Medical Staff Credentials Policy

McCullough-Hyde Memorial Hospital

A Medical Staff Document

TABLE OF CONTENTS

ARTICLE I - APPOINTMENT AND PRIVILEGING PROCEDURES

1.1 REQUEST FOR AND SUBMISSION OF APPLICATION

1.1-1 A request for an application for Medical Staff appointment and/or Privileges shall be directed to the Medical Staff Services Department.

1.1-2 The Medical Staff Services Department shall provide the requesting applicant with such application.

1.1-3 An application for Medical Staff appointment and/or Privileges must be submitted to the Medical Staff Services Department by the applicant electronically on the Hospital-approved form, signed by the applicant, and accompanied by the full amount of the non-refundable application fee.

1.1-4 The applicant will be provided access to the Medical Staff Bylaws, Policies, and Rules & Regulations at the time of application.

1.2 APPLICATION CONTENT

1.2-1 Each 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 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 Drug Enforcement Administration ("DEA") registration (to the extent required for the Privileges requested) with the issued and expiration date and number 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) Specialty or subspecialty board certification and recertification in accordance with the requirements set forth in Article VI of this Policy.

(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.

<u>For reappointment/regrant of Privileges</u>: Professional Liability Insurance coverage and information on professional liability cases filed, pending, or settled (final disposition) since the last reappointment/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: (1) license or certificate to practice any health-related profession in any state or country; (2) DEA or a state-controlled substances registration; (3) membership or fellowship in local, state, or national health or scientific professional organizations; (4) faculty membership at any medical or other professional school; (5) appointment or employment status, prerogatives, or clinical privileges at any other hospital, clinic, or health care entity or organization; (6) Professional Liability Insurance; (7) specialty or sub-specialty board certification; or (8) 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 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 Practitioner'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 Practitioner shall provide his/her professional work history from the initial date of licensure.

(i) Medical Staff category and/or specific Clinical Privileges requested.

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

(k) Peer references:

(1) The application must include the names of at least two (2) Practitioners 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.

(2) 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, *etc.*).

(3) One (1) such reference must be from a Practitioner who is in the same professional discipline/specialty as the applicant.

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

(5) 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 Practitioner-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) Such other information as may be required by the application.

1.2-2 Applicants for Medical Staff appointment and/or Privileges shall complete a criminal background check.

1.2-3 Applicants for Medical Staff appointment without Privileges shall complete such application and provide such information as set forth in §1.5 of this Policy.

1.3 EFFECT OF APPLICATION

1.3-1 The 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 appointment/reappointment and/or Privileges or for termination of appointment and/or Privileges.

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

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

(d) Agrees to fulfill his/her Medical Staff 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 holds Medical Staff appointment and/or has Privileges at the Hospital.

(f) Understands and agrees that if Medical Staff appointment and/or 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 Medical Staff appointment and/or Privileges or his/her current Medical Staff appointment and/or Privileges, the applicant will exhaust the administrative remedies afforded by the Bylaws and Fair Hearing Policy before resorting to formal legal action.

(h) Acknowledges and agrees to the provisions set forth in Article XII of the Bylaws 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 appointment and/or grant of Privileges, the applicant recognizes and understands that any and all information relative to his/her appointment and/or 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.

1.4 PROCESSING THE APPLICATION

1.4-1 APPLICANT'S BURDEN AND PROOF OF IDENTITY

(a) Applicant's Burden

(1) The applicant has the burden of producing adequate information for a proper evaluation of his/her qualifications for Medical Staff appointment and/or 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.

(2) 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

(1) 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 Medical Staff appointment and/or Privileges.

(2) For distant-site telemedicine Practitioners, applicant identity verification may be completed by the distant-site with confirmation of the verification communicated to the Medical Staff Services Department.

1.4-2 VERIFICATION OF INFORMATION

(a) The Medical Staff Services Department will coordinate the collection and verification of information regarding pending applications for Medical Staff appointment and/or Privileges consistent with the Medical Staff governing documents 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 §1.4.1 (a)(2).

(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 Medical Staff appointment and/or Privileges, upon reappointment and/or regrant of Privileges, and when a Practitioner requests additional Privileges during a current appointment/Privilege period. The Medical Staff Services Department shall also conduct an NPDB query each time a Practitioner 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.

1.4-3 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 §1.4.1 (a)(2).

(c) The Department 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 §1.4-1 (a)(2).

1.4-4 RECOMMENDATION BY THE MEDICAL EXECUTIVE COMMITTEE

(a) The MEC shall, at its next regular meeting, consider the recommendation of the Department Chairs 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 §1.4.1 (a)(2).

(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 §1.4-1 (a)(2).

(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):

(1) 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 Medical Staff appointment and/or Privileges.

(2) Favorable Recommended Action: An MEC recommendation to grant the requested Medical Staff appointment and/or Privileges is forwarded to the Board for action.

(3) Adverse Recommended Action: When the recommendation of the MEC is to deny the requested Medical Staff appointment and/or 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 the Fair Hearing Policy 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 right to a hearing, if any, as provided for in the Fair Hearing Policy.

