

# **NCH HEALTHCARE SYSTEM**

## **CREDENTIALS POLICY**

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## ARTICLE 1

### GENERAL

#### 1.A. TIME LIMITS

Time limits referred to in this Policy and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated.

#### 1.B. DELEGATION OF FUNCTIONS

- (1) When a function 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 chairperson, may delegate performance of the function to one or more designees.
- (2) When a member of the Medical Staff or the Allied Health Professional Staff is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

#### 1.C. OVERSIGHT

The President of the Medical Staff is responsible for the clinical aspects of the credentialing process described in this Policy.

#### 1.D. CONFIDENTIALITY AND PEER REVIEW PROTECTION

##### 1.D.1. Confidentiality:

Professional review activities and recommendations will be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the committees charged with such functions, except:

- (a) to another authorized individual and for the purpose of conducting professional review activity;
- (b) as authorized by a policy or as permitted or required by law; or
- (c) as authorized by the Chief Executive Officer or by legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a professional review action or appropriate legal action. Breaches of confidentiality will not constitute a waiver of any privilege.

#### 1.D.2. Peer Review Protection:

All professional review activity will be performed by the peer review committees. Peer review committees include, but are not limited to:

- (a) all standing and ad hoc medical staff and hospital committees;
- (b) all departments;
- (c) hearing and appellate review panels;
- (d) the Board and its committees; and
- (e) any individual or body acting for or on behalf of a peer review committee, Medical Staff Leaders, and experts or consultants retained to assist in professional review activity.

All oral and written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law and are deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986 (“HCQIA”), 42 U.S.C. §11101 et seq.

#### 1.E. INDEMNIFICATION

The Hospital will provide a legal defense for, and will indemnify, all Medical Staff Leaders, peer review committees, members, and authorized representatives when engaged in those capacities, in accordance with applicable laws, and Medical Staff Bylaws and related Medical Staff policies that have been approved by the Medical Executive Committee, or the Medical Staff, and adopted by the Board.

#### 1.F. EMPLOYMENT

Appointment and clinical privileges, and the process for considering an individual’s request for the same, are not part of the employment process and it is understood that the Hospital’s employment policies and processes are not applicable to the credentialing process.

#### 1.G. DEFINITIONS

The following definitions apply to terms used in this Policy:

- (1) “ADVANCED REGISTERED NURSE PRACTITIONER” means any person licensed in Florida to practice professional nursing and certified in advanced or specialized nursing practice and acceptable to the Board of the Hospital.

- (2) “ALLIED HEALTH PRACTITIONERS” means individuals other than members of the Medical Staff who are authorized by law and by the Hospital to provide patient care services. Allied health practitioners are described as licensed independent practitioners, advanced practice practitioners or dependent practitioners in the Medical Staff Bylaws documents:
- “LICENSED INDEPENDENT PRACTITIONER” means an allied health practitioner who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted. Licensed independent practitioners also include those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges as moonlighting residents.
  - “ADVANCED PRACTICE PRACTITIONER” means a type of allied health 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 Physician pursuant to a written supervision agreement.
  - “DEPENDENT PRACTITIONER” means a type of allied health practitioner who is permitted by law or the Hospital to function only under the direction of a Supervising Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted. Except as specifically indicated in Article 8 of this Policy, all aspects of the clinical practice of dependent practitioners at the Hospital will be assessed and managed in accordance with Human Resources policies and procedures, and the provisions of this Policy specifically will not apply.
  - Hereafter, except as otherwise expressly stated in this Policy and the Medical Staff Bylaws, the term “allied health practitioner” will be limited to licensed independent practitioners and advanced practice practitioners.
- (3) “ALLIED HEALTH PROFESSIONAL STAFF” means those licensed independent practitioners and advanced practice practitioners who have been appointed to this Staff by the Board.
- (4) “BOARD” means the Board of Trustees of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.
- (5) “BOARD CERTIFICATION” is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, upon an individual, as applicable.

- (6) “CHIEF EXECUTIVE OFFICER” means the individual appointed by the Board to act on its behalf in the overall management of Hospital.
- (7) “CHIEF MEDICAL OFFICER” means the physician appointed by the Hospital to act as the Chief Medical Officer of the Hospital, in cooperation with the President of the Medical Staff.
- (8) “CHIEF NURSING EXECUTIVE” means the individual appointed by the Hospital to serve as Administrative Vice President, Chief Nursing Executive.
- (9) “CLINICAL PRIVILEGES” or “PRIVILEGES” means the authorization granted by the Board to render specific clinical procedures and patient care services, subject to the provisions of this Policy.
- (10) “CORE PRIVILEGES” or “CORE” means a defined grouping of clinical privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency or fellowship training for that specialty or subspecialty and that have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.
- (11) “CREDENTIALS POLICY” means the Hospital’s Medical Staff Credentials Policy.
- (12) “DAYS” means calendar days.
- (13) “DENTIST” means a doctor of dental surgery (“D.D.S.”) or doctor of dental medicine (“D.M.D.”).
- (14) “HOSPITAL” means NCH Healthcare System.
- (15) “HOSPITAL ADMINISTRATION” or “HOSPITAL ADMINISTRATOR” means the Chief Executive Officer or his or her designee, including the administrator on call.
- (16) “MEDICAL EXECUTIVE COMMITTEE” means the Medical Executive Committee of the Medical Staff.
- (17) “MEDICAL STAFF” means all physicians, dentists, podiatrists, and psychologists who have been appointed to the Medical Staff by the Board.
- (18) “MEDICAL STAFF LEADER” means any officer of the Medical Staff, department chairperson, section chief, or committee chairperson.
- (19) “MEMBER” means any physician, dentist, podiatrist, and psychologist who has been granted appointment to the Medical Staff or the Allied Health Professional Staff by the Board to practice at the Hospital.

- (20) “NOTICE” means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail.
- (21) “PATIENT CONTACTS” includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities. Individuals in certain specialties may be exempt from the patient contact requirement. An exemption shall be based on a determination by the Medical Executive Committee and approved by the Board that the individual is in a specialty that does not require an active hospital practice but for which services are needed in the Hospital, including to fulfill on-call coverage obligations.
- (22) “PHYSICIAN” includes both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”).
- (23) “PHYSICIAN ASSISTANT” means a person who is a graduate of an approved program or its equivalent or meets standards approved by the state boards and is licensed to perform medical services delegated by the supervising physician and is acceptable to the Board of the Hospital.
- (24) “PODIATRIST” means a doctor of podiatric medicine (“D.P.M.”).
- (25) “PROFESSIONAL REVIEW ACTION” has the meaning defined in the HCQIA.
- (26) “PROFESSIONAL REVIEW ACTIVITY” has the meaning defined in the HCQIA.
- (27) “RESTRICTION” means a mandatory concurring consultation, where the consultant must approve the proposed procedure or treatment before privileges may be exercised. It does not include conditions for performance improvement placed upon the exercise of privileges, such as general consultation, second opinions, proctoring, monitoring, education, training, mentoring or specification of a maximum number of patients, nor does it include a limitation on the exercise of clinical privileges resulting from an exclusive arrangement with another physician or group of physicians or other action by the Board.
- (28) “SCOPE OF PRACTICE” means the authorization granted to a dependent practitioner by the Chief Executive Officer to perform certain clinical activities and functions under the supervision of a Supervising Physician.
- (29) “SERVICE LINE” means a group of members of the Medical Staff, allied health practitioners, and Hospital personnel organized to collaboratively address the medical, mental/emotional, nutritional, social, and other needs of patients suffering from a particular condition or group of conditions. In the event that any service lines are developed, until such time as the Medical Staff Bylaws, rules and

regulations, and policies are amended to specifically address their organizational functions, they will be guided by the principles applicable to departments and section and will be entitled to the same confidentiality, privilege, indemnification, and immunity protections that apply to departments and section and their leaders.

- (30) “SPECIAL NOTICE” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (31) “SPECIAL PRIVILEGES” means clinical privileges that fall outside of the core privileges for a given specialty, which require additional education, training, or experience beyond that required for core privileges in order to demonstrate competence.
- (32) “SUPERVISING PHYSICIAN” means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise an advanced practice practitioner or dependent practitioner and to accept full responsibility for the actions of the advanced practice practitioner or dependent practitioner while he or she is practicing in the Hospital.
- (33) “SUPERVISION” means the supervision of an advanced practice practitioner or dependent practitioner by a Supervising Physician, that may or may not require the actual presence of the Supervising Physician, but that does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) will be determined at the time each advanced practice practitioner or dependent practitioner is credentialed and will be consistent with any applicable written supervision agreement.
- (34) “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.
- (35) “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.

## ARTICLE 2

### QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

#### 2.A. QUALIFICATIONS

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

To be eligible to apply for initial appointment, reappointment or clinical privileges, an applicant must, as applicable:

- (a) have a current, unrestricted license to practice in Florida that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees, and have never had a license to practice revoked, restricted or suspended by any state licensing agency;
- (b) have a current, unrestricted DEA registration;
- (c) be located (office and residence) close enough to fulfill medical staff responsibilities and to provide timely and continuous care for his or her patients in the Hospital as recommended by the Medical Executive Committee and approved by the Board, which approval will not be unreasonably withheld;
- (d) comply with State of Florida laws governing financial responsibility requirements, or such other financial responsibility or insurance coverage required by the Board;
- (e) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (f) have never had medical staff or allied health staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;
- (g) have never resigned medical staff or allied health staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including this Hospital;
- (h) have not, within the last ten years been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare, Medicaid or other federal or state governmental or private third-party payer fraud or program abuse); (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude;

or (vii) child or elder abuse; or been required to pay a civil money penalty for governmental fraud or program abuse;

- (i) agree to fulfill all responsibilities regarding emergency call for their specialty;
- (j) have an appropriate coverage arrangement, as determined by the Credentials Committee, with other members of the Medical Staff for those times when the individual will be unavailable;
- (k) document compliance with all applicable training and educational protocols that may be adopted by the Medical Executive Committee and required by the Board, including, but not limited to, those involving electronic medical records or patient safety;
- (l) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought or granted;
- (m) if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract;
- (n) demonstrate recent clinical activity in their primary area of practice during the last two years;
- (o) have successfully completed:
  - (i) a residency and, if applicable, fellowship training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association 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;
  - (iii) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or
  - (iv) for allied health practitioners, have satisfied the applicable training requirements as established by the Hospital.
- (p) be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Dental Association, or the American Board of Podiatric Surgery, as applicable. 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;

- (q) maintain board certification in their primary area of practice at the Hospital on an ongoing basis, and satisfy all requirements of the applicable specialty/subspecialty board necessary to do so (recertification will be assessed at reappointment); and
- (r) if seeking to practice as an advanced practice practitioner or dependent practitioner, must have a written agreement with a Supervising Physician, which agreement must meet all applicable requirements of Florida law and Hospital policy.

