Medical Staff Advanced Practice Provider Policy

McCullough-Hyde Memorial Hospital

A Medical Staff Document

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DEFINITIONS

The definitions set forth below shall apply to this Advanced Practice Provider Policy unless otherwise specifically provided herein:

ADVANCED PRACTICE Provider or APP means those physician assistants (PA), advanced practice registered nurses (APRN), and other eligible advanced practice providers, as designated in Exhibit A (attached hereto and incorporated by reference herein) who have applied for, or who have applied for and been granted, Privileges to practice at the Hospital either independently or in collaboration with, or under the supervision of, a Physician, Dentist, or Podiatrist, as applicable, with Medical Staff appointment and Privileges at the Hospital.

ADVERSE means a recommendation or action of the Medical Executive Committee or Board of Directors that denies, limits (*e.g.*, suspension, restriction, *etc.*), for a period in excess of fourteen (14) days, or terminates Privileges on the basis of professional conduct or clinical competence, or as otherwise defined in this Policy.

AFFILIATE HOSPITAL(S) means Bethesda Hospital, Good Samaritan Hospital, and such other System hospitals as may hereinafter be added.

BOARD OF DIRECTORS or BOARD means the Board of Directors of the Hospital that has overall responsibility for the conduct of the Hospital including responsibility for the Medical Staff. Reference to the Board of Directors or Board shall include any Board committee or individual authorized by the Board to act on its behalf in designated matters.

CHIEF MEDICAL OFFICER or CMO means the Physician selected by the Hospital to serve as the chief medical officer for the System and as a System liaison to the Medical Staff. Associate CMOs shall report to the CMO. The applicable Associate CMO may serve as the CMO's authorized designee in the CMO's absence.

CHIEF OF STAFF means the chief officer of the Medical Staff who shall attain such position in accordance with the applicable procedure set forth in the Medical Staff Bylaws. A reference to the Chief of Staff shall include his/her authorized designee.

CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a Practitioner or an Advanced Practice Provider to render specific patient care, treatment, and/or services at/for the Hospital based upon the individual's professional license, education, training, experience, competence, ability, and judgment.

DENTIST means an individual who has received a Doctor of Dental Surgery ("D.D.S.") or Doctor of Dental Medicine ("D.M.D.") degree and who is currently licensed to practice dentistry in the State of Ohio unless otherwise provided by the Medical Staff Bylaws.

FEDERAL HEALTHCARE PROGRAM means Medicare, Medicaid, TriCare, or any other federal or state program providing healthcare benefits that is funded directly or indirectly by the United States government.

HOSPITAL means McCullough-Hyde Memorial Hospital and the Hospital's provider-based locations.

HOSPITAL PRESIDENT means the individual appointed by the Board to act on its behalf in the operation and management of the Hospital. A reference to the Hospital President shall include his/her authorized designee.

MEDICAL EXECUTIVE COMMITTEE or MEC means the executive committee of the Medical Staff.

MEDICAL STAFF means those Medical Staff Members with such responsibilities and Prerogatives as defined in the Medical Staff category to which each has been appointed.

MEDICAL STAFF BYLAWS or BYLAWS means the Medical Staff Bylaws, and amendments thereto, that constitute the basic governing document of the Medical Staff.

MEDICAL STAFF DEPARTMENT means a grouping or division of Medical Staff clinical services as provided for in the Medical Staff Organization Policy.

MEDICAL STAFF DEPARTMENT CHAIR means the qualified Practitioner elected, in accordance with the procedure set forth in the Medical Staff Bylaws, as the head of a Department or who has otherwise been appointed pursuant to contract.

MEDICAL STAFF MEMBER or MEMBER means a Practitioner who has been granted appointment to the Medical Staff of the Hospital. A Medical Staff Member must also have applied for and been granted Privileges unless his/her appointment is to a Medical Staff category without Privileges or unless otherwise provided in the Medical Staff Bylaws. References to Medical Staff appointment shall mean the same thing as Medical Staff membership for purposes of the Medical Staff governing documents.

MEDICAL STAFF POLICY(IES) or POLICY(IES) means those additional Medical Staff governing documents, recommended by the Medical Executive Committee and approved by the Board, that serve to implement the Medical Staff Bylaws including this APP Policy, the Credentials Policy, Organization Policy, Fair Hearing Policy, Professional Conduct Policy, Impairment/Wellness Policy, and Peer Review Program/Professional Practice Evaluation Policy.

MEDICAL STAFF RULES & REGULATIONS or RULES & REGULATIONS means the Medical Staff rules and regulations, recommended by the Medical Executive Committee and

approved by the Board, that govern the provision of medical/other professional care, treatment, and services to Hospital patients.

PHYSICIAN means an individual who has received a Doctor of Medicine ("M.D.") or Doctor of Osteopathic Medicine ("D.O.") degree and who is currently licensed to practice medicine in the State of Ohio unless otherwise provided in the Medical Staff Bylaws.

PODIATRIST means an individual who has received a Doctor of Podiatric Medicine ("D.P.M.") degree and who is currently licensed to practice podiatry in the State of Ohio unless otherwise provided in the Medical Staff Bylaws.

PRACTITIONER means an appropriately licensed Physician, Dentist, Podiatrist, or Psychologist.

PROFESSIONAL LIABILITY INSURANCE means professional liability insurance coverage of such kind, in such amount, and underwritten by such insurers as required and approved by the Board.

PSYCHOLOGIST means an individual with a doctoral degree in psychology or school psychology, or a doctoral degree deemed equivalent by the Ohio Board of Psychology, who is currently licensed to practice psychology in the State of Ohio unless otherwise provided in the Medical Staff Bylaws.

SPECIAL NOTICE means written notice sent by (a) certified mail, return receipt requested; or (b) personal delivery service with signed acknowledgement of receipt.

SYSTEM means TriHealth, Inc.

SYSTEM CEO means the Chief Executive Officer of the System. A reference to the System CEO shall include his/her authorized designee.

OTHER

Not a Contract. This APP Policy is not intended to and shall not create any contractual rights between the Hospital and any APP or Practitioner. Any and all contracts of association or employment shall control contractual and financial relationships between the Hospital and its APPs and Practitioners.

Designee. Whenever an individual is authorized to perform a duty by virtue of his/her position (*e.g,* the System CEO, System CMO, Associate CMO, Chief of Staff, Department Chair, *etc.*), then reference to the individual shall also include the individual's designee.

ARTICLE 1 QUALIFICATIONS & OBLIGATIONS

1.1 OVERVIEW

1.1.1 This Policy is only applicable to APPs who have applied for, or who have applied for and been granted, Privileges through the Medical Staff process.

1.1.2 All APPs who request Privileges at the Hospital must be credentialed and granted Privileges prior to providing care, treatment, and/or services to patients at the Hospital.

1.1.3 Exhibit A sets forth the APP occupations/professions that are credentialed, eligible for Privileges, and managed through the Medical Staff pursuant to this Policy.

1.1.4 The Medical Staff (through the appropriate Medical Staff leaders and/or Medical Staff committees) shall make recommendations to the Board, upon request, with respect to: (1) the APP occupations or professions that are eligible to request Privileges at the Hospital; (2) APP Privilege sets and amendments thereto; and (3) whether any changes should be made to this APP Policy.

1.2 LIMITATIONS

1.2.1 APPs are not granted appointment to/membership on the Medical Staff, may not serve as a Medical Staff officer or Department Chair, and are not entitled to the fair hearing and appeal rights afforded to Medical Staff Members in the Medical Staff Bylaws/Fair Hearing Policy.

1.2.2 APPs may attend Medical Staff meetings but may not vote on Medical Staff matters.

1.2.3 APPs may attend meetings of the Medical Staff Department to which they are assigned but may not vote on Department matters.

1.2.4 APPs may serve on designated Medical Staff committees as set forth in the Medical Staff Organization Policy.

1.2.5 APPs granted Privileges shall have such procedural rights, to the extent applicable, as set forth in Article 8 of this Policy.

1.2.6 APPs must comply with:

(a) All limitations and restrictions imposed by their respective licenses, certificates, certifications, or other credentials required by Ohio law to practice;

(b) The terms of their standard care arrangement, supervision agreement, or other required documentation, as applicable; and,

(c) May only provide care, treatment, and services in accordance with this Policy, other applicable Hospital/Medical Staff policies, the Privileges granted to them, and applicable laws, rules, and regulations.

1.3 DUTIES OF MEDICAL STAFF MEMBERS WHO SUPERVISE OR COLLABORATE WITH AN APRN OR PA

1.3.1 Those Medical Staff Members with Privileges at the Hospital who supervise or collaborate with an APRN or PA shall agree to:

(a) Acquaint the APRN or PA with the APP Policy and other applicable policies of the Medical Staff/Hospital as well as the Practitioners and Hospital personnel with whom the APRN or PA will have contact.

(b) Adhere to the requirements of any supervision agreement or standard care arrangement, as applicable, and otherwise provide appropriate supervision or collaboration consistent with this Policy, the APRN's or PA's Privilege set, and applicable laws, rules, and regulations.

(i) It shall be the responsibility of each supervising Physician or Podiatrist and his/her PA to have and maintain a current, valid supervision agreement in accordance with applicable Ohio laws and State Medical Board of Ohio rules.

(ii) It shall be the responsibility of each APRN-Certified Nurse Midwife (CNM), APRN-Clinical Nurse Specialist (CNS), or APRN-Certified Nurse Practitioner (CNP), in conjunction with his/her collaborating Physician or Podiatrist, to have and maintain a current, valid, standard care arrangement in accordance with applicable Ohio laws and Ohio Board of Nursing rules.

(c) Provide immediate notice to the Medical Staff Services Department when a collaborating or supervising Practitioner receives notice of (i) any grounds for summary suspension, automatic suspension, or automatic termination of the APRN's or PA's Privileges; or (ii) the occurrence of any action that establishes grounds for corrective action against the APRN or PA.

(d) Provide immediate notice to the Medical Staff Services Department when the standard care arrangement or supervision agreement expires or is terminated.

1.3.2 Failure to properly supervise or collaborate with an APRN or PA shall be grounds for corrective action against a Medical Staff Member pursuant to the Medical Staff Bylaws.

1.4 QUALIFICATIONS

1.4.1 Unless otherwise provided herein, each APP who applies for Privileges at the Hospital must demonstrate to the satisfaction of the Medical Staff and Board, at the time of application and initial grant of Privileges and continuously thereafter, that he/she meets all of the following qualifications for such Privileges:

(a) Baseline Qualifications

(i) Have and maintain a current, valid Ohio license (or other credentials required by Ohio law) to practice his/her profession and compliance with the continuing education requirements for such licensure as determined by the applicable State licensure board.

(ii) If necessary for the Privileges requested, have and maintain a current, valid Ohio prescriber number and Drug Enforcement Administration ("DEA") registration.

(iii) Successful completion of professional education and training as required by the applicable State licensing entity and such additional education and training as may be set forth in the applicable APP Privilege set.

(iv) Satisfaction of board certification/recertification requirements, if applicable, (*e.g.*, national nursing specialty certification for APRNs, *etc.*) in his/her area(s) of practice at the Hospital by the appropriate specialty/subspecialty board(s).

(v) Ability to read and understand the English language, to communicate effectively and intelligibly in English (written and verbal), and to prepare medical record entries and other required documentation in a legible and professional manner.

(vi) Have and maintain current, valid Professional Liability Insurance.

(vii) Be eligible to participate in Federal Healthcare Programs.

(viii) Comply with state and/or federal vaccination requirements and implementing System, Hospital, and/or Medical Staff policies or obtain an approved qualified exemption therefrom.

(ix) Designate an appropriate Practitioner with Medical Staff appointment and Privileges at the Hospital to supervise or collaborate with the PA or APRN.