1.4-5 **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:

(1) On Favorable MEC Recommendation: The Board may adopt or reject, in whole or in part, an MEC recommendation to grant the requested Medical Staff appointment and/or 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.

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

(ii) 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 the Fair Hearing Policy 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 the Fair Hearing Policy. The fact that the Adverse decision is held in abeyance shall not be deemed to confer Medical Staff appointment and/or Privileges where none existed before.

(2) 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.

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

(ii) 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 the Fair Hearing Policy. 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 the Fair Hearing Policy. The fact that the Adverse decision is held in abeyance shall not be deemed to

confer Medical Staff appointment and/or Privileges where none existed before.

(3) 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 the Fair Hearing Policy. The Board shall thereafter take final action in the matter as provided for in the Fair Hearing Policy.

(d) Joint Conference Committee Review: Whenever the Board's proposed decision is contrary to the recommendation of the MEC, there shall be 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.

1.4-6 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 an appointment and/or Privileges includes, as applicable (1) the Medical Staff category to which the applicant is appointed; (2) the Department(s) to which he/she is assigned; (3) the Clinical Privileges he/she may exercise; and (4) any special conditions attached to the appointment and/or Privileges.

1.4-7 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 Medical Staff appointment and/or 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.
MEC	Next regular meeting after receiving a recommendation 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 the Fair Hearing Policy 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.

1.5 PROCESSING APPLICATIONS FOR MEDICAL STAFF APPOINTMENT WITHOUT PRIVILEGES

1.5-1 APPLICATION CONTENT

The content of an application for Medical Staff appointment without Privileges shall include information necessary to satisfy the qualifications set forth in the applicable Medical Staff category.

1.5-2 PROCEDURE

(a) Due to the limited nature of an appointment without Privileges:

(1) An application for appointment to the consulting peer review Medical Staff category may be acted upon by the System CEO or Hospital President upon recommendation of the MEC chair if time constraints so require.

(2) Appointment to the retired Medical Staff shall require a request from the Practitioner (which may be handwritten, by email, or a verbal request documented by the Medical Staff Services Department) for a transfer to the retired Medical Staff category and written resignation of the Practitioner's Clinical Privileges.

(3) Appointment to the emeritus Medical Staff shall require a recommendation of the applicable Department Chair and MEC and approval of the Board.

(4) An application for appointment to the affiliate Medical Staff without Privileges shall be reviewed and acted upon in accordance with the routine procedure for Medical Staff appointment/reappointment, as applicable.

(5) Appointment to the reciprocal Medical Staff is automatic subject to the conditions set forth in the Medical Staff Bylaws.

1.6 COMPLETION OF TRIHEALTH CONNECT TRAINING & ACTIVATION OF CLINICAL PRIVILEGES

1.6-1 Completion of TriHealth Connect training is a prerequisite to access to the electronic medical record system and exercise of Clinical Privileges.

1.6-2 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 Practitioner's Medical Staff appointment and Clinical Privileges pursuant to the Medical Staff Bylaws until such training is successfully completed.

ARTICLE II - PROCESSING APPLICATIONS FOR MEDICAL STAFF REAPPOINTMENT AND/OR REGRANT OF PRIVILEGES

2.1 INFORMATION COLLECTION AND VERIFICATION

2.1-1 FROM PRACTITIONER

(a) Prior to the expiration date of a Practitioner's current Medical Staff appointment and/or Privileges, the Practitioner shall be notified of the date of expiration of his/her appointment and/or Clinical Privileges and sent a Hospital-approved application for reappointment/regrant of Privileges to complete. The Practitioner shall furnish, in writing, on the application for reappointment/regrant of Privileges:

(1) Complete information as set forth in §1.2-1 of this Policy to bring his/her file current and to demonstrate continued satisfaction of the qualifications for Medical Staff appointment and/or Clinical Privileges set forth in the Medical Staff Bylaws and applicable Privilege set.

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

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

(4) A request (if any) for a change of Medical Staff category.

(b) The Practitioner must sign the application for reappointment/regrant of Privileges and in so doing accepts the same conditions as set forth in §1.3-1 in connection with the initial application.

2.1-2 ADDITIONAL INFORMATION FROM INTERNAL SOURCES

(a) In addition to the information set forth in §2.1-1, the following information shall be considered in conjunction with a Practitioner's request for reappointment/regrant of Privileges:

(1) Focused and Ongoing Professional Practice Evaluation data (FPPE/OPPE) with respect to a regrant of Privileges.

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

(3) Any sanctions imposed or pending.

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

(5) Participation in Medical Staff activities and fulfillment of applicable Medical Staff responsibilities.

(6) Timely and accurate completion of medical records.

(7) Cooperativeness in working with other Practitioners and Hospital personnel.

(8) General attitude toward patients and the Hospital.

(9) Compliance with the Medical Staff Bylaws, Policies, and Rules & Regulations and applicable Hospital policies/procedures.

(10) Any other pertinent information that may be relevant to the Practitioner's Medical Staff reappointment and/or regrant of Privileges at the Hospital.

2.1-3 **PRACTITIONER'S BURDEN**

(a) The Practitioner has the burden of producing adequate information for a proper evaluation of his/her qualifications for Medical Staff reappointment and/or 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.

