initiated by:
   a. Removal of a Division Chief shall be at the discretion of the Department Chair.
   b. Removal of a Division Chief does not constitute adverse action and shall not entitle the member removed to any hearing or appeal rights regarding the issue of removal.

II. Department Meetings
   A. The Department will meet on a regular basis at a time and place designated by the Department Chair with appropriate consideration of membership needs. Department meetings may be canceled at the discretion of the Department Chair.

   B. Conduct of Business
      1. Department business shall be conducted under generally accepted parliamentary rules of order.
      2. A quorum will be required for the conduct of all business requiring the placing of motions and the taking of a vote.
      3. A quorum shall be specifically defined in the department addendum, but must have at least a minimum of three members.
      4. Unless otherwise stated in these rules, passage of all items to be voted upon requires a simple majority of voting members present or responding by email.
      5. In the absence of a quorum, the administrative business of the Department may be conducted. Such business would include reports of committees, dissemination of information and all other routine matters not requiring a vote.
      6. An Executive Session of the Department meeting may be called as determined by the Department Chair. At Executive Sessions, members shall include Active Staff members of the Department and a recording secretary.

   C. Voting Rights
      1. Active Staff
         An active staff member may vote on any matter presented at a Department meeting and any departmental committee meeting of which he/she is a member.
      2. All Other Staff Categories
         These categories of membership may only vote on matters presented to department committees to which the member has been appointed.

   D. Absent Voting Members
      1. In anticipation of an issue to be voted upon in his/her absence, a voting member may register his/her vote by written or oral proxy.
      2. Proxy votes are to be registered with the Department Chair or designee.

   E. Members with active admitting privileges are required to attend a minimum of 50 percent of department meetings. Failure to meet the attendance requirement, as defined, without excuse satisfactory to the
Department Chair or designee, may be grounds for corrective action as described in the Summa Medical Staff Bylaws.

F. Executive session of the Department meeting may be called as determined by the Chair. At Executive Sessions, members shall include Active Staff members of the Department and a recording secretary.

III. Departmental Committees
A. The Department Peer Review Committee shall serve as a standing committee. (Refer to Peer Review Committee Addendum)

B. The Radiation Generating / Radiation Safety Committee shall serve as a standing committee.

C. Other standing and ad hoc committees may be formed at the discretion of the Department Chair to attend to necessary Department functions.

IV. Division Meetings
A. Division meetings shall be held at the discretion of the Division Chief, as needed and appropriate. Members shall be notified at least three days prior to the meeting by telephone, an electronic message or written notice.

B. Attendance requirements for division meetings are at the discretion of the Division Chief.

C. A quorum for a division meeting shall be defined as those present.

D. Minutes of the division meeting shall be recorded and forwarded to the Department Chair. Any pertinent information should be reported during the Department meeting.

V. Appointment and Clinical Requirements
A. In addition to the qualifications outlined in the Summa Medical Staff Bylaws, physician members of the Department must meet the following general requirements:
   1. Must be certified by a primary board or hold appropriate sub-specialty certification within their field of practice where a specialty board exists, or become board certified within five (5) years of appropriate residency and/or fellowship training completion or within the amount of time specific by the applicant’s specialty, whoever is less. The certification must be recognized by the American Board of Medical Specialties or the American Osteopathic Association. If a period of clinical practice is required prior to certification examination, the five (5) year interval shall begin at the completion of the practice period.
   2. Must maintain an office and residence within a reasonable distance of the hospital.
   3. Must provide additional documentation and information for credentialing as requested by the Department Chair and/or Division Chief.
   4. Must demonstrate a commitment to participate as appropriate in the clinical, educational and service activities of the Department, including consults and care of the uninsured at Summa Health System.

B. Scope of Practice
The scope of practice is defined in Attachment A.

C. Terms of Appointment
1. All appointments shall be made by the Summa Health System Board in accordance with the procedures set forth in the Credentialing Appointment/Reappointment Policy and the Summa Health System Medical Staff Bylaws.
2. All initial appointments are provisional for one (1) year.
3. During the provisional period, each appointee's performance and clinical competence shall be monitored by the Department Chair, or their designee. At the conclusion of the provisional period, the Department Chair shall review the appointee's performance with regard to:
   a. quality of patient care
   b. relationship with physicians, patients, and other health care personnel
   c. ethical conduct
   d. physical and mental health
   e. compliance with the Summa Health System Medical Staff Bylaws, Department Rules and Regulations, and Hospital policies
f. timely completion of medical records
g. board certification status

4. The Department Chair shall submit a written report regarding the appointee to the Credentials Committee for approval. The report must include a recommendation for permanent appointment or continuation of the provisional appointment for a one (1) year period of time.