(x) Have and maintain a current, valid supervision agreement (for PAs) or standard care arrangement (for CNPs, CNSs, and CNMs) with his/her supervising or collaborating Practitioner, as required by Ohio law, and provide a current copy of such agreement or arrangement, and any amendments thereto, to the Hospital.

(b) Additional Qualifications

(i) Obtain and maintain a provider number for Medicare issued by the Centers for Medicare and Medicaid Services and a provider number for Medicaid issued by the Ohio Department of Medicaid, if necessary for the Privileges requested.

(ii) Document and demonstrate the ability to:

a) Provide patient care, treatment, and services consistent with acceptable standards of practice and available resources including current experience, clinical results, and utilization practice patterns.

b) Work with and relate to others in a cooperative and professional/ethical manner that maintains and promotes an environment of quality and efficient patient care.

c) Exercise the Privileges requested safely and competently with or without a reasonable accommodation.

(iii) Comply with conflict of interest policies, if any, as applicable.

(iv) Comply with criminal background check requirements.

(v) Agree to fulfill, and fulfill, the responsibilities set forth in this APP Policy.

(vi) Satisfy such other qualifications as are set forth in the applicable APP Privilege set and as otherwise provided in this APP Policy.

1.5 WAIVER OF QUALIFICATIONS

1.5.1 A written request for waiver of a qualification for Privileges may be submitted by an APP to the Medical Staff Services Department for consideration by the Medical Staff and Board. The APP who is requesting the waiver bears the burden of demonstrating that his/her qualifications are equivalent to, or exceed, the criterion/criteria in question; or, that there are other extraordinary circumstances that justify a waiver.

1.5.2 A qualification for Privileges may be waived, at the sole discretion of the Board, based upon demonstration of equivalent qualifications or extraordinary circumstances and a Board determination that such waiver will serve the best interests of patient care.

1.5.3 The applicable Department Chair shall consider the request for waiver and shall forward a recommendations to the MEC for review. The MEC will make a recommendation to the Board regarding whether to grant or deny the request for a

waiver. Upon receipt of the MEC's recommendation, the Board shall either grant or deny the waiver request.

1.5.4 Once a waiver is granted, it shall remain in effect from the time it is granted until the APP's resignation or termination of Privileges unless a shorter time period is recommended by the MEC and approved by the Board. The APP must thereafter reapply for the waiver.

1.5.5 No APP is entitled to a waiver. A determination by the Board not to grant an APP's request for a waiver; or, the Hospital's inability to process an application; or, termination of an APP's Privileges based upon failure to satisfy the qualifications for Privileges does not give rise to any procedural due process rights nor does it create a reportable event for purposes of federal or state law.

1.6 BASIC OBLIGATIONS ACCOMPANYING PRIVILEGES

1.6.1 Unless otherwise provided in this APP Policy, each APP granted Privileges at the Hospital shall, as applicable to the Privileges granted to each such APP:

(a) Manage and coordinate his/her patients' care, treatment, and services at the level of quality and efficiency professionally recognized as appropriate at facilities such as the Hospital.

(b) Abide by this APP Policy and other applicable Medical Staff Policies, the Medical Staff Rules & Regulations, and applicable System/Hospital policies including, but not limited to, the Hospital's "HIPAA/Notice of Privacy Practices of the Organized Health Care Arrangement," corporate responsibility plan, and conflict of interest policies, as applicable.

(c) Discharge such Medical Staff committee, Department, and Hospital functions for which he/she is responsible.

(d) Prepare and complete, in a timely fashion, the medical record and other required documentation for all patients he/she provides care, treatment, and/or services to in the Hospital.

(i) Incorporate into practice use of the Hospital's electronic medical record and technological advances (including, but not limited to, computerized order entry) in the electronic medical record as they are made available to APPs.

(ii) Complete educational sessions, as required, with respect to the Hospital's electronic medical record, computerized order entry system, *etc.*

(e) Provide or arrange for continuous, appropriate, and timely coverage and care for patients for whom he/she is responsible.

(i) As a precondition to the exercise of Privileges, an APP must designate another APP or Practitioner with comparable Privileges who has agreed to provide back-up coverage for the APP's patients in the event the APP is not available.

(f) Cooperate, in accordance with the Practitioner/APP Code of Professional Conduct, with Practitioners, other APPs, and Hospital personnel in relation to patient care, the orderly operation of the Hospital, and general attitude toward patients, the Hospital, and its personnel.

(g) Abide by the code of ethics established by the APP's profession.

(h) Cooperate and participate, as reasonably requested, in quality assurance/performance improvement, peer review, and utilization review activities whether related to oneself or others.

(i) Cooperate in any relevant or required review of an APP's (including his/her own) qualifications for Privileges or compliance with this APP Policy or other applicable Medical Staff governing documents and refrain from directly or indirectly interfering, obstructing, or hindering any such review whether by threat of harm or liability, by withholding information, or by refusing to perform or participate in assigned responsibilities or otherwise.

(j) Comply with such notice requirements as are set forth in this APP Policy including, but not limited to, the obligation to immediately notify the Medical Staff Services Department, in writing, of any substantive changes to the information contained in or accompanying the APP's application throughout any Privilege period.

(k) Assist with any Medical Staff approved education programs (*e.g.,* for students, *etc.*), if applicable.

(l) Complete mandated Hospital education and training as directed by the MEC.

1.6.2 Failure to satisfy any of these basic obligations is grounds, as warranted by the circumstances, for denial of regrant of Privileges or for corrective action pursuant to the procedure set forth in this APP Policy.

1.7 APPS PROVIDING PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

1.7.1 QUALIFICATIONS AND SELECTION

An APP who is or who will be providing specified professional services pursuant to a contract or employment with the Hospital (or for a group holding a contract

with the Hospital) must meet the same qualifications for Privileges, be evaluated in the same manner, and fulfill the same obligations as any other APP.

1.7.2 EFFECT OF CHANGE IN PRIVILEGES

An APP's right to provide care, treatment, and/or services at Hospital facilities is automatically terminated when his/her Privileges expire or are resigned or terminated. The effect of an Adverse change in Clinical Privileges (*e.g.* limitation, suspension, *etc.*) on continuation of a contract or employment arrangement is governed solely by the terms of the contract or employment arrangement. If the contract or employment arrangement is silent on the matter, the matter will be determined by the Board after soliciting and considering the recommendations of the MEC.

1.7.3 EFFECT OF CONTRACT EXPIRATION OR TERMINATION

(a) The effect of expiration or termination of an APP's contract or employment with the Hospital (or the expiration or termination of an APP's association with the group holding the contract with the Hospital) upon the APP's Clinical Privileges at the Hospital will be governed solely by the terms of the APP's contract or employment arrangement with the Hospital (or with the group holding the contract with the Hospital), if the same addresses the issue.

(b) If the contract/employment arrangement is silent on the matter, then contract or employment expiration or termination alone will not affect the APP's Clinical Privileges, except that the APP may not thereafter exercise any Clinical Privileges for which exclusive contractual arrangements have been made.

(c) In the absence of language in the contract to the contrary, if an exclusive contract under which an APP is engaged is terminated or expires (or if the relationship of an APP with the entity that has the exclusive contractual relationship with the Hospital is terminated or expires) then those Privileges covered by the exclusive contract shall also be automatically terminated and the procedural rights afforded by this Policy shall not apply; provided, however, that the Board in its sole discretion may waive this automatic termination result.

1.7.4 CLOSED DEPARTMENT/EXCLUSIVE CONTRACT

(a) If the Hospital adopts a policy involving a closed Department or an exclusive contract for a particular service(s), any APP who holds Privileges to provide such service(s) at the Hospital but who does not meet the closed Department requirements or who is not a party to the exclusive contract (or otherwise employed by or contracted with the group that holds the exclusive

contract with the Hospital) will no longer be able to exercise the Clinical Privileges that are within the scope of the closed Department or exclusive contract as of the effective date of the Department closure or exclusive contract irrespective of the remaining time on his/her Privilege term.

1.8 CONFLICTS OF INTEREST

1.8.1 In any instance where an APP has, or reasonably could be perceived to have, a bias or conflict of interest in any matter that comes before the Medical Staff, a Department, or Medical Staff committee, the APP is expected to disclose the conflict to the individual in charge of the meeting. The APP may be asked and is expected to answer any questions concerning the conflict. The committee (or, in the absence of a committee, the individual in charge of the meeting) is responsible for determining whether a conflict exists and, if so, whether the conflict rises to the level of precluding the APP from participating in the pending matter.

1.8.2 Medical Staff officers, Department Chairs, and committee chairs may routinely inquire, before initiating discussion, as to whether any APP has any bias or conflict of interest regarding the matter(s) to be addressed. The existence of a bias or potential conflict of interest on the part of any APP shall be called to the attention of the applicable Medical Staff officer, Department Chair, or committee chair by any Practitioner or other APP with knowledge of the conflict.

1.8.3 A Department Chair shall have the duty to delegate review of applications for Privileges/regrant of Privileges to another member of the Department if the Department Chair has a conflict of interest with the APP under review that could be reasonably perceived to create bias.

1.8.4 For purposes of this Section 1.8, the fact that APPs are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such APPs from participating in the review of applications or other Medical Staff matters with respect to their colleagues.

ARTICLE 2 PROCESSING APPLICATIONS FOR INITIAL GRANT OF PRIVILEGES

2.1 REQUEST FOR AND FILING OF APPLICATION

2.1.1 A request from an APP for an application for Privileges shall be directed to the Medical Staff Services Department.

2.1.2 The Medical Staff Services Department shall provide the requesting APP applicant with such application.

2.1.3 An application for Privileges must be submitted to the Medical Staff Services Department by the APP applicant electronically on the Hospital-approved form, signed by the applicant, and accompanied by the full amount of the non-refundable application fee.

2.1.4 The applicant will be provided access to this APP Policy, other applicable Medical Staff Policies, and the Medical Staff Rules & Regulations at the time of application.

2.2 NO ENTITLEMENT

2.2.1 No APP shall be automatically entitled to Privileges at the Hospital merely because he/she:

(a) Is licensed to practice in this or in any other state.

(b) Is certified by a clinical board.

(c) Is a member of a professional organization.

(d) Is a member of a professional school faculty.

(e) Had, or presently has, privileges at another health care facility or in another practice setting.

(f) Had, or presently has, Privileges at this Hospital.

(g) Is, or is about to become, affiliated in practice with a Practitioner who has, or with a group of Practitioners one or more of who has/have, Medical Staff appointment and/or Privileges at this Hospital.

(h) Contracts with or is employed by the Hospital

2.3 ADDITIONAL CONSIDERATIONS

2.3.1 Any policies, plans, and objectives formulated by the Board concerning the Hospital's current and projected patient care needs and the availability of adequate

facilities, equipment, staffing, and financial resources may also be considered by the applicable Medical Staff and Board authorities in making recommendations or taking action on new applications for Clinical Privileges and requests for additional Clinical Privileges during a current Privilege period.

2.4 NONDISCRIMINATION

2.4.1 No APP shall be denied Privileges on the basis of: race; color; sex (including pregnancy); sexual orientation; gender identity; gender expression; transgender status; age (40 and older); religion; marital, familial, or health status; national origin; ancestry; disability (provided that the APP can competently exercise the Privileges requested with or without a reasonable accommodation); genetic information; veteran or military status; or any other characteristic(s) or class protected by applicable law.

2.5 APPLICATION CONTENT

2.5.1 Each APP applicant must furnish complete information including, but not limited to:

(a) Professional school/postgraduate education and training including the name of each institution attended, degrees granted, programs completed, dates attended, and, for postgraduate training, names of Practitioners/APPs responsible for monitoring the applicant's performance.

(b) All past and current professional licenses (or other credentials required by Ohio law to practice his/her respective profession) and current, valid prescriber number and Drug Enforcement Administration ("DEA") registration (to the extent required for the Privileges requested) with the issued and expiration dates and numbers of each.