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

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

(3) If the Practitioner qualifies, he/she may be granted temporary Privileges to meet an important patient care need pursuant to §3.4-2 (b) of this Policy.

(b) If the Practitioner'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 Practitioner 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.*).

2.1-4 **VERIFICATION**

(a) The Medical Staff Services Department verifies the information provided on the application for reappointment/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 §1.4-2.

(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 Practitioner's file is available for review.

2.1-5 **REVIEW AND ACTION**

(a) Applications for Medical Staff reappointment and/or regrant of Privileges shall be reviewed and acted upon in accordance with the procedure set forth in §1.4-3 through §1.4-6 of this Policy.

(b) For purposes of reappointment and/or regrant of Privileges, the terms "applicant" and "appointment" and "Privileges" as used in §1.4-3 through §1.4-6 of this Policy shall be read, as "Practitioner" and "reappointment" and "regrant of Privileges," respectively.

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

2.2 REQUESTS FOR MODIFICATION OF APPOINTMENT STATUS OR CLINICAL PRIVILEGES

2.2-1 A Practitioner may, either in connection with reappointment/regrant of Privileges or at any other time, request modification of his/her Medical Staff category or Clinical Privileges by submitting a written request to the Medical Staff Services Department.

2.2-2 Requests for new/additional Privileges during a current appointment/Privilege period will require evidence of appropriate education, training, and experience supportive of the request and will be subject to initial FPPE if granted.

2.2-3 A modification request shall be processed in substantially the same manner as an application for reappointment and/or regrant of Privileges.

ARTICLE III - ADOPTION AND AMENDMENT OF PRIVILEGE SETS; TEMPORARY, DISASTER, EMERGENCY, TELEMEDICINE & MOONLIGHTING PRIVILEGES

3.1 ADOPTION AND AMENDMENT OF PRIVILEGE SETS

3.1-1 Clinical Privilege sets may only be adopted and amended following review by the applicable Department Chair, recommendation of the MEC, and approval by the Board.

3.2 RECOGNITION OF NEW SERVICE/PROCEDURE

3.2-1 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).

(c) The availability of other qualified Practitioners 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.

3.2-2 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 Practitioner 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 Practitioner believes the Hospital should recognize such Privileges, and any additional information that the Practitioner believes may be of assistance in evaluating the request.

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

(1) 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.

(2) 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.

(3) 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:

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

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

(iii) The available training programs.

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

(v) 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.

(1) If the Board approves the new Privilege set, the requesting Practitioner(s) may apply for such Privilege(s) consistent with the process set forth in Article I of this Policy.

(2) If the Board does not approve the new Privilege set, the requesting Practitioner(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 the Fair Hearing Policy.

3.3 PRIVILEGING PROCEDURE

3.3-1 REQUESTS

(a) Each application for Medical Staff appointment and reappointment with Privileges, or for Privileges only, must contain a request for the specific Clinical Privileges desired by the Practitioner.

(b) Specific requests must also be submitted for temporary, disaster, telemedicine, and moonlighting resident Privileges, as applicable, and for new or modification of existing Privileges during an appointment/Privilege period.

(c) The qualifications for an initial grant or regrant of Clinical Privileges are set forth in the Bylaws, this Policy, and in the applicable Privilege set. The Clinical Privileges requested shall be consistent with: the Practitioner's education, training, board certification, and documented experience in his/her specialty; the results of care, treatment, and/or services provided; and, the conclusions drawn from professional practice evaluation, quality assessment, and performance improvement activities when available.

3.3-2 PROCESSING REQUESTS

(a) Except as otherwise provided in this Article, a request for Clinical Privileges is processed according to the procedures outlined in Article I or Article II, as applicable.

(1) Requests for temporary Privileges are processed according to §3.4 of this Policy.

(2) Requests for disaster Privileges are processed according to §3.6 of this Policy.

(3) Requests for telemedicine Privileges are processed according to §3.7 of this Policy.

(4) Requests for moonlighting resident/fellow Privileges are processed according to §3.8 of this Policy.

3.4 TEMPORARY PRIVILEGES

3.4-1 CONDITIONS

Temporary Privileges may be granted only in the circumstances and under the conditions described in §3.4-2. Special requirements of consultation and reporting may be imposed by the applicable Department Chair. Under all circumstances, the Practitioner requesting temporary Privileges shall agree to abide by the Medical Staff Bylaws, Policies, Rules & Regulations, and applicable Hospital policies in all matters relating to his/her activities in the Hospital.

3.4-2 **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:

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

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

(3) Review and verification of the information set forth in §2.1-1 of the Medical Staff Bylaws and §1.2 of this Policy.

(4) Completion of a query and evaluation of the National Practitioner Data Bank information and such other queries as required by §1.4-2 of this Policy.

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

(6) Confirmation that the applicant has not been subject to the involuntary termination of his/her medical staff appointment at another organization.

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

(8) 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 a Practitioner applying for Privileges at the Hospital for the first time; a Practitioner currently holding Privileges who is requesting one or more additional Privileges during his/her current appointment/Privilege period; and a Practitioner who is in the reappointment/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

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

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

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

(iii) For a Practitioner who temporarily comes to the Hospital to learn (be proctored on) or to teach (proctor) a procedure.