#### 2.A.2. Extension of Time Frame to Satisfy Board Certification Criterion:

In exceptional circumstances, the time frame for initial applicants to obtain certification and the time frame for recertification by existing members may be extended for one additional appointment term, not to exceed two years, in order to permit an individual an opportunity to obtain certification. In order to be eligible to request an extension in these situations, an individual must, at a minimum, satisfy the following criteria:

- (a) the individual has been on the Hospital's Medical Staff for at least three consecutive years;
- (b) there have been no documented peer review concerns related to the individual's competence or behavior at the Hospital during the individual's tenure that have risen to the level of the involvement of the Medical Executive Committee;
- (c) the individual provides a letter from the appropriate certifying board confirming that the individual remains eligible to take the certification examination within the next two years; and
- (d) the appropriate department chairperson provides a favorable report concerning the individual's qualifications.

#### 2.A.3. Waiver of Threshold Eligibility Criteria:

- (a) Any applicant who does not satisfy one or more of the threshold eligibility criteria may request that it be waived. Waivers of threshold eligibility criteria will not be granted routinely. The applicant 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.

- (b) A request for a waiver must 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 department chairperson, 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.
- (c) The Credentials Committee will forward its recommendation, including the basis for such, to the Medical Executive Committee. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (d) The Medical Executive Committee will 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.
- (e) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the individual who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.

#### 2.A.4. Factors for Evaluation:

The following factors will be evaluated as part of the appointment and reappointment processes:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the 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, a commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

#### 2.A.5. No Entitlement to Appointment:

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

- (a) is employed by this Hospital or its subsidiaries or has a contract with this Hospital;
- (b) is or is not a member or employee of any particular physician group;
- (c) is licensed 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, medical staff or allied health staff 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, health maintenance organization, preferred physician organization, or other entity.

#### 2.A.6. Nondiscrimination:

No one will be denied appointment or clinical privileges on the basis of gender, race, creed, sexual orientation, age, or national origin.

### 2.B. GENERAL CONDITIONS OF APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGES

#### 2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment, reappointment or clinical privileges and as a condition of ongoing appointment and maintenance of clinical privileges, every individual specifically agrees to the following:

- (a) to provide continuous and timely care;
- (b) to abide by the bylaws, policies, and rules and regulations of the Hospital and Medical Staff and any revisions or amendments thereto;

- (c) to participate in medical staff affairs through committee service and participation in performance improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;
- (d) to comply with clinical practice or evidence-based protocols pertinent to his or her medical specialty, as may be adopted by the Medical Executive Committee or document the clinical reasons for variance;
- (e) to obtain, where there is reasonable cause to so request, as determined by the Medical Executive Committee or the Leadership Council, an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood and/or urine test) or a complete physical, mental, and/or behavioral evaluation, as set forth in this Policy;
- (f) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;
- (g) to use the Hospital sufficiently to allow continuing assessment of current competence;
- (h) to seek consultation whenever necessary;
- (i) to complete in a timely manner all medical and other required records;
- (j) to perform all services and to act in a cooperative and professional manner;
- (k) to promptly pay any applicable dues, assessments, or fines;
- (l) to utilize the Hospital's electronic medical record system;
- (m) to satisfy continuing education requirements;
- (n) to attend and participate in any applicable orientation programs at the Hospital before participating in direct patient care;
- (o) to comply with all applicable training and educational protocols that may be adopted by the Medical Executive Committee, including, but not limited to, those involving electronic medical records, patient safety, and infection control;
- (p) to maintain a current e-mail address with the Medical Staff Office, which will be the primary mechanism used to communicate Medical Staff or Allied Health Professional Staff information to the member;
- (q) to disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, other vendors or other persons or entities as may be required by Hospital or Medical Staff policies, including, but not limited

to, disclosure of financial interests in any product, service, or medical device not already in use at the Hospital that a member of the Medical Staff may request the Hospital to purchase;

- (r) that, if the individual is a member of the Medical Staff who serves or plans to serve as a Supervising Physician to an advanced practice practitioner or dependent practitioner, the member of the Medical Staff will abide by the supervision requirements and conditions of practice set forth in Article 8; and
- (s) that, if the individual is an advanced practice practitioner or dependent practitioner, he or she will abide by the conditions of practice set forth in Article 8.

#### 2.B.2. Burden of Providing Information:

- (a) All applicants and members 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.
- (b) Applicants have the burden of providing evidence that all the statements made and all information provided by the applicant in support of 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. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.
- (d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.
- (e) Applicants and members are responsible for notifying the President of the Medical Staff or the Chief Executive Officer of any change in status or any change in the information provided on the application form, including any changes in eligibility to participate in Medicare, Medicaid, or other federal or state governmental health care program.

To monitor changes in status and to ensure eligibility for such participation, the Hospital will review the following: (i) the National Practitioner Data Bank at initial appointment and reappointment (with continuous query in place after July 1, 2018); (ii) the Centers for Medicare & Medicaid Services' Opt-Out Affidavit List at initial appointment and on a quarterly-basis thereafter, (iii) the United States Department of Health and Human Services Office of Inspector

General (“OIG”) List of Excluded Individuals and Entities and System for Award Management on a monthly basis; (iv) appropriate Medicaid exclusion lists at initial appointment and reappointment; and (v) the Florida Board of Medicine database for license actions on a monthly basis.

## 2.C. APPLICATION

### 2.C.1. Information:

- (a) As a precondition of changes in application forms for appointment, reappointment, and clinical privileges becoming effective and used in the credentialing and re-credentialing process, such application forms must be approved by the Credentials Committee and the Medical Executive Committee, and the Board. Board approval will not be unreasonably withheld.
- (b) The application will contain a request for specific clinical privileges and will require detailed information concerning the applicant’s professional qualifications. 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. Misstatements and Omissions:

- (a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The President of the Medical Staff and Chief Executive Officer will review the response and determine whether the application should be processed further.
- (b) If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished pursuant to this Policy.
- (c) No action taken pursuant to this section will entitle the applicant or member to a hearing or appeal.

### 2.C.3. Grant of Immunity and Authorization to Obtain/Release Information:

- (a) Conditions Prerequisite to Application and Consideration:

As a condition of having a request for application considered or applying for appointment, reappointment, or clinical privileges, every individual accepts the terms set forth in this Section.

(b) Scope of Conditions:

The terms set forth in this Section:

- (1) commence with the individual's initial contact with the Hospital, whether an application is furnished or appointment, or clinical privileges are granted;
- (2) apply throughout the credentialing process and the term of any appointment, reappointment, clinical privileges, or scope of practice; and
- (3) survive for all time, even if appointment, reappointment, or clinical privileges is denied, revoked, reduced, restricted, suspended, or otherwise affected as part of the Hospital's professional review activities and even if the individual no longer maintains appointment, or clinical privileges at the Hospital.

(c) Use and Disclosure of Information about Individuals:

(1) Information Defined:

For purposes of this Section, "information" means information about the individual, regardless of the form (which will include verbal, electronic, and paper), which pertains to the individual's appointment, reappointment, or clinical privileges, or the individual's qualifications for the same, including, but not limited to:

- (i) information pertaining to the individual's clinical competence, professional conduct, reputation, ethics, and ability to practice safely with or without accommodation;
- (ii) any matter addressed on the application form or in the Medical Staff Bylaws, Credentials Policy, and other Hospital or Medical Staff policies and rules and regulations;
- (iii) any reports about the individual which are made by the Hospital, its Medical Staff Leaders, or their representatives to the National Practitioner Data Bank or relevant state licensing boards/agencies; and
- (iv) any references received or given about the individual.

(2) Authorization for Criminal Background Check:

The individual agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

(3) Authorization to Share Information within the System:

The individual authorizes the Hospital and its affiliates, by written agreement, to share information with one another.

(4) Authorization to Obtain Information from Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to request or obtain information from third parties and specifically authorizes third parties to release information to the Hospital.

(5) Authorization to Disclose Information to Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to disclose accurate information, including any response from or on behalf of the physician with regard to any action taken by the Hospital to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives to assist them in evaluating the individual's qualifications

(6) Applicant's Right to Review Information and to Correct Erroneous Information:

- (i) Applicants have the right to be informed of the status of their credentialing or recredentialing application upon request.
- (ii) Applicants for both initial appointment and reappointment have the right to review all information submitted in support of their application, upon request, provided that, the identity of individuals providing information is not disclosed.
- (iii) If any information that was obtained in the verification process during either initial credentialing or recredentialing varies substantially from the information provided by the applicant, the applicant will be notified prior to the application being considered by the Credentials Committee. The applicant will be given the opportunity to submit in writing any correction or clarification of the conflicting information that was obtained. Sensitive information must be reviewed in the presence of the Chief Medical

Officer and may be redacted to protect the source of such information.