(c) Evidence of participation in continuing education activities at the level required by the applicant's licensing board. The Hospital, in its discretion, has the right to audit and verify the applicant's participation in any such continuing education activities at any time.

(d) Board certification and recertification, if applicable (*e.g.*, national nursing specialty certification for advanced practice registered nurses, *etc.*)

(e) Ability to fully and competently exercise the Clinical Privileges requested, with or without a reasonable accommodation.

(f) <u>For initial applicants</u>: Professional Liability Insurance coverage and information on professional liability claims history and experience (suits filed, pending, or settled) including the names and addresses of present and past insurance carriers for the last ten (10) years.

For regrant of Privileges: Professional Liability Insurance coverage and information on professional liability cases filed, pending, or settled (final disposition) since the last regrant cycle.

(g) All proposed, pending, and completed actions whether voluntary (while under investigation or to avoid investigation for conduct or clinical competency concerns) or involuntary related to, as applicable: denial, revocation/termination, suspension, reduction, limitation, probation, withdrawal, and/or any non-renewal, relinquishment, or resignation of a:

(i) License or other credentials required to practice any health-related profession in any state or country.

(ii) Prescriber number; DEA or state-controlled substances registration.

(iii) Membership or fellowship in local, state, or national health or scientific professional organizations.

(iv) Faculty appointment at any professional school.

(v) Employment status or clinical privileges at any other hospital, clinic, or health care entity or organization.

(vi) Professional Liability Insurance.

(vii) Board certification/recertification.

(viii) Participation in any Federal Healthcare Program.

(h) Chronological professional work history including, but not limited to, location of offices; names and contact information (*e.g.,* email addresses, *etc.*) for other APPs and Practitioners with whom the applicant is or was associated and inclusive dates of such associations; names, locations, and contact information for all other hospitals, clinics, or health care organizations where or through which the applicant provides or provided clinical services with the inclusive dates of each affiliation, status held, and general scope of clinical privileges or services provided. A minimum of the most recent seven (7) years of work history as a health professional shall be obtained through the APP's application. If the applicant is a new graduate and has fewer than seven (7) years of work history at the time of application, the APP shall provide his/her professional work history from the initial date of licensure.

(i) Clinical Privileges requested at Hospital.

(j) Any current, past, or pending criminal convictions (other than minor traffic/motor vehicle violations) and resolution.

(k) Peer references:

(i) The application must include the names of at least two (2) Practitioners or APPs who have had recent extensive experience in observing and working with the applicant and who can provide adequate information pertaining to the applicant's present professional conduct, clinical competence, and character.

(ii) One (1) such reference must be from a Practitioner who has had organizational responsibility for supervision of the applicant's performance (*e.g.*, department chair, service chief, training program supervisor, supervising or collaborating Practitioner, *etc.*).

(iii) One (1) such reference must be from an APP who is in the same professional discipline/specialty as the applicant.

(iv) References may not come from the applicant's family members.

(v) Peer recommendations shall include information regarding the applicant's medical/clinical knowledge, technical/clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. Peer recommendations may be in the form of written documentation reflecting informed opinions on the applicant's scope and level of performance or a written peer evaluation of APP-specific data collected from various sources for the purpose of validating current competence.

(l) Information as to whether the applicant has been the subject of investigation by a Federal Healthcare Program and, if so, the outcome of such investigation.

(m) Information required by applicable conflict of interest policies.

(n) Documentation of compliance with state and/or federal vaccination requirements or an exemption thereto.

(o) The name of the PA's or APRN's supervising or collaborating Practitioner with Medical Staff appointment and Privileges at the Hospital.

(p) A copy of the current, valid standard care arrangement (for CNPs, CNSs, and CNMs) or supervision agreement (for PAs) and any amendments thereto.

(q) Such other information as may be required by the application.

2.5.2 Applicants for Privileges shall complete a criminal background check.

2.6 EFFECT OF APPLICATION

2.6.1 The APP applicant must sign the application and in so doing:

(a) Attests that all information furnished is correct and complete and acknowledges that any material misstatement in, or omission from, the application constitutes grounds for denial of Privileges or for termination of Privileges.

(b) Signifies his/her willingness to be interviewed in connection with his/her application.

(c) Acknowledges receiving access to the APP Policy, other applicable Medical Staff Policies, and the Medical Staff Rules & Regulations and agrees to abide by the Medical Staff governing documents, as well as applicable System/Hospital policies, if granted Clinical Privileges at the Hospital and in all matters relating to consideration of the application without regard to whether or not Privileges are granted.

(d) Agrees to fulfill his/her obligations including, but not limited to, maintaining an ethical practice and providing continuous care to his/her patients.

(e) Agrees to notify the Medical Staff Services Department immediately if any information contained in the application changes. The foregoing obligation shall be a continuing obligation of the applicant so long as he/she has Privileges at the Hospital.

(f) Understands and agrees that if requested Privileges are denied based upon the applicant's clinical competence or conduct, the applicant may be subject to reporting to the National Practitioner Data Bank and/or state authorities.

(g) Agrees that if an Adverse recommendation or action is made/taken with respect to his/her application for Privileges or his/her current Privileges, the applicant will exhaust the administrative remedies afforded by Article 8 of this APP Policy before resorting to formal legal action.

(h) Acknowledges and agrees to the provisions set forth in Article 9 regarding authorization to obtain and release information, confidentiality of information, immunity for reviews, release of liability, and the right to secure releases for obtaining and sharing information.

(i) Acknowledges that the Hospital and Affiliate Hospitals are part of a System and that information is shared within the System. As a condition of granting Privileges, the applicant recognizes and understands that any and all information relative to his/her Privileges may be shared between the Hospital and Affiliate Hospitals including peer review that is maintained, received, and/or generated by any of them. The applicant further

understands that this information may be used as part of the respective Hospital's/Affiliate Hospital's quality assessment and improvement activities and can form the basis for corrective action.

2.7 PROCESSING THE APPLICATION

2.7.1 APPLICANT'S BURDEN AND PROOF OF IDENTITY

(a) Applicant's Burden

(i) The applicant has the burden of producing adequate information for a proper evaluation of his/her qualifications for Privileges, of resolving any doubts about such qualifications, and of satisfying requests for additional information or clarification made by appropriate Medical Staff or Hospital authorities.

(ii) Failure, without good cause, by an applicant to respond to a request for additional information regarding his/her pending application within ninety (90) days following written request therefore may be deemed a voluntary withdrawal of the application.

(b) Proof of Identity

(i) The applicant must provide a copy of a current valid government-issued photo identification (*e.g.* driver's license or passport) to verify that the applicant is, in fact, the individual requesting Privileges.

2.7.2 VERIFICATION OF INFORMATION

(a) The Medical Staff Services Department will coordinate the collection and verification of information regarding pending applications for Privileges consistent with this APP Policy and applicable laws, rules, regulations, and accreditation standards.

(b) Action on the applicant's application will not be taken until the required information is available and verified by the Medical Staff Services Department.

(c) If problems are encountered in obtaining the required information, the Medical Staff Services Department shall notify the applicant, in writing, indicating the nature of the problem and what additional information the applicant must provide in accordance with the time period set forth in §2.7.1 (a)(ii).

(d) A National Practitioner Data Bank query shall be conducted by the Medical Staff Services Department on all applicants at the time of initial request for Privileges, upon regrant of Privileges, and when an APP requests additional

Privileges during a current Privilege period. The Medical Staff Services Department shall also conduct an NPDB query each time an APP applies for temporary Privileges. The NPDB continuous query process may be used.

(e) The Medical Staff Services Department (or the Hospital's compliance staff) shall also query the Office of Inspector General's Cumulative Sanction report, the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, and any other appropriate sources to determine whether the applicant has been convicted of a health care related offense, or debarred, excluded, precluded, or otherwise made ineligible from/for participation in a Federal Healthcare Program.

(f) A complete application is one for which all requested information has been received and for which all such information has been verified as provided in this section.

(g) When the application is complete and collection and verification is accomplished, the Medical Staff Services Department shall notify the applicable Department Chair that the applicant's file is available for review.

2.7.3 DEPARTMENT CHAIR EVALUATION

(a) The chair of each Department in which the applicant seeks Privileges shall review the application and accompanying material and forward a written recommendation to the Medical Executive Committee.

(b) The Department Chair may, at his/her discretion, conduct an interview with the applicant. Failure by the applicant, without good cause, to respond to a request for an interview will be deemed a voluntary withdrawal of the application in accordance with §2.7.1 (a)(ii).

(c) The Department Chair may request additional information through the Medical Staff Services Department. Failure by the applicant, without good cause, to respond in a satisfactory manner to a request from the Medical Staff Services Department for additional information will be deemed a voluntary withdrawal of the application in accordance with §2.7.1 (a)(ii).

2.7.4 RECOMMENDATION BY THE MEDICAL EXECUTIVE COMMITTEE

(a) The MEC shall, at its next regular meeting, consider the recommendation of the Department Chair and such other documentation as the MEC deems appropriate.

(b) The MEC may, at its discretion, conduct an interview with the applicant or designate one (1) or more of its members to do so. Failure by the applicant,

without good cause, to respond to a request for an interview will be deemed a voluntary withdrawal of the application in accordance with §2.7.1 (a)(ii).

(c) The MEC may request additional information through the Medical Staff Services Department. Failure by the applicant, without good cause, to respond in a satisfactory manner to a request from the MEC for additional information will be deemed a voluntary withdrawal of the application in accordance with §2.7.1 (a)(ii).

(d) The MEC may table transmitting its recommendation to the Board and note in the MEC minutes the request for additional information and/or deferral and the reason(s) therefore.

(e) Upon completion of its review, the MEC may take any of the following actions (which may be set forth in the MEC's meeting minutes):

(i) Deferral: A decision by the MEC to defer (*i.e.*, to table) the application for further consideration must be revisited at the next regularly scheduled meeting, except for good cause, at which point the MEC shall issue its recommendation as to approval or denial of the requested Privileges.

(ii) Favorable Recommended Action: An MEC recommendation to grant the requested Privileges is forwarded to the Board for action.

(iii) Adverse Recommended Action: When the recommendation of the MEC is to deny the requested Privileges, the Chief of Staff shall promptly provide the applicant Special Notice of the Adverse recommendation and the applicant shall be entitled, if applicable, to the procedural due process rights set forth in Article 8 upon proper and timely request therefore. No such Adverse recommendation shall be forwarded to the Board until after the applicant has exercised or has been deemed to have waived his or her procedural due process rights, if any, as provided for in Article 8.

2.7.5 BOARD ACTION

(a) The Board shall, at its next regular meeting, consider the recommendation of the MEC and such other documentation as the Board deems appropriate

(b) The Board may refer the application back to the MEC for additional information and/or table the Board's decision on the application and note in the Board minutes the referral/deferral and the grounds therefore.

(c) Upon completion of its review, the Board may take any of the following actions:

(i) On Favorable MEC Recommendation: The Board may adopt or reject, in whole or in part, an MEC recommendation to grant the requested Privileges or refer the application back to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent MEC recommendation must be made to the Board.

a) If the Board's decision is favorable to the applicant, the action shall be effective as its final decision.

b) If the Board's decision is Adverse to the applicant, the System CEO or Hospital President shall so notify the applicant, by Special Notice, and the applicant shall be entitled, if applicable, to the procedural due process rights provided for in Article 8 upon proper and timely request therefore. Such Adverse decision shall be held in abeyance until the applicant has exercised or been deemed to have waived his/her procedural due process rights, if any, under Article 8. The fact that the Adverse decision is held in abeyance shall not be deemed to confer Privileges where none existed before.