(iv) A Practitioner who seeks to act in the capacity of a *locum tenens* to another Practitioner.

(2) 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:

(i) Receipt of a written request from the Practitioner for the specific temporary Clinical Privileges desired.

(ii) Verification of the Practitioner'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 Practitioner'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 Practitioner's current principal hospital affiliation).

3) DEA registration if applicable to the Privileges requested.

4) Professional Liability Insurance.

(iii) Completion of a query and evaluation of the National Practitioner Data Bank information and such other queries as required by §1.4-2 of this Policy.

(3) 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 Practitioner must apply for Medical Staff appointment and Privileges at the Hospital.

3.5 EMERGENCY PRIVILEGES

3.5-1 In case of an emergency, as defined below, any Practitioner 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 Practitioner's license and notwithstanding the Practitioner's Medical Staff category or Clinical Privileges. A Practitioner 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 Practitioner must request the temporary Privileges necessary to continue to treat the patient. In the event such temporary 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.

3.5-2 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.

3.5-3 Emergency Privileges shall automatically terminate upon alleviation of the emergency situation. A Practitioner who exercises emergency Privileges shall not be entitled to the procedural due process rights set forth in the Fair Hearing Policy.

3.6 DISASTER PRIVILEGES

3.6-1 Disaster Privileges may be granted to volunteer Practitioners (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.

3.6-2 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 Practitioner and his/her qualifications by a Hospital employee or Practitioner with Privileges at the Hospital.

3.6-3 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 Practitioner 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 Practitioner's demonstrated ability to provide adequate care, treatment, and services.

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

3.6-4 Primary source verification of licensure is not required if the volunteer Practitioner has not provided care, treatment, or services under the disaster Privileges.

3.6-5 It is anticipated that disaster Privileges may be granted to state-wide and out-of-state volunteer Practitioners, as necessary, in accordance with applicable Ohio licensure laws, rules, and regulations.

3.6-6 All volunteer Practitioners 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 Practitioner does not have such identification, he/she will be issued a temporary badge by the Hospital Security Department identifying him/her and designating the Practitioner as a volunteer Practitioner disaster care provider.

3.6-7 The professional performance of volunteer Practitioners who receive disaster Privileges shall be managed by and under the direct observation of a Medical Staff Member with Privileges appropriate to the volunteer Practitioner'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 Practitioner's arrival at the Hospital, based upon information obtained regarding the professional practice of the volunteer Practitioner, as to whether to authorize continued exercise of the disaster Privileges initially granted.

3.6-8 Disaster Privileges shall cease upon alleviation of the circumstances of disaster as determined by the System CEO or Hospital President.

3.7 TELEMEDICINE PRIVILEGES

3.7-1 Section 3.7 applies to distant site telemedicine Practitioners who will not practice on-site at the Hospital.

3.7-2 Distant site Practitioners who are responsible for a patient's care, treatment, and services via a telemedicine link shall be credentialed and privileged to do so by the Hospital in accordance with the Bylaws and this Policy, accreditation standards, and applicable laws, rules, and regulations. If the Hospital has a pressing clinical need and the distant site Practitioner can supply that service through a telemedicine link, the Practitioner may be evaluated for temporary Privileges in accordance with the procedures set forth in §3.4. Distant site Practitioners providing telemedicine services to Hospital patients shall be credentialed and privileged to do so through one of the following mechanisms:

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

(b) The distant site Practitioner is credentialed and privileged by the Hospital in accordance with the routine credentialing and privileging procedure set forth Article I or II 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 Practitioner provided that the Hospital has entered into a written agreement with the distant site and all of the following requirements are met:

(1) 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.

(i) 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 Practitioners providing telemedicine services.

(ii) 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 Practitioners 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.

(2) Each distant site Practitioner 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 Practitioner's privileges at the distant site.

(3) Each distant site Practitioner 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 Practitioner is located.

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

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

(ii) All complaints the Hospital receives about a distant site Practitioner.

3.8 MOONLIGHTING PRIVILEGES

3.8-1 QUALIFICATIONS

(a) Moonlighting Privileges may be granted to fellows or residents who:

(1) Obtain prior written approval of the director of the applicable fellowship or residency program.

(2) Are in good standing in his/her fellowship or residency program as verified by the director of such program.

(3) Are requesting Privileges to provide clinical care, treatment, and/or services to patients at the Hospital (or a provider-based location thereof) outside of the time periods that the fellow or resident is participating in their fellowship or residency training program.

(4) Have and maintain a current, valid Ohio license (not a training certificate) to practice his/her profession and compliance with the continuing education requirements for such licensure as determined by the applicable State licensure board.

(5) Have and maintain, if necessary for the Privileges requested, a current, valid Drug Enforcement Administration ("DEA") individual registration.

(6) Provide documentation of successful completion of applicable professional education.

(7) Are able 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.

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

(9) Are eligible to participate in Federal Healthcare Programs.

(10) Are able to provide patient care, treatment, and services consistent with acceptable standards of practice and available resources.