D. Professional Practice Evaluations

All appointees will be subject to professional practice evaluations.

1. Initial appointments and new privileges will merit a Focused Professional Practice Evaluation (FPPE), as determined by the Department Chair and/or designee and established in Department rules and regulations, in accordance with bylaws and available standards, and approved by the Medical Executive Committee. Final report will be submitted to the Medical Staff Credentials Committee for approval.

2. All medical staff appointees will have Ongoing Professional Practice Evaluations (OPPE), at an interval not less than every 6 months. Specifications are determined by the Department Chair and/or designee and established in Department rules and regulations, in accordance with bylaws and available standards, and approved by the Medical Executive Committee. This information will be submitted to the Medical Staff Credentials Committee, to be used in the reappointment process.

3. When a practitioner’s clinical competence, practice behavior, or performance of privileges indicate the need for a period of focused performance monitoring, a targeted FPPE will be developed and implemented by the Department Chair and/or designee, in accordance with bylaws and available standards, and approved by the Medical Executive Committee. The result of the FPPE will be handled in accordance with Medical Staff Policy 1.29.

E. Revocation, Suspension or Limitation of Department Membership

Membership in the Department may be revoked, restricted, or suspended as outlined in Article V of the Summa Medical Staff Bylaws.

VI. Amendments

These Rules and Regulations may be amended at any regular Department meeting. The proposed amendment must be sent to each voting member at least seven (7) days before the scheduled meeting. Providing a quorum is present, a two-thirds (2/3) majority vote shall be required for adoption of each amendment proposed. Approval of these amendments shall be subject to approval of the Medical Executive Committee and the Summa Health System Board.

VII. Matters Not Addressed by the Departmental Rules and Regulations

The Bylaws, Policies and Procedures of the Medical Staff shall serve as a reference until the Department Rules and Regulations can be amended to address such matters.

VIII. Appendices to the Rules and Regulations of the Department include:

A. Scope of Practice
B. Delineation of Privileges
C. Peer Review/Quality Improvement Program
D. Resident and Medical Student Rotators
E. Non-Physician Practitioners
F. FPPE and OPPE

IX. Medical Staff Definitions (Refer to the Medical Staff Bylaws)

X. Ethics and Ethical Relationships

The Principles of Medical Ethics are consistent with those outlined in the Medical Staff Bylaws.
XI. Appendices

A. Scope of Practice.
The Department of Radiology consists of those physicians appointed to the Medical Staff whose practice is limited to diagnostic and interventional radiology, radiation oncology, and qualifies experts in radiologic physics. The professional activities of the Department encompass the professional supervision and interpretation of diagnostic imaging, the performance and interpretation of interventional procedures, and the performance and interpretation of radiation oncology procedures. The Department provides accountability for the performance, quality, and ethical conduct of its members.

B. Delineation of Privileges.
The current delineation of privileges forms are attached as Appendix B Form 1.

C. Peer Review/Quality Improvement.
There are three basic components to the Department of Radiology peer review programs:

ACR Rad Peer Program
The Radpeer program is an American College of Radiology program designed to support analysis of random sampled peer-review / overread of radiology cases. Each radiologist overreads at least 100 cases per quarter, and fills out the electronic Radpeer forms, which have a four-point scale to rate the interpretations. Chairperson/Peer Review Committee members personally overreads the cases graded as 2b, 3 or 4. This data is sent to the ACR, computer processed, and the peer-review data are generated and compared to national benchmarks. The data are reviewed by the Chair quarterly, and are reviewed in closed session of the Department Meetings, and become part of the radiologists data for OPPE.

Targeted QA – High Sampling Rate
Completed on admission cases for Trauma PI, Stroke PI cases. These peer review activities are performed in the multidisciplinary conferences for Trauma and Stroke services. Some of these cases of educational merit become green card cases.

Additionally, in the first four weeks of service, a new radiologist will have a representative sampling of dictated cases (typically 50-100 cases) peer reviewed by the chairperson to evaluate quality, reporting guidelines, and content. This data is part of a new radiologists FPPE data.

Green Card – Peer review cases
These are selected cases which come from any source, including peers, consultants, hospital QA programs, etc. These cases may be based on incorrect interpretations, communication or process flaws, complications, interpretations resulting in unnecessary further testing, or any situation where suboptimal care or service was provided. These cases are analyzed for significant educational merit, and selected cases are discussed at quarterly Peer Review Meetings, and all radiologists must review and sign off on the educational peer review cases. Participation in the green card educational process is part of the radiologists OPPE data.

The Department Chair and/or designee participate in multidisciplinary performance improvement conferences, organizational Quality Assurance and Performance Improvement conferences, and Clinical Consensus Groups.