(d) Hearing and Appeal Procedures:

With respect to any professional review action taken by the Hospital, the individual agrees that he or she must exhaust the hearing and appeal procedures set forth in this Policy.

(e) Immunity:

To the fullest extent provided by applicable law, the individual extends any immunity granted by said law to the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, and Allied Health Professional Staff. This paragraph shall also apply to any third party who provides information.

Nothing in this Article, or the Medical Staff Bylaws or related documents will limit the right of the individual to assert any available legal or equitable claims, pursuant to applicable law.

This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, its representatives, or third parties, in the course of credentialing and peer review activities or when using or disclosing information as described in this Section. Nothing herein will be deemed to waive any other immunity or privilege provided by federal or Florida law.

(f) Legal Actions:

The immunities which are the subject of this Article and the Bylaws and related documents only apply in the absence of intentional fraud.

If an individual institutes legal action challenging any credentialing, privileging, peer review, or other professional review action or activity and does not prevail, he or she will reimburse the Hospital and any member of the Medical Staff, or Allied Health Professional Staff, or Board involved in the action for all costs incurred in defending such legal action, including costs and attorney's fees, and expert witness fees.

## ARTICLE 3

### PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

#### 3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

##### 3.A.1. Application:

- (a) Prospective applicants will be sent the application form and a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges.
- (b) A completed application form with copies of all required documents must be returned to the Medical Staff Office within 45 days after receipt. The application must be accompanied by the application fee.
- (c) Applications may be provided to residents who are in the final six months of their training. Final action will not be taken until all applicable threshold eligibility criteria are satisfied.

##### 3.A.2. Initial Review of Application:

- (a) As a preliminary step, the application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.
- (b) The Medical Staff Office will oversee the process of gathering and verifying relevant information, and confirming that all references and other information deemed pertinent have been received.
- (c) The Medical Staff Office may use any of the following primary sources to verify relevant information: (i) the Florida Board of Medicine website (for verification of state licenses); (ii) the AMA Physician Masterfile (for verification of education and training); (iii) Certifax or the Federation of State Medical Boards (for verification of board certification); (iv) the individual's malpractice carrier (for verification of history of malpractice claims or settlements); (v) the National Practitioner Data Bank (for verification of state license actions, clinical privileges actions, etc.); (vi) Universal Background Screening (for performing criminal background checks); and (vii) the OIG List of Excluded Individuals and Entities (for verification of any federal sanctions).

- (d) Before a recommendation is made on an application, the applicant will receive written notice if the information the hospital obtained through the credentialing process varies substantially from the information provided by the applicant.
- (e) 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 chairperson at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. The National Practitioner Data Bank and the Office of Inspector General, Medicare/Medicaid Exclusions will be queried, as required, and a criminal background check will be obtained.
- (f) An interview(s) with the applicant will 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 will be conducted by one or any combination of any of the following: department chairperson, the Credentials Committee, a Credentials Committee representative, the Allied Health Committee, the Medical Executive Committee, the President of the Medical Staff, the Chief Medical Officer, the Chief Nursing Executive, or the Chief Executive Officer.
- (g) The names of applicants will be posted so that member of the Medical Staff may submit, in writing, information bearing on the applicant's qualifications for appointment or clinical privileges.

#### 3.A.3. Department Chairperson and Chief Nursing Executive Procedure:

- (a) The Medical Staff Office will transmit the complete application and all supporting materials to the chairperson of each department in which the applicant seeks clinical privileges (and, where applicable, to the service chief). The chairperson or section chiefs will prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested. The report will be on a form provided by the Medical Staff Office.
- (b) The Chief Nursing Executive will also review and report on the applications for all advanced practice registered nurses.

#### 3.A.4. Allied Health Committee Procedure:

- (a) For individuals seeking to practice as allied health practitioners, the Allied Health Committee will consider the report prepared by the department chairperson or section chief and the Chief Nursing Executive, if applicable, and will make a recommendation.

- (b) The Allied Health Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. The Allied Health Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of the applicant's compliance with any conditions.
- (c) If the recommendation of the Allied Health Committee is delayed longer than 60 days, the chairperson will send a letter to the applicant, with a copy to the Chief Executive Officer explaining the reasons for the delay.
- (d) The recommendation of the Allied Health Committee will be forwarded to the Credentials Committee.

#### 3.A.5. Credentials Committee Procedure:

- (a) The Credentials Committee will consider the report prepared by the department chairperson(s), section chief, and the Chief Nursing Executive, and the Allied Health Committee if applicable, and will make a recommendation.
- (b) The Credentials Committee may use the expertise of the department chairperson, section chief, the Allied Health Committee, the Chief Nursing Executive, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and privileges, if there is reasonable cause to question the applicant's physical or mental ability to perform the privileges requested and the responsibilities of appointment, the Credentials Committee may require a fitness for practice evaluation by a physician(s) satisfactory to the Credentials Committee. The results of this evaluation will be made available to the Committee
- (d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. 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 the applicant's compliance with any conditions.
- (e) In the event the Credentials Committee is inclined to render an adverse recommendation with regard to an applicant's request for appointment or clinical privileges, then the applicant shall be notified in writing of that potentially negative recommendation, and permitted to withdraw his or her application.
- (f) If the recommendation of the Credentials Committee is delayed longer than 60 days, the chairperson of the Credentials Committee will send a letter to the applicant, with a copy to the Chief Executive Officer, explaining the reasons for the delay.

### 3.A.6. Medical Executive Committee Recommendation:

- (a) At its next regular meeting after receipt of the written report and recommendation of the Credentials Committee, and the Allied Health Committee, if applicable, the Medical Executive Committee will:
  - (1) adopt the report and recommendation of the Credentials Committee as its own; or
  - (2) refer the matter back to the Credentials Committee or the Allied Health Committee for further consideration of specific questions; or
  - (3) make a recommendation that is different from the Credentials Committee and state its reasons for disagreement with the report and recommendation of the Credentials Committee.
- (b) If the recommendation of the Medical Executive Committee is to appoint, the recommendation will be forwarded to the Professional Capabilities Committee.
- (c) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing, the Medical Executive Committee will forward its recommendation to the Chief Executive Officer, who will promptly send special notice to the applicant. The Chief Executive Officer will then hold the application until after the applicant has completed or waived a hearing and appeal.

### 3.A.7. Board Action:

- (a) The Board has delegated to the Professional Capabilities Committee, a committee made up of at least two Board members, the authority to act on appointment, reappointment, and clinical privileges, 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:
  - (1) a current or previously successful challenge to any license or registration;
  - (2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or
  - (3) 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 Professional Capabilities Committee to appoint will be effective immediately and will be forwarded to the Board for consideration at its next meeting.

- (b) When there has been no delegation to the Professional Capabilities Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:
  - (1) grant appointment and clinical privileges as recommended; or
  - (2) refer the matter back to the Credentials Committee, the Allied Health Committee or Medical Executive Committee for additional research or information; or
  - (3) modify the recommendation.
- (c) If the Board disagrees with a favorable recommendation, it should first discuss the matter with the chairperson of the Credentials Committee and the chairperson of the Medical Executive Committee. If the Board's determination remains unfavorable, the Chief Executive Officer will promptly send special notice that the applicant is entitled to request a hearing.
- (d) Any final decision by the Board to grant, deny, modify, or revoke appointment or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities. The Board will act on applications for initial appointment within 60 days of the Credentials Committee making a recommendation.

3.A.8. Time Periods for Processing:

- (a) Once an application is deemed complete, it is expected to be processed within 120 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.
- (b) If processing of an application goes beyond 180 days for any reason, any primary or secondary source verification not reviewed by the Credentials Committee will be re-verified.
- (c) All applications will be signed and dated within 180 days prior to review by the Credentials Committee.
- (d) Applicants will be provided with written notification of a final decision to grant, deny, modify, or revoke appointment or clinical privileges within ten business days of the decision.

## 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 practice at the Hospital. Only those clinical privileges granted by the Board may be exercised, subject to the terms of this Policy.
- (b) A request for privileges will be processed only when an applicant satisfies threshold eligibility criteria for the delineated privileges. An individual who does not satisfy the eligibility criteria for clinical privileges may request that the criteria be waived.
- (c) Requests for clinical privileges that are subject to an exclusive contract or arrangement will not be processed except as consistent with the applicable contract.
- (d) Recommendations for clinical privileges will be based on consideration of the following:
  - (1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, 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 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, when available; and
  - (12) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions.
- (e) Requests for additional clinical privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the request is complete, it will be processed in the same manner as an application for initial clinical privileges.

#### 4.A.2. Requests for Limited Privilege Within a Core or Specialty:

- (a) When clinical privileges have been delineated by core or specialty, a request for privileges will only be processed if the individual applies for the full core or specialty delineation. (This only applies to requests for privileges within the individual's primary specialty.)
- (b) In appropriate circumstances, the Hospital may grant limited clinical privileges within a core or specialty as requested by an individual. The request must indicate the specific clinical privileges within the core or specialty that the individual does not wish to provide, state a basis for the request, and include evidence that the individual does **not** provide the patient care services in any health care facility in that area.
- (c) A request for limited clinical privileges will be reviewed by the relevant department chairperson, the Credentials Committee, the Medical Executive Committee, and the Board.
- (d) The following factors, among others, may be considered in deciding whether to grant a waiver:
  - (1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care;

- (2) the effect of the request on the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act;
  - (3) the expectations of members who rely on the specialty;
  - (4) fairness to the individual requesting the waiver;
  - (5) fairness to other members of the Medical Staff who serve on the call roster in the relevant specialty, including the effect that the modification would have on them; and
  - (6) the potential removal for gaps in call coverage that might result from an individual's removal from the call roster and the feasibility of safely transferring patients to other facilities.
- (e) No one is entitled to be granted limited clinical privileges within a core or specialty and denial of such a request does not trigger a right to a hearing or appeal.