(11) Are able to 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.

(12) Are able to exercise the Privileges requested safely and competently with or without a reasonable accommodation.

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

(14) Comply with criminal background check requirements.

(15) Agree to fulfill, and fulfill, such responsibilities as are applicable.

(16) Satisfy such other applicable qualifications, if any, as are set forth in the Medical Staff governing documents, the moonlighting Privilege set, and/or as provided in the resident/fellow written agreement.

3.8-2 **CONDITIONS**

(a) Fellows and residents on J-1 visas, military support, or as otherwise prohibited by applicable laws, rules, and/or regulations are not permitted to moonlight. Fellows employed under an H1-B visa may be able to moonlight under specific, very limited circumstances.

(b) PGY-1 and PGY-2 residents are not permitted to moonlight.

(c) A moonlighting fellow or resident must request and be granted Privileges prior to providing any clinical care, treatment, or services to patients at the Hospital (or a provider-based location thereof) outside of the time periods that the fellow or resident is participating in his/her fellowship or residency training program.

(d) Special requirements of consultation and reporting may be imposed at such time as moonlighting Privileges are granted.

(e) A moonlighting fellow or resident must agree, in writing, to abide by the Medical Staff Bylaws, Policies, Rules & Regulations, and the policies of the Hospital in all matters relating to his/her moonlighting activities at the Hospital.

(f) Moonlighting is not required and must not interfere with the ability of the fellow or resident to otherwise achieve the goals, assigned duties, responsibilities and objectives of his/her fellowship or residency education/training program.

(g) All moonlighting hours must be reported and counted towards work duty hour requirements.

(h) The moonlighting fellow or resident will be subject to FPPE/OPPE with respect to the moonlighting Privileges granted in accordance with the procedures set forth in applicable Medical Staff Policies.

(i) Permission for moonlighting may be withdrawn if the moonlighting fellow's or resident's program director believes the fellow's or resident's education/training is negatively impacted as a result of his/her moonlighting activities.

3.8-3 PROCESSING A REQUEST FOR MOONLIGHTING PRIVILEGES

(a) A request for moonlighting Privileges shall be processed in accordance with the routine credentialing and privileging process set forth in this Policy.

(b) Moonlighting Privileges may be granted/regranted for a period of up to three (3) years as recommended by the MEC and approved by the Board.

3.8-4 MEDICAL STAFF APPOINTMENT

(a) Residents and fellows are not eligible for appointment to the Medical Staff with the limited exception that:

(1) A Physician who has completed a residency and who is pursuing a second residency may apply for and be granted Medical Staff appointment and Privileges (in the specialty in which he/she has completed residency training) provided that he/she otherwise meets the qualifications set forth in the Medical Staff Bylaws to do so.

(2) A Physician who has completed a residency and who is pursuing a fellowship in a sub-specialty may apply for and be granted Medical Staff appointment and Privileges (in the specialty in which he/she has completed residency training) provided he/she otherwise meets the qualifications set forth in the Medical Staff Bylaws to do so.

3.9 TERMINATION OF TEMPORARY, DISASTER, TELEMEDICINE, AND MOONLIGHTING PRIVILEGES

3.9-1 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 a Practitioner's temporary, disaster, or telemedicine Privileges or a fellow's/resident's moonlighting Privileges. Where the life or well-being of a patient is determined to be endangered, the Practitioner's or fellow's/resident's Privileges may be

terminated by any person entitled to impose a summary suspension pursuant to the Bylaws.

3.9-2 PROCEDURAL DUE PROCESS RIGHTS

A Practitioner who has been granted temporary, disaster, or telemedicine Privileges and a fellow/resident who has been granted moonlighting Privileges is not a Medical Staff Member and is not entitled to the procedural due process rights afforded to Medical Staff Members. A Practitioner/fellow/resident shall not be entitled to the procedural due process rights set forth in the Fair Hearing Policy because the Practitioner's request for temporary, disaster, or telemedicine Privileges or a fellow's/resident's request for moonlighting 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.

3.9-3 PATIENT CARE

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

3.10 PROFESSIONAL PRACTICE EVALUATION

3.10-1 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) Practitioners requesting initial Privileges; (b) existing Practitioners requesting new Privileges during the course of an appointment/Privilege period; and (c) in response to concerns regarding a Practitioner's ability to provide safe, high quality patient care. The FPPE period shall be used to determine the Practitioner's current clinical competence and ability to perform the requested Privileges.

3.10-2 ONGOING PROFESSIONAL PRACTICE EVALUATION

Upon conclusion of the FPPE period, OPPE shall be conducted on all Practitioners 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 Practitioners with Privileges on an ongoing basis.

3.11 DENTISTS, PODIATRISTS, AND PSYCHOLOGISTS

3.11-1 DENTAL CARE

(a) Dentists and Oral Surgeons may admit patients to the Hospital if granted Privileges by the Hospital to do so.

(b) A qualified Oral Surgeon may perform the medical history and physical examination (and update, when required) or outpatient assessment, as applicable, for his or her patients if granted Privileges by the Hospital to do so.

(c) Dentist Responsibilities:

(1) A detailed dental history/assessment justifying Hospital admission/registration.