(ii) Without Benefit of Medical Executive Committee Recommendation: If the Board, in its determination, does not receive a recommendation from the MEC within an appropriate time frame, the Board may, after notifying the MEC of the Board's intent and providing a reasonable period of time for response by the MEC, take action on its own initiative employing the same type of information usually considered by the Medical Staff authorities.

a) If the Board's decision is favorable to the applicant, the Board action shall be effective as its final decision.

b) If the Board's decision is Adverse to the applicant, the System CEO or Hospital President shall inform the applicant, by Special Notice, and the applicant shall be entitled, if applicable, to the procedural due process rights provided for in Article 8. Such Adverse decision shall be held in abeyance until the applicant has exercised or been deemed to have waived his/her procedural due process rights, if any, under Article 8. The fact that the Adverse decision is held in abeyance shall not be deemed to confer Privileges where none existed before.

(iii) Adverse MEC Recommendation: If the Board is to receive an Adverse MEC recommendation, the Chief of Staff shall withhold the recommendation and not forward it to the Board until after the

applicant either exercises or waives his/her right, if any, to the procedural due process rights set forth in Article 8. The Board shall thereafter take final action in the matter as provided for in this APP Policy.

(d) Joint Conference Committee Review: Whenever the Board's proposed decision is contrary to the recommendation of the MEC, there shall be a further review of the recommendation by the Joint Conference Committee. This committee shall, after due consideration, make its written recommendation to the Board within fifteen (15) days after referral to the committee. Thereafter, the Board may act. Such action by the Board may include accepting, rejecting, or modifying, in whole or in part, the recommendation of the Joint Conference Committee.

2.7.6 NOTICE OF FINAL DECISION

(a) Written notice of the Board's final decision shall be provided to the applicant. Appropriate Hospital and Medical Staff leaders shall also be notified.

(b) A decision and notice to grant Privileges includes, as applicable (1) the Department to which the APP is assigned; (2) the Clinical Privileges he/she may exercise; and (3) any special conditions attached to the Privileges.

2.7.7 TIME PERIODS FOR PROCESSING

(a) The time periods set forth below are guidelines only and are not directives such as to create any right for an applicant to have an application processed within these precise periods.

(b) All individuals and groups required to act on an application for Privileges should do so in a timely and good faith manner and, except for obtaining additional information or for other good cause, within:

INDIVIDUAL/GROUP	TIME
Department Chair	Within 30 days after receiving notice from the Medical Staff Services Department of the availability of a complete and verified application.
Medical Executive	Next regular meeting after receiving a report from the Department Chair.
Board	Next regular meeting after receiving a recommendation from the MEC.

(c) If additional information is needed from the applicant, the time awaiting a response from the applicant shall not count towards the applicable time period guideline.

(d) If the provisions of Article 8 are activated, the time requirements provided therein govern the continued processing of the application

(e) If action does not occur at a particular step in the process and the delay is without good cause, the next higher authority may immediately proceed to consider the application and accompanying material or may be directed by the Chief of Staff (on behalf of the MEC) or by the System CEO or Hospital President (on behalf of the Board) to so proceed.

2.8 TERM OF GRANT/REGRANT OF PRIVILEGES

2.8.1 The granting/regranting of Clinical Privileges is for a period of up to three (3) years.

2.8.2 A grant/regrant of Privileges of less than three (3) years shall not be deemed Adverse for purposes of Article 8.

2.9 COMPLETION OF TRIHEALTH CONNECT TRAINING & ACTIVATION OF CLINICAL PRIVILEGES

2.9.1 Completion of TriHealth Connect training is a prerequisite to access to the electronic medical record system and exercise of Clinical Privileges.

2.9.2 Failure to complete TriHealth Connect training within ninety (90) days after Board approval of Clinical Privileges shall be deemed to be an automatic suspension of the APP's Clinical Privileges pursuant to this APP Policy until such training is successfully completed.

ARTICLE 3 PROCESSING APPLICATIONS FOR REGRANT OF PRIVILEGES

3.1 INFORMATION COLLECTION AND VERIFICATION

3.1.1 FROM APP

(a) Prior to the expiration date of an APP's current Privilege period, the APP shall be notified of such date and sent a Hospital-approved application to complete for regrant of Privileges. The APP shall furnish, in writing, on the application for regrant of Privileges:

(i) Complete information as set forth in Section 2.5 of this Policy to bring his/her file current and to demonstrate continued satisfaction of the qualifications for Clinical Privileges set forth in Section 1.4 of this APP Policy and the applicable Privilege set.

(ii) Attestation of continuing education external to the Hospital during the preceding Privilege period necessary to comply with state licensure requirements.

(iii) A request, if any, for additions to or deletions from the Clinical Privileges presently held.

(b) The APP must sign the application for regrant of Privileges and in so doing accepts the same conditions as set forth in Section 2.6 in connection with the initial application.

3.1.2 ADDITIONAL INFORMATION FROM INTERNAL SOURCES

(a) In addition to the information set forth in Sections 1.4 and 2.5, the following information shall be considered in conjunction with an APP's request for regrant of Privileges:

(i) Focused and ongoing professional practice evaluation data

(ii) Patterns of care and utilization as demonstrated in the findings of APP quality review, risk management, and utilization review activities.

(iii) Any sanctions imposed or pending.

(iv) Ability to fully and competently carry out the Clinical Privileges requested with or without a reasonable accommodation.

(v) Fulfillment of applicable APP responsibilities.

(vi) Timely and accurate completion of medical records.

(vii) Cooperativeness in working with other APPs, Practitioners, and Hospital personnel.

(viii) General attitude toward patients and the Hospital.

(ix) Compliance with this APP Policy, other applicable Medical Staff Policies, the Medical Staff Rules & Regulations and applicable System/Hospital policies/procedures.

(x) Any other pertinent information that may be relevant to the APP's regrant of Privileges at the Hospital.

3.1.3 APP'S BURDEN

(a) The APP has the burden of producing adequate information for a proper evaluation of his/her qualifications for regrant of Privileges, of resolving any doubts about such qualifications, and of satisfying requests for additional information or clarification made by appropriate Medical Staff or Hospital authorities.

(i) Failure to return the application for regrant of Privileges by the expiration date of the APP's current Privilege period is deemed a voluntary resignation and results in automatic termination of the APP's Privileges at the expiration of the APP's current Privilege term. For any future consideration for Privileges, the APP must submit a new, complete application for Privileges including application fee.

(ii) If an application for regrant of Privileges has not been fully processed by the expiration date of the APP's current Privilege period, the APP's Privileges shall terminate as of the last date of his/her current Privilege period.

(iii) If the APP qualifies, he/she may be granted temporary Privileges to meet an important patient care need pursuant to §4.4-2 (b) of this Policy.

(b) If the APP's level of clinical activity at the Hospital is not sufficient to permit the applicable Medical Staff and Board authorities to make an informed judgment as to his/her current competence in exercising the Clinical Privileges requested, the APP shall have the burden of providing supplemental documentation of clinical performance at his/her principal institution in such form as may be required by said authorities (*e.g.*, additional peer recommendations, *etc.*).

3.1.4 VERIFICATION

(a) The Medical Staff Services Department verifies the information provided on the application for regrant of Privileges working with the same authorities and generally in the same manner, to the extent applicable, as provided for in the initial application process set forth in §2.7.2.

(b) When the application is complete and collection and verification is accomplished, the Medical Staff Services Department shall notify the applicable Department Chair that the applicant's file is available for review.

3.1.5 REVIEW AND ACTION

(a) Applications for regrant of Privileges shall be reviewed and acted upon in accordance with the procedure set forth in §2.7-3 through §2.7-6 of this Policy.

(b) For purposes of regrant of Privileges, the terms "applicant" and "Privileges" as used in §2.7-3 through §2.7-6 of this Policy shall be read, as "APP" and "regrant of Privileges," respectively.

(c) All individuals and groups required to act on an application for regrant of Privileges must do so in a timely and good faith manner.

3.2 REQUESTS FOR MODIFICATION OF CLINICAL PRIVILEGES

3.2.1 An APP may, either in connection with regrant of Privileges or at any other time, request modification of his/her Clinical Privileges by submitting a written request to the Medical Staff Services Department.

3.2.2 Requests for new/additional Privileges during a current Privilege period will require evidence of appropriate education, training, and experience supportive of the request and will be subject to initial FPPE if granted.

3.2.3 A modification request shall be processed in substantially the same manner as an application for regrant of Privileges.

ARTICLE 4 ADOPTION AND AMENDMENT OF PRIVILEGE SETS; TEMPORARY, DISASTER, EMERGENCY, & TELEMEDICINE PRIVILEGES

4.1 ADOPTION AND AMENDMENT OF PRIVILEGE SETS

4.1.1 Privilege sets may be adopted and amended following review by the applicable Department Chair, recommendation of the MEC, and approval by the Board.

4.2 RECOGNITION OF NEW SERVICE/PROCEDURE

4.2.1 Considerations. The Board shall determine the Hospital's scope of patient care services based upon recommendations from the Medical Executive Committee. Overall considerations for establishing new services and procedures include, but are not limited to:

(a) The Hospital's available resources and staff.

(b) The Hospital's ability to appropriately monitor and review the competence of the performing Practitioner(s)/APP(s).

(c) The availability of other qualified Practitioners/APPs with Privileges at the Hospital to provide coverage for the service or procedure when needed.

(d) The quality and availability of training programs.

(e) Whether such service or procedure currently, or in the future, would be more appropriately provided through a contractual arrangement with the Hospital.

(f) Whether there is a community need for the service or procedure.

4.2.2 Privilege Requests for a New Service or Procedure. Requests for Privileges for a new service or procedure that has not yet been recognized by the Board shall be processed as follows:

(a) The APP must submit a written Privilege request for a new service or procedure to the Medical Staff Services Department. The request should include a description of the Privileges being requested, the reason why the APP believes the Hospital should recognize such Privileges, and any additional information that the APP believes may be of assistance in evaluating the request.

(b) The Medical Staff Services Department will notify the applicable Department Chair of such request.

(i) If the Department Chair determines that the service or procedure should not be recognized at the Hospital, the Department Chair will provide the basis for his/her recommendation to the MEC.

(ii) If the Department Chair determines that the service or procedure should be included in an existing Privilege set, the Department Chair will provide the basis for his/her recommendation to the MEC.

(iii) If the Department Chair determines that the new Privileges should be recognized at the Hospital and that a new Privilege set is required, the applicable Department shall develop and submit to the MEC a new Privilege set based upon:

a) A determination as to what specialties are likely to request the Privileges.

b) The positions of specialty societies, certifying boards, *etc.*

c) The available training programs.

d) Recommended standards to be met with respect to the following: education; training; board certification; experience; and initial FPPE requirements to establish current clinical competency.

e) Criteria required by other hospitals with similar resources and staffing.

(c) Upon receipt of a recommendation from the Department Chair, the MEC shall review the matter and forward its recommendation to the Board.

(d) The recommendation of the MEC, whether favorable or not favorable, will be reviewed and acted upon by the Board.

(i) If the Board approves the new Privilege set, the requesting APP(s) may apply for such Privilege(s) consistent with the process set forth in Section 2.7 of this Policy.

(ii) If the Board does not approve the new Privilege set, the requesting APP(s) shall be so notified. A decision by the Board not to recognize a new service or procedure does not give rise to the procedural due process rights provided in Article 8.

4.3 PRIVILEGING PROCEDURE

4.3.1 Each application must contain a request for the specific Clinical Privileges desired by the APP.

4.3.2 Except as otherwise provided in this Article, a request for Clinical Privileges is processed according to the procedures outlined in Section 2.7 or Section 3.1, as applicable.

(a) Requests for temporary Privileges are processed according to Section 4.4 of this Policy.

(b) Requests for disaster Privileges are processed according to Section 4.6 of this Policy.

(c) Requests for telemedicine Privileges are processed according to Section 4.7 of this Policy.