#### 4.A.3. Resignation of Limited Clinical Privileges:

A request to resign limited clinical privileges, whether or not part of the core, must provide a basis for the request. All such requests will be processed in the same manner as a request for limited clinical privileges, as described above.

#### 4.A.4. Resignation of Appointment and Clinical Privileges:

A request to resign **all** clinical privileges should (a) specify the desired date of resignation, (b) affirm that the individual has completed all medical records, and (c) affirm that the individual will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the President of the Medical Staff, the Board will act on the request. Absent a compelling reason, requests for resignation will be granted.

#### 4.A.5. 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 ("new procedure") will not be processed until a determination has been made that the procedure will be offered by the Hospital and criteria for the clinical privilege(s) have been adopted.
- (b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the department chairperson 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 department chairperson 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 at the Hospital.

- (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. 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.

#### 4.A.6. Clinical Privileges That Cross Specialty Lines:

- (a) Requests for clinical privileges that previously have been exercised only by members in another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.
- (b) As an initial step in the process, the individual seeking the privilege will 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 clinical privilege at other similar hospitals, and the experiences of those other hospitals.
- (c) The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairpersons, 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 clinical 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.

#### 4.A.7. Physicians in Training:

- (a) Physicians in training will not be granted medical staff appointment or clinical privileges. The program director, clinical faculty, or attending staff member will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols approved by the Medical Executive Committee or its designee, and the Graduate Medical Education Committee of the Hospital. The applicable program director will be responsible for verifying and evaluating the qualifications of each physician in training.
- (b) Individuals who are in training who wish to moonlight (outside of the training program) will be granted specific privileges as set forth in this Policy. A resident who is moonlighting must comply with the institutional and program training requirements. Loss of employment by the Hospital in the training program will result in the automatic relinquishment of clinical privileges, without a right to the hearing and appeal procedures.

#### 4.A.8. Telemedicine Privileges:

- (a) Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications.
- (b) A qualified individual may be granted telemedicine privileges, but need not be appointed to the Medical Staff or Allied Health Professional Staff.
- (c) Requests for initial or renewed telemedicine privileges will be processed through one of the following options, as determined by the Chief Executive Officer in consultation with the President of the Medical Staff:
  - (1) A request for telemedicine privileges may be processed through the same process for medical staff and allied health 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, coverage arrangements, and emergency call responsibilities.
  - (2) If 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), and the hospital or telemedicine entity is accredited by the Joint Commission, a request for telemedicine privileges may be processed using an alternative process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement that the distant hospital or telemedicine entity complies

with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

- (i) confirmation that the practitioner is licensed in Florida;
- (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 received about the individual requesting telemedicine privileges will be provided to the Medical Executive Committee for review and recommendation and 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.9. Focused Professional Practice Evaluation for Initial Privileges:

- (a) All initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to focused

professional practice evaluation by the department chairperson, section chief, or by a physician(s) designated by the Credentials Committee.

- (b) This focused professional practice evaluation may include chart review, monitoring, proctoring, external review, and other information. The clinical activity requirements, including numbers and types of cases to be reviewed, will be recommended by the department chairperson and evaluated by the Credentials Committee with approval by the Medical Executive Committee.
- (c) A newly appointed member's appointment and privileges will expire if he or she fails to fulfill the clinical activity requirements within the time frame recommended by the Medical Executive Committee. In such case, the individual may not reapply for initial appointment or privileges for two years.
- (d) If a member who has been granted additional clinical privileges fails to fulfill the clinical activity requirements within the time frame recommended by the Medical Executive Committee, the additional clinical privileges will expire and the member may not reapply for the privileges in question for two years.
- (e) When, based upon information obtained through the focused professional practice evaluation process, a recommendation is made to terminate, revoke, or restrict clinical privileges for reasons related to clinical competence or professional conduct, the member will be entitled to a hearing and appeal.

#### 4.B. TEMPORARY CLINICAL PRIVILEGES

##### 4.B.1. Temporary Clinical Privileges:

- (a) Temporary privileges may be granted by the Chief Executive Officer, upon recommendation of the President of the Medical Staff, the chairperson of the relevant department and the chairperson of the Credentials Committee, to:
  - (1) applicants for initial appointment whose complete application is pending review by the Medical Executive Committee and Board, following a favorable recommendation of the Credentials Committee. In order to be eligible for temporary clinical privileges, an applicant must have demonstrated ability to perform the clinical privileges requested and have had no (i) current or previously successful challenges to licensure or registration or (ii) involuntary restriction, reduction, denial or termination of membership or clinical privileges at another health care facility.
  - (2) non-applicants, when there is an important patient care, treatment, or service need, including the following:
    - (i) the care of a specific patient;

- (ii) when necessary to prevent a lack of services in a needed specialty area;
  - (iii) proctoring; or
  - (iv) when serving as a locum tenens for a member of the Medical Staff or Allied Health Professional Staff.
- (b) The following verified information will be considered prior to the granting of any temporary clinical privileges: current licensure, relevant training, experience, current competence, current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank.
- (c) The grant of temporary clinical privileges will not exceed 120 days and will be reviewed and approved by the Medical Executive Committee as soon as possible.
- (d) For non-applicants, who are granted temporary locum tenens privileges, the individual may exercise locum tenens privileges for a maximum of 120 days, consecutive or not, anytime during the 24-month period following the grant of privileges, subject to the following conditions:
  - (1) the individual must notify the Medical Staff Office at least 15 days prior to exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and
  - (2) the individual must inform the Medical Staff Office of any change that has occurred to the information provided on the application form for locum tenens privileges.
- (e) Prior to any temporary clinical 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.
- (f) The granting of temporary clinical privileges is a courtesy that may be withdrawn by the Chief Executive Officer at any time, with the consent of the President of the Medical Staff, the chairperson of the Credentials Committee or the department chairperson.
- (g) The department chairperson or the President of the Medical Staff will assign to another member of the Medical Staff responsibility for the care of patients until they are discharged. 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 patient(s) and in which any delay in administering treatment would add to that harm.
- (2) In an emergency situation, a member may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.
- (3) When the emergency situation no longer exists, the patient will be assigned by the department chairperson 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 Chief Executive 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: (1) current Hospital picture ID card that clearly identifies the individual’s professional designation; (2) current license to practice; (3) primary source verification of the license; (4) 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 Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (5) identification by a current Hospital employee or member of the Medical Staff or Allied Health Professional Staff 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. EXCLUSIVE ARRANGEMENTS

##### 4.E.1. Preliminary Process:

- (a) From time to time, the Board may consider entering into exclusive contracts or arrangements 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 in accordance with the terms of this Policy.
- (b) To the extent that:
  - (1) any exclusive arrangement confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or
  - (2) the Board, by resolution or other exclusive arrangement, limits the practitioners who may exercise specific clinical privileges or services to employees of the Hospital or their affiliates,no practitioner, except those authorized by or pursuant to the exclusive arrangement, may exercise clinical privileges to perform the specified services, and only practitioners so authorized are eligible to apply for the clinical privileges included in the exclusive arrangement.
- (c) As soon as possible, after deciding to propose an exclusive arrangement in a clinical service that is not currently covered by an exclusive arrangement ("new exclusive arrangement"), the Board will request, in writing, that the Medical Executive Committee review the proposed new exclusive arrangement. Within 30 days after receipt of the Board's request, the Medical Executive Committee will provide written comments and recommendations to the Board regarding the quality of care and service implications of the proposed new exclusive arrangement.

- (d) As part of its review of the proposed new exclusive arrangement, the Medical Executive Committee may obtain relevant information pertaining to 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. A failure to provide relevant information to the Medical Executive Committee within 20 days after receipt of the Board's request will extend the 30-day review period until at least 10 days following the receipt of the relevant information.
- (e) The Board will meet to consider the comments and recommendations of the Medical Executive Committee regarding the proposed new exclusive arrangement. The Medical Staff officers will be invited to the meeting to address the recommendations of the Medical Executive Committee. Thereafter, the Board will consider whether to proceed with the proposed new exclusive arrangement.
- (f) If the Board makes a determination to proceed with a new exclusive arrangement, and that determination is consistent with the recommendations of the Medical Executive Committee, then the Board's decision will be final. Such a decision by the Board will be made by a vote of the full Board and may not be delegated.
- (g) The provisions of this Section 4.E.1 will also be applicable in the event the Board determines, through a medical staff development plan or some similar mechanism, to close a clinical service to new physicians that is not currently closed ("closure of clinical service").

#### 4.E.2. Review by Professional Capabilities/Joint Conference Committee:

- (a) If the Board makes a preliminary determination to proceed with a new exclusive arrangement, and that determination is contrary to the recommendations of the Medical Executive Committee, then the matter will be submitted for review by the Professional Capabilities/Joint Conference Committee.
- (b) All practitioners whose clinical privileges would be affected by the proposed new exclusive arrangement will have the right to meet with the Professional Capabilities/Joint Conference Committee to discuss the matter. At this meeting, affected practitioners will be entitled to present information relevant to the decision to enter into the new exclusive arrangement. The Professional Capabilities/Joint Conference Committee will forward any comments regarding the new exclusive arrangement to the Board.

#### 4.E.3. Review by Full Board:

- (a) After receiving comments from the Professional Capabilities/Joint Conference Committee, the Board will consider whether or not to proceed with the new exclusive arrangement.