(2) A detailed description/assessment of the examination of the oral cavity and a preoperative diagnosis.

(3) A complete operative report in accordance with the requirements set forth in the Medical Staff Rules & Regulations or applicable Medical Staff/Hospital policy, as applicable. In cases of extraction of teeth, the Dentist shall clearly state the number of teeth and fragments removed. All tissue except teeth and fragments shall be sent to the Hospital pathologist for examination.

(4) Progress notes as are pertinent to the oral condition.

(5) Discharge summary statement.

(6) Completion of medical records such as relates to his/her dental care of the patient.

(7) Arrange for a Physician Medical Staff Member with appropriate Privileges to complete the medical history and physical examination (and update, when required) or outpatient assessment, as applicable, for the Dentist's patients with the exception of patients of an Oral Surgeon granted Privileges to complete the H&P (and update, when required) or outpatient assessment, as applicable.

(8) Obtain medical consultation from a Physician Medical Staff Member with appropriate Privileges for the care and treatment of any medical condition that is present at the time of admission/registration of the Dentist's patient or that may arise during hospitalization that is outside the scope of practice of the Dentist. If there is a medical problem, the consulting Physician shall participate in the discharge of the Dentist's patient and the completion of medical records such as relates to the Physician's care of the patient.

3.11-2 **PODIATRIC CARE**

(a) Podiatrists may admit patients to the Hospital if granted Privileges by the Hospital to do so.

(b) Podiatrist Responsibilities:

(1) A detailed history/assessment of the podiatric problem justifying Hospital admission/registration.

(2) A detailed description/assessment of the examination of the pedal member(s) and a preoperative diagnosis.

(3) A complete operative report in accordance with the requirements set forth in the Medical Staff Rules & Regulations or applicable Medical Staff/Hospital policy, as applicable. All tissue removed shall be sent to the Hospital pathologist for examination.

(4) Progress notes as are pertinent to the pedal condition.

(5) Discharge summary statement.

(6) Completion of medical records such as relates to his/her podiatric care of the patient.

(7) Arrange for a Physician Medical Staff Member with appropriate Privileges to complete the medical history and physical examination (and update, when required) or outpatient assessment, as applicable, for the Podiatrist's patients.

(8) Obtain medical consultation from a Physician Medical Staff Member with appropriate Privileges for the care and treatment of any medical condition that is present at the time of admission/registration of the Podiatrist's patient or that may arise during hospitalization that is outside the scope of practice of the Podiatrist. If there is a medical problem, the consulting Physician shall participate in the discharge of the Podiatrist's patient and the completion of medical records such as relates to the Physician's care of the patient.

3.11-3 **PSYCHOLOGICAL CARE**

(a) Psychologists shall not be authorized to admit or co-admit patients to the Hospital.

(b) Psychologists shall be authorized to treat only those patients who have been admitted by a Physician Medical Staff Member with admitting Privileges and must maintain a consultative relationship with the attending Physician during the course of treatment of the patient.

ARTICLE IV - LEAVES OF ABSENCE

4.1 APPROVED LEAVES

4.1-1 REQUESTING AND GRANTING A LEAVE

(a) A Medical Staff Member 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) A Medical Staff Member may not take a leave of absence to avoid fulfilling a Medical Staff obligation including, but not limited to, call coverage.

(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 4.1-1 (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 Member's current appointment and Privilege period:

(1) The Member may apply for reappointment to a Medical Staff category without Privileges.

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

(3) The Practitioner may apply for a new grant of Privileges at such time as the Practitioner applies for reinstatement following the leave and requests to transfer back to a Medical Staff category with Privileges.

(e) During the period of the leave, the Member's Clinical Privileges and Medical Staff appointment Prerogatives and responsibilities shall be inactive/held in abeyance and the Member is not required to pay Medical Staff dues.

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

(g) In order to qualify for reinstatement of Medical Staff appointment and, as applicable reinstatement or a grant of new Privileges following a leave of absence, the Practitioner must maintain Professional Liability Insurance coverage during the leave or purchase tail coverage for all periods during which the Member held Privileges at the Hospital. The Member shall provide information to demonstrate satisfaction of continuing Professional Liability Insurance or tail coverage as required by this provision upon request for reinstatement of Medical Staff appointment and, as applicable, reinstatement or a grant of new Privileges.

4.1-2 **RETURN FROM LEAVE**

(a) A Medical Staff Member may request reinstatement of his/her Medical Staff appointment and, as applicable, reinstatement or a grant of new Privileges by sending a written notice to the Medical Staff Services Department.

(b) The Member must submit a written summary of relevant activities during the leave as well as such additional information (*e.g.,* current license, DEA registration, Professional Liability Insurance, *etc.*) as is reasonably necessary to reflect that the Member is qualified for reinstatement of Medical Staff appointment and, as applicable reinstatement or a grant of new Privileges.

(c) If the absence was due to medical issues, the MEC may request that the Member obtain an impartial physical examination or mental evaluation. Failure to do so, without good cause, shall preclude the Member 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 Member chooses the evaluator and the MEC is not satisfied with the report, the MEC may request that the Member 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 Member's request for reinstatement of Medical Staff appointment and/or reinstatement or a grant of new Privileges is deemed complete, the procedure for reappointment/grant of new Privileges set forth in Article I or II shall, as applicable, be followed in evaluating and acting on such request.