4.4 TEMPORARY PRIVILEGES

4.4.1 CONDITIONS

Temporary Privileges may be granted only in the circumstances and under the conditions described in §4.4.2. Special requirements of consultation and reporting may be imposed by the applicable Department Chair. Under all circumstances, the APP requesting temporary Privileges shall agree to abide by this Policy, other applicable Medical Staff Policies, the Medical Staff Rules & Regulations, and applicable System/Hospital policies in all matters relating to his/her activities in the Hospital.

4.4.2 GROUNDS

Temporary Clinical Privileges may be granted on a case-by-case basis in the following circumstances:

(a) Pendency of a Completed Application: Temporary Privileges may be granted by the System CEO (or the Hospital President, Chief Medical Officer, or Associate CMO as the System CEO's designee) to applicants for new Privileges awaiting application review and action by the MEC and Board upon satisfaction of the following:

(i) Receipt of a written request from the applicant for such temporary Privileges.

(ii) Receipt of a complete application that raises no concerns.

(iii) Review and verification of the information set forth in Section 1.4 and Section 2.5 of this Policy.

(iv) Completion of a query and evaluation of the National Practitioner Data Bank information and such other queries as required by Section 2.7.2 of this Policy.

(v) Confirmation that the applicant has no current or previously successful challenges to his/her licensure or registration.

(vi) Confirmation that the applicant has not been subject to the involuntary limitation, reduction, denial, or loss of his/her clinical privileges.

(vii) Review of the pending application by, and written recommendation from, the applicable Department Chair (as the Chief of Staff's designee.

Applicants for new Privileges include an APP applying for Privileges at the Hospital for the first time; an APP currently holding Privileges who is requesting one or more additional Privileges during his/her current Privilege period; and an APP who is in the regrant process and is requesting one or more additional Privileges.

Temporary Privileges may be granted in this circumstance for a period not to exceed the pendency of the application (*i.e.*, completion of review and action on the application by the MEC and Board) or one hundred twenty (120) days whichever is less. Under no circumstances may temporary Privileges be granted if the application is pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

(b) Important Patient Care Need

(i) Temporary Privileges may be granted to an APP to meet an important patient care need including, but not limited to:

a) Care of a specific patient(s) or group of patients.

b) When necessary to prevent a lack or lapse of services in a needed specialty area.

c) For an APP who temporarily comes to the Hospital to learn (be proctored on) or to teach (proctor) a procedure.

d) An APP who seeks to act in the capacity of a *locum tenens*.

(ii) Temporary Privileges for an important patient care need may be granted by the System CEO (or the Hospital President, Chief Medical Officer, or Associate CMO as the System CEO's designee) upon written recommendation of the applicable Department Chair (as the Chief of Staff's designee) and satisfaction of the following:

a) Receipt of a written request from the APP for the specific temporary Clinical Privileges desired.

b) Verification of the APP's:

1) Current licensure.

2) Current competence relative to the Privileges being requested (*e.g.,* a fully positive written or documented oral reference specific to the APP's current competence with respect to the Clinical Privileges being requested from a responsible medical staff authority (*e.g.,* department/section leader, *etc*.)) at the APP's current principal hospital affiliation).

3) DEA registration if applicable to the Privileges requested.

4) Professional Liability Insurance.

5) The PA's or APRN's supervising or collaborating Practitioner who must have Medical Staff appointment and Privileges at the Hospital.

c) Completion of a query and evaluation of the National Practitioner Data Bank information and such other queries as required by §2.7-2 of this Policy.

d) Receipt of a copy of the current, valid standard care arrangement (for CNPs, CNSs, and CNMs) or supervision agreement (for PAs) and any amendments thereto.

(iii) Temporary Clinical Privileges may be granted in this circumstance for an initial period of up to thirty (30) days and may be regranted, as necessary, for additional periods of up to thirty (30) days not to exceed a total period of ninety (90) days after which the APP must apply for traditional Privileges at the Hospital.

4.5 EMERGENCY PRIVILEGES

4.5.1 In case of an emergency, as defined below, any APP is authorized and shall be assisted to render care, treatment, and/or services to attempt to save a patient's life, or to save a patient from serious/permanent harm, as permitted within the scope of the APP's license and notwithstanding the APP's Clinical Privileges. An APP exercising emergency Privileges must obtain all consultative assistance deemed necessary and arrange for appropriate post-emergency care. When the emergency situation no longer exists, such APP must request the Privileges necessary to continue to treat the patient. In the event such Privileges are denied or are not requested, the patient shall be assigned by the Chief of Staff to a Medical Staff Member with appropriate Clinical Privileges.

4.5.2 For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger.

4.5.3 Emergency Privileges shall automatically terminate upon alleviation of the emergency situation. An APP who exercises emergency Privileges shall not be entitled to the procedural due process rights set forth in Article 8.

4.6 DISASTER PRIVILEGES

4.6.1 Disaster Privileges may be granted to volunteer APPs (subject to applicable Ohio licensure laws, rules, and regulations) when the Hospital's emergency management plan has been activated and the Hospital is unable to meet immediate patient needs.

4.6.2 The on-call Associate Chief Medical Officer, System Chief Medical Officer, System CEO, Hospital President, or Chief of Staff may grant such disaster Privileges on a case-by-case basis after verification of a valid government-issued photo identification (*e.g.,* driver's license or passport) and at least one of the following:

(a) A current license to practice.

(b) Primary source verification of the license.

(c) A current hospital photo identification card that clearly identifies professional designation.

(d) Identification indicating the individual is a member of a Disaster Medical Assistance Team ("DMAT"), the Medical Reserve Corps. ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP"), or other recognized state or federal response organization or group.

(e) Identification indicating the individual has been granted authority to render patient care, treatment, or services in disaster circumstances by a government agency.

(f) Confirmation of the identity of the volunteer APP and his/her qualifications by a Hospital employee or Practitioner or APP with Privileges at the Hospital.

4.6.3 Unless otherwise provided by applicable Ohio licensure laws, rules, and regulations, the volunteer PA or APRN shall also provide the name of his/her collaborating or supervising Practitioner(s), as applicable, (who must also apply for and be granted disaster Privileges at the Hospital in order for the volunteer PA or APRN to be granted disaster Privileges) along with a copy of a current, valid supervision agreement (for PAs) or standard care arrangement (for CNPs, CNSs, and CNMs).

4.6.4 Primary source verification of licensure will begin as soon as the immediate situation is under control or within 72 hours from the time the volunteer APP presents to the Hospital, whichever comes first. Under extraordinary circumstances where primary source verification cannot be completed within 72 hours (due to, for example, no means of communication or lack of resources), the Medical Staff Services Department shall document the following:

(a) Why primary source verification could not be performed in the required time frame.

(b) Evidence of the volunteer APP's demonstrated ability to provide adequate care, treatment, and services.

(c) An attempt to rectify the situation as soon as possible.

4.6.5 Primary source verification of licensure is not required if the volunteer APP has not provided care, treatment, or services under the disaster Privileges.

4.6.6 It is anticipated that disaster Privileges may be granted to state-wide and out-of-state volunteer APPs, as necessary, in accordance with applicable Ohio licensure laws, rules, and regulations.

4.6.7 All volunteer APPs who receive disaster Privileges must, at all times while at the Hospital, wear a photo identification badge from the facility at which they otherwise hold Privileges. If a volunteer APP does not have such identification, he/she will be issued a temporary badge by the Hospital Security Department identifying him/her and designating the APP as a volunteer APP disaster care provider.

4.6.8 The professional performance of volunteer APPs who receive disaster Privileges shall be managed by and under the direct observation of an APP and/or Medical Staff Member with Privileges appropriate to the volunteer APP's specialty assigned by the applicable Department Chair. The Department Chair shall be responsible for selecting an appropriate method of clinical oversight. Based upon such oversight, the on-call Associate Chief Medical Officer, System Chief Medical Officer, System CEO, Hospital President, or Chief of Staff, in consultation with the applicable Department Chair, will make a decision within 72 hours after the volunteer APP's arrival at the Hospital, based upon information obtained regarding the professional practice of the volunteer APP, as to whether to authorize continued exercise of the disaster Privileges initially granted.

4.6.9 Disaster Privileges shall cease upon alleviation of the circumstances of disaster as determined by the System CEO or Hospital President.

4.7 TELEMEDICINE PRIVILEGES

4.7.1 Section 4.7 applies to distant site telemedicine APPs who will not practice on-site at the Hospital.

4.7.2 APPs who are responsible for a patient's care, treatment, or services via a telemedicine link shall be credentialed and privileged to do so by the Hospital in accordance with this Policy, accreditation standards, and applicable laws, rules, and regulations. If the Hospital has a pressing clinical need and the distant site APP can supply that service through a telemedicine link, the APP may be evaluated for temporary Privileges in accordance with the procedures set forth in §4.4. Distant site APPs providing telemedicine services to Hospital patients shall be credentialed and privileged to do so through one of the following mechanisms:

(a) The distant site APP is credentialed and privileged by the Hospital in accordance with the routine credentialing and privileging procedure set forth in Article 2 or 3 of this Policy, as applicable; OR,

(b) The distant site APP is credentialed and privileged by the Hospital in accordance with the routine credentialing and privileging procedure set forth in Article 2 or 3 of this Policy, as applicable, with the exception that the credentialing information and/or privileging decision from the distant site may be relied upon by the Hospital Medical Staff and Board in making its telemedicine privileging recommendations/decision regarding each distant site APP provided that the Hospital has entered into a written agreement with the distant site and all of the following requirements are met:

(i) The distant site is a Medicare-participating hospital; **OR**, a facility that qualifies as a "distant site telemedicine entity." A "distant site telemedicine entity" is defined as an entity that (1) provides telemedicine services, (2) is not a Medicare-participating hospital, and (3) provides contracted services in a manner that enables hospitals using its services to meet all applicable conditions of participation, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of the hospital.

a) When the distant site is a Medicare-participating hospital, the written agreement shall specify that it is the responsibility of the distant site hospital to meet the credentialing requirements of 42 C.F.R. 482.12 (a)(1)-(a)(7), as that provision may be amended from time to time, with regard to the distant site hospital APPs providing telemedicine services.

b) When the distant site is a "distant site telemedicine entity" the written agreement shall specify that the distant site telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services

including, but not limited to, 42 C.F.R. 482.12 (a)(1)-(a)(7) with regard to the distant site telemedicine entity APPs providing telemedicine services. The written agreement shall further specify that the distant site telemedicine entity's medical staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 C.F.R. 482.12 (a)(1)-(a)(7) and at 42 C.F.R. 482.22 (a)(1)-(a)(2), as those provisions may be amended from time to time.

(ii) The distant site is TJC accredited.

(iii) Each distant site APP is privileged at the distant site for those services to be provided to Hospital patients via telemedicine link; and, the Hospital is provided with a current list of each such APP's privileges at the distant site.

(iv) Each distant site APP holds a license issued by the appropriate licensing entity in the state in which the Hospital whose patients are receiving the telemedicine services is located in addition to meeting the licensing standards, as applicable, in the State in which the APP is located.

(v) The Hospital maintains documentation of its internal review of the performance of each distant site APP and sends the distant site such performance information for use in the distant site's periodic appraisal of each such distant site APP. At a minimum, this information must include:

a) All adverse events that result from the telemedicine services provided by a distant site APP to Hospital patients.

b) All complaints the Hospital receives about a distant site APP.

4.8 TERMINATION OF TEMPORARY, DISASTER, OR TELEMEDICINE PRIVILEGES

4.8.1 TERMINATION

The System CEO, the System Chief Medical Officer, an Associate Chief Medical Officer, the Hospital President, or the Chief of Staff may, at any time, terminate any or all of an APP's temporary, disaster, or telemedicine Privileges. Where the life or well-being of a patient is determined to be endangered, the APP's Privileges may be terminated by any person entitled to impose a summary suspension pursuant to this APP Policy.