- (b) The Board, by a vote of at least 75% of the members of the full Board voting in favor, may reject the recommendation of the Professional Capabilities/Joint Conference Committee but shall not do so unreasonably. Such a decision by the Board may not be delegated.
- (c) Any decision by the Board to enter into a new exclusive arrangement shall consider, among other things, quality of care, efficiency, and service, and shall not be based solely on economic reason(s).
- (d) The Board shall report its reasons for the awarding of a new exclusive agreement to the Medical Executive Committee.
- (e) If the Board makes a preliminary determination to proceed with an exclusive arrangement that would have the effect of preventing a practitioner from exercising clinical privileges that had previously been granted, the following notice and review procedures will be followed:
  - (1) The affected practitioner(s) will receive notice of the proposed new exclusive arrangement and the right to request to meet with the full Board to discuss the matter prior to the proposed effective date of such arrangement.
  - (2) At the meeting, the affected practitioner(s) will be entitled to present information relevant to the decision to enter into the new exclusive arrangement.
  - (3) If, following this meeting, the Board determines to enter into the new exclusive arrangement, the affected practitioner(s) will be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusivity. The ineligibility begins as of the effective date of the new exclusive arrangement, unless otherwise determined by the Board (e.g., current provider is grandfathered).
  - (4) The procedural rights outlined above will be the member's exclusive administrative remedy. The provisions in Article 7 of this Policy are inapplicable to this administrative determination.
- (f) The inability of a member to exercise clinical privileges because of a new exclusive arrangement or closure of a clinical service is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.
- (g) Except as provided above, in the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract or arrangement, the terms of the contract or arrangement will control.

#### 4.E.4. Quality Metrics for Exclusive Arrangements:

- (a) For any new exclusive arrangement, the Medical Executive Committee will develop objective quality metrics with the assistance of the Chief Medical Officer. These quality metrics will be used by the Hospital in evaluating the performance of the new exclusive provider at intervals throughout the first year (e.g., every quarter).
- (b) Feedback on compliance with the quality metrics will be provided to the exclusive contract provider, the Board, and to the Medical Executive Committee. If the exclusive contractor is failing to meet the quality metrics, the exclusive provider will be required to present the Board and the Medical Executive Committee with a plan of corrective actions that will enable the exclusive provider to achieve those metrics.
- (c) At the end of the first year, compliance with the quality metrics will be validated by an independent consultant, agreed upon by the Board and the Medical Executive Committee unless the Board and the Medical Executive Committee agree that such validation is not necessary. The results of the independent consultant will be shared with the Board and the Medical Executive Committee.

## 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 and to reappointment.

#### 5.B. REAPPOINTMENT CRITERIA

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

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

- (a) completed all medical records;
- (b) completed all continuing education requirements;
- (c) satisfied all medical staff and allied health professional staff responsibilities, including payment of any dues, fines, and assessments;
- (d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;
- (e) paid any applicable reappointment processing fee; and
- (f) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or insurer), before the application will be considered complete and processed further.

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

In considering an 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:

- (a) compliance with the bylaws, rules and regulations, and policies of the Medical Staff and the Hospital;

- (b) participation in medical staff duties, including committee assignments and emergency call;
- (c) the results of the Hospital's performance improvement 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);
- (d) any focused professional practice evaluations;
- (e) verified complaints received from patients or staff; and
- (f) other reasonable indicators of continuing qualifications.

### 5.C. REAPPOINTMENT PROCESS

#### 5.C.1. Reappointment Application Form:

- (a) Appointment terms will not extend beyond two years.
- (b) An application for reappointment will be furnished to members at least three months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within 30 days, along with the reappointment application fee.
- (c) Failure to return a completed application within 30 days will result in the assessment of an additional reappointment processing fee. Failure to return a complete application within 60 days of receipt may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.
- (d) The application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.
- (e) The Medical Staff Office will oversee the process of gathering and verifying relevant information. The Medical Staff Office will also be responsible for confirming that all relevant information has been received.

#### 5.C.2. Conditional Reappointments:

- (a) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., professional code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of continuing education requirements). Reappointments may be recommended for periods of less than two years in order

to permit closer monitoring of a member's compliance with any conditions that may be imposed.

- (b) A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.
- (c) If questions or concerns are being addressed at reappointment or if an applicant for reappointment is the subject of an 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.C.3. Potential Adverse Recommendation:

- (a) If the Allied Health Committee, the Credentials Committee, or the Medical Executive Committee is considering a recommendation, the committee chairperson may notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.
- (b) Prior to this meeting, the member may be notified of the general nature of the information supporting the recommendation contemplated.
- (c) At the meeting, the member may be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation.
- (d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be represented by legal counsel at this meeting.
- (e) Unless otherwise required by law, the member may at this time withdraw his or her application.

## ARTICLE 6

### QUESTIONS INVOLVING MEDICAL STAFF OR ALLIED HEALTH PROFESSIONAL STAFF MEMBERS

#### 6.A. OVERVIEW AND GENERAL PRINCIPLES

##### 6.A.1. Options Available to Medical Staff Leaders and the Chief Medical Officer:

- (a) This Policy empowers Medical Staff Leaders and the Chief Medical Officer to use various options to address and resolve questions that may be raised about members of the Medical Staff and the Allied Health Professional Staff. The various options available to Medical Staff Leaders and the Chief Medical Officer and the mechanisms they may use when questions pertaining to competence, health or behavior are raised are outlined below and include, but are not limited to, the following:
  - (1) collegial intervention and progressive steps;
  - (2) ongoing and focused professional practice evaluations;
  - (3) mandatory meeting;
  - (4) fitness for practice evaluation (including blood and/or urine test);
  - (5) competency assessment;
  - (6) automatic relinquishment of appointment and clinical privileges;
  - (7) leaves of absence;
  - (8) precautionary suspension; and
  - (9) formal investigation.
- (b) In addition to these options, Medical Staff Leaders and the Chief Medical Officer also have the discretion to determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the Medical Executive Committee for further action.

##### 6.A.2. Documentation:

- (a) Except as otherwise expressly provided, Medical Staff Leaders and the Chief Medical Officer may use their discretion to decide whether to document any

meeting with an individual that may take place pursuant to the processes and procedures outlined in this Article.

- (b) Any documentation that is prepared for and maintained in the individual's confidential file will be shared with the individual. The individual will have an opportunity to review the documentation and respond to it. The initial documentation, along with any response, will be maintained in the individual's confidential file.

#### 6.A.3. No Recordings of Meetings:

It is the policy of the Hospital to maintain the confidentiality of all medical staff meetings, including, but not limited to, discussions relating to credentialing, quality assessment, performance improvement, and peer review activities. The discussions that take place at such meetings are private conversations that occur in a private place. In addition to existing bylaws and policies governing confidentiality, individuals in attendance at such meetings are prohibited from making audio or video recordings at such meetings unless authorized to do so in writing by the individual chairing the meeting or by the Chief Executive Officer.

#### 6.A.4. No Right to Counsel:

- (a) The processes and procedures contained in this Article are designed to be carried out in an informal manner. However, individuals shall be afforded access to their attorneys during any meeting which takes place pursuant to this Article. If it is determined that an individual's attorney may not attend the meeting, then the individual shall be permitted to consult with his or her attorney at any time during the meeting, and as many times as the individual deems necessary during the meeting. The parties may agree that counsel for both sides and the Hospital will be permitted to attend the meeting and participate in it to the extent agreed upon.
- (b) If the individual refuses to meet without his or her lawyer present, the meeting will be canceled and it will be reported to the Medical Executive Committee that the individual failed to attend the meeting.

#### 6.A.5. No Right to the Presence of Others:

Peer review activities are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends or relatives when attending a meeting that takes place pursuant to this Article. Subject to the approval of a Medical Staff Leader, an individual may be permitted to be accompanied by a colleague at a meeting so long as the colleague signs a confidentiality agreement.

6.A.6. Involvement of Supervising Physician in Matters Pertaining to Allied Health Professional Staff Members:

If any peer review activity pertains to the clinical competence or professional conduct of a member of the Allied Health Professional Staff, the Supervising Physician (if any) will be notified and may be invited to participate.

6.B. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

- (1) The use of collegial intervention efforts and progressive steps by Medical Staff Leaders and the Chief Medical Officer is encouraged.
- (2) The goal of those efforts is to arrive at voluntary, responsive actions by the individual to resolve an issue that has been raised. Collegial efforts and progressive steps may be carried out, within the discretion of Medical Staff Leaders and the Chief Medical Officer, but are not mandatory.
- (3) Collegial intervention efforts and progressive steps are part of the Hospital's ongoing and focused professional practice evaluation activities and may include, but are not limited to, the following:
  - (a) sharing and discussing applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
  - (b) counseling, mentoring, monitoring, proctoring, consultation, and education;
  - (c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist an individual to conform his or her practice to appropriate norms;
  - (d) communicating expectations for professionalism and behaviors that promote a culture of safety;
  - (e) informational letters of guidance, education, or counseling; and
  - (f) Performance Improvement Plans.

6.C. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

- (1) Individuals who are 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 to confirm their competence.

- (2) All individuals who provide patient care services at the Hospital will have their care evaluated on an ongoing basis. This ongoing professional practice evaluation process may include an analysis of data to provide feedback and to identify issues in an individual's professional performance, if any.
- (3) When concerns are raised about an individual's practice through the ongoing practice evaluation process or through a specialty-specific trigger, a reported concern, or other triggers (i.e., clinical trend or specific case that requires further review, patient complaint, corporate compliance issue, or sentinel event), a focused professional practice evaluation will be undertaken to evaluate the concern.

#### 6.D. MANDATORY MEETING

- (1) Whenever there is a concern regarding an individual's clinical practice or professional conduct, Medical Staff Leaders may require the individual to attend a mandatory meeting.
- (2) Special notice will be given at least three days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.
- (3) Failure of an individual to attend a mandatory meeting may result in an automatic relinquishment of appointment and privileges as set forth below.

#### 6.E. FITNESS FOR PRACTICE EVALUATION

- (1) An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test), or a comprehensive fitness for practice evaluation which may include a physical, psychological, or cognitive assessment to determine his or her ability to safely practice upon a showing of reasonable cause by the individual requesting such an examination, that such an examination is medically necessary to evaluate the fitness for practice of the individual.
- (2) Upon a showing of reasonable cause, an individual may be requested to submit to an appropriate evaluation as referenced above. A request for a fitness for practice evaluation may be made of an applicant during the initial appointment or reappointment processes or of a member during an investigation.
- (3) A request for an **immediate** evaluation may also be made when the Leadership Council is concerned with the individual's ability to safely and competently care for patients.
- (4) The Medical Staff Leaders, the Chief Medical Officer, or medical staff 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 and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to discuss and report the results to the Medical Staff Leaders or relevant committee. The individual will also be provided with the reasons for the evaluation and the result of the evaluation.