4.1-3 **FAILURE TO RETURN FROM LEAVE**

(a) If a Member 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 V - REAPPLICATION & VOLUNTARY RESIGNATION OF MEDICAL STAFF APPOINTMENT & PRIVILEGES

5.1 REAPPLICATION AFTER ADVERSE AND CERTAIN OTHER CREDENTIALING DECISIONS

5.1-1 Except as otherwise provided in the Medical Staff Bylaws or this Policy or as recommended by the MEC and approved by the Board in light of exceptional circumstances, a Practitioner:

(a) Who has received a final Adverse decision regarding appointment/reappointment and/or Privileges/regrant of Privileges shall not be eligible to reapply for Medical Staff appointment and/or 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 appointment and Privileges automatically terminated pursuant to §9.5-1 (a), (b), (d), and (e) of the Medical Staff Bylaws shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years after the effective date of the automatic termination.

(c) Who has resigned his/her Medical Staff appointment and/or Privileges or fails to seek reappointment and/or 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 Medical Staff appointment and/or 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 Medical Staff appointment and/or Privileges as a result of unprofessional conduct or clinical competency concerns shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years after the effective date of the withdrawal.

Any such reapplication shall be processed as an initial application, in accordance with the procedure set forth in Article I, and the Practitioner 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.

5.1-2 No Practitioner may submit or have in process at any given time more than one (1) application for Medical Staff appointment and/or Clinical Privileges.

5.2 VOLUNTARY RESIGNATION OF MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

5.2-1 Resignation of Medical Staff appointment and/or 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.

5.2-2 A Practitioner who resigns his/her Medical Staff appointment and/or 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 a Practitioner fails to do so, consideration may be given by the Hospital to contacting the applicable State licensing board regarding the Practitioner's actions.

5.2-3 A request for appointment and/or Privileges subsequently received from a Practitioner who resigns his/her Medical Staff appointment/Privileges shall be processed in the manner specified for initial applications for Medical Staff appointment and/or Privileges.

ARTICLE VI - BOARD CERTIFICATION

6.1 BOARD CERTIFICATION QUALIFICATIONS

6.1-1 Unless otherwise provided in the Medical Staff governing documents, all Physicians, Podiatrists, and Oral Surgeons shall at the time of initial application for Medical Staff appointment and/or Privileges be board certified as follows:

(a) Physicians: By the American Board of Medical Specialties or American Osteopathic Association board applicable to their specialty/sub-specialty.

(b) Podiatrists: By the American Board of Podiatric Medicine or American Board of Foot and Ankle Surgery.

(c) Oral Surgeons: By the American Board of Oral & Maxillofacial Surgery.

6.1-2 A Physician, Podiatrist, or Oral Surgeon who is a qualified candidate for board certification at the time of initial application for Medical Staff appointment and/or Privileges shall have five (5) years (or such other longer or shorter time period set by the applicable certifying board) from the date of completion of residency or fellowship training to become board certified.

6.1-3 Physicians who were granted Medical Staff appointment and Privileges at the Hospital prior to January 1, 2020, who were not board certified at the time Medical Staff appointment and Privileges were initially granted, and who have continuously held appointment and Privileges at the Hospital (without board certification) since the time such appointment and Privileges were initially granted, are not required to be board certified.

6.1-4 Physicians, Podiatrists, and Oral Surgeons for whom board certification is required shall continuously maintain board certification as specified by the applicable specialty/subspecialty board unless a waiver is otherwise granted by the Board.

6.2 WAIVER OF BOARD CERTIFICATION

6.2-1 A written request for a waiver of the board certification qualification may be submitted by the Practitioner for consideration by the MEC and Board in accordance with the waiver procedure set forth in the Medical Staff Bylaws.

6.2-2 Examples of when a waiver of the board certification qualification may be requested includes, but is not limited to, the following circumstances:

(a) When a Physician, Podiatrist, or Oral Surgeon is not eligible for board certification (*e.g.*, foreign trained, *etc.*) but possesses equivalent qualifications.

(b) When a Physician, Podiatrist, or Oral Surgeon who is required to be board certified fails to attain board certification within the time period set by the applicable certifying board but possesses equivalent qualifications.

(c) When a Physician, Podiatrist, or Oral Surgeon who is required to maintain board certification fails the recertification examination. In such event, the Physician,

Podiatrist, or Oral Surgeon may request a temporary waiver in order to retake the examination at the next earliest available time the examination is offered.

(d) When a Physician, Podiatrist, or Oral Surgeon who is required to be board certified fails to maintain board certification but possesses equivalent qualifications.

6.2-3 Unless a waiver is requested and subsequently granted, a Physician's, Podiatrist's, or Oral Surgeon's failure to:

(a) Satisfy the requirement of board certification (or board eligibility, as applicable) at the time of initial application shall result in the Hospital's inability to process the application as a result of the Physician's, Podiatrist's, or Oral Surgeon's failure to meet baseline qualifications.