D. Medical Student and Resident Rotators in Radiology.
The Department of Radiology does not have a residency program. Medical student and resident rotator in the Department are coordinated and supervised through the office of the Department Chair. All electives will be coordinated with the student’s school through the GME office.

E. Non Physician Practitioners.
Non-physician practitioners may be used for certain services in the Department of Radiology. NPPs do not provide physician level supervision of diagnostic tests. All NPP utilization will be with full adherence to applicable regulations, and with the approval of the Hospital compliance officer.

F. Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE)
All Medical Staff members of the Department of Radiology will participate in professional practice evaluations.

1. On initial appointment, and for new privileges, a Focused Professional Practice Evaluation (FPPE) process will be completed. The FPPE process is determined by the Department Chair, in accordance with Medical Staff Bylaws and Joint Commission standards, and approved by the Medical Executive Committee.
   a. The period of FPPE will be in the first 90 days of practice
   b. The data used for the FPPE process will be a review of 100 cases, including 25 in the physician’s specialty, using a RadPEER process. This will be performed by the Chair and/or designee, evaluating diagnostic accuracy, report quality, and adherence to critical test results reporting guidelines. For procedural specialists, this will also include evaluation of results and complications from interventions. The FPPE process also includes specific instruction on the critical test results process, the Medical Staff Code of Conduct, and introduction to Medical Staff Bylaws and Department Policies. The New Physician FPPE Form is in Appendix F form 1.
   c. The trigger for indicating the need for further focused monitoring is defined as > 2% RadPEER 3 and 4 rated cases. The measures used to resolve performance issues may include targeted CME, proctoring, instruction on reporting guidelines. After 90 days, a repeated review of 100 cases will be performed. The Chair will make a final recommendation to the Medical Staff Credentials Committee for approval, suspension, or revocation of privileges.
   d. The FPPE information is stored in protected fashion, in the Department office as well as in electronic form in the Medical Staff credentialing software.

2. All medical staff appointees will have Ongoing Professional Practice Evaluations (OPPE), at an interval not less than every 6 months. The 6 month blocks are defined as the 1st and 2nd quarters of a calendar year, and the 3rd and 4th quarters of the calendar year. There are 4 blocks in the 2 year recredentialing cycle. The OPPE process is determined by the Department Chair, in accordance with Medical Staff bylaws and Joint Commission standards, and approved by the Medical Executive Committee. This information will be submitted to the Medical Staff Credentials Committee, to be used in the reappointment process.
   a. Data are collected on all practitioners with appointments in the Department of Radiology. Specific monitors are determined by the Department Chair to correspond to the 6 elements of general professional competency. The majority of triggers are applied generally to all practitioners; some cohorts of specialists (interventionalists, breast specialists) will have additional triggers. Data comes from RadPEER, the radiology information system, the laboratory information system, the mammography reporting system, Hospital Quality reports, Hospital analytic reports, and logs of Department activities.
   b. The specific template of OPPE monitors and triggers is approved by the Medical Executive Committee. The OPPE Form is in Appendix F Form 2.
   c. OPPE data is compiled by the Chair and/or designee within 90 days of the completion of the 6 month period, and the results are reviewed by the Chair and the Quality committee. The Chair meets with individual staff members to review the OPPE information.
   d. The OPPE information for all practitioners is submitted to the Medical Staff Credentialing Committee, and stored in protected fashion, in the Department office as well as in the Medical Staff electronic credentialing software, so that it is available at the time of recredentialing.

3. When a practitioner’s clinical competence, practice behavior, or performance of a privilege(s) indicate the need for a period of focused performance monitoring, a targeted FPPE will be developed and implemented by the Department Chair and/or designee, in accordance with the Medical Staff bylaws and Joint Commission standards, and approved by the Medical Executive Committee.
   a. The scope of this FPPE will be determined by the Chair and/or designee, focused on the identified deficiency, not influencing remaining privileges.
b. Typical FPPE period is 90 - 180 days, and during this time period, the privilege is under an action plan. The Chair and/or designee will specify the monitoring process, and will clearly define the specific triggers. The standard Action Plan Form is in Appendix F Form 3.

c. The Chair and/or designee will define the measures employed to resolve the performance issues, and develop a specific action plan, which is reviewed and signed by the Chair and the practitioner. This plan may include targeted education, proctoring, simulation training, counseling, or other programs.

d. The results of the FPPE are reviewed by the Chair and the Quality committee, and the Chair will determine the continuation, suspension, or revocation of the specific privilege(s). The FPPE results are reviewed by the Medical Staff Cabinet, and submitted to the Medical Staff Credentials Committee.

e. The FPPE data is stored in protected fashion, in the department office and in electronic form in the Medical Staff credentialing software.

Approved by:
Medical Executive Committee 12.9.2016