- (5) Failure to obtain the requested evaluation may result in an application being withdrawn or an automatic relinquishment of appointment and privileges as set forth below.

#### 6.F. AUTOMATIC RELINQUISHMENT

Any of the occurrences described in this Section will constitute grounds for the automatic relinquishment of an individual's appointment and clinical privileges. 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 or the State Board.

Except as otherwise provided below, an automatic relinquishment of appointment and privileges will be effective immediately upon actual or special notice to the individual.

##### 6.F.1. Failure to Complete Medical Records:

Failure of an individual to complete medical records, after notification by the medical records department of delinquency in accordance with applicable policies and rules and regulations, may result in automatic relinquishment of all clinical privileges.

##### 6.F.2. 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.

##### 6.F.3. Criminal Activity:

The occurrence of specific criminal actions will result in the automatic relinquishment of appointment and clinical privileges. Specifically, an arrest, charge, indictment, conviction, plea of guilty or plea of no contest pertaining to any felony or misdemeanor involving the following will result in an automatic relinquishment: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; or (g) child or elder abuse.

#### 6.F.4. Failure to Provide Information:

- (a) Failure of an individual to notify the President of the Medical Staff or Chief Executive Officer of any change in any information provided on an application for initial appointment or reappointment which might materially affect appointment and privileges, may, as determined by the Medical Executive Committee, result in an automatic leave of absence of appointment and clinical privileges.
- (b) Failure of an individual to provide information material to an individual's qualifications for appointment or clinical privileges in response to a written request from the Credentials Committee, the Allied Health Committee, the Medical Executive Committee, or any other authorized committee may, as determined by the Medical Executive Committee, result in the automatic leave of absence of appointment and clinical privileges until the information is provided to the satisfaction of the requesting party.
- (c) Prior to the automatic leave of absence going into effect, the individual will be provided with notice and an opportunity to provide coverage for patients in the Hospital.

#### 6.F.5. Failure to Attend a Mandatory Meeting:

Refusal of an individual to attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration, without a reasonable excuse, after appropriate notice has been given, may, as determined by the Medical Executive Committee, result in an automatic leave of absence of appointment and clinical privileges. The leave of absence will remain in effect until the individual attends the mandatory meeting and reinstatement is granted.

#### 6.F.6. Failure to Complete or Comply with Training or Educational Requirements:

Failure of an individual to complete or comply with training and educational requirements that are adopted by the Medical Executive Committee and/or required by the Board, including, but not limited to, those pertinent to electronic medical records or patient safety, will result in the automatic relinquishment of clinical privileges.

#### 6.F.7. Failure to Comply with Request for Fitness for Practice Evaluation:

- (a) Failure of an applicant to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will be considered a voluntary withdrawal of the application.

- (b) Failure of a member to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will result in the automatic relinquishment of appointment and privileges.

6.F.8. Failure to Comply with Request for Competency Assessment:

Failure of a member to undergo a requested competency assessment or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the assessment and to allow the health care professional to report the results of the assessment to the Medical Staff Leaders or relevant committee) will result in the automatic relinquishment of appointment and privileges.

6.F.9. Reinstatement from Automatic Relinquishment and Automatic Resignation:

- (a) If an individual believes that the matter leading to the automatic relinquishment of appointment and privileges has been resolved within 90 days of the relinquishment, the individual may request to be reinstated.
- (b) A request for reinstatement from an automatic relinquishment following completion of all delinquent records will be processed in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required will result in automatic resignation from the Medical Staff or Allied Health Professional Staff.
- (c) Requests for reinstatement from an automatic relinquishment following the expiration or lapse of a license, controlled substance authorization, or insurance coverage will be processed by the Medical Staff Office. If any questions or concerns are noted, the Medical Staff Office will refer the matter for further review in accordance with (d) below.
- (d) All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant department chairperson, the chairperson of the Credentials Committee, the President of the Medical Staff, and the 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 Allied Health Committee, as appropriate, 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 Allied Health Committee, as appropriate, the Credentials Committee, Medical Executive Committee and Board for review and recommendation.

- (e) Failure to resolve a matter leading to an automatic relinquishment within 90 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.G. LEAVES OF ABSENCE

### 6.G.1. Initiation:

- (a) A leave of absence of up to one year must be requested in writing and submitted to the Chief Executive Officer. The request should, when possible, state the beginning and ending dates and the reasons for the leave. Except in extraordinary circumstances, the request will be submitted at least 30 days prior to the anticipated start of the leave.
- (b) The President of the Medical Staff will determine whether a request for a leave of absence will be granted, after consulting with the Chief Medical Officer, the relevant department chairperson, the chairperson of the Credentials Committee, 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.
- (c) Members of the Medical Staff or Allied Health Professional Staff must report to the Chief Executive Officer any time they are away from medical staff, allied health staff, or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Upon becoming aware of such circumstances, the Chief Executive Officer will notify the President of the Medical Staff who may trigger an automatic medical leave of absence at any point after becoming aware of the member's absence from patient care, subject to approval by the Medical Executive Committee.
- (d) Leaves of absence are matters of courtesy, not of right. A determination whether to grant a leave or an extension will be final, with no recourse to a hearing and appeal.

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

During a leave of absence, the individual will not exercise any clinical privileges and will be excused from medical staff and allied health professional staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations). The obligation to pay dues will continue during a leave of absence except that a member granted a leave of absence for U.S. military service will be exempt from this obligation.

### 6.G.3. Reinstatement:

- (a) 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. Requests for reinstatement will then be reviewed by the relevant department chairperson, the chairperson of the Allied Health Committee, if appropriate, the chairperson of the Credentials Committee, the President of the Medical Staff, and the Chief Executive Officer.
- (b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Allied Health Committee, if appropriate, Credentials Committee, Medical Executive Committee, and Board.
- (c) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is capable of resuming a hospital practice and safely exercising the clinical privileges requested.
- (d) Absence for longer than one year will result in resignation of appointment to the Medical Staff or Allied Health Professional Staff and clinical privileges unless an extension is granted by the Board. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.
- (e) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will expire at the end of the appointment period, and the individual will be required to apply for reappointment.

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

### 6.H.1. Grounds for Precautionary Suspension or Restriction:

- (a) Whenever failure to take action may result in imminent danger to the health and/or safety of any person, any three of the following individuals (two of whom must be physicians) the President of the Medical Staff, relevant department chairperson, chairperson of the Credentials Committee, chairperson of the Peer Review Committee, the Chief Medical Officer, or Chief Executive Officer, or the Medical Executive Committee, are authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed; or (2) suspend or restrict all or any portion of an individual's clinical privileges.

- (b) So long as the standard set forth in (a) above is first met, a precautionary suspension can be imposed at any time, including after a specific event or pattern of events that evidence a concern about imminent danger, or a recommendation by the Medical Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the persons considering the suspension will meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.
- (c) Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.
- (d) A precautionary suspension is effective immediately and will be promptly reported to the Chief Executive Officer, the President of the Medical Staff, and the chairperson of the Credentials Committee. A precautionary suspension will remain in effect unless it is modified as set forth below.
- (e) Within three days of the imposition of a suspension, the individual will be provided with 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). The notice will advise the individual that suspensions lasting longer than 30 days must be reported to the National Practitioner Data Bank.
- (f) The relevant Supervising Physician will be notified when the affected individual is a member of the Allied Health Professional Staff.

#### 6.H.2. Medical Executive Committee Procedure:

- (a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension, the Medical Executive Committee will review the reasons for the suspension.
- (b) As part of this review, the individual will be invited to meet with the Medical Executive Committee. In advance of the meeting, the individual may submit a written statement and other information to the Medical Executive Committee.
- (c) At the meeting, the individual may provide information to the Medical Executive Committee and should respond to questions that may be raised by committee members. The individual may also propose ways, other than precautionary suspension, to protect patients, employees or others while the matter is being reviewed.
- (d) After considering the reasons for the suspension and the individual's response, if any, the Medical Executive Committee will determine whether the precautionary

suspension should be continued, modified, or lifted. The Medical Executive Committee may also determine whether to begin an investigation.

- (e) If the Medical Executive Committee decides to continue the suspension, it will send the individual written notice of its decision, including the basis for it.
- (f) There is no right to an immediate hearing based on the imposition or continuation of a precautionary suspension. The procedures outlined above are deemed to be fair under the circumstances. However, if the Medical Executive Committee makes an adverse recommendation following an investigation and such recommendation triggers a right to a hearing, the hearing shall also address the imposition and continuation of the precautionary suspension.
- (g) Upon the imposition of a precautionary suspension, the President of the Medical Staff will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

## 6.I. INVESTIGATIONS

### 6.I.1. Initial Review:

- (a) Whenever collegial efforts have not resolved an issue regarding the following, or when a serious question has been raised that would be impractical to address through collegial steps, the matter may be referred to the President of the Medical Staff, the department chairperson, or chairperson of a standing committee:
  - (1) clinical competence or clinical practice, including patient care, treatment or management;
  - (2) the safety or proper care being provided to patients;
  - (3) the known or suspected violation of applicable ethical standards or the bylaws, policies, rules and regulations of the Hospital or the Medical Staff; or
  - (4) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital, its Medical Staff or its Allied Health Professional Staff, including the inability of the member to work harmoniously with others.
- (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.