(b) Continuously satisfy the requirement of board certification (or board eligibility, as applicable) following attainment of Medical Staff appointment and/or Privileges shall result in an automatic termination of Medical Staff appointment and Privileges for failure to meet baseline qualifications.

ARTICLE VII - MISCELLANEOUS

7.1 DEFINITIONS

7.1-1 The definitions set forth in the Medical Staff Bylaws apply to this Medical Staff Policy unless otherwise provided herein.

7.1-2 For purposes of this Policy, whenever an individual is authorized to perform a duty by virtue of his/her position (*e.g*, the System CEO, System CMO, an Associate CMO, Hospital President, Chief of Staff, Department Chair, *etc.*), then reference to the individual shall also include the individual's designee.

7.2 MEDICAL STAFF DUES

7.2-1 APPLICABILITY

(a) Members of the Medical Staff (with the exception of emeritus, retired, consulting peer review, and reciprocal Members) shall pay annual dues in an amount recommended by the Medical Executive Committee and approved by the Board.

7.2-2 PROCEDURE

(a) Dues are payable for the calendar year within 45 days after the invoice date. Invoices are to be mailed no later than February 15th annually.

(b) If payment is not rendered within 45 days after the invoice date, a certified letter requesting payment and explaining the consequences of nonpayment shall be sent.

(c) Any Medical Staff Member whose dues have not been received by the Medical Staff Services Department within 30 days after the date of the certified letter shall have his/her Medical Staff appointment and Privileges automatically suspended until such time as the dues are paid.

(d) A Medical Staff Member with outstanding dues is not permitted to reapply for Medical Staff appointment and/or Privileges until the dues are paid.

7.3 PRACTITIONERS PROVIDING PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

7.3-1 QUALIFICATIONS AND SELECTION

A Practitioner 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 Medical Staff appointment and/or Privileges, be evaluated in the same manner, and fulfill the same Medical Staff obligations as any other Practitioner.

7.3-2 EFFECT OF CHANGE IN PRIVILEGES

A Practitioner'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 Medical Staff appointment and/or 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.

7.3-3 EFFECT OF CONTRACT EXPIRATION OR TERMINATION

(a) The effect of expiration or termination of a Practitioner's contract or employment with the Hospital (or the expiration or termination of a Practitioner's association with the group holding the contract with the Hospital) upon the Practitioner's Medical Staff appointment and/or Clinical Privileges at the Hospital will be governed solely by the terms of the Practitioner'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 Practitioner's appointment or Clinical Privileges, except that the Practitioner 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 a Practitioner is engaged is terminated or expires (or if the relationship of a Practitioner with the entity that has the exclusive contractual relationship with the Hospital is terminated or expires) then the Practitioner's Medical Staff appointment and those Privileges covered by the exclusive contract shall also be automatically terminated and the procedural rights afforded by the Fair Hearing Policy shall not apply; provided, however, that the Board in its sole discretion may waive this automatic termination result.

7.3-4 CLOSED DEPARTMENT/EXCLUSIVE CONTRACT

If the Hospital adopts a policy involving a closed Department or an exclusive contract for a particular service(s), any Practitioner 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 appointment/Privilege term.

7.4 CONFLICTS OF INTEREST

7.4-1 PROCESS

(a) In any instance where a Practitioner 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 Practitioner is expected to disclose the conflict to the individual in charge of the meeting. The Practitioner

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 Practitioner from participating in the pending matter.

(b) Medical Staff officers, Department Chairs, and committee chairs may routinely inquire, before initiating discussion, as to whether any Practitioner 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 Practitioner shall be called to the attention of the applicable Medical Staff officer, Department Chair, or committee chair by any Practitioner with knowledge of the conflict.

7.4-2 **DELEGATION**

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

7.4-3 **NO AUTOMATIC DISQUALIFICATION**

For purposes of Section 7.4, the fact that Practitioners are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such Practitioners from participating in the review of applications or other Medical Staff matters with respect to their colleagues.

7.5 **LEADERSHIP CONFLICTS OF INTEREST**

7.5-1 All Medical Staff nominees for a Medical Staff office, for a position on the MEC, for a Department Chair position, or for such other leadership positions as may be set forth in applicable conflict of interest policies shall disclose, in writing, those personal, professional, or financial affiliations or relationships that may result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff or Hospital and shall be managed in accordance with the applicable conflict of interest policies, as such policies may be amended from time to time.

7.5-2 Required disclosures shall be made prior to the applicable election or appointment. The requirement to disclose conflicts of interest is an ongoing obligation of Practitioners for as long as they hold Medical Staff appointment and/or Privileges at the Hospital.

7.5-3 The decision as to whether a conflict of interest exists precluding the Practitioner from holding such position shall be made in accordance with the applicable conflict of interest policies, as such policies may be amended from time to time.

7.6 **ADOPTION & AMENDMENT**

7.6-1 This Credentials Policy may be adopted and amended in accordance with the applicable procedure set forth in the Medical Staff Bylaws.

CERTIFICATION OF ADOPTION & APPROVAL

Adopted by the Medical Executive Committee on:

Approved by the Board on: