**MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS**
**OF**
**THE CHRIST HOSPITAL HEALTH NETWORK**

# MEDICAL STAFF CREDENTIALS POLICY

***Adopted by the Medical Executive Committee on July 26, 2022***
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ARTICLE 1

GENERAL

## 1.A. DEFINITIONS

The following definitions will apply to terms used in this Policy:

(1) "ALLIED HEALTH PROFESSIONALS" ("AHPs") means Category I, Category II, or Category III practitioners, as follows:

- "CATEGORY I PRACTITIONER" means a Licensed Independent Practitioner who is permitted by law and by the Hospital to provide patient care services without direction or supervision/collaboration, within the scope of his or her license and consistent with the clinical privileges granted. (See Appendix A to this Policy.)

- "CATEGORY II PRACTITIONER" means an Advanced Dependent Practitioner who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising/Collaborating Physician pursuant to a written practice protocol or supervision or collaborative agreement, as applicable. (See Appendix B to this Policy.)

- "CATEGORY III PRACTITIONER" means a Dependent Practitioner who is permitted by law or the Hospital to function only under the direction of a Supervising/Collaborating Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted. (See Appendix C to this Policy.)

(2) "BOARD" means the Board of Directors of The Christ Hospital (or its designated committee), which is registered to do business as The Christ Hospital Health Network, and thereby has the overall authority for the Hospital.

(3) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria, as well as focused and ongoing professional practice evaluation standards.

(4) "CORE PRIVILEGES" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and

which have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.

(5) "DAYS" means calendar days except for time periods identified as "business days," meaning any day Monday through Friday, except holidays.

(6) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(7) "HOSPITAL" means The Christ Hospital and the Liberty Township Medical Center (including all provider-based sites and facilities, as defined by the Centers for Medicare & Medicaid Services[1]), and is registered to do business as The Christ Hospital Health Network.

(8) "MEDICAL EXECUTIVE COMMITTEE" means the Medical Executive Committee of the Medical Staff.

(9) "MEDICAL STAFF" means all physicians, dentists, oral surgeons, podiatrists, and psychologists who have been appointed by the Board to the Medical Staff of TCHHN, which is also the Medical Staff of the Hospital.

(10) "MEDICAL STAFF LEADER" means any Medical Staff Officer, service line medical director, division chief, medical director, committee chair, and program director for graduate medical education.

(11) "MEDICAL STAFF SERVICES" means the Medical Staff Services Office at the Hospital or the TCHHN Credentials Verification Organization ("CVO").

(12) "MEMBER" means any physicians, dentists, oral surgeons, podiatrists, and psychologists who have been granted appointment by the Board.

(13) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, website, Hospital mail, hand delivery, or other electronic method.

(14) "ORAL AND MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or a D.M.D. degree, who has completed additional training in oral and maxillofacial surgery.

(15) "PATIENT CONTACTS" includes any admission, consultation (including laboratory and radiologic), or procedure (inpatient or outpatient) performed in the Hospital. It will not include referrals for diagnostic or laboratory tests or radiology services.

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[1] The locations of all provider-based sites and facilities shall be maintained in Medical Staff Services.

(16) "PERMISSION TO PRACTICE" means the authorization granted to an Allied Health Professional by the Board to exercise a scope of practice or clinical privileges.

(17) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(18) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

(19) "PRESIDENT & CHIEF EXECUTIVE OFFICER" means the individual appointed by the Board to act on its behalf in the overall management of TCHHN.

(20) "SCOPE OF PRACTICE" means the authorization granted to a Category III practitioner to perform certain clinical activities and functions under the supervision of, or in collaboration with, a Supervising/Collaborating Physician.

(21) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(22) "SPECIAL PRIVILEGES" means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.

(23) "SUPERVISING/COLLABORATING PHYSICIAN" means (i) a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise or collaborate with a Category II or Category III practitioner and to accept full responsibility for the actions of the Category II or Category III practitioner while he or she is practicing in the Hospital, or (ii) where a written agreement or practice protocols are not required by state law, a member of the Medical Staff who directs or oversees the actions of the Category II or Category III practitioner while he or she is practicing in the Hospital. In either case, the Supervising/Collaborating Physician agrees to evaluate the performance of the Category II or Category III practitioner and perform those oversight responsibilities set forth in Article 8 and as required by any other relevant policies.

(24) "SUPERVISION/COLLABORATION" means the supervision of (or collaboration with) a Category II or Category III practitioner by a Supervising/Collaborating Physician, that may or may not require the actual presence of the Supervising/Collaborating Physician, but that does require, at a minimum, that the Supervising/Collaborating Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) will be determined at the time each Category II or Category III practitioner is credentialed and will be consistent with any applicable written practice protocol or supervision or collaboration agreement that may exist. ("General" supervision means that the physician is immediately available by phone, "direct" supervision means that the

physician is immediately available to the Hospital to furnish assistance and direction throughout the performance of the procedure, and "personal" supervision means that the physician is in the same room.)

(25) "THE CHRIST HOSPITAL HEALTH NETWORK" or "TCHHN" is the registered trade name of The Christ Hospital, and includes the Hospital and all affiliated centers and physician practices.

(26) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

(27) "VP & CHIEF CLINICAL OFFICER" means the chief administrative clinical officer for TCHHN, or his or her designee (e.g., a VPMA or CMO), who is responsible for carrying out any assigned functions set forth in the Medical Staff Bylaws and related documents.

## 1.B. ALLIED HEALTH PROFESSIONALS

(1) Unless specified otherwise, Allied Health Professionals who seek permission to practice at the Hospital shall be subject to the same terms and conditions of appointment and reappointment as specified for members of the Medical Staff. Applications for permission to practice by Allied Health Professionals shall be submitted and processed in the same manner as outlined for Medical Staff members in this Policy. For ease of use, when applicable to an Allied Health Professional, any reference in this Policy to "appointment" or "reappointment" shall be interpreted as a reference to initial or continued permission to practice.

(2) A request for clinical privileges, on an initial basis or for renewal, submitted by a Category I or Category II practitioner who is seeking employment or who is employed by the Hospital, will be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications will then be made to Hospital Administration or Human Resources (as appropriate) to assist the Hospital in making employment decisions. Failure to maintain an employment relationship with the Hospital once appointment and clinical privileges are granted will result in the automatic relinquishment of the same as a failure to maintain threshold eligibility criteria.

(3) A request for a scope of practice on an initial basis or for renewal from a Category III practitioner who is seeking employment or is employed by the Hospital will be evaluated by Human Resources through the Human Resources policies and procedures, using the same qualifications set forth in Section 2.A.1 of this Policy.

## 1.C. TIME LIMITS

Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

## 1.D. DELEGATION OF FUNCTIONS

(1) When a function under this Policy is to be carried out by a member of Hospital Administration, by a Medical Staff Leader, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. The delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee is a record of the committee that is ultimately responsible for the review in a particular matter.

(2) When a Medical Staff Leader is unavailable or unable to perform an assigned function, a Medical Staff Officer may perform the function personally or delegate it to another appropriate individual.

## 1.E. TCHHN EMPLOYEES

(1) Any member of the Medical Staff or Allied Health Professional Staff who is employed by TCHHN or a TCHHN affiliated group is bound by all of the same conditions and requirements in this Policy that apply to members who are not employed by TCHHN or a TCHHN affiliated group.

(2) If a concern about an employed member's clinical competence, conduct or behavior arises, the concern may be reviewed and addressed in accordance with this or another Medical Staff policy, in which event a report may be provided to TCHHN. This provision does not preclude the TCHHN or a TCHHN-affiliated group from addressing an issue in accordance with its employment policies/manuals or in accordance with the terms of any applicable employment contract.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

## 2.A. QUALIFICATIONS

### 2.A.1. Threshold Eligibility Criteria:

(a) To be eligible to apply for and maintain initial appointment or reappointment to the Medical Staff, an individual must, where applicable:

(1) have a current, unrestricted license, certification, or registration to practice in Ohio (and/or Indiana or Kentucky, if applicable to the individual's practice site) that is not subject to probation, and have never had a license, certification, or registration to practice revoked, suspended, or restricted by a state licensing agency (except for a license restriction related to (i) a failure to complete continuing medical education ("CME"), as certified on a renewal application, or (ii) an impairment where the individual can document his or her completion of a recovery program);

(2) where applicable to their practice, have a current, unrestricted DEA certificate with a local address that corresponds to the primary office address of the individual's practice. An individual with an out-of-state address on his or her DEA certificate may be credentialed if proof is provided that the individual has applied for a change of address to a new primary practice location;

(3) except for telemedicine and long-term locum tenens providers, or where there is a demonstrated need which is endorsed by the service line medical director, maintain a principal place of practice and a personal residence located within Hamilton County, Ohio or the surrounding tri state area, both of which locations are a reasonable distance from the Hospital;

(4) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital, as applicable to their practice (for new applicants, this criterion can be met by providing documentation showing that such coverage will be in place and effective at the time appointment and/or clinical privileges are approved by the Board);

(5) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

(6) not be currently excluded, debarred, suspended, or otherwise ineligible to participate in Medicare, Medicaid, or other federal or state governmental health care program, as evidenced by inclusion on the General Services Administration's List of Parties Excluded from Federal Programs, the HHS/OIG List of Excluded Individuals/Entities, or state exclusion lists;

(7) have not been convicted of, or entered a plea of guilty or no contest to, any misdemeanor relating to controlled substances or illegal drugs in the time since commencing medical school. Any such incident will be reviewed by the Chair of the Credentials Committee, President of the Medical Staff, and the VP & Chief Clinical Officer so that they may understand the circumstances surrounding the incident;

(8) have never been convicted of, or entered a plea of guilty or no contest to, any misdemeanor relating to insurance or health care fraud or abuse, child abuse, elder abuse, or violence;

(9) have never been convicted of, or entered a plea of guilty or no contest, to any felony;

(10) except for telemedicine providers, have appropriate coverage arrangements (as determined by the Credentials Committee) with other members of the Medical Staff for those times when the individual will be unavailable;

(11) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought;

(12) if applying for privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract;

(13) document compliance with any vaccination, immunization, and/or health screening requirements as may be adopted by the MEC, Hospital, or TCHHN (e.g., TB testing, mandatory flu vaccines, and infectious agent exposures);

(14) if functioning as a Supervising/Collaborating Physician for a Category II or Category III practitioner, have a written practice protocol or supervision/collaboration agreement, as applicable, which meets all applicable requirements of state law and Hospital policy;

(15) have successfully completed:*

(i) a residency or fellowship training program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in the specialty in which the applicant seeks clinical privileges;

(ii) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA");

(iii) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(iv) a clinical psychology training program accredited by the American Psychological Association; and

* This requirement is applicable only to those individuals who apply for initial staff appointment after July 16, 2014. Those Medical Staff members who were appointed prior to that date will be grandfathered and will be governed by the residency training requirements in effect at the time of their initial appointments.

(16) must satisfy the following board certification requirements:

New Medical Staff Members

(i) All applicants for initial appointment must be board certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, American Osteopathic Association, American Board of Podiatric Surgery, The American Board of Physician Specialties (for Emergency Medicine only), or The American Board of Podiatric Surgery, The American Board of Podiatric Medicine, and the American Board of Orthopedic and Primary Podiatric Medicine (recognizing any subsequent name changes that are adopted by these bodies). Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years will be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training.

(ii) Members must maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements in accordance with the recertification guidelines below.

Existing Medical Staff Members

(i) Those Medical Staff members appointed on or after May 1, 2011, who currently possess board certification in their primary area of practice at the Hospital are required to maintain it. Recertification will be assessed at reappointment in accordance with the recertification guidelines below.

(ii) Those Medical Staff members appointed between September 1, 2006 and April 30, 2011, who are board admissible must obtain board certification in their proposed area of practice within five (5) years of initially becoming board admissible.

(iii) Those existing Medical Staff members who were appointed to the Medical Staff prior to September 1, 2006 and who do not possess board certification are encouraged to obtain it, but shall be grandfathered.

Recertification Guidelines

Recertification will be assessed at reappointment for a determination as to whether the individual is eligible for reappointment. An applicant for reappointment whose board certification has lapsed must request a waiver of the applicable board certification requirement.

With the exception of the specific guidelines regarding board certification, the threshold eligibility criteria outlined in Section 2.A.1 will be applicable to those individuals who apply for initial staff appointment after the date of adoption of this Policy. Existing members will be governed by the eligibility criteria in effect at the time of their initial appointment.

(b) In addition to the applicable criteria outlined in (a) above, an Allied Health Professional seeking to practice as a Category II or Category III practitioner must have a written practice protocol or agreement, as applicable, with a Supervising/Collaborating Physician in order to be eligible to apply for initial and continued permission to practice at the Hospital. Such a practice protocol or agreement must meet all applicable requirements of state law and Hospital policy.

2.A.2. Waiver of Threshold Eligibility Criteria:

(a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating (i) that he or she is otherwise qualified, and (ii) **exceptional** circumstances exist (e.g., when there is demonstrated community need for the services in question). Exceptional circumstances generally do not

include situations in which a waiver is sought for the convenience of an applicant (e.g., applicants who wish to defer taking Board examinations).

(b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant service line medical director or division chief, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the Medical Executive Committee. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(c) The Medical Executive Committee shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(d) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the state board or the National Practitioner Data Bank.

(e) The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants.

(f) An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

(g) If a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at each subsequent reappointment cycle. The waiver remains in effect for the entirety of the individual's tenure at the Hospital, so long as the individual continuously remains a member of the Medical Staff or the Allied Health Professional Staff.

2.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as part of the appointment and reappointment processes, as reflected in the following factors:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;

(c) good reputation and character;

(d) ability to safely and competently perform the clinical privileges requested;

(e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care, patient safety, and a recognition that interpersonal skills, cooperation, and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment:

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or Allied Health Professional Staff or to be granted particular clinical privileges merely because he or she:

(a) is employed by the Hospital or its subsidiaries or has a contract with the Hospital;

(b) is or is not a member or employee of any particular physician group;

(c) is licensed or certified to practice a profession in this or any other state;

(d) is a member of any particular professional organization;

(e) has had in the past, or currently has, appointment or privileges at any hospital or health care facility;

(f) resides in the geographic service area of the Hospital; or

(g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No individual will be denied appointment or reappointment on the basis of gender, race, creed, national origin, sexual orientation, or disability.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

(a) As a condition of being granted appointment or reappointment, and as a condition of ongoing membership, every member specifically agrees to the following:

(1) executes the Code of Conduct of the Hospital and the Medical Staff/Allied Health Practitioners Code of Professionalism, undergo any applicable orientation programs at the Hospital, and for those individuals who are required, to have arrangements training, general compliance training and/or any other special compliance training before participating in direct patient care;

(2) to be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of Emergency Department patients in a prompt, efficient, and conscientious manner. ("Appropriate coverage" means coverage by another member of the Medical Staff with appropriate specialty-specific privileges as determined by the Credentials Committee.) Compliance with this responsibility means that, absent extraordinary circumstances, the practitioner must:

(i) respond immediately (no later than 30 minutes), via phone, to all pages from the Hospital; and

(ii) where requested, appear in person (or via telemedicine) to attend to a patient within 60 minutes (or at a time as otherwise agreed to by the requesting practitioner or as required for a particular specialty as recommended by the Medical Executive Committee and approved by the Board) of being requested to do so;

(3) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed;

(4) to participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, and by performing such other reasonable duties and responsibilities as may be assigned;

(5) within the scope of his or her privileges, to provide emergency service call coverage, consultations, and care for unassigned patients in his or her

specialty or to obtain appropriate coverage by another member of the Medical Staff. The applicable service line medical director is charged with preparing the on-call schedule for his or her service line. If a member seeks to (i) receive additional days of call coverage, or (ii) be relieved of any or all of his or her call obligation, the individual must submit such a request, in writing, to the applicable service line medical director. If the service line medical director objects to the request, the member may petition the President of the Medical Staff, in writing, to review the request. Based on the needs and distribution of call within the specialty area in which the physician practices, the President of the Medical Staff will either confirm the service line medical director's objections or make a recommendation to the Medical Executive Committee to authorize the member's request. Any request that is granted is subject to change by the Medical Executive Committee and/or the Board upon their determination that call coverage in the member's specialty area is not adequate or fairly distributed;

(6) to comply with clinical practice or evidence-based medicine pathways or protocols pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff Leaders, or clearly document the clinical reasons for variance;

(7) to comply with clinical practice or evidence-based protocols and pathways that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or to clearly document the clinical reasons for variance;

(8) to comply with all applicable training and/or educational protocols that may be adopted by the Medical Executive Committee and/or required by the Hospital, including, but not limited to, those involving electronic medical records, patient safety, and infection control;

(9) to notify the VP & Chief Clinical Officer or the President of the Medical Staff, in writing, within 5 business days of any change in the practitioner's status or any change in the information provided on the individual's application form. This information will be provided with or without request, at the time the change occurs, and will include, but not be limited to:

- any and all complaints regarding, or changes in, licensure status or DEA controlled substance authorization;
- changes in professional liability insurance coverage;
- any settlement or judgment of a professional liability lawsuit against the practitioner;

- changes in the practitioner's Medical Staff status (appointment and/or privileges) at any other hospital or health care entity as a result of a professional review action or in order to avoid initiation of an investigation (e.g., surrender of clinical privileges while under investigation or in return for not conducting an investigation);

- changes in the individual's employment status at TCCHN or a TCHHN-related entity if the change was related to issues involving clinical competence or professional conduct;

- knowledge of a criminal investigation involving the member, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation;

- changes in the practitioner's eligibility to participate in Medicare, Medicaid, or other federal or state governmental health care program, including exclusion, debarment, or suspension, as evidenced by inclusion on the General Services Administration's List of Parties Excluded from Federal Programs, the HHS/OIG List of Excluded Individuals/Entities, or state exclusion lists;

- any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, a physical, mental or emotional condition that could adversely affect the practitioner's ability to practice safely and competently, or impairment due to addiction, alcohol use, or other similar issue (all of which will be referred for review under the Practitioner Health Policy); and

- any charge of, or arrest for, driving under the influence ("DUI") or related to a controlled substance or illegal drugs. (Any such incident will be reviewed by the President of the Medical Staff and the VP & Chief Clinical Officer so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review under Article 6 or the Practitioner Health Policy.);

(10) to immediately submit to an appropriate evaluation, which may include diagnostic testing (such as blood and/or urine test) or a complete physical, mental, and/or behavioral evaluation. Such a request may be made:

- where the President of the Medical Staff, VP & Chief Clinical Officer, or another Medical Staff Leader are concerned with the individual's ability to safely and competently care for patients;

- during the initial appointment or reappointment processes;
- during an investigation;
- whenever a report of a health issue that poses an immediate threat has been made to the VP & Chief Clinical Officer or the President of the Medical Staff; or
- at the request of the Practitioner Aid Committee.

In each of these situations, the Medical Staff and/or Hospital leaders or committee that requests the evaluation will: (i) identify the health care professional(s) to perform the evaluation; (ii) inform the individual of the time period within which the evaluation must occur; and (iii) provide the individual with all appropriate releases to allow for the sharing of information between the health care professional(s) performing the evaluation and the relevant Medical Staff and/or Hospital leaders or committee. Whenever a request for such an evaluation is made, the individual member or applicant will be responsible for any costs associated with obtaining this evaluation;

(11) to meet with Medical Staff Leaders and/or Hospital administration upon request, to provide information regarding professional qualifications upon written request, and to participate in collegial efforts as may be requested;

(12) to appear for personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;

(13) to complete in a timely manner all medical and other required records and to utilize the electronic medical record as required with respect to health care delivered in the Hospital;

(14) if exercising clinical privileges, to use the Hospital sufficiently to allow continuing assessment of current competence;

(15) to maintain and monitor a current Hospital e-mail address with Medical Staff Services, which will be the primary mechanism used to communicate all Medical Staff information to the member;

(16) to provide valid contact information in order to facilitate practitioner to practitioner communication (e.g., mobile phone number or valid answering service information);

(17) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(18) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(19) to refrain from deceiving patients as to the identity of any individual providing treatment or services;

(20) to seek consultation whenever required or necessary;

(21) to complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital;

(22) to cooperate with all utilization oversight activities;

(23) to perform all services and conduct himself/herself at all times in a cooperative and professional manner, and resolve in a timely fashion any validated complaints received from patients or staff;

(24) to promptly pay any applicable dues, assessments, and/or fines;

(25) to satisfy all applicable continuing medical education requirements necessary in order to maintain licensure or certification in Ohio (or Indiana or Kentucky, where applicable) or as otherwise required by the Hospital;

(26) to participate in an Organized Health Care Arrangement ("OHCA") with the Hospital and abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital (an OHCA means the term used by the HIPAA Privacy Rule which permits the Hospital and Medical Staff to use joint notice of privacy practices information when patients are admitted to the Hospital. Practically speaking, being part of an OHCA allows the members of the Medical Staff to rely upon the Hospital notice of privacy practices and therefore relieves Medical Staff members of their responsibility to provide a separate notice when members consult or otherwise treat Hospital inpatients); and

(27) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to the procedural rights in Article 7 or Article 8 of this Policy. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Credentials Committee's consideration. If the determination is made to not process an application or that appointment and privileges should be automatically relinquished pursuant to this provision,

the individual may not reapply to the Medical Staff or the Allied Health Professional Staff for a period of at least two years.

(b) In addition to the applicable responsibilities outlined in (a) above, as a condition of initial and continued permission to practice at the Hospital, an Allied Health Professional specifically agrees to the following:

(1) to refrain from deceiving patients as to his or her status as an Allied Health Professional; and

(2) to strictly comply with the standards of practice applicable to the functioning of Category II practitioners in the inpatient hospital setting, as set forth in Section 8.A.2 of this Policy.

2.B.2. Professional Conduct:

(a) Individuals appointed to the Medical Staff are expected to relate in a professional manner to other health care professionals, and to work collegially with the Medical Staff leadership and Hospital management and personnel. Disruptive conduct and behavior, specifically including threatening or abusive language and actions, are unacceptable and below the standard expected of members of the Medical Staff.

(b) All individuals appointed to the Medical Staff are specifically required to abide by the Code of Conduct of the Hospital and the Medical Staff Professionalism Policy.

(c) All such individuals are also required to provide services and to conduct themselves in an ethical and lawful manner, in accordance with the Hospital's Corporate Compliance Program.

(d) Misuse or misappropriation of health information may result in civil and/or criminal penalties. In addition, violations of the Hospital's privacy policies and procedures may result in notification to law enforcement officials and regulatory, accreditation, and licensure organizations.

2.B.3. Burden of Providing Information:

(a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges or scope of practice, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care

organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

(b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.

(c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required will be deemed to be withdrawn.

(d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

## 2.C. APPLICATION

### 2.C.1. Information:

(a) Applications for appointment and reappointment will contain a request for specific clinical privileges or scope of practice and will require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.

(b) In addition to other information, a completed application will contain the following:

(1) information as to whether the applicant's appointment or clinical privileges or scope of practice has been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed by any other hospital, health care facility, or other organization, or is currently being investigated or challenged;

(2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, limited, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or

settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the Medical Executive Committee, or the Board may request;

(4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and

(5) a copy of a government-issued photo identification, which will be verified in accordance with the Hospital's Medical Staff Services Identification Policy.

(c) The applicant will sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for appointment, reappointment, clinical privileges, or scope of practice, the individual expressly accepts the conditions set forth in this Section:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, scope of practice, or the individual's qualifications for the same. This immunity covers any actions, recommendations, communications, and/or disclosures involving the individual that are made or taken by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities. This immunity also extends to any reports that are made to government regulatory and licensure boards or agencies pursuant to federal or state law.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff or the Allied Health Professional Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically

authorizes third parties to release this information to the Hospital and its authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to (i) other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and (ii) government regulatory and licensure boards or agencies pursuant to federal or state law.

(d) Authorization to Share Information Within TCHHN:

The individual specifically authorizes TCHHN Entities (as defined below) to share with one another credentialing, peer review, and other information and documentation pertaining to the individual's clinical competence, professional conduct, and health. This information and documentation may be shared at any time, including, but not limited to, any initial evaluation of an individual's qualifications, any periodic reassessment of those qualifications, or when a question is raised about the individual.

For purposes of this Section, a TCHHN Entity means any entity which, directly or indirectly, through one or more intermediaries, is controlled by TCHHN. This includes, but is not limited to, TCHHN hospitals, ambulatory surgery centers, and affiliated physician groups.

(e) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy are the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or privileges, or any report that may be made to a regulatory board or agency, and does not prevail, he or she will reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

(g) Scope of Section:

All of the provisions in this Section 2.C.2 are applicable in the following situations:

(1) whether or not appointment, clinical privileges, or scope of practice is granted;

(2) throughout the term of any appointment or reappointment period and thereafter;

(3) should appointment, reappointment, clinical privileges, or scope of practice be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities;

(4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure as a member of the Medical Staff or Allied Health Professional Staff; and

(5) as applicable, to any reports that may be made to government regulatory and licensing boards or agencies pursuant to federal or state law.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

## 3.A. APPLICATION FOR INITIAL APPOINTMENT

(1) Applications for appointment may be approved by the Board, upon recommendation by the Medical Executive Committee and Credentials Committee.

(2) An individual seeking initial appointment will be sent (i) a letter that outlines the threshold eligibility criteria for appointment outlined earlier in this Policy, and (ii) a Request for Application form that requests confirmation that the individual meets the applicable criteria for appointment and the clinical privileges or scope of practice being sought. Medical Staff Services will provide an application to an individual who demonstrates his or her eligibility for membership. Individuals who fail to meet these criteria will not be given an application and will be notified that they are ineligible, unless a waiver has been granted pursuant to Section 2.A.2 of this Policy. There is no right to a hearing on a determination of ineligibility.

(3) Applications may be provided to residents or fellows who are in the final six months of their training. Such applications may be processed, but final action will not be taken until all applicable threshold eligibility criteria are satisfied.

## 3.B. INITIAL REVIEW OF APPLICATION

The burden of producing all necessary documentation shall be the sole responsibility of the applicant. Although Medical Staff Services will assist the applicant in gathering some of the documentation, the responsibility for this function is not transferred from the applicant. Medical Staff Services will send initial requests for documentation to the proper primary sources, and will follow up with additional requests, to primary and designated equivalent sources where necessary in periodic intervals. Where a period of ninety (90) days elapses without a response from primary or appropriate designated equivalent sources, the applicant will be advised of what documentation is needed to complete the application. An additional thirty (30) days will be provided for the applicant to secure and provide the documentation necessary for the application to be considered complete. If at the end of this additional thirty (30) day period, documentation has still not been received, the application will, absent good cause, be categorized as "incomplete" and no further processing by Medical Staff Services will take place. Should the applicant subsequently desire to seek appointment, the applicant must then complete and submit a new application including application fees.

An application is considered "complete" and the procedures for appointment started when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources.

## 3.C. STEPS TO BE FOLLOWED FOR ALL INITIAL APPLICANTS

(1) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references, and other available sources, including the applicant's past or current department or section chief at other health care entities, residency training director, supervisors, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(2) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by any of the following: the service line medical director, the division chief, the Credentials Committee, a Credentials Committee representative, the Medical Executive Committee, the President of the Medical Staff, the VP & Chief Clinical Officer, and/or the President & Chief Executive Officer.

## 3.D. SERVICE LINE MEDICAL DIRECTOR/DIVISION CHIEF PROCEDURE

(1) Medical Staff Services will provide the complete application and all supporting materials to the appropriate service line medical director or division chief. The service line medical director or division chief will prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges or scope of practice requested.

(2) The service line medical director or division chief will be available to the Credentials Committee, the Medical Executive Committee, and the Board to answer any questions that may be raised with respect to the report and findings of that individual.

## 3.E. CREDENTIALS COMMITTEE PROCEDURE

(1) The Credentials Committee will review and consider the report prepared by the relevant service line medical director or division chief and will make a recommendation.

(2) The Credentials Committee may use the expertise of the service line medical director, division chief or any member of the service line or division, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(3) After determining that an applicant is otherwise qualified for appointment and privileges or scope of practice requested, if there is any question about the applicant's ability to perform the privileges or scope of practice requested and the responsibilities of appointment, the Credentials Committee may require the

applicant undergo a physical or mental examination by a physician(s) satisfactory to the Credentials Committee in accordance with the steps outlined in Section 2.B.1(a)(10). The results of this examination will be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee will be considered a voluntary withdrawal of the application and all processing of the application shall cease.

(4) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) or 8.B.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 or Article 8 of this Policy.

## 3.F. MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION

(1) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee will:

(a) adopt the findings and recommendation of the Credentials Committee, as its own; or

(b) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or

(c) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(2) If the recommendation of the Medical Executive Committee is to appoint, the recommendation will be forwarded to the Board through the President of the Medical Staff.

(3) If the recommendation of the Medical Executive Committee is unfavorable and would entitle the applicant to request a hearing in accordance with Section 7.A.1(a) or 8.B.1(a) of this Policy, the Medical Executive Committee will forward its recommendation to the President & Chief Executive Officer, who will promptly send special notice to the applicant. The President & Chief Executive Officer will then hold the application until after the applicant has completed or waived a hearing and appeal.

## 3.G. BOARD ACTION

(1) Expedited Review. The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges or scope of practice if there has been a favorable recommendation from the Credentials Committee and the Medical Executive Committee and there is no evidence of any of the following:

(a) a current or previously successful challenge to any license or registration;

(b) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges/scope of practice at any other hospital or other entity; or

(c) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board committee to appoint will be effective immediately and will be forwarded to the Board for information at its next meeting.

(2) Full Board Review. When there has been no delegation to a Board committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges or scope of practice, the Board may:

(a) appoint the applicant and grant clinical privileges or scope of practice as recommended; or

(b) refer the matter back to the Credentials Committee or Medical Executive Committee or to another source inside or outside the Hospital for additional research or information; or

(c) reject or modify the recommendation.

(3) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the President of the Medical Staff. If the Board's determination remains unfavorable to the applicant, the President & Chief Executive Officer will promptly send special notice to the applicant that the applicant is entitled to request a hearing.

(4) Any final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges or scope of practice will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

## 3.H. TIME PERIODS FOR PROCESSING

Once an application is deemed complete, it is expected to be processed within 90 business days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

## 3.I. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in the FPPE Policy to Confirm Practitioner Competence and Professionalism.

ARTICLE 4

CLINICAL PRIVILEGES

## 4.A. CLINICAL PRIVILEGES

### 4.A.1. General:

(a) Appointment or reappointment will not confer any clinical privileges or right to admit or treat patients at the Hospital. Each individual who has been appointed to the Medical Staff or Allied Health Professional Staff is entitled to exercise only those clinical privileges specifically granted by the Board.

(b) For privilege requests to be processed, the applicant must satisfy any applicable threshold eligibility criteria.

(c) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with the contract.

(d) Requests for clinical privileges that have been grouped into core privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria (or has obtained a waiver in accordance with Section 4.A.2).

(e) The clinical privileges recommended to the Board will be based upon consideration of the following factors:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

(3) ability to perform the privileges requested competently and safely;

(4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;

(5) availability of other qualified staff members with appropriate privileges (as determined by the Credentials Committee) to provide coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Hospital's available resources and personnel;

(8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(10) practitioner-specific data as compared to aggregate data, when available;

(11) morbidity and mortality data related to the specific individual, and when statistically and qualitatively significant and meaningful, when available; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

(f) The applicant has the burden of establishing his or her qualifications and current competence for all clinical privileges requested.

(g) The report of the relevant service line medical director or division chief will be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

4.A.2. Privilege Modifications, Waivers, and Resignations:

(a) Scope. This Section applies to all requests for modification of clinical privileges during the term of appointment (increases and relinquishments), waivers related to eligibility criteria for privileges or the scope of those privileges, and resignations of all clinical privileges and appointment to the Medical Staff or the Allied Health Professionals Staff. Any such requests should be submitted in writing or via e-mail to Medical Staff Services.

(b) Increased Privileges.

(1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.

(2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.

(c) Relinquishment of Privileges.

A request to relinquish any individual clinical privilege, whether or not part of the core, will be processed in accordance with the following:

(1) Formal Request: The individual must forward a written or electronic request to Medical Staff Services, which must indicate the specific patient care services that the member does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.

(2) Review Process: A request for a relinquishment shall be submitted to the Credentials Committee for consideration. In reviewing the request, the Credentials Committee may obtain input from the relevant service line medical director and/or the division chief and shall consider the following factors:

(i) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;

(ii) whether sufficient notice has been given to provide a smooth transition of patient care services;

(iii) fairness to the individual requesting the relinquishment, including past service and the other demands placed upon the individual;

(iv) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the relinquishment would have on them and any inequalities that may be created;

(v) the expectations of other members of the Medical Staff who are in different specialties but who rely on the specialty in question in the care of patients who present to the Hospital;

(vi) any gaps in call coverage that might/would result from an individual's removal from the call roster for the relevant privilege and the feasibility and safety of transferring patients to other facilities in that situation; and

(vii) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

Upon completion of its review, the Credentials Committee will forward its recommendation to the Medical Executive Committee, which shall review the recommendation of the Credentials Committee and make its own recommendation to the Board regarding whether to grant or deny the request. Any recommendation to grant a request should include the specific basis for the recommendation.

(3) On-Call Obligations: By limiting the scope of privileges, the individual nevertheless agrees to participate in the general on-call schedule for the relevant specialty and to maintain sufficient competency to assist other physicians on the Medical Staff in assessing and stabilizing patients who require services within that specialty, if this call responsibility is required by the Medical Staff leadership after review of the specific circumstances involved. If, upon assessment, a patient needs a service that is no longer provided by the individual due to this request, the individual shall work cooperatively with the other physicians in arranging for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.

(4) Effective Date: If the Board grants a relinquishment of privileges, it shall specify the date that the relinquishment will be effective. Failure of a member to request a relinquishment in accordance with this section shall, as applicable, result in the member retaining his or her clinical privileges and all associated responsibilities.

(d) Waivers.

(1) Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating **exceptional** circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question. All such requests will be processed in accordance with the process described in Section 2.A.2.

(2) If the individual is requesting a waiver of the requirement that each member apply for the full core of privileges in his or her specialty, the process set forth in paragraph (c) above shall be followed.

(e) Resignation of Appointment and Privileges.

(1) Any individual who wishes to resign all of his or her clinical privileges and appointment shall provide notification of such decision to Medical Staff Services. This notification should indicate the individual's specific resignation date.

(2) On the effective date of the individual's resignation, completion of the following Medical Staff obligations will be confirmed, recorded in the individual's credentials file, and divulged in response to any future credentialing inquiries concerning the individual:

(i) completion of all medical records;

(ii) appropriate management of any hospitalized patients who were under the individual's care at the time of resignation (i.e., patients were discharged or transferred to another member with appropriate clinical privileges); and

(iii) completion of any scheduled emergency service call (or arrangement for appropriate coverage) prior to resigning.

(f) Procedural Rights. No individual is entitled to a modification or waiver related to privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of privileges is not granted.

4.A.3. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure (hereafter, "new procedure") will not be processed until (1) a determination has been made that the procedure will be offered by the Hospital and (2) criteria to be eligible to request those clinical privileges have been established.

(b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the service line medical director and the Credentials Committee addressing the following:

(1) minimum education, training, and experience necessary to perform the new procedure safely and competently;

(2) clinical indications for when the new procedure is appropriate;

(3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

(4) whether proficiency for the new procedure is volume sensitive and if the requisite volume would be available;

(5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and

(6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The service line medical director and the Credentials Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered to the community.

(c) If the preliminary recommendation is favorable, the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the Hospital. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the procedure or service;

(2) the clinical indications for when the procedure or service is appropriate;

(3) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted; and

(4) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities.

(d) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

(e) The Board will make a reasonable effort to render the final decision at the next Board meeting if given adequate notice of the Medical Executive Committee's recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.

(f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to perform the procedure or service may be processed.

4.A.4. Clinical Privileges That Cross Specialty Lines:

(a) Requests for clinical privileges that previously at the Hospital have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.

(b) As an initial step in the process, the individual seeking the privilege will prepare and submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.

(c) The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., service line medical directors, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

(d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the clinical privileges in question;

(2) the clinical indications for when the procedure is appropriate;

(3) the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;

(4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;

(5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and

(6) the impact, if any, on emergency call responsibilities.

(e) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action. The Board will make a reasonable effort to render the final decision at the next Board meeting if given adequate notice of the Medical Executive Committee's recommendation.

(f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to exercise the privileges in question may be processed.

4.A.5. Physicians in Training:

(a) Physicians in training (i.e., residents and fellows) at the Hospital will not hold appointments to the Medical Staff and will not be granted specific privileges (except as noted in (d) below). Rather, they shall be permitted to perform only those clinical functions set out in training protocols developed and approved by the appropriate training program director and Graduate Medical Education Committee.

(b) The Graduate Medical Education Office is responsible for verifying the qualifications and credentials of each physician in training who seeks permission to function in the Hospital. All such individuals must follow the rules and policies outlined in their respective Program Manuals, the general GME policies, and, if applicable, their Resident or Fellowship Training Agreement, and/or the Hospital's Human Resources Policies and Procedures.

(c) The program director and/or attending staff member shall be responsible for the orientation, direction, and supervision of the on-site/off-site and/or day to day patient care activities of each physician in training.

(d) Physicians in training may be granted clinical privileges to provide specified patient care services at the Hospital that are outside of the scope of their training programs if deemed qualified by the Credentials Committee and the Medical Executive Committee (i.e., moonlighting physicians), subject to the following:

(1) Physicians in training who are granted privileges outside of the scope of their training programs shall not hold appointments to the Medical Staff.

(2) Physicians in training who request clinical privileges in accordance with this Section must submit an application as prescribed in this Policy.

(3) Physicians in training must satisfy all of the threshold eligibility criteria set forth in Section 2.A.1 with the exception of those related to residency and board certification.

(4) Loss of employment through dismissal from the training program by the Hospital will result in the automatic relinquishment of clinical privileges, without a right to the hearing and appeal procedures.

4.A.6. Telemedicine Privileges:

(a) The Medical Executive Committee, in consultation with Hospital Administration, will determine which clinical services can be provided by another hospital or telemedicine entity through the use of telemedicine technology. "Telemedicine" means the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services.

(b) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.

(c) Requests for initial or renewed telemedicine privileges will be processed through one of the following options, as determined by the President of the Medical Staff in consultation with the President & Chief Executive Officer or VP & Chief Clinical Officer:

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location and coverage arrangements.

(2) A request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity if:

(i) the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare);

(ii) the hospital or telemedicine entity is accredited by the Joint Commission; and

(iii) Medical Staff Services determines that the hospital or telemedicine entity's credentialing process and Medical Staff requirements are acceptable to the Hospital.

In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. In addition, the distant hospital or telemedicine entity must provide:

(i) confirmation that the practitioner is licensed in Ohio (or Indiana or Kentucky, where applicable);

(ii) a current list of privileges granted to the practitioner;

(iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;

(iv) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(v) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up to date; and

(vi) any other attestations or information required by the agreement or requested by the Hospital.

This information will be provided to the Credentials Committee and the Medical Executive Committee for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

(d) Telemedicine privileges, if granted, will be for a period of not more than two years.

(e) Individuals granted telemedicine privileges will be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

(f) Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

4.A.7. Privileges for Locum Tenens:

(a) Short-Term Need. The President of the Medical Staff may grant privileges (both admitting and treatment) to a locum tenens physician who is filling in for a member of the Medical Staff who is on vacation, attending an educational seminar, ill, and/or otherwise needs coverage assistance for a limited period of time, under the following conditions:

(1) the applicant has submitted an appropriate application, along with the application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence (verification of good standing in all hospitals where the individual practiced for at least the previous two years), ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

(4) the applicant has received a favorable recommendation from the Credentials Committee Chair, after considering the evaluation of the service line medical director or division chief;

(5) the applicant will not be appointed to the Medical Staff, but will be subject to any focused professional practice requirements established by the Hospital; and

(6) the individual may exercise privileges as a locum tenens physician for a maximum of 120 days, consecutive or not, anytime during the 24 month period following the date they are granted, subject to the following conditions:

(i) the individual must notify Medical Staff Services at least 15 days prior to each time that he or she will be exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and

(ii) along with this notification, the individual must inform Medical Staff Services of any change that has occurred to any of the information provided on the initial application for privileges.

(b) Long-Term Need. In those cases where a long-term need for a locums tenens physician has been identified (e.g., the individual is filling a vacancy until a permanent health care professional is hired or is assisting with seasonal coverage needs), the request for privileges will be processed through the same process for Medical Staff applications, as set forth in this Policy. In such case, the individual will not be appointed to the Medical Staff, but must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location. The individual will face no limitations on the number of days he or she may practice. However, in order to ensure that the continued need for the individual is assessed in a timely manner, any individual who is granted long-term locum tenens privileges will be recredentialed on an annual basis.

(c) Compliance with Bylaws and Policies. Prior to any privileges being granted to a locum tenens physician, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures, and protocols of the Medical Staff and the Hospital.

(d) FPPE. Individuals who are granted privileges as a locum tenens physician will be subject to the Hospital policy regarding focused professional practice evaluation.

(e) Withdrawal of Locum Tenens Privileges. The granting of privileges to a locum tenens physician is a courtesy and may be withdrawn at any time by the President of the Medical Staff.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Eligibility to Request Temporary Clinical Privileges:

(a) Applicants. Temporary privileges for an applicant for initial appointment may be granted by the President of the Medical Staff under the following conditions:

(1) the applicant has submitted a complete application, along with the application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility;

(4) the application is pending review by the Medical Executive Committee and the Board, following a favorable recommendation by the Chair of the Credentials Committee (or, if the Chair is unavailable, the Medical Staff Secretary-Treasurer, who serves as Co-Chair of the Credentials Committee), after considering the evaluation of the service line medical director; and

(5) temporary privileges for a Medical Staff applicant will be granted for a maximum period of 120 consecutive days.

(b) Visiting. Temporary privileges may also be granted in other limited situations by the President of the Medical Staff and the applicable service line medical director or division chief when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following:

(1) the care of a specific patient;

(2) when a proctoring or consulting physician is needed, but is otherwise unavailable; or

(3) when necessary to prevent a lack or lapse of services in a needed specialty area.

At a minimum, the following factors will be considered and verified prior to the granting of temporary privileges in these situations: current licensure, relevant training or experience, current competence (verification of good standing in all hospitals where the individual practiced for at least the previous two years), current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank and from the OIG. The granting of clinical privileges in these situations shall be restricted to the treatment of not more than three patients in any one calendar year by any practitioner, and will not exceed 60 days. In exceptional situations, this period of time may be extended in the discretion of the President of the Medical Staff.

(c) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures, and protocols of the Medical Staff and the Hospital.

(d) FPPE. Individuals who are granted temporary privileges will be subject to the Hospital policy regarding focused professional practice evaluation.

4.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.B.3. Withdrawal and Termination of Temporary Clinical Privileges:

(a) The granting of temporary privileges is a courtesy and may be withdrawn at any time by the President of the Medical Staff.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the President & Chief Executive Officer, VP & Chief Clinical Officer, the relevant service line medical director or division chief, or the President of the Medical Staff may immediately terminate all temporary privileges. The President of the Medical Staff will assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

## 4.C. EMERGENCY SITUATIONS

(1) For the purpose of this Section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of his or her specific grant of clinical privileges.

(3) When the emergency situation no longer exists, the patient will be assigned by the service line medical director or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

## 4.D. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the President & Chief Executive Officer, the VP & Chief Clinical Officer, or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

(2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

(a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).

(b) A volunteer's license may be verified in any of the following ways: (i) current hospital picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current Hospital employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

(4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

## 4.E. CONTRACTS FOR SERVICES AND EMPLOYED MEDICAL STAFF MEMBERS

(1) From time to time, the Hospital may enter into contracts with practitioners and/or groups of practitioners for the performance of clinical and administrative services at the Hospital. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of this Policy.

(2) To the extent that:

(a) any such contract confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or

(b) the Board by resolution limits the practitioners who may exercise privileges in any clinical specialty to employees of the Hospital or its affiliates,

no other practitioner except those authorized by or pursuant to the contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only authorized practitioners are eligible to apply for appointment or reappointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.

(3) Prior to the Hospital signing any exclusive contract and/or passing any Board resolution described in paragraph (2) in a specialty area that has not previously been subject to such a contract or resolution, the Board will request the Medical Executive Committee's review of the matter. The Medical Executive Committee (or a subcommittee of its members appointed by the President of the Medical Staff) will review the quality of care and service implications of the proposed exclusive contract or Board resolution, and provide a report of its findings and recommendations to the Board within 30 days of the Board's request. As part of its review, the Medical Executive Committee (or subcommittee) may obtain relevant information concerning quality of care and service matters from (i) members of the applicable specialty involved, (ii) members of other specialties who

directly utilize or rely on the specialty in question, and (iii) Hospital administration. However, the actual terms of any such exclusive arrangement or employment contract, and any financial information related to them, including but not limited to the remuneration to be paid to Medical Staff members who may be a party to the arrangement, are not relevant and will neither be disclosed to the Medical Executive Committee nor discussed as part of the Medical Executive Committee's review.