- (c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, may forward it to the Medical Executive Committee. If the question pertains to a member of the Allied Health Professional Staff, the Supervising Physician may also be notified.
- (d) To preserve impartiality, the person to whom the matter is directed will not be in direct competition with, or a relative of, the person who is being reviewed.
- (e) No action taken pursuant to this section will constitute an investigation.

#### 6.I.2. Initiation of Investigation:

- (a) The Medical Executive Committee will review the matter in question, may discuss the matter with the individual, and will determine whether to conduct an investigation or direct that the matter be handled pursuant to another policy. An investigation will commence only after a determination by the Medical Executive Committee.
- (b) The Medical Executive Committee will inform the individual that an investigation has begun at the time of its commencement.
- (c) The Board may also determine to commence an investigation and may delegate the investigation to the Medical Executive Committee, the Credentials Committee, a subcommittee of the Board, or an ad hoc committee.

#### 6.I.3. Investigative Procedure:

- (a) Once a determination has been made to begin an investigation, the Medical Executive Committee will investigate the matter itself or appoint a committee ("Investigating Committee") to do so. The Investigating Committee shall be made up of individuals who are members of the Medical Staff and will not include any individual who:
  - (1) is in direct economic competition with the individual being investigated;
  - (2) is a relative of, or involved in a referral relationship with, the individual being investigated;
  - (3) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or
  - (4) actively participated in the matter at any previous level.
- (b) Whenever the questions raised concern the clinical competence of the individual under review, the Investigating Committee will include a peer of the individual (e.g., physician, dentist, oral surgeon, or podiatrist). A peer is defined as someone

with substantially similar education, training, education, board certification, and practice as the individual under review.

- (c) The individual will be notified of the composition of the Investigating Committee. Within five days of receipt of this notice, the individual must submit any reasonable objections to the service of any Investigating Committee member to the Chief Executive Officer. The objections must be in writing. The President of the Medical Staff will review the objection and determine whether another member should be selected to serve on the Investigating Committee.
- (d) The Investigating Committee may:
  - (1) review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;
  - (2) conduct interviews;
  - (3) use outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; or
  - (4) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated will execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.
- (e) As part of the investigation, the individual will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual will be informed of the questions being investigated and will be invited to discuss, explain, or refute the questions. A summary of the interview will be made and included with the Investigating Committee's report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting. However, the individual shall be permitted to consult with his or her attorney at any time during this meeting, as many times as the individual deems necessary.
- (f) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 60 days, provided that an outside review is not necessary. When an outside review is used, the Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

- (g) At the conclusion of the investigation, the Investigating Committee will prepare a report to the Medical Executive Committee with its findings, conclusions, and recommendations.

#### 6.I.4. Recommendation:

- (a) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, 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) require monitoring, proctoring or consultation;
  - (5) require additional training or education;
  - (6) recommend reduction or restriction of clinical privileges;
  - (7) recommend suspension of clinical privileges for a term;
  - (8) recommend revocation of appointment or clinical privileges; or
  - (9) make any other recommendation that it deems necessary or appropriate.
- (b) If the recommendation 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.
- (c) A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing will be forwarded to the Chief Executive Officer, who will promptly inform the individual by special notice. The recommendation will not be forwarded to the Board until after the individual has completed or waived a hearing and appeal.
- (d) If the Board makes a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the 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.

## ARTICLE 7

### HEARING AND APPEAL PROCEDURES

#### 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, reappointment or requested clinical privileges;
  - (2) revocation of appointment or clinical privileges;
  - (3) suspension of clinical privileges for more than 30 days (other than precautionary suspension);
  - (4) restriction of clinical privileges, meaning a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance; or
  - (5) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.
- (b) No other recommendation or action will entitle the individual to a hearing.
- (c) If the Board determines to take any of these actions without an adverse recommendation by the Medical Executive Committee, an individual is 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 proposed action 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 constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her file:

- (a) a letter of guidance, counsel, warning, or reprimand;
- (b) conditions, monitoring, proctoring, or a general consultation requirement;

- (c) a lapse, withdrawal of or decision not to grant or not to renew temporary privileges;
- (d) automatic relinquishment of appointment or privileges;
- (e) a requirement for additional training or continuing education;
- (f) precautionary suspension;
- (g) denial of a request for leave of absence or for an extension of a leave;
- (h) removal from the on-call roster or any reading or rotational panel;
- (i) the voluntary acceptance of a performance improvement plan option;
- (j) determination that an application is incomplete;
- (k) determination that an application will not be processed due to a misstatement or omission; or
- (l) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

#### 7.A.3. Notice of Recommendation:

The Chief Executive Officer will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will be provided within 30 days of the recommendation and 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.A.4. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing, in writing, to the Chief Executive Officer, including 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.A.5. Notice of Hearing and Statement of Reasons:

- (a) The Chief Executive Officer will schedule the hearing and provide to the individual requesting the hearing, by special notice, 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 specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and respond with additional information.
- (b) The hearing will begin as soon as practicable, but 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.A.6. Witness List:

- (a) At least 15 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.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

- (a) Hearing Panel:

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

- (1) The Hearing Panel will consist of at least three members, all of whom will be members of the Medical Staff and one of whom will be designated as chairperson.
- (2) In the event that the individual subject to the hearing is an Allied Health Practitioner, then at least one member of the panel shall be a member of the Allied Health Professional Staff.
- (3) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Hearing Panel.
- (4) Employment by, or other contractual arrangement with, the Hospital or an affiliate will not be a reason to preclude an individual from serving on the Panel.
- (5) The Hearing Panel will not include any individual who:
  - (i) is in direct economic competition with the individual requesting the hearing;
  - (ii) is professionally associated with, a relative of, or involved in a referral relationship with, the individual requesting the hearing;
  - (iii) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or
  - (iv) actively participated in the matter at any previous level.

(b) Presiding Officer:

- (1) The President of the Medical Staff, in consultation with the Chief Medical Officer, will appoint an attorney to serve as Presiding Officer. The Presiding Officer will not act as an advocate for either side at the hearing.
- (2) The Presiding Officer will:
  - (i) schedule and conduct a pre-hearing conference;
  - (ii) 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;
  - (iii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

- (iv) maintain decorum throughout the hearing;
- (v) determine the order of procedure;
- (vi) rule on matters of procedure and the admissibility of evidence; and
- (vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

- (3) The Presiding Officer may seek the advice of legal counsel to the Hospital with regard to the hearing procedure.
- (4) The Presiding Officer may serve as a legal advisor to the Hearing Panel during its private deliberation, and may draft the report of the Hearing Panel's decision based upon the findings and discussions of the Panel, but will not vote on its recommendations.

(c) Hearing Officer:

- (1) As an alternative to a Hearing Panel, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies and not issues of clinical competence, knowledge, or technical skill, the Chief Executive Officer, after consulting with and obtaining the agreement of the President of the Medical Staff, may appoint a Hearing Officer. The Hearing Officer, who shall be an attorney, will perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, 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" will be deemed to refer to the Hearing Officer.

(d) Compensation:

Members of the Hearing Panel, the Presiding Officer, or the Hearing Officer may be compensated for their service by the Medical Executive Committee, the individual who is subject to the hearing and/or the Hospital. The Hearing Panel, Presiding Officer or Hearing Officer will be told only that the parties have agreed to the arrangement. Compensation will not constitute grounds for challenging the impartiality of the Hearing Panel members, the Presiding Officer, or the Hearing Officer.

(e) Objections:

Any objection to any member of the Hearing Panel will be made in writing, within ten days of receipt of notice, to the Presiding Officer. The objection must include reasons to support it. A copy of the objection will be provided to the President of the Medical Staff. The President of the Medical Staff will be given a reasonable opportunity to comment. The Presiding Officer will rule on the objection and give notice to the parties. In the event of an objection to the Presiding Officer, the President of the Medical Staff, in consultation with the Chief Medical Officer, shall decide such objections.

7.A.8. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party shall be attorneys at law licensed to practice, in good standing, in any state.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

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

7.B.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 exhibits at least 10 days prior to the pre-hearing conference; and
- (c) any objections to witnesses and/or proposed exhibits must be provided at least five days prior to the pre-hearing conference.

7.B.3. Provision of Relevant Information:

- (a) Prior to receiving any confidential documents, the individual requesting the hearing shall agree that all documents and information will be maintained as confidential pursuant to the Medical Staff Bylaws and/or applicable law. The individual must also provide a written representation that his or 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 minutes of any meeting during the period of time in which any of the events that are the subject of the adverse recommendation occurred and upon which the adverse recommendation is based (with portions regarding other physicians and unrelated matters deleted); and
  - (4) copies of any other documents reviewed, considered or relied upon by the Medical Executive Committee, or any other committee investigating or reviewing the individual.

The provision of this information is not intended to waive any privilege.

- (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 or Allied Health Professional Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.
- (d) Ten days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits.
- (e) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this section 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 requested the hearing once it has contacted such employees and confirmed their willingness to meet. Any employee may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.
- (f) In the event that a Hospital employee declines to be interviewed by the individual or the individual's representatives, then during that employee's testimony at the hearing, he or she may be questioned about this decision.

#### 7.B.4. Pre-Hearing Conference:

- (a) The Presiding Officer will require the individual and the Medical Executive Committee (or a representative of each, who may be counsel) to participate in a

pre-hearing conference. The Medical Executive Committee, should it choose to have counsel, must be represented by counsel other than any attorney who represents the Hospital in any capacity, unless otherwise agreed to by the physician.

- (b) All objections to exhibits or witnesses will be submitted, in writing, 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.
- (c) At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses.
- (d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges will be excluded.
- (e) The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination.

#### 7.B.5. Stipulations:

The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

#### 7.B.6. 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) stipulations agreed to by the parties.

### 7.C. THE HEARING

#### 7.C.1. Time Allotted for Hearing:

It is expected that the hearing will last no more than 40 hours, with each side being afforded approximately 20 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 40 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.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 testimony will be taken on oath or affirmation administered by any authorized person.