4.8.2 PROCEDURAL DUE PROCESS RIGHTS

An APP who has been granted temporary, disaster, or telemedicine Privileges is not a Medical Staff Member and is not entitled to the procedural due process rights afforded to Medical Staff Members. An APP shall not be entitled to the procedural due process rights set forth in this Policy because the APP's request for temporary, disaster, or telemedicine Privileges are refused, in whole or in part, or because all or any portion of such Privileges are terminated, not renewed, restricted, suspended, or otherwise limited, modified, or monitored in any way.

4.8.3 PATIENT CARE

In the event an APP's Privileges are revoked, the APP's patients then in the Hospital shall be assigned to another APP or Practitioner with appropriate Privileges by the applicable Department Chair. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner/APP.

4.9 PROFESSIONAL PRACTICE EVALUATION

4.9.1 FOCUSED PROFESSIONAL PRACTICE EVALUATION

The Medical Staff's FPPE process is set forth in detail in the Medical Staff Peer Review/Professional Practice Evaluation Policy. FPPE shall be implemented for all: (a) APPs requesting initial Privileges; (b) existing APPs requesting new Privileges during the course of a Privilege period; and (c) in response to concerns regarding an APP's ability to provide safe, high quality patient care. The FPPE period shall be used to determine the APP's current clinical competence and ability to perform the requested Privileges.

4.9.2 ONGOING PROFESSIONAL PRACTICE EVALUATION

Upon conclusion of the FPPE period, OPPE shall be conducted on all APPs with Privileges at the Hospital. The Medical Staff's OPPE process is set forth, in detail, in the Medical Staff Peer Review/Professional Practice Evaluation Policy and requires the Hospital/Medical Staff to gather, maintain, and review data on the performance of all APPs with Privileges on an ongoing basis.

ARTICLE 5 LEAVES OF ABSENCE

5.1 LEAVE OF ABSENCE PROCEDURE

5.1.1 NOTIFICATION OF A LEAVE

(a) An APP may, for good cause (which may include, but not be limited to, illness, injury, military duty, or educational sabbatical), take a voluntary leave of absence by giving written notice to the Medical Staff Services Department who shall communicate receipt of such notification as appropriate. The notice must state the reason for the leave and the approximate period of time of the leave which may not exceed two (2) years except for military service.

(b) An APP may not take a leave of absence to avoid fulfilling an APP obligation.

(c) The Medical Executive Committee may decline a leave of absence in the event that such leave does not satisfy the criteria set forth in Section 5.1-1 (a)/(b). The decision of the Medical Executive Committee is final without right to appeal.

(d) In the event that a leave of absence extends beyond the final date of the APP's current Privilege period:

(i) The APP's Privileges will terminate at the end of the current Privilege period. The APP may not apply for a regrant of Privileges during a leave.

(ii) The APP may apply for a new grant of Privileges at such time as the APP is able to return to practice.

(e) During the period of the leave, the APP's Clinical Privileges and responsibilities shall be inactive.

(f) Prior to taking a leave of absence, the APP shall have made arrangements for the care of his/her patients during the leave.

(g) In order to qualify, as applicable, for reinstatement or a grant of new Privileges following a leave of absence, the APP (or his/her employer on the APP's behalf) must maintain Professional Liability Insurance coverage during the leave or purchase tail coverage for all periods during which the APP held Privileges at the Hospital. The APP (or his/her employer on the APP's behalf) shall provide information to demonstrate satisfaction of continuing Professional Liability Insurance or tail coverage as required by this provision upon request for, as applicable, reinstatement or a grant of new Privileges.

5.1.2 RETURN FROM LEAVE

(a) An APP may request, as applicable, reinstatement or a grant of new Privileges by sending a written notice to the Medical Staff Services Department.

(b) The APP must submit a written summary of relevant activities during the leave as well as such additional information (*e.g.*, current license, DEA registration, supervision agreement/standard care arrangement, Professional Liability Insurance, *etc.*) as is reasonably necessary to reflect that the APP is qualified for, as applicable, reinstatement or a grant of new Privileges.

(c) If the absence was due to medical issues, the MEC may request that the APP obtain an impartial physical examination or mental evaluation. Failure to do so, without good cause, shall preclude the APP from, as applicable, being reinstated or granted new Privileges. Fees for such evaluation shall be paid by the Hospital only if the evaluator is chosen by the MEC or its designated agents. In the event the APP chooses the evaluator and the MEC is not satisfied with the report, the MEC may request that the APP obtain a second examination or evaluation by a Practitioner of the MEC's choice.

(d) The MEC may recommend reinstatement of Privileges subject to FPPE to assess current clinical competency upon return from the leave of absence. A grant of new Privileges is subject to initial FPPE.

(e) Once the APP's request for reinstatement or a grant of new Privileges is deemed complete, the procedure set forth in Article 2 or 3 shall, as applicable, be followed in evaluating and acting on such request.

5.1.3 FAILURE TO RETURN FROM LEAVE

(a) If an APP fails to return from a leave of absence, the MEC shall make a recommendation to the Board as to how such failure should be construed.

ARTICLE 6 REAPPLICATION & VOLUNTARY RESIGNATION OF PRIVILEGES

6.1 REAPPLICATION AFTER ADVERSE AND CERTAIN OTHER CREDENTIALING DECISIONS

6.1.1 Except as otherwise provided in this APP Policy or as recommended by the MEC and approved by the Board in light of exceptional circumstances, an APP:

(a) Who has received a final Adverse decision regarding Privileges/regrant of Privileges shall not be eligible to reapply for Privileges for a period of at least two (2) years after the date of the notice of the final Adverse decision or final court decision, whichever is later.

(b) Who has had his/her Privileges automatically terminated pursuant to Section 7.5.1 (a), (b), (d), and (e) of this Policy shall not be eligible to reapply for Privileges for a period of at least two (2) years after the effective date of the automatic termination.

(c) Who has resigned his/her Privileges or fails to seek regrant of Privileges while under investigation or to avoid an investigation for unprofessional conduct or clinical competency concerns shall not be eligible to reapply for Privileges for a period of at least two (2) years after the effective date of the resignation.

(d) Who has withdrawn an initial application for Privileges as a result of unprofessional conduct or clinical competency concerns shall not be eligible to reapply for Privileges for a period of at least two (2) years after the effective date of the withdrawal.

6.1.2 Any such reapplication shall be processed as an initial application, in accordance with the procedure set forth in Article 2, and the APP must submit such additional information as may be reasonably required to demonstrate that the basis of the Adverse decision, automatic termination, resignation, or withdrawal has been resolved or no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be further processed.

6.1.3 No APP may submit or have in process at any given time more than one (1) application for Clinical Privileges.

6.2 VOLUNTARY RESIGNATION OF PRIVILEGES

6.2.1 Resignation of Privileges shall be submitted in writing to the Medical Staff Services Department. Such resignation will take effect on the date set forth in the resignation notice. A resignation should be submitted sufficiently in advance to provide for continuity of patient care and to avoid disruption in patient care services.

Notification of the resignation shall be communicated by the Medical Staff Services Department as appropriate.

6.2.2 An APP who resigns his/her Privileges is obligated to complete all medical records for which he/she is responsible prior to the effective date of the resignation. In the event an APP fails to do so, consideration may be given by the Hospital to contacting the applicable State licensing board regarding the APP's actions.

6.2.3 A request for Privileges subsequently received from an APP who resigns his/her Privileges shall be processed in the manner specified for initial applications for Privileges.

ARTICLE 7 COLLEGIAL INTERVENTION, REMEDIATION, FORMAL CORRECTIVE ACTION, SUMMARY SUSPENSION, & AUTOMATIC SUSPENSION/AUTOMATIC TERMINATION

7.1 COLLEGIAL INTERVENTION & REMEDIATION

7.1.1 COLLEGIAL INTERVENTION

(a) Prior to initiating corrective action against an APP for professional conduct or clinical competency concerns, the Medical Staff leaders or Board (through the System CEO, an Associate CMO, or the Hospital President as its administrative agents) may elect to attempt to resolve the concerns collegially.

7.1.2 REMEDIATION

(a) An appropriately designated Medical Staff peer review committee may enter into a voluntary remedial agreement with an APP, consistent with the applicable Medical Staff Policy, to resolve potential clinical competency or conduct issues.

(b) If the affected APP fails to abide by the terms of an agreed-to remedial agreement, the APP may be subject to the formal corrective action procedure set forth in §7.2.

7.1.3 NO OBLIGATION; DOCUMENTATION OF INTERVENTIONS

(a) Nothing in this Section shall be construed as obligating the Hospital or Medical Staff leadership to engage in collegial intervention or remediation prior to implementing formal corrective action on the basis of a single incident.

(b) A written record of any collegial intervention and/or remediation efforts should be prepared and maintained in the APP's confidential peer review file.

7.2 FORMAL CORRECTIVE ACTION

7.2.1 GROUNDS

(a) Corrective action against an APP may be taken whenever the Member engages in conduct, either within or outside the Hospital, that is or is reasonably likely to be:

(i) Contrary to this APP Policy, other applicable Medical Staff Policies, the Medical Staff Rules & Regulations, or applicable System/Hospital policies or procedures.

(ii) Detrimental to patient safety or to the quality or efficiency of patient care in the Hospital.

(iii) Disruptive to Hospital operations.

(iv) Damaging to the Medical Staff's or the Hospital's reputation.

(v) Unethical or below the applicable standard of care.

7.2.2 REQUEST FOR CORRECTIVE ACTION

(a) Any of the following may request that corrective action be initiated:

(i) An officer of the Medical Staff.

(ii) The chair of any Department in which the APP exercises Privileges.

(iii) Any standing committee of the Medical Staff (including the MEC) or chair thereof.

(iv) The System CEO, Hospital President, System Chief Medical Officer, or an Associate Chief Medical Officer.

(v) The Board or Board chair.

(b) All requests for corrective action shall be submitted to the MEC in writing, which writing may be reflected in minutes. The request must be supported by reference to the specific action(s) that constitute(s) the grounds for the request. In the event the request for corrective action is initiated by the MEC, it shall reflect the basis in its minutes.

(c) The chair of the MEC shall promptly notify the System CEO, the Hospital President, and, as applicable, the System/Associate Chief Medical Officers, in writing, of all requests for corrective action and shall continue to keep them fully informed of all action taken in conjunction therewith.

7.2.3 MEC OPTIONS

(a) Upon receipt of a request for corrective action, the MEC shall act on the request. The MEC may:

(i) Determine that no corrective action is warranted and close the matter.

(ii) Determine that no corrective action is warranted but remand the matter for collegial intervention or remediation/resolution consistent with the applicable Medical Staff governing documents.

(iii) Initiate a formal corrective action investigation.

7.2.4 COMMENCEMENT OF FORMAL CORRECTIVE ACTION INVESTIGATION

(a) A matter shall be deemed to be under formal investigation upon the start of a MEC meeting at which a request for corrective action is being presented.

(b) For the sole purpose of determining whether there is a potential reportable event, the matter will be deemed to be under formal corrective action until the end of the MEC meeting at which the issue is presented; provided, however, that if the MEC determines to proceed with a formal corrective action investigation, the matter shall remain under formal investigation until such time as the MEC rejects the request for corrective action, closes the investigation, or a final decision is rendered by the Board.

(c) The affected APP shall be provided with written notice of a determination by the MEC to initiate a corrective action investigation.

7.2.5 FORMAL CORRECTIVE ACTION INVESTIGATION

(a) The corrective action investigation process does not entitle the APP to the procedural rights provided in Article 8.

(b) The MEC may:

(i) Conduct such investigation itself.

(ii) Assign the task to a Medical Staff officer, Department Chair, the System or an Associate Chief Medical Officer, or a standing or *ad hoc* Medical Staff committee.

(iii) Refer the matter to the Board for investigation and resolution.