(4) The Board (or a subcommittee) will consider the report of the Medical Executive Committee, and other appropriate materials, before making a decision about the exclusive contract or Board resolution. If any such exclusive contract or Board resolution would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, in addition to meeting with the Medical Executive Committee, the following notice and review procedures apply:

(a) The affected member will be given at least 30 days' advance notice of the exclusive contract or Board resolution and have the right to meet with a committee designated by the Board. At the meeting, the affected member will be entitled to present any information that he or she deems relevant to the decision to enter into the exclusive contract or enact the Board resolution.

(b) If, following this meeting, the Board confirms its initial determination to enter into the exclusive contract or enact the Board resolution, the affected member will be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board resolution. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or Board resolution is in effect.

(c) The affected member will not be entitled to any procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 7 or Article 8 of this Policy.

(d) The inability of a physician to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the Ohio (or Indiana or Kentucky, where applicable) licensure board or to the National Practitioner Data Bank.

(5) Except as provided in paragraph (1), in the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract will control.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

## 5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment will apply to continued appointment and clinical privileges or scope of practice and to reappointment.

### 5.A.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges or scope of practice, an individual must have, during the previous appointment term:

(a) completed all medical records and be current at the time of reappointment;

(b) completed all continuing medical education requirements;

(c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges or scope of practice requested, including those set forth in Section 2.A.1 of this Policy;

(e) if applying for clinical privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization or insurer), before the application will be considered complete and processed further; and

(f) paid the reappointment processing fee, if applicable.

### 5.A.2. Factors for Evaluation:

(a) Information considered for all practitioners. In considering an individual's application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

(1) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;

(2) participation in Medical Staff duties, including committee assignments, emergency call, consultation requests, participation in quality improvement, utilization activities, and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;

(3) the results of the Hospital's performance improvement and professional practice evaluation activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

(4) any focused professional practice evaluations;

(5) verified complaints received from patients, families, and/or staff; and

(6) other reasonable indicators of continuing qualifications.

(b) Additional information specific to Category II practitioners. In addition to consideration of the factors listed in (a), an assessment prepared by the Supervising/Collaborating Physician(s) will be considered in the continued permission to practice process for Category II practitioners. An assessment prepared by the applicable Hospital supervisor (i.e., OR Supervisor, Nursing Supervisor) will also be considered, where applicable.

(c) Additional information specific to Category III practitioners. As part of the process for renewal of scope of practice, an assessment performed by the Supervising/Collaborating Physician(s) will be considered. An annual competency assessment by the applicable Hospital supervisor (i.e., OR Supervisor, Nursing Supervisor) will also be considered, where applicable.

5.A.3. Reappointment Application:

(a) An application for reappointment will be made available to members at least 120 days prior to the expiration of their current appointment term. A completed reappointment application must be returned to Medical Staff Services within 60 days.

(b) Failure to return a completed application within 60 days may result in the assessment of a reappointment late fee, which must be paid prior to the application being processed. Failure to submit a complete application within 30 days prior to the expiration of the member's current term will result in the automatic expiration of appointment and clinical privileges or scope of practice at the end of the then current term of appointment unless the application can still be processed in the

normal course, without extraordinary effort on the part of Medical Staff Services and Medical Staff Leaders. A late processing fee will also be assessed and must accompany the completed reappointment application.

(c) Reappointment will be for a period of not more than two years.

(d) The application will be reviewed by Medical Staff Services to determine that all questions have been answered, that the member has signed the Code of Conduct of the Hospital and the Medical Staff/Allied Health Practitioners Code of Professionalism, and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(e) Medical Staff Services will oversee the process of gathering and verifying relevant information and will also be responsible for confirming that all relevant information has been received.

5.A.4. Processing Applications for Reappointment:

(a) Medical Staff Services will forward the application to the relevant service line medical director or division chief and the application for reappointment will be processed in a manner consistent with applications for initial appointment.

(b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.

(c) If it becomes apparent to the Credentials Committee or the Medical Executive Committee that it is considering a recommendation to deny reappointment or to reduce clinical privileges or a scope of practice, the chair of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and will be invited to discuss, explain, or refute it, or to withdraw the application. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual requesting reappointment will not have the right to be represented by legal counsel at this meeting. The committee will indicate as part of its report whether such a meeting occurred and will include a summary of the meeting with its minutes.

5.A.5. Conditional Reappointments:

(a) Recommendations for reappointment and renewed privileges or scope of practice may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) or 8.B.1(a)

of this Policy (as applicable), the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article 7 or Article 8 of this Policy.

(b) Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7 or Article 8.

(c) In addition, in the event the applicant for reappointment is the subject of an unresolved professional practice evaluation concern, a formal investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.A.6. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 90 days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

5.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in the FPPE Policy to Confirm Practitioner Competence and Professionalism.

ARTICLE 6

PROCEDURES FOR QUESTIONS INVOLVING
MEDICAL STAFF MEMBERS

## 6.A. COLLEGIAL EFFORTS AND PROGRESSIVE STEPS

(1) This Policy encourages the use of collegial efforts and progressive steps by Medical Staff Leaders and Hospital management to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

(2) Collegial efforts and progressive steps include, but are not limited to:

(a) informal mentoring, coaching, or counseling by a Medical Staff Leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, emergency call obligations, or the timely and adequate completion of medical records);

(b) sharing comparative data, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist the individual with conforming his or her practice to appropriate norms;

(c) addressing minor performance issues through an Informational Letter;

(d) sending an Educational Letter that describes opportunities for improvement and provides guidance and suggestions;

(e) facilitating a formal Collegial Intervention (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders) in order to directly discuss a matter and the steps needed to be taken to resolve it; and

(f) developing a Performance Enhancement Plan, which may include a wide variety of tools and techniques that can result in a constructive and successful resolution of the concern.

(3) All collegial efforts and progressive steps are fundamental and integral components of the Hospital's professional practice evaluation activities, and are confidential and privileged in accordance with applicable state law.

(4) Copies of any formal documentation that is prepared by a Medical Staff Leader regarding such collegial efforts and progressive steps, including letters that follow a formal Collegial Intervention, will be included in an individual's confidential file

and maintained in a confidential manner consistent with its privileged status. Any written responses to collegial efforts and progressive steps that may be received from an individual shall also be included in the individual's confidential file.

(5) Collegial efforts and progressive steps are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders and Hospital management. When a question arises, the Medical Staff and/or Hospital Leaders may:

(a) address it pursuant to the collegial efforts and progressive steps provisions of this Section;

(b) refer the matter for review in accordance with the Professional Practice Evaluation Policy, Professionalism Policy, Practitioner Health Policy, and/or other relevant policy; or

(c) refer it to the Medical Executive Committee for its review and consideration in accordance with Section 6.D of this Article.

(6) Should any recommendation be made or an action taken that entitles an individual to a hearing in accordance with this Policy, the individual is entitled to be accompanied by legal counsel at that hearing. However, Medical Staff members do not have the right to be accompanied by counsel when the Medical Staff Leaders and Hospital management are engaged in collegial efforts or other progressive steps. These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. In addition, there shall be no recording (audio or video) or transcript made of any meetings that involve collegial efforts or progressive steps activities.

## 6.B. PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

Professional practice evaluation activities shall be conducted in accordance with the Professional Practice Evaluation Policy, the Professionalism Policy, the Practitioner Health Policy, and/or other relevant policy. Matters that are not satisfactorily resolved through collegial efforts or through one of these policies shall be referred to the Medical Executive Committee for its review in accordance with Section 6.D below. Such interventions and evaluations, however, are not mandatory prerequisites to Medical Executive Committee review.

## 6.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

### 6.C.1. Grounds for Precautionary Suspension or Restriction/Requests to Voluntarily Refrain:

(a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the Medical Executive Committee, OR any Medical Staff Officer, service line medical director,

or division chief, acting in conjunction with the President and Chief Executive Officer or the VP & Chief Clinical Officer, shall have the authority to proceed as follows:

(1) request that the individual agree to voluntarily refrain from exercising privileges pending further review of the circumstances in accordance with Section 6.C.2 of this Policy; or

(2) if the individual is unwilling to voluntarily refrain from practicing pending further review, to suspend or restrict all or any portion of the individual's clinical privileges as a precaution, which shall be reviewed in accordance with Section 6.C.3 of this Policy.

(b) The above actions can be taken at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the individual to request a hearing.

(c) Precautionary suspension or restriction, or an agreement to refrain, is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension, restriction, or agreement.

(d) These actions shall become effective immediately, shall promptly be reported in writing to the President & Chief Executive Officer, the VP & Chief Clinical Officer, and the President of the Medical Staff, and shall remain in effect unless the action is modified by the President & Chief Executive Officer or Medical Executive Committee.

(e) The individual in question shall be provided a letter via special notice that memorializes the individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension and terms related to the same. The correspondence shall also contain a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any), within three days of the action.

6.C.2. Review Process for an Agreement to Voluntarily Refrain from Practicing:

(a) The Leadership Council shall review the matter resulting in an individual's agreement to voluntarily refrain from exercising clinical privileges within a reasonable time under the circumstances, not to exceed 14 days. As part of this review, the individual shall be given an opportunity to meet with the Leadership Council. Neither the Leadership Council nor the individual shall be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, minutes of the meeting shall be prepared.

(b) After considering the matter resulting in an individual's agreement to voluntarily refrain and the individual's response, if any, the Leadership Council shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review, referring the matter for review pursuant to another policy, referring the matter to the Medical Executive Committee with a recommendation to initiate a formal investigation, or to take some other action that is deemed appropriate under the circumstances. The Leadership Council shall also determine whether the agreement to voluntarily refrain from practicing should be continued throughout any further review process.

(c) There is no right to a hearing based on an individual's agreement to voluntarily refrain from practicing in accordance with this Section.

6.C.3. Review Process for Precautionary Suspensions or Restrictions:

(a) The Medical Executive Committee shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. As part of this review, the individual shall be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients and/or employees, depending on the circumstances. Neither the Medical Executive Committee nor the individual shall be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, minutes of the meeting shall be prepared.

(b) After considering the matters resulting in the suspension or restriction, and the individual's response, if any, the Medical Executive Committee shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review or a formal investigation, or recommending some other action that is deemed appropriate under the circumstances. The Medical Executive Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the focused review or investigation (and hearing and appeal, if applicable).

(c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

6.C.4. Care of Patients:

(a) Immediately upon an individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension or restriction, the service line medical director or the President of the Medical Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the individual's hospitalized patients, or to otherwise aid in implementing the

precautionary suspension, restriction, or agreement to refrain from practicing, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.

(b) All members of the Medical Staff have a duty to cooperate with the President of the Medical Staff, the service line medical director, the Medical Executive Committee, the VP & Chief Clinical Officer, and the President & Chief Executive Officer in enforcing precautionary suspensions or restrictions, or agreements to voluntarily refrain from practicing.

6.D. INVESTIGATIONS

6.D.1. Initial Review:

(a) Where collegial efforts or actions under one or more of the policies referenced in this Article have not resolved an issue, and/or when there is a single instance of such severity that in the discretion of Medical Staff Leaders it requires further review, regarding:

(1) the clinical competence or clinical practice of any member of the Medical Staff or Allied Health Professional Staff, including the care, treatment or management of a patient or patients;

(2) the safety or proper care being provided to patients;

(3) the known or suspected violation by any member of the Medical Staff or Allied Health Professional Staff of applicable ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; and/or

(4) conduct by any member that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others,

the matter will be referred to the President of the Medical Staff, who may refer to the relevant service line medical director or division chief, the chair of a standing committee, the VP & Chief Clinical Officer, or the President & Chief Executive Officer.

(b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any member of the Medical Staff or Allied Health Professional Staff, the matter will be referred to the President of the Medical Staff, who may refer to the relevant service line medical director or division chief, the chair of a

standing committee, the VP & Chief Clinical Officer, or the President & Chief Executive Officer for review and appropriate action in accordance with this Policy.

(c) The person to whom the matter is referred will conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, will forward it in writing to the Medical Executive Committee.

(d) No action taken pursuant to this Section will constitute an investigation.

6.D.2. Initiation of Investigation:

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Medical Executive Committee, the Medical Executive Committee shall review the matter and determine whether to conduct a formal investigation, to direct the matter to be handled pursuant to another policy (e.g., Professionalism Policy; Practitioner Health Policy; Professional Practice Evaluation Policy), or to proceed in another manner that the Medical Executive Committee believes is appropriate. Prior to making its determination, the Medical Executive Committee may discuss the matter with the individual involved. An investigation shall begin only after a formal determination by the Medical Executive Committee to do so. The Medical Executive Committee's determination shall be recorded in the minutes of the meeting where the determination is made.

(b) The Medical Executive Committee will inform the individual that an investigation has begun. The notification shall include:

(1) the date on which the investigation was commenced;

(2) the committee that will be conducting the investigation, if already identified;

(3) a statement that the physician will be given the opportunity to meet with the committee conducting the investigation before the investigation concludes; and

(4) a copy of Section 6.D.3 of this Policy, which outlines the process for investigations.

Notification may be delayed if, in the Medical Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

6.D.3. Investigative Procedure:

(a) Selection of Investigating Committee.

Once a determination has been made to begin an investigation, the Medical Executive Committee shall either investigate the matter itself or appoint an ad hoc committee to conduct the investigation, keeping in mind the conflict of interest guidelines outlined in Article 9. Any ad hoc committee may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, podiatrist, or oral surgeon).

(b) Investigating Committee's Review Process.

(1) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. A summary of each interview will be prepared and the interviewee will be asked to review, revise, and sign his or her summary, which will then be included as an attachment to the investigating committee's report.

(2) The investigating committee shall also have available to it the full resources of the Medical Staff and the Hospital, including the authority to arrange for an external review, if needed. An external review may be used whenever the Hospital and investigating committee determine that:

(i) there are ambiguous or conflicting findings by internal reviewers;

(ii) the clinical expertise needed to conduct the review is not available on the Medical Staff;

(iii) an external review is advisable to prevent allegations of bias, even if unfounded; or

(iv) the thoroughness and objectivity of the investigation would be aided by such an external review.

If a decision is made to obtain an external review, the individual under investigation shall be notified of that decision and the nature of the external review. Upon completion of the external review, the individual shall be provided a copy of the reviewer's report.

(3) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing

(i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination shall be borne by the individual.

(c) Meeting with the Investigating Committee.

(1) The individual under investigation shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. The investigating committee may also ask the individual to provide written responses to specific questions related to the investigation and/or a written explanation of his or her perspective on the events that led to the investigation for review by the investigating committee prior to the meeting.

(2) This meeting is not a hearing, and none of the procedural rules for hearings shall apply. No recording (audio or video) or transcript of the meeting shall be permitted or made. Neither the individual being investigated nor the investigating committee will be accompanied by legal counsel at this meeting.

(3) At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation or that have been identified by the investigating committee during its review. A summary of the interview shall be prepared by the investigating committee and included with its report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report, so that he or she may review it and recommend suggested changes. A suggested change should only be accepted if the investigating committee believes it more accurately reflects what occurred at the meeting.

(d) Time Frames for Investigation.

The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an external review is not necessary. When an external review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the external review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods.

(e) Investigating Committee's Report.

(1) At the conclusion of the investigation, the investigating committee shall prepare a report of the investigation. The report should include a summary of the review process (e.g., a list of documents that were reviewed, any individuals who were interviewed, etc.), specific findings and conclusions regarding each concern that was under review, and the investigating committee's recommendations.

(2) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(i) relevant literature and clinical practice guidelines, as appropriate;

(ii) all of the opinions and views that were expressed throughout the review, including report(s) from any external review(s);

(iii) any information or explanations provided by the individual under review; and

(iv) other information as deemed relevant, reasonable, and necessary by the investigating committee.

6.D.4. Recommendation:

(a) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an ad hoc investigating committee if one was appointed by the Medical Executive Committee. In either case, at the conclusion of the investigation, the Medical Executive Committee may:

(1) determine that no action is justified;

(2) issue a letter of guidance, counsel, warning, or reprimand;

(3) impose conditions for continued appointment;

(4) impose a requirement for monitoring, proctoring, or consultation;

(5) impose a requirement for additional training or education;

(6) recommend reduction of clinical privileges;

(7) recommend suspension of clinical privileges for a term;

(8) recommend revocation of appointment and/or clinical privileges; or

(9) make any other recommendation that it deems necessary or appropriate.

(b) A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing will be forwarded to the President & Chief Executive Officer, who will promptly inform the individual by special notice. The President & Chief Executive Officer will hold the recommendation until after the individual has completed or waived a hearing and appeal. Pursuant to Section 6.C, any precautionary suspension (or agreement to voluntarily refrain from exercising clinical privileges or scope of practice) will remain in effect pending the completion or waiver of a hearing and appeal, unless the Medical Executive Committee makes a determination to terminate or modify the suspension or agreement.

(c) If the determination of the Medical Executive Committee does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Board.

(d) In the event the Board considers a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the President & Chief Executive Officer will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

(e) When applicable, any recommendation or action that is the result of an investigation or hearing and appeal will be monitored by Medical Staff Leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

## 6.E. AUTOMATIC RELINQUISHMENT

(1) Any of the occurrences described in this Section will constitute grounds for the automatic relinquishment of an individual's appointment and clinical privileges or scope of practice. An automatic relinquishment is considered an administrative action and, as such, it does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank and will take effect without hearing or appeal.

(2) Except as otherwise provided below, an automatic relinquishment of appointment and clinical privileges or scope of practice will be effective immediately upon actual or special notice to the individual. Such notice will be provided after confirmation of the event(s) that led to the automatic relinquishment by the President of the Medical Staff and/or VP & Chief Clinical Officer. Notice will also be given to the applicable service line medical director.

6.E.1. Failure to Satisfy Threshold Eligibility Criteria:

Failure of an individual to satisfy any of the threshold eligibility criteria set forth in this Policy will result in automatic relinquishment of appointment and clinical privileges or scope of practice.

6.E.2. Criminal Activity:

The occurrence of specific criminal actions will result in the automatic relinquishment of appointment and clinical privileges or scope of practice. Specifically, an arrest, charge, indictment, conviction, or a plea of guilty or no contest pertaining to (1) any felony or to (2) a misdemeanor involving the following will result in an automatic relinquishment: (i) insurance or health care fraud or abuse; (ii) child abuse; (iii) elder abuse; or (iv) violence. (DUIs and incidents related to controlled substances or illegal drugs will be addressed in the manner outlined in Section 2.B.1(a)(9).)

6.E.3. Failure to Complete or Comply with Training, Counseling, or Educational Requirements:

Failure to complete and/or comply with training, counseling, or educational requirements that are adopted by the Medical Executive Committee and/or required by the Hospital, including, but not limited to, those pertinent to electronic medical records, professionalism, interpersonal relationships, patient safety, and infection control, will result in the automatic relinquishment of all clinical privileges or scope of practice.

6.E.4. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for appointment, reappointment, and/or clinical privileges or scope of practice, in response to a written request from the Credentials Committee, the Medical Executive Committee, the Medical Staff Quality Committee, the Peer Review Committee, the President & Chief Executive Officer, or any other committee authorized to request such information, will result in the automatic relinquishment of all clinical privileges or scope of practice if the information is not provided within the time frame established by the requesting party.

6.E.5. Failure to Attend Special Meeting:

(a) Whenever there is a concern regarding the clinical practice or professional conduct involving any individual, a Medical Staff Leader may require the individual to attend a special meeting with one or more of the Medical Staff Leaders and/or with a standing or ad hoc committee of the Medical Staff.

(b) No legal counsel shall be present at this meeting, and no recording (audio or video) or transcript shall be permitted or made.

(c) The notice to the individual regarding this meeting shall be given by Special Notice at least five days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.

(d) Failure of the individual to attend the meeting shall result in the automatic relinquishment of all clinical privileges until such time as the individual does attend the special meeting. If the individual does not attend the special meeting within 30 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

6.E.6. Failure to Obtain a Requested Evaluation:

As discussed in Section 2.B.1(a)(10), an individual may be required to submit to an appropriate evaluation (such as blood and/or urine test), or a complete physical, mental, and/or behavioral evaluation to determine his or her ability to safely practice. Failure of a member to undergo a requested evaluation or to execute any of the appropriate releases will result in the automatic relinquishment of appointment and privileges or scope of practice.

6.E.7. Reinstatement from Automatic Relinquishment and Automatic Resignation:

(a) If an individual believes that the matter leading to the automatic relinquishment of appointment and privileges or scope of practice has been resolved within 60 days of the relinquishment, the individual may request to be reinstated.

(b) Requests for reinstatement following the expiration or lapse of a license, controlled substance authorization, and/or insurance coverage will be processed by Medical Staff Services, in consultation with the Chair of the Credentials Committee. If any questions or concerns are noted, the request will be referred for further review in accordance with (c) below.

(c) All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant service line medical director, the Chair of the Credentials Committee, the President of the Medical Staff, and the President & Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board (or subcommittee) for review and recommendation.

(d) Failure to resolve a matter leading to an automatic relinquishment within 60 days of the relinquishment, and to be reinstated as set forth above, will result in an automatic resignation from the Medical Staff or Allied Health Professional Staff.

## 6.F. LEAVES OF ABSENCE

### 6.F.1. Initiation:

(a) Any leave of absence that is expected to last for 60 days or more must be requested in writing and submitted to the President of the Medical Staff. The request must state the beginning and ending dates of the leave, the reasons for the leave, and the arrangement that has been made for patient coverage.

(b) The President of the Medical Staff will determine whether a request for a leave of absence will be granted, after consulting with the relevant service line medical director or division chief and the Medical Executive Committee. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records. However, in the case of military leave, the President of the Medical Staff shall have the authority to approve a leave of absence immediately.

(c) Except for maternity leaves of 12 weeks or less, individuals must report to the President of the Medical Staff anytime they are away from the Hospital or patient care responsibilities for longer than 30 days and the reason for the absence is related to their physical or mental health. Under such circumstances, the President of the Medical Staff, in consultation with the relevant service line medical director or division chief and the Medical Executive Committee, may trigger an automatic medical leave of absence. A request for reinstatement from an automatic medical leave of absence will be processed in accordance with the Practitioner Health Policy. Failure to report such circumstances may also trigger an automatic medical leave of absence.

(d) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

(e) Any question or concern about a member's failure to request a leave of absence in accordance with this Section will be referred to the Medical Executive Committee for review. A confirmed violation of this Section may result in disciplinary action, as determined by the Medical Executive Committee.

### 6.F.2. Duties of Member on Leave:

During the leave of absence, the individual will not exercise any clinical privileges or scope of practice and will be excused from all Medical Staff duties (e.g., meeting attendance, committee service, emergency service call obligations, and payment of dues), but will maintain current, valid professional liability insurance coverage or tail coverage during the leave. However, all medical records must be completed as soon as reasonably possible.

6.F.3. Reinstatement:

(a) Except for a request for reinstatement related to physical or mental health (other than maternity leave), which will be processed in accordance with the Practitioner Health Policy, individuals requesting reinstatement will submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital not less than thirty (30) days prior to the date on which he or she desires to return. Requests for reinstatement will then be reviewed by the Credentials Committee.

(b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. This determination will then be forwarded to the Medical Executive Committee and the Board for ratification. If, however, the Medical Executive Committee or Board has any questions, those questions will be noted and the reinstatement request will be forwarded to the Credentials Committee for further review.

(c) If any request for reinstatement is not granted and a report to the National Practitioner Data Bank is determined to be required, the individual will be entitled to request a hearing and appeal.

(d) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement will be processed in accordance with the Practitioner Health Policy.

(e) With the exception of military leaves of absence, absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges or scope of practice unless an extension is granted by the President of the Medical Staff, in consultation with the relevant service line medical director or division chief and the Medical Executive Committee.

(f) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges or scope of practice will expire at the end of the appointment period, and the individual will be required to apply for reappointment simultaneously with the request for reinstatement.

# ARTICLE 7

## HEARING AND APPEAL PROCEDURES

The hearing and appeal procedures in this Article are only applicable to physician members of the Medical Staff and are not applicable to members of the Allied Health Professionals Staff. The due process rights for allied health professionals are set forth in Article 8 of this Policy.

### 7.A. INITIATION OF HEARING

#### 7.A.1. Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations:

(1) denial of initial appointment to the Medical Staff;

(2) denial of reappointment to the Medical Staff;

(3) revocation of appointment to the Medical Staff;

(4) denial of requested clinical privileges;

(5) revocation of clinical privileges;

(6) suspension of clinical privileges for more than 30 days (other than precautionary suspension);

(7) restriction of clinical privileges, meaning a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance; or

(8) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

(b) No other recommendations will entitle the individual to a hearing.

(c) If the Board makes any of these determinations without an adverse recommendation by the Medical Executive Committee, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Medical Executive Committee. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "Medical Executive Committee" will be interpreted as a reference to the "Board."

7.A.2. Actions Not Grounds for Hearing:

None of the following actions will constitute grounds for a hearing, and they will take effect without hearing or appeal, provided that the individual will be entitled to submit a written explanation to be placed into his or her file:

(a) determination that an applicant for membership fails to meet the threshold eligibility qualifications or criteria for membership;

(b) ineligibility to request membership or privileges, or to continue privileges, because a relevant specialty is closed under a Medical Staff development plan or is covered under an exclusive provider agreement;

(c) failure to process a request for a privilege when the individual does not meet the eligibility criteria to hold the privilege;

(d) determination that an application is incomplete or untimely;

(e) determination that an application shall not be processed due to a misstatement or omission;

(f) change in assigned staff category or a determination that an individual is not eligible for a specific staff category;

(g) expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

(h) issuance of a letter of guidance, counsel, warning, or reprimand;

(i) determination that conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment) is appropriate for an individual;

(j) determination that a requirement for additional training or continuing education is appropriate for an individual;

(k) the voluntary acceptance of a Performance Enhancement Plan;

(l) any requirement to complete a health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;

(m) conducting an investigation into any matter or the appointment of an ad hoc investigating committee;

(n) grant of conditional appointment or reappointment or of an appointment or reappointment period that is less than two years;

(o) refusal of the Hospital to consider a request for appointment, reappointment, or privileges within five years of a final adverse decision regarding such request;

(p) precautionary suspension;

(q) automatic relinquishment of appointment or privileges or automatic resignation;

(r) denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;

(s) removal from the on-call roster or any other reading panel;

(t) withdrawal of temporary privileges;

(u) requirement to appear for a special meeting; and

(v) termination of any contract with or employment by the Hospital.

7.B. THE HEARING

7.B.1. Notice of Recommendation:

The President & Chief Executive Officer will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and

(c) a copy of this Article.

7.B.2. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request will be in writing to the President & Chief Executive Officer and will include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

7.B.3. Notice of Hearing and Statement of Reasons:

(a) The President & Chief Executive Officer and President of the Medical Staff will schedule the hearing and provide, by special notice to the individual requesting the hearing, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer), if known; and

(4) a statement of the reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.

(b) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.B.4. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The President & Chief Executive Officer, after consulting with the President of the Medical Staff, will appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel will consist of at least three members and may include any combination of:

(i) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level; and/or

(ii) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).

(2) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Panel.

(3) Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Panel.

(4) The Panel will not include any individual who is in direct economic competition with the individual requesting the hearing.

(5) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(6) In addition, the appointment of the Hearing Panel shall comply with the guidelines set forth in the conflict of interest provisions found in Article 9 of this Policy.

(b) Presiding Officer:

(1) The President & Chief Executive Officer, after consulting with the President of the Medical Staff, will appoint a Presiding Officer who will be an attorney. The Presiding Officer may not be, or represent clients who are, in direct competition with the individual who requested the hearing and may not currently represent the Hospital in any legal matters. The Presiding Officer shall not act as an advocate for either side at the hearing. The Presiding Officer will be compensated by the Hospital, but the individual requesting the hearing may participate in that compensation should the individual wish to do so.

(2) The Presiding Officer will:

(i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross examination;

(ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

(v) rule on all matters of procedure and the admissibility of evidence; and

(vi) conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.

(3) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

(4) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but will not be entitled to vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, for matters limited to issues involving professional conduct, the President & Chief Executive Officer, after consulting with the President of the Medical Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.

(d) Objections:

Any objection to any member of the Hearing Panel, the Presiding Officer, or to the Hearing Officer, will be made in writing, within 10 days of receipt of notice, to the President & Chief Executive Officer. A copy of such written objection must be provided to the President of the Medical Staff and must include the basis for the objection. The President of the Medical Staff will be given a reasonable opportunity to comment. The President & Chief Executive Officer will rule on the objection and give notice to the parties. The President & Chief Executive Officer may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.B.5. Counsel:

Counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

(a) The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.

(b) Neither party has the right to issue subpoenas or interrogatories or to depose witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in the hearing or pre-hearing process.

(c) Neither the individual who has requested the hearing, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this Article concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who has requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing. If an employee or Medical Staff member who is on the Medical Executive Committee's witness list agrees to be interviewed pursuant to this provision, counsel for the Medical Executive Committee may be present during the interview.

7.C.2. Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, will govern the timing of pre-hearing procedures:

(a) the pre-hearing conference will be scheduled at least 14 days prior to the hearing;

(b) the parties will exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and

(c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

7.C.3. Witness List:

(a) At least 10 days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list will include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.C.4. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the Medical Executive Committee;

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the Medical Executive Committee.

The provision of this information is not intended to waive any privilege under the Ohio peer review protection statutes.

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical Staff.

(d) At least 10 days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party will provide the other party with its proposed exhibits. All objections to documents or witnesses will then be submitted in writing at least five days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges will be excluded.

7.C.5. Pre-Hearing Conference:

The Presiding Officer will require the individual and the Medical Executive Committee or their representatives (who may be counsel) to participate in a pre-hearing conference, which will be held no later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer will establish the time to be allotted to each

witness's testimony and cross-examination. It is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.C.6. Stipulations:

The parties and their counsel, if applicable, will use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

7.C.7. Provision of Information to the Hearing Panel:

The following documents will be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre hearing conference (without the need for authentication); and (c) any stipulations agreed to by the parties.

7.D. HEARING PROCEDURES

7.D.1. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues;

(4) to have representation by counsel who may call, examine, and cross examine witnesses and present the case; and

(5) to submit proposed findings, conclusions, and recommendations to the Hearing Panel as a part of the Post-Hearing statement referenced in this Article, following the close of the hearing session(s).

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

7.D.2. Record of Hearing:

A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Hospital. Copies of the transcript will be available at the individual's expense. Oral evidence will be taken only on oath or affirmation administered by any person entitled to notarize documents in Ohio.

7.D.3. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing will constitute a waiver of the right to a hearing and the matter will be transmitted to the Board for final action.

7.D.4. Presence of Hearing Panel Members:

A majority of the Hearing Panel will be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she will read the entire transcript of the portion of the hearing from which he or she was absent.

7.D.5. Persons to Be Present:

The hearing will be restricted to those individuals who are formally involved in the proceeding. Administrative personnel and Medical Staff Leaders may also be present during the proceeding, as authorized by the Presiding Officer.

7.D.6. Order of Presentation:

The Medical Executive Committee will first present evidence in support of its recommendation. Thereafter, the burden will shift to the individual who requested the hearing to present evidence.

7.D.7. Admissibility of Evidence:

The hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle will be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.D.8. Post-Hearing Statement:

Each party will have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

7.D.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but will be permitted only by the Presiding Officer or the President & Chief Executive Officer on a showing of good cause.

7.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.E.1. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges, the Hearing Panel will recommend in favor of the Medical Executive Committee unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.E.2. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel will conduct its deliberations outside the presence of any other person except the Presiding Officer. Thereafter, the Hearing Panel will render a recommendation, accompanied by a report, which will contain a concise statement of the basis for its recommendation.

7.E.3. Disposition of Hearing Panel Report:

The Hearing Panel will deliver its report to the President & Chief Executive Officer. The President & Chief Executive Officer will send by special notice a copy of the report to the individual who requested the hearing. The President & Chief Executive Officer will also provide a copy of the report to the Medical Executive Committee.

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

(a) Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the President & Chief Executive Officer either in person or by certified mail, return receipt

requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

7.F.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with this Policy and/or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; and/or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

7.F.3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board (or the President & Chief Executive Officer on behalf of the Chair) will schedule and arrange for an appeal. The individual will be given special notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.F.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital. The Review Panel will consider the record upon which the recommendation in front of it was made and recommend final action to the Board.

(b) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(c) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Such additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

## 7.G. BOARD ACTION

### 7.G.1. Final Decision of the Board:

(a) Within 30 days after the Board (i) considers the appeal (as the Review Panel), (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board will consider the matter and take final action.

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.

(c) The Board will render its final decision in writing, including specific reasons, and will send special notice to the individual. A copy will also be provided to the Medical Executive Committee for its information.

### 7.G.2. Further Review:

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board will be effective immediately and will not be subject to further review. If the matter is referred for further action and recommendation, such recommendation will be promptly made to the Board in accordance with the instructions given by the Board.

### 7.G.3. Right to One Hearing and One Appeal Only:

No member of the Medical Staff will be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

# ARTICLE 8

# ALLIED HEALTH PROFESSIONALS

## 8.A. CONDITIONS OF PRACTICE APPLICABLE TO CATEGORY II AND CATEGORY III PRACTITIONERS

### 8.A.1. General:

Category II and Category III practitioners are not permitted to function independently in the inpatient Hospital setting. As a condition of being granted permission to practice at the Hospital, all Category II and Category III practitioners specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of Category II and Category III practitioners in the Hospital, all Medical Staff members who serve as Supervising/Collaborating Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

### 8.A.2. Standards of Practice for the Utilization of Category II Practitioners in the Inpatient Setting:

The following standards of practice apply only to the functioning of Category II practitioners in the inpatient Hospital setting:

(a) Admitting Privileges. Category II practitioners are not granted inpatient admitting privileges and therefore may not admit patients independent of the Supervising/Collaborating Physician. However, a Category II practitioner may be permitted by his/her delineation of privileges to act as a proxy for his/her Supervising/Collaborating Physician. Any such admission order must be co-signed by the Supervising/Collaborating Physician, who will have ultimate responsibility for the care of the patient.

(b) Consultations. Category II practitioners may perform patient consultations in collaboration with or on behalf of their Supervising/Collaborating Physicians. A Category II practitioner may examine patients, gather data, order tests, and develop an assessment and plan. However, the Supervising/Collaborating Physician must still personally see the patient within the time frames outlined in the Medical Staff Rules and Regulations, unless the ordering physician specifically approves the use of a Category II practitioner to perform the consultation.

(c) Emergency On-Call Coverage. It shall be within the discretion of the Emergency Department personnel requesting assistance whether it is appropriate to contact a Category II practitioner prior to the Supervising/Collaborating Physician. Category II practitioners may not independently participate in the emergency on call roster (formally, or informally by agreement with their Supervising/ Collaborating Physicians), in lieu of the Supervising/Collaborating Physician. The

Supervising/Collaborating Physician (or his or her covering physician) must personally respond to all calls directed to him or her in a timely manner, in accordance with requirements set forth in this Policy. Following discussion with the Emergency Department, the Supervising/Collaborating Physician may direct a Category II practitioner to see the patient, gather data, and order tests for further review by the Supervising/Collaborating Physician. However, the Supervising/ Collaborating Physician must still personally see the patient when requested by the Emergency Department physician.

(d) Calls Regarding Supervising/Collaborating Physician's Hospitalized Inpatients. It shall be within the discretion of the Hospital personnel requesting assistance whether it is appropriate to contact a Category II practitioner prior to the Supervising/Collaborating Physician. Whenever first contact is made to a Category II practitioner, the practitioner must provide timely notice of the request to his or her Supervising/Collaborating Physician. However, the Supervising/Collaborating Physician must personally respond to all calls directed to him or her in a timely manner.

(e) Daily Inpatient Rounds. Category II practitioners may not independently perform daily inpatient rounds in lieu of their Supervising/Collaborating Physicians. A Category II practitioner is permitted to perform daily inpatient rounds; however, all inpatients must normally be visited daily or at least within 24 hours by the Supervising/Collaborating Physician (or a designated physician).

8.A.3. Oversight by Supervising/Collaborating Physician:

(a) Category II and Category III practitioners may function in the Hospital only so long as they have a Supervising/Collaborating Physician.

(b) Any activities permitted to be performed at the Hospital by a Category II or Category III practitioner will be performed only under the oversight of the Supervising/Collaborating Physician.

(c) If the appointment or clinical privileges of a Supervising/Collaborating Physician are resigned, revoked or terminated, or the Category II or Category III practitioner fails, for any reason, to maintain an appropriate supervision relationship with a Supervising/Collaborating Physician as defined in this Policy, the Category II or Category III practitioner's clinical privileges or scope of practice will be automatically relinquished, unless he or she has another Supervising/ Collaborating Physician who has been approved as part of the credentialing process.

(d) As a condition of clinical privileges or scope of practice, a Category II or Category III practitioner and the Supervising/Collaborating Physician must provide the Hospital with a copy of the written practice protocols or agreement between them on an annual basis. Notice of any revisions or modifications to the practice

protocols or agreement must be provided to the VP & Chief Clinical Officer or President of the Medical Staff within three days of any such change.

8.A.4. Questions Regarding the Authority of a Category II or Category III Practitioner:

(a) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the authority of a Category II or Category III practitioner to act or issue instructions outside the presence of the Supervising/Collaborating Physician, such individual will refer the matter to the Chair of the Credentials Committee (or, if the Chair is unavailable, one of the Medical Staff Officers) to validate the act or instructions of the Category II or Category III practitioner.

(b) The act or instruction of the Category II or Category III practitioner will be delayed until such time as the Chair of the Credentials Committee (or Medical Staff Officer, as applicable) confirms that the act or instruction is clearly within the clinical privileges or scope of practice granted to the individual.

(c) If the Chair of the Credentials Committee (or applicable Medical Staff Officer) has questions or concerns regarding the conduct of a Category II or Category III practitioner, the Supervising/Collaborating Physician will be contacted to discuss the matter and facilitate the ongoing care of the patient. The question or concern will then be reported to the Credentials Committee for further review.

8.A.5. Responsibilities of Supervising/Collaborating Physicians:

(a) Physicians who wish to utilize the services of a Category II or Category III practitioner in their clinical practice at the Hospital must notify Medical Staff Services of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy before the Category II or Category III practitioner participates in any clinical or direct patient care of any kind in the Hospital.

(b) Supervising/Collaborating Physicians who wish to utilize the services of Category II practitioners in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 8.A.2 above.

(c) The number of Category II or Category III practitioners acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising/Collaborating Physician will make all appropriate filings with the appropriate Ohio licensure board regarding the supervision and responsibilities of the Category II or Category III practitioner, to the extent that such filings are required.

(d) It will be the responsibility of the Supervising/Collaborating Physician to provide, or to arrange for, professional liability insurance coverage for the Category II or Category III practitioner in amounts required by the Hospital. The insurance must cover any and all activities of the Category II or Category III practitioner in the Hospital. The Supervising/Collaborating Physician will furnish evidence of such coverage to the Hospital. The Category II or Category III practitioner will act in the Hospital only while such coverage is in effect.

## 8.B. PROCEDURAL RIGHTS FOR CATEGORY I AND CATEGORY II PRACTITIONERS

### 8.B.1. Notice of Recommendation and Hearing Rights:

(a) In the event a recommendation is made by the Medical Executive Committee that a Category I or Category II practitioner not be granted clinical privileges or that the privileges previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual will receive special notice of the recommendation from the President & Chief Executive Officer. The special notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing.

(b) The rights and procedures in this Section will also apply if the Board, without a prior adverse recommendation from the Medical Executive Committee, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated, or not renewed. In this instance, all references in this Article to the Medical Executive Committee will be interpreted as a reference to the Board.

(c) If the Category I or Category II practitioner wants to request a hearing, the request must be in writing, directed to the President & Chief Executive Officer, within 30 days after receipt of written notice of the adverse recommendation.

(d) The hearing will be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

### 8.B.2. Hearing Committee:

(a) If a request for a hearing is made timely, the President & Chief Executive Officer, in consultation with the President of the Medical Staff, will appoint a Hearing Committee composed of up to three individuals (including, but not limited to, members of the Medical Staff, Hospital management, individuals not connected with the Hospital, or any combination of these individuals). The Hearing Committee will not include anyone who previously participated in the recommendation, any relatives or practice partners of the Category I or Category II practitioner, or any competitors of the affected individual.

(b) The President & Chief Executive Officer, in consultation with the President of the Medical Staff, will appoint a Presiding Officer, who will be an attorney and may be legal counsel to the Hospital. The role of the Presiding Officer will be to allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross examination. The Presiding Officer will maintain decorum throughout the hearing.

8.B.3. Hearing Officer Alternative:

(a) As an alternative to a Hearing Committee, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies (not issues of clinical competence, knowledge, or technical skill), the President & Chief Executive Officer, in consultation with the President of the Medical Staff, may appoint a Hearing Officer.

(b) The Hearing Officer will be an attorney and will perform the functions of the Hearing Committee and the Presiding Officer. The Hearing Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing and will not act as a prosecuting officer or as an advocate to either side at the hearing.

(c) If a Hearing Officer is appointed instead of a Hearing Committee, all references in Section 8.B to the Hearing Committee or Presiding Officer will be deemed to refer instead to the Hearing Officer.

8.B.4. Hearing Process:

(a) A record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the individual's expense.

(b) The hearing will last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross examination of witnesses.

(c) At the hearing, a representative of the Medical Executive Committee will first present the reasons for the recommendation. The Category I or Category II practitioner will be invited to present information to refute the reasons for the recommendation.

(d) Both parties will have the right to present witnesses. The Presiding Officer will permit reasonable questioning of such witnesses.

(e) The Category I or Category II practitioner and the Medical Executive Committee may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross examine witnesses or present the case.

(f) The Category I or Category II practitioner will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the Medical Executive Committee was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital will be the paramount considerations.

(g) The Category I or Category II practitioner and the Medical Executive Committee will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

8.B.5. Hearing Committee Report:

(a) Within 20 days after the conclusion of the proceeding or submission of the post hearing memoranda, whichever date is later, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information, to the President & Chief Executive Officer. The President & Chief Executive Officer will send a copy of the written report and recommendation by special notice to the Category I or Category II practitioner and to the Medical Executive Committee.

(b) Within ten days after notice of such recommendation, the Category I or Category II practitioner and/or the Medical Executive Committee may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.

(c) The grounds for appeal will be limited to an assertion that there was substantial failure to comply with this Policy during the hearing, so as to deny a fair hearing, and/or that the recommendation of the Hearing Committee was arbitrary, capricious, or not supported by substantial evidence.

(d) The request for an appeal will be delivered to the President & Chief Executive Officer by special notice.

(e) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the President & Chief Executive Officer will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board will arrange for an appeal.

8.B.6. Appellate Review:

(a) An Appellate Review Committee appointed by the Chair of the Board will consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review will be conducted within 30 days after receiving the request for appeal.

(b) The Category I or Category II practitioner and the Medical Executive Committee will each have the right to present a written statement on appeal.

(c) At the sole discretion of the Appellate Review Committee, the Category I or Category II practitioner and a representative of the Medical Executive Committee may also appear personally to discuss their position.

(d) Upon completion of the review, the Appellate Review Committee will provide a report and recommendation to the full Board for action. Within 30 days of receiving the recommendation of the Appellate Review Committee, the Board will then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.

(e) The Category I or Category II practitioner will receive special notice of the Board's action. A copy of the Board's final action will also be sent to the Medical Executive Committee for information.

8.C. PROCEDURAL RIGHTS FOR CATEGORY III PRACTITIONERS

(1) In the event a recommendation is made by the Medical Executive Committee that a Category III practitioner not be granted a scope of practice or that a scope of practice previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual will receive special notice of the recommendation. The notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a meeting with the Medical Executive Committee.

(2) If a meeting is requested, the meeting will be scheduled to take place within a reasonable time frame. The meeting will be informal and will not be considered a hearing. The Supervising/Collaborating Physician and the Category III practitioner will both be permitted to attend this meeting. However, no counsel for either party will be present.

(3) Following this meeting, the Medical Executive Committee will make a recommendation to the Board, which will take final action on the matter.

# ARTICLE 9

## CONFLICT OF INTEREST GUIDELINES

(A chart summarizing the following guidelines can be found in Appendix D to this Policy.)

### 9.A. GENERAL PRINCIPLES

(1) All those involved in credentialing and professional practice evaluation activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review process.

(2) It is also essential that peers participate in credentialing and professional practice evaluation review activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

(3) The steps outlined in this Article are intended to be guidelines only, with the intent that all credentialing and professional practice evaluation activities be carried out in a reasonable and fair manner. However, nothing within this Article is intended to prevent the Medical Staff from carrying out its duties as they relate to credentialing and peer review.

### 9.B. IMMEDIATE FAMILY MEMBERS

No immediate family member (spouse, parent, child, sibling, or in-law) of a practitioner whose application or care is being reviewed will participate in any aspect of the review process, except to provide information.

### 9.C. EMPLOYMENT BY OR CONTRACTUAL RELATIONSHIP WITH THE HOSPITAL

Employment by, or other contractual arrangement with, the Hospital or an affiliate will not, in and of itself, preclude an individual from participating in credentialing and professional practice evaluation activities. Rather, participation by such individuals will be evaluated as outlined in the paragraphs below.

### 9.D. ACTUAL OR POTENTIAL CONFLICT SITUATIONS

With respect to a practitioner whose application or care is under review, actual or potential conflict situations involving other members of the Medical Staff include, but are not limited to, the following:

(1) membership in the same group practice;

(2) having a direct or indirect financial relationship;

(3) being a direct competitor;

(4) close friendship;

(5) a history of personal conflict;

(6) personal involvement in the care of a patient which is subject to review;

(7) raising the concern that triggered the review; or

(8) prior participation in review of the matter at a previous level.

Any such individual will be referred to as an "Interested Member" in the remainder of this Article for ease of reference.

## 9.E. GUIDELINES FOR PARTICIPATION IN CREDENTIALING AND PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

An Interested Member will have the obligation to disclose any actual or potential conflict of interest. When an actual or potential conflict situation exists as outlined in the paragraph above, the following guidelines will be used.

(1) Initial Reviewers. An Interested Member may participate as an initial reviewer as long as there is a check and balance provided by subsequent review by a Medical Staff committee. This applies, but is not limited to, the following situations:

(a) participation in the review of applications for appointment, reappointment, and clinical privileges because of the Credentials Committee's and Medical Executive Committee's subsequent review of credentialing matters; and

(b) participation as case reviewers in professional practice evaluation activities because of the Medical Staff Quality or Peer Review Committee's subsequent review of peer review matters.

(2) Credentials Committee, Leadership Council, and Provider Performance Enhancement Committee Member. An Interested Member may fully participate as a member of these committees (and subcommittees) because these committees do not make any final recommendation that could adversely affect the clinical privileges of a practitioner, which is only within the authority of the Medical Executive Committee. However, the chairs of these committees always have the discretion to recuse an Interested Member if they determine that the Interested Member's presence would inhibit full and fair discussion of the issue or would skew the recommendation or determination of the committee.

(3) Ad Hoc Investigating Committee. Once a formal investigation has been initiated, additional precautions are required. Therefore, an Interested Member may not be appointed as a member of an ad hoc investigating committee, but may be interviewed and provide information to the ad hoc investigating committee if necessary for the committee to conduct a full and thorough investigation.

(4) Medical Executive Committee. An Interested Member may be recused and not participate as a member of the Medical Executive Committee when the Medical Executive Committee is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

(5) Board. An Interested Member will be recused and may not participate as a member of the Board when the Board is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

## 9.F. GUIDELINES FOR PARTICIPATION IN DEVELOPMENT OF PRIVILEGING CRITERIA

Recognizing that the development of privileging criteria can have a direct or indirect financial impact on particular physicians, the following guidelines apply. Any individual who has a personal interest in privileging criteria, including criteria for privileges that cross specialty lines or criteria for new procedures, may:

(1) provide information and input to the Credentials Committee or an ad hoc committee charged with development of such criteria;

(2) serve on the Credentials Committee or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the Chair of the Credentials Committee or ad hoc committee always has the discretion to recuse an Interested Member in a particular situation, in accordance with the rules for recusal outlined below); but

(3) not participate in the discussions or action of the Medical Executive Committee when it is considering its final recommendation to the Board regarding the criteria or participate in the final discussions or action of the Board related to the criteria.

## 9.G. RULES FOR RECUSAL

(1) Any Interested Member who is recused from participating in a committee or Board meeting must leave the meeting room prior to the committee's or Board's final deliberation and determination, but may answer questions and provide input before leaving.

(2) Any recusal will be documented in the committee's or Board's minutes.

(3) Whenever possible, an actual or potential conflict should be brought to the attention of the President of the Medical Staff or committee/Board chair, a recusal determination made, and the Interested Member informed of the recusal determination prior to the meeting.

9.H. OTHER CONSIDERATIONS

(1) Any member of the Medical Staff who is concerned about a potential conflict of interest on the part of any other member, including but not limited to the situations noted in the paragraphs above, must call the conflict of interest to the attention of the President of the Medical Staff (or to the President-Elect if the President of the Medical Staff is the person with the potential conflict), or the applicable committee/Board chair. The member's failure to notify will constitute a waiver of the claimed conflict. The President of the Medical Staff or the applicable committee/Board chair has the authority to make a final determination as to how best to manage the situation, guided by this Article, including recusal of the Interested Member, if necessary.

(2) No staff member has a right to compel the disqualification of another staff member based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders or Board chair, guided by this Article.

(3) The fact that an individual chooses to refrain from participation or is excused from participation in any credentialing or peer review activity, will not be interpreted as a finding of actual conflict that inappropriately influenced the review process.

(4) The Hospital's Conflict of Interest Policy for Managed and Employed/Contracted Medical Staff Members will also apply to any member of the Medical Staff who is determined to be a "Selected Physician" pursuant to that Policy.

ARTICLE 10

CONFIDENTIALITY AND PEER REVIEW PROTECTION

## 10.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy will be strictly confidential. Individuals participating in, or subject to, credentialing and professional practice evaluation activities will make no disclosures of any such information (discussions or documentation) outside of committee meetings, except:

(1) to another authorized member of the Medical Staff or authorized Hospital employee and are for the purpose of researching, investigating, implementing or otherwise conducting legitimate credentialing and professional practice evaluation activities;

(2) as authorized by a Medical Staff or Hospital policy; or

(3) as authorized, in writing, by the President & Chief Executive Officer or by legal counsel to the Hospital.

An authorized disclosure will not constitute a waiver of the peer review privilege. Such unauthorized disclosures may subject the individual who made the unauthorized disclosure to professional review action and/or appropriate legal sanctions. Any member of the Medical Staff who becomes aware of an unauthorized disclosure must immediately inform the President & Chief Executive Officer, the VP & Chief Clinical Officer, or the President of the Medical Staff (or the President-Elect if the President of the Medical Staff is the person committing the claimed disclosure).

## 10.B. PEER REVIEW PROTECTION

(1) All credentialing and professional practice evaluation activities pursuant to this Policy and related Medical Staff documents will be performed by "Peer Review Committees" in accordance with Ohio law. These committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees;

(b) all service lines and divisions;

(c) hearing or appellate review panels;

(d) the Board and its committees; and

(e) any individual acting for or on behalf of any such entity, including but not limited to service line medical directors, division chiefs, committee chairs

and members, officers of the Medical Staff, all Hospital personnel, and experts or consultants retained to assist in peer review activities.

All oral or written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the applicable provisions of state or federal law providing protection for credentialing and peer review activities.

(2) All peer review committees will also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 et seq.

## ARTICLE 11

## AMENDMENTS

This Policy may be amended in accordance with Article 8 of the Medical Staff Bylaws.

ARTICLE 12

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Originally adopted by the Medical Staff on June 24, 2014 and approved by the Board on July 16, 2014.

Revised: Medical Executive Committee – October 20, 2015.
Board – April 27, 2016.

Revised: Medical Executive Committee – March 28, 2017.
Board – April 18, 2017.

Revised: Medical Executive Committee – February 26, 2019.
Board – February 27, 2019.

Revised: Medical Executive Committee – August 5, 2021.
Board – September 1, 2021.

# APPENDIX A

There are currently no Allied Health Professionals practicing as Category I practitioners at the Hospital.

## APPENDIX B

Those Allied Health Professionals currently practicing as Category II practitioners at the Hospital are as follows:

Anesthesiologist Assistants

Clinical Nurse Specialists

Certified Nurse-Midwives

Certified Nurse Practitioners

Certified Registered Nurse Anesthetists

Dietician*

Pharmacist*

Physician Assistants

Prosthetics & Orthotics*

Registered Nurse*

Registered Nurse First Assists ("RNFA")

Surgical Assistants

* Only for those individuals who are not credentialed through TCHHN Human Resources.

## APPENDIX C

Those Allied Health Professionals currently practicing as Category III practitioners at the Hospital are as follows:

Perfusionist

Surgical Technologists

## APPENDIX D

## CONFLICT OF INTEREST GUIDELINES

| Potential Conflicts | Levels of Participation | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Provide Information | Individual Reviewer Application/ Case | Committee Member | | | | | Hearing Panel | Board |
| | | | Credentials | Leadership Council | PPEC | MEC | Investigating Committee | | |
| Employment/contract relationship with Hospital | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Family member | Y | N | R | R | R | R | N | N | R |
| Significant financial relationship | Y | Y | Y | Y | Y | R | N | N | R |
| Direct competitor | Y | Y | Y | Y | Y | R | N | N | R |
| Close friends | Y | Y | Y | Y | Y | R | N | N | R |
| History of conflict | Y | Y | Y | Y | Y | R | N | N | R |
| Provided care in case under review (but not subject of review) | Y | Y | Y | Y | Y | R | N | N | R |
| Involvement in prior PEP or disciplinary action | Y | Y | Y | Y | Y | R | N | N | R |
| Formally raised the concern | Y | Y | Y | Y | Y | R | N | N | R |

**Y** – (Green "Y") means the Interested Member may serve in the indicated role; no extra precautions are necessary.

**Y** – (Yellow "Y") means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials Committee, Leadership Council, and PPEC have no disciplinary authority.

In addition, the Chair of the Credentials Committee, Leadership Council, or PPEC always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the practitioner under review.

**N** – (Red "N") means the Interested Member should not serve in the indicated role.

**R** – (Red "R") means the Interested Member should be recused, in accordance with the guidelines on the next page.

| RULES FOR RECUSAL | |
|---|---|
| **STEP 1**<br>Confirm the conflict of interest | The Committee Chair or Board Chair should confirm the existence of a conflict of interest relevant to the matter under consideration. |
| **STEP 2**<br>Participation by the Interested Member at the meeting | The Interested Member may participate in any part of the meeting that does not involve the conflict of interest situation.<br><br>When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Board Chair will note that the Interested Member will be excused from the meeting prior to the group's deliberation and decision-making.<br><br>Prior to being excused, the Interested Member may provide information and answer any questions regarding the following:<br><br>(i) any factual information for which the Interested Member is the original source;<br><br>(ii) clinical expertise that is relevant to the matter under consideration;<br><br>(iii) any policies or procedures that are applicable to the committee or Board or are relevant to the matter under consideration;<br><br>(iv) the Interested Member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the MEC prior to being excused from the meeting); and<br><br>(v) how the committee or Board has, in the past, managed issues similar or identical to the matter under consideration. |
| **STEP 3**<br>The Interested Member is excused from the meeting | The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's or Board's deliberation and decision-making. |
| **STEP 4**<br>Record the recusal in the minutes | The recusal should be documented in the minutes of the committee or Board. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making. |

## APPENDIX E

## DELEGATED CREDENTIALING PROCEDURES

The procedures outlined in this Appendix will apply when this Policy is used for delegated credentialing for third-party payors.

E-1. Scope

The types of practitioners that will be subject to delegated credentialing include physicians, dentists, oral surgeons, podiatrists, psychologists, acupuncturists, audiologists, board certified behavior analysts, registered behavior technicians, certified registered nurse anesthetists, certified nurse midwives, certified registered nurse practitioners, chiropractors, genetic counselors, occupational therapists, optometrists, physical therapists, physician assistants, speech language therapists, licensed professional counselors, registered dieticians, and workers (both licensed social workers and licensed clinical social workers).

E-2. Sub-Delegation

Sub-delegation to an entity outside the Hospital of the functions described in this Policy and Appendix will not occur.

If a need arises for the Hospital to sub-delegate any of the functions described in this Policy and Appendix, the sub-delegation will include the following:

(a) a delegation agreement that:

(1) is mutually agreed upon;

(2) describes the delegated activities and the responsibilities of the Hospital and the sub-delegated entity;

(3) requires at least semi-annual reporting by the sub-delegated entity to the Hospital;

(4) describes the process by which the Hospital evaluates the sub-delegated entity's performance;

(5) specifies that the Hospital retains the right to approve, suspend, and terminate individual practitioners; and

(6) describes the remedies available to the Hospital if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement;

(b) a pre-delegation evaluation that evaluates the capacity of the sub-delegated entity to meet regulatory and accreditation requirements; and

(c) for arrangements in effect for more than 12 months, the Hospital will annually:

(1) review the sub-delegate's credentialing policies and procedures;

(2) audit the sub-delegate's credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect;

(3) evaluate the sub-delegate's performance against NCQA standards for delegated activities;

(4) monitor the sub-delegate's credentialing system security controls to ensure that the sub-delegate monitors its compliance with the delegation agreement or with the sub-delegate's policies and procedures; and

(5) act on all findings regarding credentialing system security controls and implement a quarterly monitoring process until the sub-delegate demonstrates improvement for one finding over three consecutive quarters.

The Hospital will also identify and follow up on opportunities for improvement, if applicable.

E-3. Confidentiality of Credentialing Information

In addition to the requirements for confidentiality outlined in this Policy, the confidentiality of information collected during the credentialing process will be maintained through electronic security controls that are a part of the credentialing software used. Any hard copies of information collected during the credentialing process will be stored in a secure location that is accessible only by individuals involved in the credentialing process.

E-4. Practitioner Rights

Practitioners who are undergoing the delegated credentialing process have the following rights:

(a) to review information submitted in support of their application consistent with this Policy and the Policy on Practitioner Access to Confidential Files;

(b) to be informed, upon request, of the status of their application (requests will be submitted to Medical Staff Services which will respond to such requests in a reasonable amount of time, not to exceed 60 days); and

(c) to correct or clarify erroneous or inconsistent information from other sources (if information is received from other sources that appears to be erroneous, Medical Staff Services will notify the practitioner, who will have 60 days to provide information to support the need to correct such information. Medical Staff Services will also inform the practitioner of the format for submitting the information and where such information should be submitted).

Nothing in this Section prohibits the Hospital from addressing misstatements and omissions through the process described earlier in this Policy.

E-5. Review of Policy

For purposes of delegated credentialing, the Credentials Committee will review the effectiveness of this Policy and recommend revisions or modifications on a yearly basis.

E-6. Oversight of Delegated Credentialing Program

The VP & Chief Clinical Officer will serve as the medical director of the delegated credentialing program. The VP & Chief Clinical Officer will be responsible for the program's compliance with relevant laws, regulations, and accreditation standards. The VP & Chief Clinical Officer will also oversee the delegated credentialing, recredentialing, and ongoing monitoring processes.

E-7. Credentialing System Controls

Credentialing system controls are in place and performed consistent with this section:

(a) Credentialing applications and supporting documents, such as primary source verified information, are confidentially and securely received via an electronic application and other electronic means, reviewed by Medical Staff Services staff (the receipt of which is dated, tracked, and stored within the practitioner's electronic credentialing file). File progress is tracked via internal credentialing checklists as described in this Appendix and the electronic database.

(b) Information collected during the credentialing and recredentialing processes is stored in a secure manner in the electronic credentialing system used by the Hospital. Access to practitioner credentialing files, including initially verified information, is limited to users within the Medical Staff Services department, authorized Medical Staff committees and leaders, and database administrators using security groups, configured within the credentialing software.

(c) Modification or deletion of specific fields in electronic credentialing files are managed through the database administrator granting security permissions to specific user groups, including the Medical Staff Services staff. Information may be modified or deleted when inaccurate or duplicative (e.g., incorrect insurance carrier/broker).

(d) Modifications to credentialing records are tracked through the credentialing software, which has an audit log showing the date/time of change, what was modified, and the user who made the modification. If a modification is made to change the verification date/user/source, a note will be made to reflect the reason for the change.

(e) The accuracy of credentialing and recredentialing information is maintained using secure, electronic storage, which limits access to those who have a business need to access such information, as described in this section. Workstations are in physically secure areas and computer screens are positioned to prevent viewing by unauthorized individuals. Credentialing information is only released to authorized individuals consistent with the purposes described in this Policy, such as for legal support and to facilitate the delegated credentialing program (e.g., to third-party payors during audits or regulatory and accreditation entities if requested).

(f) Authorized individuals who are given access to confidential credentialing information and credentialing platforms create a username and password and are periodically instructed on best practices for maintaining the confidentiality of this information (e.g., using a strong password, avoiding writing down passwords, using different passwords for different accounts, and changing passwords when appropriate or at defined intervals). Appropriate staff (e.g., those in the IT department) are alerted when an employee with access leaves the organization so that his or her account and access can be disabled and when there is a potential breach of security (e.g., through a virus) so that authorized individuals may be instructed on the need to change their password or take other remedial steps.

(g) The Hospital monitors its compliance with the controls described in this section at least annually and takes appropriate action when needed.

(1) As noted above, modifications to credentialing records are tracked through the credentialing software and will be reviewed by the Medical Staff Services manager to ensure accuracy, appropriate access, and compliance with this Policy.

(2) Modifications that do not meet the requirements in this section will be identified and documented by the Medical Staff Services manager, who will analyze the improper modification and implement a corrective action plan appropriate to the circumstances. Any such corrective action plan will be monitored for effectiveness on a quarterly basis until improvement is demonstrated over at least three consecutive quarters.

(3) The analysis of improper modifications will include both a qualitative (e.g., an examination of the underlying reasons giving rise to the modification at issue) and quantitative (e.g., a comparison of number of improper modifications against a standard or benchmark, trended over time) aspect.

E-8. Application

(a) The Hospital will use the state-required application (i.e., Council for Affordable Quality Healthcare ("CAQH") credentialing application for physician and non-physician providers).

(b) The application will specifically seek, among other things, information pertaining to the following:

(1) reasons for inability to perform the essential functions of the position, if applicable;

(2) lack of present illegal drug use;

(3) history of loss of license and felony convictions;

(4) history of loss or limitation of privileges or disciplinary actions;

(5) current malpractice insurance coverage or, if no current malpractice insurance coverage, eligibility for malpractice insurance coverage on the effective date of membership; and

(6) clinical privileges, or evidence of an admitting arrangement, for admitting patients to the Hospital.

(c) The application will also include a requirement for the applicant to attest, via signature, to the correctness and completeness of the application.

(d) As a preliminary step, an application will be reviewed by Medical Staff Services to determine that all questions have been answered and are accurate (including a review for conflicting information), and that the applicant satisfies the threshold eligibility criteria. Individuals who fail to meet these criteria will be notified in writing that they are ineligible to apply and the reasons for ineligibility. A complete application for an individual eligible for an unrestricted DEA license, in which the applicant's DEA license is in active-pending status, may still be presented to the Credentials Committee provided that the individual has confirmed that a practitioner with appropriate clinical privileges with a current, unrestricted DEA license is willing to write all prescriptions requiring a DEA Number for the individual until his or her DEA license is granted.

E-9. Clean Application Process

(a) A "Clean Application" is, for purposes of delegated credentialing, an application that meets all the threshold eligibility criteria and does not raise any issues (e.g., unfavorable peer reference, gaps in experience, etc.).

(b) For Clean Applications and when the applicant is not seeking Medical Staff appointment and/or clinical privileges, the following process may be used:

(1) The application will be presented, along with all supporting materials, to the VP & Chief Clinical Officer.

(2) All verifications will be reviewed by the VP & Chief Clinical Officer in accordance with the time limits outlined in the NCQA standards. Verifications not reviewed within the time limits under the NCQA standards will be rerun.

(3) The VP & Chief Clinical Officer will review the application and supporting materials and make a decision regarding whether the applicant satisfies standards for delegated credentialing.

Nothing herein precludes the VP & Chief Clinical Officer from forwarding an application and all supporting materials for review in accordance with Section 3.A of this Policy if the VP & Chief Clinical Officer has concerns about the application and/or supporting materials and the VP & Chief Clinical Officer articulates those concerns in writing and provides them to the Credentials Committee.

E-10. Time Periods for Processing

(a) Once an application is deemed complete, it will be processed in accordance with state time requirements (e.g., within 90 days of receiving a complete application), unless it becomes incomplete. Notification of credentialing decisions will be made in accordance with any accreditation and/or regulatory requirements.

(b) Applicants will be notified of incomplete applications by electronic means, facsimile, or certified mail (return receipt requested) no later than 21 days after the Hospital discovers the need for the additional information.

(c) The verifications to be performed and the relevant NCQA time limits are as follows:

(1) Current, valid license and any sanctions or restrictions on licensure or limitations on scope of practice – must be reviewed within 180 calendar days of verification;

(2) Valid DEA certificate for practitioners who are qualified to write prescriptions of controlled substances – for non-pending DEA certificates, must be reviewed prior to the credentialing decision;

(3) Education and training – must be reviewed prior to the credentialing decision;

(4) Board certification status if practitioner states on application that he or she is board certified – must be reviewed within 180 calendar days of verification;

(5) Work history – a minimum of five years of work history must be reviewed within 365 calendar days of verification;

(6) Malpractice history (i.e., claims that resulted in settlement or judgment paid on behalf of the practitioner) – a minimum of five years of malpractice history must be reviewed within 180 calendar days of verification;

(7) State sanctions, restrictions on licensure and limitations on scope of practice – a minimum of the most-recent five-year period must be reviewed within 180 calendar days of the verification;

(8) Medicare and Medicaid sanctions – must be reviewed within 180 calendar days of verification; and

(9) Attestation on application – must be reviewed within 180 calendar days of the date the attestation is made.

The NCQA time limits set forth above are current as of the adoption date of this Policy. If these time limits are shortened before this Appendix can be amended, the shorter time limits will be used until this Appendix can be amended.

E-11. Verification Sources

Verification of information required for credentialing and recredentialing (verification of education and training and work history are not applicable for recredentialing) will be performed as follows:

(a) Licensure and limitations or restrictions on licensure or limitations on scope of practice – directly from state licensing or certification agency and/or the National Practitioner Data Bank.

(b) DEA – DEA, DEA certification, documented visual inspection of the original DEA certificate, confirmation from the American Medical Association ("AMA") Physician Masterfile (DEA only), or confirmation from the American Osteopathic Association Official Osteopathic Physician Profile Report or Physician Master File (DEA only).

(c) Education and training – primary source, the state licensing agency, specialty board, or registry if they perform primary source verification, or sealed transcripts if there is written documentation that the transcript was inspected and confirmation that the practitioner completed the appropriate training program. For physicians, other acceptable verification sources include (when appropriate for the degree)

AMA Physician Masterfile, American Osteopathic Association ("AOA") Official Osteopathic Physician Profile Report or Physician Masterfile, and the Educational Commission for Foreign Medical Graduates for international medical graduates licensed after 1996. When the state licensing agency, specialty board, or registry is used, the Hospital will: (1) obtain written confirmation of primary source verification from the primary source at least annually, (2) provide a printed, dated screenshot of the state licensing agency, specialty board or registry website displaying the statement that it performs primary source verification of practitioner education and training information, or (3) provide evidence of a state statute requiring the licensing agency, specialty board or registry to obtain verification of education and training directly from the institution.

(d) Board certification status – primary source (appropriate specialty board) and the state licensing agency. For physicians, other acceptable verification sources include the ABMS or its member boards, or an official ABMS Display Agent, where a dated certificate of primary source authenticity has been provided, AMA Physician Masterfile, AOA Official Osteopathic Physician Profile Report or Physician Masterfile, and boards in the United States that are not members of the ABMS or AOA if the organization documents within its policies and procedures which specialty boards it accepts and obtains annual written confirmation from the board that the board performs primary source verification of completion of education and training.

(e) Work history – application or CV with the beginning and ending month and year for each position of employment experience, unless the individual has had continuous employment for five years or more with no gap where providing the year satisfies the requirement in this section.

(f) Gaps in work history – application or CV (A review of work history and any gaps will be documented. If a gap in employment exceeds six months, the practitioner will be required to clarify the reasons for the gap verbally or in writing and the Hospital will document the verbal clarification or include the written notice in the individual's credentials file. If a gap in employment exceeds one year, the practitioner will be required to clarify the reasons for the gap in writing and the Hospital will document its review of the clarification).

(g) Malpractice history – the malpractice carrier or the National Practitioner Data Bank.

(h) State sanctions, restrictions on licensure and limitations on scope of practice –

- For physicians: appropriate state agency or Federation of State Medical Boards.

- For oral surgeons: State Board of Dental Examiners or State Medical Board.

- For podiatrists: State Board of Podiatric Examiners or Federation of Podiatric Medical Boards.

- For Allied Health Professionals: applicable state licensure or certification board or other appropriate state agency.

(i) Medicare and Medicaid sanctions – National Practitioner Data Bank or other NCQA-approved source.

(j) During initial credentialing and recredentialing, the Hospital will review the National Plan and Provider Enumeration System, Centers for Medicare & Medicaid Services' ("CMS") Opt-Out Affidavit List to determine if an applicant has elected to opt out of Medicare and a CMS-approved sanctions list (e.g., Office of Inspector General List of Excluded Individuals/Entities) to determine if an applicant is eligible for participation in Medicare. The Hospital will also review the General Services Administration's System for Awards Management, and the Social Security Administration Death Master File during initial credentialing and recredentialing to verify that the applicant is a living person.

(k) For Medicaid managed care plans, the Hospital will validate that the applicant is active in the Ohio Department of Medicaid provider network management system and enrolled for the applicable service and/or specialty.

E-12. Documentation of Information and Activities in Credentials Files

The Medical Staff Office will use an electronic checklist to document verification of information for practitioner credentials files. The electronic checklist includes, among other things, the source used for verification purposes, the date that the verification was conducted, the electronic signature of the individual conducting the verification, and, where applicable, the report date.

E-13. Site Assessments

(a) Site assessments may be conducted to ensure that the offices of all practitioners meet office site standards. If site assessments are conducted as a part of the delegated credentialing process, the provisions in this section will apply.

(b) The quality, safety and accessibility of practitioners' offices will be assessed based on the following factors:

(1) Physical accessibility, including for the handicapped accessible/parking;

(2) Physical appearance, that is, cleanliness, adequate seating, hours posted, etc.;

(3) Adequacy of waiting and examining room space; and

(4) Adequacy of medical/treatment record keeping.

Patient complaints for practitioner office sites will also be monitored.

(c) The results of the assessments will be scored on a 0 to 100% compliance scale.

(1) For sites demonstrating 80% or greater compliance, no follow-up is required.

(2) For sites demonstrating less than 80% compliance, an action plan will be developed and monitored. Follow-up to the site assessment action plan will occur, and be documented, at least every six months until the deficiency is resolved.

(d) A site assessment will be completed as follows:

(1) At initial credentialing of a practitioner at a site which has not been assessed;

(2) Every three years after the initial site assessment;

(3) When patient complaints for a site exceed the threshold established (under such circumstances, site visits will be conducted within 60 days of the threshold being met and communicated to the VP & Chief Clinical Officer); and

(4) As part of the follow-up when a site demonstrates less than 80% compliance.

E-14. Ongoing Monitoring

(a) The following will be reviewed as part of the ongoing monitoring process (i.e., during the credentialing cycle/period):

(1) Medicare and Medicaid sanctions;

(2) sanctions or limitations on licensure;

(3) confirmed and validated grievances from patients or complaints from staff, including any history of such grievances or complaints (confirmed and validated grievances will be reviewed upon their receipt and any history of such grievances will be evaluated at least every six months); and

(4) information from identified adverse events.

(b) Sanctions information will also be reviewed within 30 days of its release by the reporting entity. If the reporting entity does not publish sanctions information on a set schedule, it will be documented that the reporting entity does not release information on a set schedule, and a query of the reporting entity for the necessary information will occur at least every six months. If there is a subscription to a sanctions alert service, the information provided through the service as a part of an alert will be reviewed within 30 days of a new alert being issued.

(c) Concerns identified through the ongoing monitoring procedures outlined in this Section will be addressed through the Professional Practice Evaluation Policy and process.

E-15. Reporting to Authorities

(a) Reporting to the National Practitioner Data Bank:

(1) A report will be submitted to the National Practitioner Data Bank after a physician or dentist has exercised or waived his or her hearing rights and the Board takes one of the following reportable professional review actions:

(i) denial of request for initial or renewed Medical Staff membership or clinical privileges;

(ii) revocation of Medical Staff membership or clinical privileges; or

(iii) suspension of Medical Staff membership or clinical privileges for more than 30 days.

(2) A report will also be submitted to the National Practitioner Data Bank if the Hospital accepts the surrender, restriction, or resignation of a physician's or dentist's Medical Staff membership or clinical privileges while under an investigation, or in return for not conducting an investigation, or in return for not taking an adverse professional review action. Under such circumstances, the physician or dentist will be informed that a report will be made to the National Practitioner Data Bank.

(3) Reports to the National Practitioner Data Bank of adverse actions and surrender involving practitioners other than physicians and dentists are not mandatory under federal law and will not be made.

(4) Reports to the National Practitioner Data Bank and query results received by the National Practitioner Data Bank are confidential and will not be shared with third-party payors who have delegated credentialing. However, the fact that a query was conducted may be disclosed to third-party payors. Copies of all information obtained through queries to the National Data

Bank shall be maintained as part of the individual's permanent confidential credentials file.

(b) State law reporting requirements

The state law reporting requirements are not identical to the National Practitioner Data Bank requirements. On a case by-case basis, legal counsel will be consulted to determine if there is an obligation to file a report under the state reporting requirements when a practitioner has his or her request for membership or clinical privileges denied or current membership or clinical privileges are revoked, denied, restricted, or suspended, or surrenders or relinquishes membership or clinical privileges for any period of time. Reports will be made consistent with applicable state law.

E-16. Miscellaneous

(a) When a practitioner requests a hearing for one of the recommendations enumerated in the Credentials Policy that are grounds for a hearing, a Hearing Panel will be convened for the hearing and the Hearing Officer option will not be used when the recommendation would affect the individual's credentialing with third-party payors. Moreover, the majority of the Hearing Panel members will be "peers" of the practitioner requesting the hearing.

(b) For purposes of delegated credentialing and reporting practitioner effective dates to third-party payors, the date that the Credentials Committee or VP & Chief Clinical Officer approves the practitioner's credentialing will be used as the practitioner's effective date. Practitioners will be notified of initial credentialing decisions and recredentialing denials in a time frame that does not exceed 60 days from the decision/recommendation of the Credentials Committee or VP & Chief Clinical Officer.

(c) The Hospital will not discriminate in credentialing and recredentialing consistent with the Nondiscrimination section of this Policy. Monitoring and preventing such discrimination shall be done by completing audits, at least annually, of the files of individuals who are denied membership or have their membership revoked or suspended. All Credentials Committee members will be required to sign annually an affirmative statement that any decisions or recommendations that they make will be done in a nondiscriminatory manner.

(d) Communication between individuals and the Hospital as described in this Appendix will be through electronic means, facsimile, or certified mail (return receipt requested).