### 7.C.3. 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;
  - (4) to have representation by counsel who may fully participate in all aspects of the hearing including calling, examining, and cross-examining witnesses in presenting the case;
  - (5) to submit a written statement at the close of the hearing; and
  - (6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.
- (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, or request documentary evidence.

### 7.C.4. 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. The burden of proof shall be upon the Medical Executive Committee to prove its assertions concerning the action taken against the individual by a preponderance of the evidence.

#### 7.C.5. 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. 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.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief Executive Officer or the President of the Medical Staff.

#### 7.C.7. 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, that Hearing Panel member must certify that he or she read the entire transcript of the portion of the hearing from which he or she was absent.

#### 7.C.8. 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 forwarded to the Board for final action.

#### 7.C.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 Chief Executive Officer on a showing of good cause.

### 7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

#### 7.D.1. 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. The Hearing Panel will render a recommendation, accompanied by a report, which will contain a statement of the basis for its recommendation.

#### 7.D.2. Disposition of Hearing Panel Report:

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

#### 7.E. APPEAL PROCEDURE

##### 7.E.1. Time for Appeal:

- (a) Within 30 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the Chief Executive Officer 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 30 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.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

- (a) that the action taken or recommended against the individual was not supported by a preponderance of the evidence presented at the hearing; or
- (b) the recommendations of the Hearing Panel were not substantiated or supported by the preponderance of the evidence presented at the hearing.

##### 7.E.3. Time, Place and Notice:

Whenever an appeal is requested, the chairperson of the Board 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.E.4. Nature of Appellate Review:

- (a) The Chairperson of the Board will appoint a Review Panel, composed of not fewer than three members of the Board.
- (b) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the Medical Executive Committee and Hearing

Panel and any other information that it deems relevant, and recommend final action to the Board.

- (c) 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. Upon the request of either party, the Review Panel shall allow each party or its representatives to appear personally and make oral arguments not to exceed 60 minutes each.
- (d) 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. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

#### 7.F. BOARD ACTION

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

- (a) The Board will take final action within 30 days after it (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report when no appeal has been requested.
- (b) The Board may review the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel (if applicable), and the transcript of the proceedings, together with any evidence and testimony elicited at the hearing.
- (c) Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.
- (d) The Board will render its final decision in writing, including the basis for its decision, and will send special notice to the individual. A copy will also be provided to the President of the Medical Staff.
- (e) Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

##### 7.F.2. Right to One Hearing and One Appeal Only:

No individual will be entitled to more than one hearing and one appeal on any matter.

## ARTICLE 8

### ADVANCED PRACTICE PRACTITIONERS AND DEPENDENT PRACTITIONERS

#### 8.A. CONDITIONS OF PRACTICE APPLICABLE TO ALLIED HEALTH PRACTITIONERS

##### 8.A.1. Standards of Practice for the Utilization of Advanced Practice Practitioners and Dependent Practitioners in the Inpatient Setting:

- (a) Advanced practice practitioners and dependent practitioners are not permitted to function independently in the inpatient Hospital setting. As a condition of being granted clinical privileges or a scope of practice at the Hospital, all advanced practice practitioners and dependent 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 advanced practice practitioners and dependent practitioners in the Hospital, all members of the Medical Staff who serve as Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.
- (b) The following standards of practice apply to the functioning of advanced practice practitioners and dependent practitioners in the inpatient hospital setting:
  - (1) Admitting Privileges. Advanced practice practitioners and dependent practitioners are not granted inpatient admitting privileges and therefore may not admit patients independent of the Supervising Physician.
  - (2) Consultations. Advanced practice practitioners and dependent practitioners may not independently provide patient consultations in lieu of the practitioners' Supervising Physicians. Advanced practice practitioners and dependent practitioners may gather data and advanced practice practitioners may order tests. However, the Supervising Physician must personally perform the requested consultation within 24 hours (or more timely in the case of any emergency consultation request).
  - (3) Emergency On-Call Coverage. It will be within the discretion of the Emergency Department physician requesting assistance whether it is appropriate to contact an advanced practice practitioner or dependent practitioner prior to the Supervising Physician. Advanced practice practitioners and dependent practitioners may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Supervising Physicians), in lieu of the Supervising Physician. The Supervising 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

Physician may direct an advanced practice practitioner or dependent practitioner to see the patient, gather data, and order tests for further review by the Supervising Physician. However, the Supervising Physician must still personally see the patient when requested by the Emergency Department physician.

- (4) Calls Regarding Supervising Physician's Hospitalized Inpatients. It will be within the discretion of the Hospital personnel requesting assistance to determine whether it is appropriate to contact an advanced practice practitioner or dependent practitioner prior to the Supervising Physician. However, the Supervising Physician must personally respond to all calls directed to him or her in a timely manner.
- (5) Daily Inpatient Rounds. An advanced practice practitioner or dependent practitioner may assist his or her Supervising Physician in fulfilling his or her responsibility to round daily on all inpatients for whom the Supervising Physician is the designated attending physician, as appropriate.

8.A.2. Oversight by Supervising Physician:

- (a) Advanced practice practitioners and dependent practitioners may function in the Hospital only so long as they have a Supervising Physician.
- (b) Any activities permitted to be performed at the Hospital by an advanced practice practitioner or dependent practitioner will be performed only under the oversight of the Supervising Physician.
- (c) If the medical staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the advanced practice practitioner or dependent practitioner fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in this Policy, the advanced practice practitioner or dependent practitioner's clinical privileges or scope of practice will be automatically relinquished, unless he or she has another Supervising Physician who has been approved as part of the credentialing process.
- (d) As a condition of clinical privileges or scope of practice, an advanced practice practitioner or dependent practitioner and the Supervising Physician must provide the Hospital with notice of any revisions or modifications that are made to the agreement between them. This notice must be provided to the Chief Executive Officer within three days of any such change.

#### 8.A.3. Responsibilities of Supervising Physicians:

- (a) Physicians who wish to utilize the services of an advanced practice practitioner or dependent practitioner in their clinical practice at the Hospital must notify the Medical Staff Office of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy before the advanced practice practitioner or dependent practitioner performs services or engages in any kind of activity in the Hospital.
- (b) The number of advanced practice practitioners or dependent 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 Physician will make all appropriate filings with the state regarding the supervision and responsibilities of the advanced practice practitioner or dependent practitioner, to the extent that such filings are required.
- (c) It will be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the advanced practice practitioner or dependent practitioner in amounts required by the Board. The insurance must cover any and all activities of the advanced practice practitioner or dependent practitioner in the Hospital. The Supervising Physician will furnish evidence of such coverage to the Hospital. The advanced practice practitioner or dependent practitioner will act in the Hospital only while such coverage is in effect.

#### 8.B. PROCEDURAL RIGHTS FOR LICENSED INDEPENDENT PRACTITIONERS AND ADVANCED PRACTICE PRACTITIONERS

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

In the event a recommendation is made by the Medical Executive Committee or the Board pertaining to licensed independent practitioners or advanced practice practitioners that would constitute grounds for a hearing, the process set forth in Article 7 of this Policy will be followed.

## ARTICLE 9

### CONFLICTS OF INTEREST

- (a) Any member who has, or may have, a conflict of interest with respect to any function outlined in this Policy, the Medical Staff Bylaws, or another policy of the Medical Staff is expected to call the potential conflict of interest to the attention of the President of the Medical Staff (or the President-Elect of the Medical Staff if the President is the person with the potential conflict) or the applicable department or committee chairperson. Any member who has knowledge of a potential conflict of interest on the part of any other member is encouraged to call the potential conflict of interest to the attention of the President of the Medical Staff or the applicable department or committee chairperson.
- (b) The President of the Medical Staff (or the President-Elect of the Medical Staff if the President is the person with the potential conflict) or the applicable department or committee chairperson will evaluate the potential conflict of interest and consider if it can be managed or whether the presence of the member with the potential conflict might inhibit full and fair discussion of the issue or might create the perception that the recommendation was tainted or based on something other than relevant information.
- (c) If the President of the Medical Staff or the applicable department or committee chairperson makes a determination that the conflict of interest cannot be managed, he or she will notify the person with the conflict. The member with the conflict may provide relevant information and may answer any questions concerning the matter. After doing so, the member will be excused from the meeting and will not participate in the final discussion or voting. This will be recorded in the minutes.
- (d) The fact that a department chairperson or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.
- (e) The fact that a department or committee member or Medical Staff Leader chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of actual conflict.

## ARTICLE 10

### HOSPITAL EMPLOYEES

- (a) Except as provided below, the employment of an individual by the Hospital or one of its affiliates will be governed by applicable employment policies and manuals and the terms of the individual's employment relationship or written contract. To the extent that applicable employment policies or manuals, or the terms of any employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship or written contract will apply.
- (b) A request for appointment, reappointment or clinical privileges, submitted by an applicant or member who is employed by the Hospital, or one of its affiliates, will be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications will be made to appropriate management personnel to assist with employment decisions.
- (c) If a concern about an employed member's clinical competence, conduct or behavior arises, then the concern may be reviewed and addressed in accordance with this Policy, in which event a report will be provided to appropriate management personnel. The individual's employer shall be required to follow this Policy in the same way as any other party bound by its terms and provisions in taking action with respect to the individual's appointment and clinical privileges. This section shall not affect decisions made pursuant to an employment contract.

## ARTICLE 11

### AMENDMENTS AND ADOPTION

- (a) The amendment process for this Policy is set forth in the Bylaws.
- (b) 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.
- (c) This Policy may only be amended in the same manner and to the same requirements as are contained in the Medical Staff Bylaws, and which must be fulfilled in order for the Medical Staff Bylaws to be amended.

Adopted by the Medical Executive Committee: July 10, 2018

Approved by the Board: July 12, 2018

Revisions approved by the Medical Executive Committee: April 14, 2020

Revisions approved by the Board: May 12, 2020