(c) The investigating individual/group will proceed with its investigation in a prompt manner. The investigative process may include, without limitation: a meeting with the APP involved who may be given an opportunity to provide information in a manner and upon such terms as the investigating individual/group deems appropriate; with the individual or group who made the request; and/or with other individuals who may have knowledge of or information relevant to the events involved.

(d) If the investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of its investigation, which may be reflected by minutes, to the MEC as soon as is practicable after its receipt of the assignment to investigate. The report should contain such detail as is necessary for the MEC to rely upon it including recommendations for appropriate corrective action, or no action at all, and the basis for such recommendations.

(e) The MEC may, at any time in its discretion and shall at the request of the Board, terminate the investigative process and proceed with action as provided below.

7.2.6 MEC ACTION

(a) As soon as is practicable following completion of its report (which may be reflected by minutes), or receipt of a report from the investigating individual or group, the MEC shall act upon the request for corrective action. The MEC's actions may include, without limitation, the following:

(i) A determination that no corrective action be taken.

(ii) Issuance of a verbal or written warning or a letter of reprimand.

(iii) Imposition of a focused professional practice evaluation period with retrospective review of cases and/or other review of clinical competence or conduct but without a requirement of prior or concurrent consultation or direct supervision.

(iv) Imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the APP's ability to continue to exercise previously exercised Privileges for a period up to fourteen (14) days.

(v) Imposition of a reduction, limitation/restriction, or suspension of all, or any part, of the APP's Privileges for a period up to fourteen (14) days.

(vi) Other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the APP's Privileges for a period up to fourteen (14) days.

(vii) Recommendation of imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the APP's ability to exercise previously exercised Privileges for a period in excess of fourteen (14) days.

(viii) Recommendation of a limitation/restriction, reduction, or suspension of all, or any part, of the APP's Privileges for a period in excess of fourteen (14) days.

(ix) Recommendation of other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the APP's Privileges for a period in excess of fourteen (14) days.

(x) Recommendation of revocation of all, or any part, of the APP's Privileges.

7.2.7 EFFECT OF MEC ACTION

(a) Adverse

(i) When the MEC's recommendation is Adverse (as defined in this APP Policy) to the APP, the Chief of Staff shall inform the APP, by Special Notice, and the APP shall be entitled, upon timely and proper request, to the procedural due process rights contained in this APP Policy. The Chief of Staff shall then hold the Adverse recommendation in abeyance until the APP has exercised or waived his/her procedural due process rights after which the final MEC recommendation, together with all accompanying information, shall be forwarded to the Board.

(b) Referral/Failure to Act

(i) If the MEC (1) refers the matter to the Board; or (2) fails to act on a request for corrective action within an appropriate time as determined by the Board, the Board may proceed with its own investigation or determination as applicable to the circumstances. In the case of (2), the Board shall make such determination after notifying the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC.

a) If the Board's decision is not Adverse to the APP, the action shall be effective as its final decision and the System CEO or Hospital President shall inform the APP of the Board's decision by Special Notice.

b) If the Board's action is Adverse to the APP, the System CEO or Hospital President shall inform the APP, by Special Notice, and the APP shall be entitled, upon timely and proper request, to the procedural due process rights set forth in this APP Policy.

7.2.8 Other Action

The commencement of corrective action procedures against an APP shall not preclude the summary suspension or automatic suspension or automatic termination of all, or any portion, of the APP's Privileges in accordance with the applicable procedures set forth in this Article.

7.3 SUMMARY SUSPENSION

7.3.1 Whenever an APP's conduct is of such a nature as to require immediate action to protect the life of any patient(s) or to reduce the substantial likelihood of imminent danger to the health or safety of any patient, employee, or other person present in

the Hospital, any of the following have the authority to summarily suspend all, or any portion, of the Clinical Privileges of such APP:

(a) Chief of Staff

(b) Applicable Department Chair

(c) MEC

(d) System CEO or Hospital President

(e) System Chief Medical Officer or an Associate Chief Medical Officer

(f) Board or its chair

7.3.2 A summary suspension is effective immediately.

7.3.3 The person(s) or group imposing the summary suspension shall immediately inform the System CEO, Hospital President, and, as applicable, the System/Associate Chief Medical Officers of the suspension. The System CEO or Hospital President shall promptly give Special Notice thereof to the APP.

7.3.4 The Chief of Staff or applicable Department Chair shall assign a suspended APP's patients then in the Hospital to another APP or Practitioner with appropriate Privileges considering the wishes of the patient, where feasible, in selecting such substitute.

7.3.5 As soon as possible, but in no event later than five (5) days after a summary suspension is imposed, the MEC, if it did not impose the summary suspension, shall convene to review the matter and consider the need, if any, for formal corrective action pursuant to §7.2.

7.3.6 The MEC may modify, continue, or terminate a summary suspension provided that the summary suspension was not imposed by the Board (or the System CEO, Hospital President, System CMO, or an Associate CMO).

7.3.7 In the case of a summary suspension imposed by the Board (or the System CEO, Hospital President, System CMO, or an Associate CMO) the MEC shall give its recommendation to the Board as to whether such summary suspension should be modified, continued, or terminated. The Board may accept, modify, or reject the MEC's recommendation.

7.3.8 Not later than fourteen (14) days following the original imposition of the summary suspension, the APP shall be advised, by Special Notice, of the MEC's determination; or, in the case of a summary suspension imposed by the Board (or the System CEO, Hospital President, System CMO, or an Associate CMO), of the MEC's recommendation as to whether such summary suspension should be terminated, modified, or sustained.

7.3.9 If a summary suspension remains in place for more than 14 days, the APP shall be advised, by Special Notice, of the APP's procedural due process rights, if any, pursuant to Article 8 of this Policy.

7.4 AUTOMATIC SUSPENSION

7.4.1 GROUNDS FOR AUTOMATIC SUSPENSION/LIMITATION

The following events shall result in an automatic suspension (or limitation) of an APP's Privileges, as applicable, without recourse to the procedural due process rights set forth in Article 8 of this Policy.

(a) License Suspension/Expiration

(i) Whenever an APP's license is suspended by the applicable licensing entity or expires (subject to §7.5-1(a)), his/her Clinical Privileges shall be automatically suspended.

(b) License Restriction

(i) Whenever an APP's license is limited or restricted by the applicable licensing entity, his/her Clinical Privileges will be similarly automatically limited or restricted.

(c) Prescribing Authority/DEA Registration Suspension

(i) Whenever an APP's DEA registration (or other authorization to prescribe) is suspended, his/her Clinical Privileges shall be automatically suspended.

(d) Prescribing Authority/DEA Registration Restriction

(i) Whenever an APP's DEA registration (or other authorization to prescribe) is limited or restricted, his/her right to prescribe medications will be similarly automatically limited or restricted.

(e) Federal Healthcare Program Suspension

(i) Whenever an APP is suspended from participating in a Federal Healthcare Program, his/her Privileges shall be automatically suspended.

(f) Failure to Satisfy Professional Liability Insurance Requirements

(i) If an APP's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the APP's Privileges shall be automatically suspended until Professional Liability Insurance

coverage is restored or the matter is otherwise resolved pursuant to §7.5-1(c) below.

(ii) The Medical Staff Services Department must be provided with a certified copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the APP's non-compliance with the Hospital's Professional Liability Insurance requirements, any limitation on the new policy, and a summary of relevant activities during the period of non-compliance.

(iii) For purposes of this section, the failure of an APP to provide proof of Professional Liability Insurance shall constitute failure to meet the requirements of this provision.

(g) Failure to Complete Required Education/Training

(i) Failure by an APP to complete Hospital training (*e.g.*, EPIC, safety, *etc.*) as required shall result in automatic suspension of the APP's Privileges.

(h) Lapse/Suspension/Termination of Supervising or Collaborating Practitioner's Appointment/Privileges

(i) Lapse, suspension, or termination of a PA's or an APRN's supervising or collaborating Practitioner's Medical Staff appointment and/or Privileges, for any reason, shall result in an automatic suspension of the APP's Privileges unless the APP has more than one (1) supervising or collaborating Practitioner with Medical Staff appointment and Privileges at the Hospital.

(i) Termination/Expiration of Standard Care Arrangement or Supervision Agreement

(i) Termination or expiration of the standard care arrangement (for CNPs, CNSs, or CNMs) or supervision agreement (for PAs) shall result in an automatic suspension of the APP's Privileges unless the APP has more than one (1) current, valid standard care arrangement or supervision agreement with an appropriate Practitioner with Medical Staff appointment and Privileges at the Hospital on file in Medical Staff Services.

(j) Vaccinations/Immunizations/Health Screenings

(i) Failure to provide documentation of required vaccinations, immunizations, and/or health screenings (or an approved qualified exemption therefrom); failure to comply with vaccination exemption conditions; or failure to otherwise take a leave of absence

(when applicable) in accordance with the requirements set forth in the applicable System, Hospital, and/or Medical Staff policies will result in an automatic suspension of the APP's Privileges subject to §7.5-1 (h) below.

(k) Delinquent Medical Records

(i) Failure by an APP to complete medical records (or components thereof), as provided for in the Delinquent Medical Records Policy, shall result in an automatic suspension of the APP's Clinical Privileges.

7.4.2 EFFECT OF AUTOMATIC SUSPENSION

(a) During such period of time when an APP's Privileges are automatically suspended or limited pursuant to §7.4-1 (a)-(j), he/she may not provide any care, treatment, and/or services at the Hospital.

(b) An APP whose Privileges are automatically suspended or limited pursuant to §7.4-1 (k) for delinquent medical records is subject to the same limitations except that such APP may, as applicable:

(i) Conclude the management of any patient under his or her care in the Hospital at the time of the effective date of the automatic suspension/limitation of Privileges.

(ii) Attend an obstetrical patient who has been under his or her care and management and who is admitted to the Hospital.

7.4.3 ACTION FOLLOWING AUTOMATIC SUSPENSION

(a) Following imposition of an automatic suspension or limitation, the MEC shall convene, as necessary, to determine if corrective action is necessary in accordance with §7.2.

(b) The lifting of the action or inaction that gave rise to an automatic suspension or limitation of the APP's Privileges shall result in the automatic reinstatement of such Privileges; provided; however, that the APP shall be obligated to provide such information as the Medical Staff Services Department shall reasonably request to assure that all information in the APP's credentials file is current.

7.5 AUTOMATIC TERMINATION

7.5.1 GROUNDS FOR AUTOMATIC TERMINATION

The following events shall result in an automatic termination of the APP's Privileges without recourse to the procedural due process rights set forth in Article 8 of this APP Policy.

(a) License Termination/Expiration

(i) Whenever an APP's license to practice is revoked by the applicable licensing entity or an APP (whose Privileges were automatically suspended pursuant to §7.4-1 (a) for an expired license) fails to renew his/her license within thirty (30) days after its expiration, his/her Privileges shall be automatically terminated.

(b) Revocation of DEA Registration/Prescribing Authority

(i) Whenever an APP's DEA registration (or other authorization to prescribe) is revoked, his/her Privileges shall be automatically terminated.

(c) Failure to Satisfy Professional Liability Insurance Requirements

(i) If an APP's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect for a period greater than sixty (60) days, the APP's Privileges shall automatically terminate as of the sixty-first (61^{st}) day. For purposes of this provision, the failure of an APP to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this provision.

(d) Federal Healthcare Program Exclusion

(i) Whenever an APP is excluded from participating in a Federal Healthcare Program, his/her Privileges shall be automatically terminated.

(e) Felony/Other Designated Offenses

(i) If an APP pleads guilty to, is found guilty of, or pleads no contest to a felony, the APP's Privileges shall be automatically terminated.

(ii) If an APP pleads guilty to, is found guilty of, or pleads no contest to an offense that involves: (i) violence or abuse upon a person; (ii) conversion, embezzlement, or misappropriation of property; (iii) fraud, bribery, evidence tampering, or perjury; or, (iv) drugs, the APP's Privileges shall be automatically terminated.

(f) Supervising/Collaborating Practitioner

(i) If a PA's or an APRN's Privileges are suspended pursuant to §7.4.1 (h) and the APP does not make arrangements for supervision by or collaboration with an appropriate Practitioner with Medical Staff appointment and Privileges at the Hospital within thirty (30) days after the automatic suspension, the APP's Privileges at the Hospital shall automatically terminate as of the thirty-first (31st) day.

(g) Failure to Submit New Standard Care Arrangement or Supervision Agreement

(i) If a PA's or an APRN's Privileges are suspended pursuant to §7.4.1 (i) and the APP does not submit a new, executed standard care arrangement (for CNPs, CNSs, and CNMs) or supervision agreement (for PAs) with an appropriate Practitioner with Medical Staff appointment and Privileges at the Hospital within thirty (30) days after the automatic suspension, the APP's Privileges shall automatically terminate as of the thirty-first (31st) day.

(h) Vaccinations/Immunizations/Health Screenings

(i) In the event that documentation of required vaccinations, immunizations, and/or health screenings (or an approved qualified exemption therefrom) is not provided; or, such other identified deficiency is not corrected within thirty (30) days following the date of an automatic suspension of Privileges pursuant to §7.4-1 (j), the APP's Privileges shall automatically terminate as of the thirty-first (31st) day.

7.6 CONSISTENCY OF ACTIONS AT HOSPITAL AND AFFILIATE HOSPITALS

7.6.1 So that there is consistency between the Hospital and Affiliate Hospitals regarding corrective action and the status of privileges considering that the Hospital and the Affiliate Hospitals are part of the same Health System, and that the Hospital and the Affiliate Hospitals have agreed to share information regarding privileges, the following automatic actions shall occur:

(a) With the exception of an automatic suspension for delinquent medical records, if an APP's privileges are automatically suspended or automatically terminated, in whole or in part, at an Affiliate Hospital(s), the APP's Privileges at this Hospital shall automatically and immediately become subject to the same action without recourse to the procedural due process rights set forth in Article 8 of this APP Policy.

(b) If an APP's privileges are summarily suspended or if an APP voluntarily agrees not to exercise privileges while undergoing an investigation at an Affiliate Hospital(s), such summary suspension or voluntary agreement not

to exercise privileges shall automatically and equally apply to the APP's Privileges at this Hospital and shall remain in effect until such time as the Affiliate Hospital(s) render(s) a final decision or otherwise terminate(s) the process.

(c) If an APP's privileges are limited, suspended, or terminated at an Affiliate Hospital, in whole or in part, based on professional conduct or clinical competency concerns, the APP's Privileges at this Hospital shall automatically and immediately become subject to the same decision without recourse to the procedural due process rights set forth in Article 8 of this APP Policy unless otherwise provided in the final decision at the Affiliate Hospital(s).

(d) If an APP resigns his/her privileges or fails to seek regrant of privileges at an Affiliate Hospital(s) while under investigation or to avoid investigation for professional conduct or clinical competency concerns, such resignation shall automatically and equally apply to the APP's Privileges at this Hospital without recourse to the procedural due process rights set forth in Article 8 of this APP Policy.

(e) If an APP withdraws an initial application for privileges at an Affiliate Hospital(s) for professional conduct or clinical competency concerns, such application withdrawal shall automatically and equally apply to applications for Privileges at this Hospital without recourse to the procedural due process rights set forth in Article 8 of this APP Policy.

ARTICLE 8 APP PROCEDURAL DUE PROCESS RIGHTS

8.1 APPLICABILITY

8.1.1 The procedural due process rights set forth in this Policy are only applicable to APPs requesting or granted Privileges through the Medical Staff process.

8.1.2 The provisions in the Medical Staff Bylaws setting forth the hearing and appeal rights of Medical Staff applicants and Medical Staff Members do not apply to APPs.

8.2 PROCEDURAL DUE PROCESS RIGHTS FOLLOWING RECOMMENDATION OF DENIAL OF APPLICATION FOR PRIVILEGES

8.2.1 When the MEC proposes to make a recommendation to deny an APP's application for Privileges based upon professional conduct or clinical competence concerns, the APP shall be provided written notice, by Special Notice, of the MEC's proposed recommendation.

8.2.2 The APP shall then have five (5) days in which to submit a written response to the MEC as to why such Adverse recommendation should be withdrawn and a favorable recommendation made. The APP may meet with the MEC (or a subcommittee of the MEC) upon request. After reviewing the APP's written response and meeting with the APP (if applicable), the MEC shall make its final recommendation to the Board. The APP will be advised, by Special Notice, of the MEC's final recommendation; and, if applicable, the APP's right to appeal.

8.2.3 If the MEC's recommendation continues to be Adverse to the APP, the APP shall have five (5) days in which to submit a written appeal to the Board. At the Board's discretion, it may meet (or have a committee of the Board meet) with the APP. During this meeting, the basis of the Adverse recommendation that gave rise to the appeal will be reviewed with the APP. After reviewing the Adverse recommendation of the MEC, the APP's written response/appeal, and the results of meetings with the APP, if any, the Board shall take action.

8.2.4 Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC, and the matter has not previously been submitted to an *ad hoc* Joint Conference Committee, the matter will be submitted to such committee for review and recommendation before the Board makes its final decision.

8.2.5 The APP will receive written notice, by Special Notice, of the Board's final decision.

8.3 PROCEDURAL DUE PROCESS RIGHTS FOLLOWING CORRECTIVE ACTION OR SUMMARY SUSPENSION

8.3.1 The APP shall have five (5) days in which to submit a written response to the MEC as to why such limitation, suspension, or termination of the APP's Privileges should, as applicable, be lifted, rescinded, or not take place. The APP may meet with the MEC (or a subcommittee of the MEC) upon request. After reviewing the APP's written response and meeting with the APP (as applicable), the MEC shall make a recommendation regarding the limitation, suspension, or termination of the APP's Privileges to the Board. The APP shall be advised, by Special Notice, of the MEC's recommendation, the basis for such recommendation; and, if applicable, the APP's right to appeal.

8.3.2 If the MEC's recommendation continues to be Adverse to the APP, the APP shall have five (5) days in which to submit a written appeal to the Board. At the Board's discretion, it may meet (or have a committee of the Board meet) with the affected APP. During this meeting, the basis of the Adverse recommendation/action that gave rise to the appeal will be reviewed with the APP. After reviewing, as applicable, the recommendation of the person/group that imposed a summary suspension, the recommendation of the MEC, the APP's written response/appeal, and the results of meetings with the APP, if any, the Board shall take action.

8.3.3 Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC, and the matter has not previously been submitted to the *ad hoc* Joint Conference Committee, the matter will be submitted to such committee for review and recommendation before the Board makes its final decision.

8.3.4 The APP will receive written notice, by Special Notice, of the Board's final decision.

ARTICLE 9 CONFIDENTIALITY, IMMUNITY, AND RELEASES

9.1 SPECIAL DEFINITIONS

9.1.1 For purposes of this Article only, the following definitions shall apply:

(a) Information means documentation of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data, and other disclosures or communications, whether in written or oral form, relating to any of the subject matter specified in §9.5.

(b) Representative means the Board of the Hospital and any trustee/director or committee thereof; the System CEO, Hospital President, System Chief Medical Officer, and Associate Chief Medical Officers; the Hospital and authorized Hospital employees; the Medical Staff, its Departments, committees, and any Medical Staff officer, chair, or member thereof; and agents authorized by any of the foregoing to perform specific information gathering, analysis, use, or disseminating functions.

(c) Third Parties means both individuals and organizations providing information to any Representative.

9.2 AUTHORIZATIONS AND CONDITIONS

9.2.1 By submitting an application for grant/regrant of Clinical Privileges and at all times that an APP holds Clinical Privileges at the Hospital, the APP:

(a) Authorizes Representatives and Third Parties, as applicable, to solicit, provide, and act upon Information bearing on his/her qualifications for Clinical Privileges.

(b) Agrees to be bound by the provisions of this Article and to waive all legal claims against Representatives and Third Parties who act in accordance with the provisions of this Article.

(c) Acknowledges that the provisions of this Article are express conditions to his/her application for and, as applicable, acceptance and continuation of Clinical Privileges at the Hospital.

9.3 CONFIDENTIALITY OF INFORMATION

9.3.1 All Information submitted, collected, or prepared by any Representative of this Hospital or by any other health care facility or organization or medical staff for the purpose of:

(a) Reviewing, evaluating, monitoring, or improving the quality and efficiency of patient care;

(b) Reducing morbidity and mortality;

(c) Evaluating qualifications (including, but not limited to, current clinical competence) for clinical privileges;

(d) Contributing to teaching or clinical research;

(e) Determining that health care services are professionally indicated and performed in accordance with the applicable standard of care;

(f) Enforcing guidelines to help keep health care costs within reasonable bounds;

shall, to the fullest extent permitted by law, be confidential.

9.3.2 Dissemination of such Information shall only be made where expressly required by law or authorized by applicable Hospital/Medical Staff policies including, but not limited to, sharing of information policies. Such confidentiality shall also extend to Information of like kind that may be provided by Third Parties. This Information shall not become part of any particular patient's record. It is expressly acknowledged by each APP that violation of the confidentiality provisions provided herein is grounds for corrective action pursuant to this Policy.

9.4 IMMUNITY FROM LIABILITY

9.4.1 FOR ACTION TAKEN

No Representative or Third Party, as applicable, shall be liable to an APP for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as a Representative or Third Party provided that such Representative or Third Party does not act on the basis of false information knowing it to be false as provided for in the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. §11101, *et seq*.

9.4.2 FOR GATHERING/PROVIDING INFORMATION

No Representative or Third Party, as applicable, shall be liable to an APP for damages or other relief by reason of providing Information, including otherwise privileged or confidential information, concerning said APP provided that such Representative or Third Party is acting within the scope of his/her duties and does not act on the basis of false information knowing it to be false as provided for in the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. §11101, *et seq.*

9.5 ACTIVITIES AND INFORMATION COVERED

9.5.1 ACTIVITIES

The confidentiality requirements and immunity provided by this Article apply to all Information in connection with the activities of this Hospital or any other health care facility or organization or medical staff concerning, but not limited to:

(a) Applications for clinical privileges.

(b) Periodic regrant of clinical privileges.

(c) Corrective actions.

(d) Procedural due process rights.

(e) Quality/peer review program activities.

(f) Utilization review and management activities.

(g) Other Hospital, committee, Department, or Medical Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

9.5.2 INFORMATION

The Information referred to in this Article may relate to an APP's qualifications for clinical privileges (including, but not limited to, clinical competency, conduct judgment, character, ability to exercise the Privileges requested with or without a reasonable accommodation, professional ethics, *etc.*) or any other matter that might directly or indirectly affect patient care.

9.6 RELEASES

Each APP shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to applicable state and federal laws. Execution of such releases is not a prerequisite to the effectiveness of this Article.

9.7 CUMULATIVE EFFECT AND SEVERABILITY

Provisions in this APP Policy and in application forms relating to authorizations, confidentiality of Information, and immunity from liability are in addition to other protections provided by relevant state and federal laws and not in limitation thereof. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.

CERTIFICATION OF ADOPTION & APPROVAL

This APP Policy may be adopted and amended in accordance with the procedure set forth in the Medical Staff Bylaws for adoption and amendment of Medical Staff Policies.

Adopted by the Medical Executive Committee on _____.

Approved by the Board on _____.

EXHIBIT A

Advanced Practice Providers eligible to be granted Clinical Privileges at the Hospital:

- Certified Nurse Practitioners
- Certified Nurse-Midwives
- Certified Registered Nurse Anesthetists