St. David's South Austin Medical Center

CREDENTIALS POLICY

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CREDENTIALS POLICY
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ARTICLE 1 - <u>GENERAL</u>

<u>1.A. DEFINITIONS</u>

The following definitions apply to terms used in this Policy, the Medical Staff Bylaws and the Organization Manual:

(1) "ADVANCED PRACTICE PROFESSIONALS" ("APPs") means individuals other than Physicians, Dentists, Oral Maxillofacial Surgeons, and Podiatrists who are authorized by law and by the Hospital to provide a certain level of patient care services pursuant to a delineation of Clinical Privileges. Generally the APP is required by law and/or the Hospital to exercise some or all of those Clinical Privileges pursuant to a written sponsorship/Supervision/collaborative agreement, delegation, direction or supervision by or in collaboration with a Supervising/Collaborating Practitioner. See Article 8 for further detail.

(2) "AFFILIATED ENTITY" means any entity which directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the Hospital.

(3) "APPLICANT" means an individual who has submitted a Request for Consideration ("RFC"), Recredentialing Request for Consideration ("RRFC"), Request for Increased New Clinical Privileges, or Change in Prescriptive Authority ("RFINCP"), or request for any other Clinical Privileges (for example, a request for temporary Privileges)" to the CPC and, after evaluation, has had his or her RFC/RRFC/RFINCP or other request for Privileges forwarded to the Medical Staff Office to be processed by the Hospital and Medical Staff Leaders as an Application.

(4) "APPLICATION" means a Request for Consideration ("RFC"), Recredentialing Request for Consideration ("RRFC"), Request for Additional Privileges ("RFINCP"), or other request for Clinical Privileges that has been forwarded by the CPC, after evaluation, to the Medical Staff Office for review in accordance with this Policy.

(5) "BOARD" or "BOARD OF TRUSTEES" means the local governing body of the Hospital, appointed by the Board of Directors which delegates specific authority and responsibility to the Board of Trustees. It is the governing body for purposes of compliance with The Joint Commission standards for the accreditation of hospitals and the Centers for Medicare & Medicaid Services ("CMS") Conditions of Participation for Hospitals. All references herein to "Board" are to the Board of Trustees unless specifically indicated otherwise and, specifically, are not references to the "Board of Directors."

(6) "BOARD OF DIRECTORS" means the body of individuals elected by the shareholders of the Corporation (or selected or appointed by the Partnership) to hold ultimate responsibility for the Hospital and to serve as the ultimate governing body of the Corporation (or Partnership).

(7) "BOARD CERTIFICATION" or "BOARD CERTIFIED" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the National Board of Physicians and Surgeons, the American Osteopathic Association, the American Board

of Oral and Maxillofacial Surgery, the American Board of Podiatric Medicine, or the American Board of Foot and Ankle Surgery, upon a Physician, Dentist, oral and maxillofacial surgeon, or Podiatrist, as applicable, or, for an Advanced Practice Professional, the designation conferred by a certifying body approved by the Hospital, as set forth in Hospital policy and/or the relevant delineation of Clinical Privileges.

(8) "CHIEF EXECUTIVE OFFICER" ("CEO") means the individual appointed by the Board of Directors to act on its behalf and on the behalf of the Board of Trustees in the overall management of the Hospital, or his or her designee.

(9) "CHIEF MEDICAL OFFICER" means the individual appointed by the Hospital to act as the Chief Medical Officer of the Hospital, at the direction of the CEO and in cooperation with the Chief of Staff, or his or her designee.

(10) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific clinical procedures and patient care services, subject to the provisions of this Policy.

(11) "COMPLETE" means, in the context of an Application for Membership or Clinical Privileges, that all questions presented to the individual have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. A Complete Application for Membership or Clinical Privileges will become incomplete if the need arises for new, additional, or clarifying information at any time.

(12) "CORE PRIVILEGES" or "CORE" means a defined grouping of Clinical Privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency or fellowship training for that specialty or subspecialty and that have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.

(13) "CREDENTIALING PROCESSING CENTER" ("CPC") means the regional credentialing center that provides intake, follow-up, data/image management, and verification of Requests for Consideration ("RFC"), Recredentialing Requests for Consideration ("RRFC"), Requests for Additional Privileges ("RFINCP"), and all other request for Clinical Privileges (for example temporary Privileges)2 pursuant to a Service Level Agreement with the Hospital.

(14) "DAYS" means calendar Days.

(15) "DENTIST" means a doctor of dental surgery ("D.D.S."), doctor of dental medicine ("D.M.D.") or doctor or Oral/Maxillofacial surgery ("O.M.S").

(16) "FAVORABLE RECOMMENDATION" means a recommendation that does not entitle an individual to request a hearing as provided in Article 8 of the Medical Staff Bylaws or the Hearing and Appeals Article in this Policy.

(17) "GOOD STANDING" means that ***none*** of the following have occurred with a Practitioner during the most recent five (5) years the Practitioner was on the Medical Staff (the "Good

Standing” definition is effective relative to actions taken on or after June 1, 2019, it is not retroactive for purposes of providing Affiliation Verifications):

(1) automatic relinquishment (or resignation) of appointment or clinical privileges for any reason set forth in the Medical Staff Bylaws, Credentials Policy, or other Medical Staff policies (except for those relinquishments that result from incomplete medical records);

(2) voluntary agreement to modify clinical privileges or to refrain from exercising some or all clinical privileges for a period of time for reasons related to the Practitioner’s qualifications or performance;

(3) participation in a Performance Improvement Plan under the Professional Practice Evaluation Policy or Medical Staff Professionalism Policy;

(4) resignation of membership or clinical privileges while clinical care, professional conduct, or health status is being reviewed under the Professional Practice Evaluation Policy (Peer Review), Medical Staff Professionalism Policy, or Practitioner Health Policy;

(5) resignation of membership or clinical privileges while under an investigation in accordance with the Medical Staff Credentials Policy, or in exchange for not conducting an investigation;

(6) precautionary suspension or restriction of the Practitioner’s clinical privileges;

(7) formal investigation in accordance with the Medical Staff Credentials Policy;

(8) a grant of conditional membership or privileges (either at initial appointment or reappointment), or conditional continued membership;

(9) any recommendation that would entitle the Practitioner to a Medical Staff hearing pursuant to the Medical Staff Credentials Policy or procedural rights under the Policy on Advanced Practice Professionals; and/or

(10) a Health Issue that was assessed under the Practitioner Health Policy.

(18) “HCA” means Hospital Corporation of America which is a joint owner of the Hospital and provides management services.

(19) “HOSPITAL” means St. David’s South Austin Medical Center.

(20) “INELIGIBLE PERSON” means any individual who is (1) currently excluded, suspended, debarred, or otherwise ineligible to participate in federal health care programs; (2) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible; or (3) is currently excluded on a Texas exclusion list, including but not limited to, the Texas

Health and Human Services Commission Office of Inspector General Exclusion List (TXOIG).

(21) "INVESTIGATION" means the process of gathering and reviewing information related to a concern involving a Practitioner, which begins after a formal resolution by the Medical Executive Committee or Board to commence an Investigation and is concluded after final action has been taken on the matter that was subject to Investigation, as set forth in this Policy.

(22) "MEDICAL EXECUTIVE COMMITTEE" or "MEC" means the Medical Executive Committee of the Medical Staff.

(23) "MEDICAL PEER REVIEW" means "medical peer review" as defined by Texas Occupations Code Section 151.002(a)(7), which is "the evaluation of medical and health care services, including evaluation of the qualifications and professional conduct of professional health care practitioners and of patient care provided by those practitioners. The term includes evaluation of the: (A) merits of a complaint relating to a health care practitioner and a determination or recommendation regarding the complaint; (B) accuracy of a diagnosis; (C) quality of the care provided by a health care practitioner; (D) report made to a medical peer review committee concerning activities under the committee's review authority; (E) report made by a medical peer review committee to another committee or to the board as permitted or required by law; and (F) implementation of the duties of a medical peer review committee by a member, agent, or employee of the committee." Medical Peer Review includes a "Professional Review Action" and "Professional Review Activity" as defined below.

(24) "MEDICAL STAFF" means the body comprised of all Physicians, Dentists, Oral Maxillofacial Surgeons, and Podiatrists who have been granted Membership in the Medical Staff by the Board.

(25) "MEDICAL STAFF LEADER" means any Medical Staff officer, department chairperson, section chair, or committee chairperson.

(26) "MEDICAL STAFF YEAR" means the period from June 1 to May 31 each year.

(27) "MEMBER" means any Physician, Dentist, Oral Maxillofacial Surgeon, or Podiatrist, who currently holds Membership in the Medical Staff.

(28) "MEMBERSHIP" means the designation of being a Member of the Medical Staff, following a grant of Membership in the Medical Staff by the Board.

(29) "NON-PRIVILEGED HEALTHCARE PRACTITIONER" means an individual who by HCA Policy is allowed to order specific outpatient diagnostic tests and services, but who is not a Member of the Medical Staff or an Advanced Practice Professional, and has not been granted Clinical Privileges to practice at the Hospital.

(30) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail or hand delivery. Notice by U.S. mail or Hospital mail shall be deemed delivered on the third day following deposit with the U.S. mail or Hospital mail.

(31) "ORAL MAXILLOFACIAL SURGEON" means an individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation (CODA).

(32) "PATIENT CONTACT" includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital, including outpatient facilities.

(33) "PHYSICIAN" means a doctor of medicine ("M.D.~~s~~") or a doctor of osteopathy ("D.O.~~s~~").

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

(35) "PRACTITIONER" means any individual who has been granted Clinical Privileges and/or Membership by the Board, including, but not limited to, Members of the Medical Staff and Advanced Practice Professionals.

(36) "PRESENT" and "PRESENCE" means in-person attendance or active participation by telephone or other electronic means in a meeting unless otherwise provided.

(37) "PROFESSIONAL PRACTICE EVALUATION" ("PPE") refers to the Hospital's ongoing Medical Peer Review processes. These processes include, but are not limited to, the review and assessment of Practitioners' clinical performance, professionalism, and health status/ability to exercise Clinical Privileges safely and competently.[1]

(38) "REQUEST FOR INCREASED, NEW CLINICAL PRIVILEGES, OR CHANGE IN PRESCRIPTIVE AUTHORITY" ("RFINCP") means the form that a Practitioner completes and submits to the CPC for evaluation in order to request consideration for Clinical Privileges that are in addition to those Clinical Privileges that have already been granted to the Practitioner at the Hospital.

(39) "PROFESSIONAL REVIEW ACTION" and "PROFESSIONAL REVIEW ACTIVITY" have the meanings defined in the Health Care Quality Improvement Act of 1986 ("HCQIA")[2], specifically an action or recommendation of a professional review body (Board or Medical Staff committee): (a) which is taken or made in the conduct of professional review activity, (b) which is based on the competence or professional conduct of a Practitioner, (c) which conduct affects or could affect adversely the heath or welfare of a patient or patients, and (d) which affects (or may affect) adversely the clinical privilege of the Practitioner. [2]

(40) "PSYCHOLOGIST" means an individual with a Ph.D. in clinical psychology.

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[1] MS.08.01.01; MS.08.01.03

[2] 42 U.S.C. §11101 *et seq.*

(41) "QUORUM" means, unless specifically stated otherwise, 10% of those Medical Staff Members with the prerogative to vote and who are voting members Present (but not fewer than three members) at any regular or special meeting of the Medical Staff, department, section, committee, or other body.

(42) "RECREDENTIALING REQUEST FOR CONSIDERATION" ("RRFC") means the form that a Practitioner submits to the CPC for evaluation in order to request consideration for renewed Medical Staff Membership and Clinical Privileges.

(43) "REQUEST FOR CONSIDERATION" ("RFC") means the form that a Practitioner completes and submits to the CPC for evaluation in order to request consideration for initial Membership in the Medical Staff and Clinical Privileges.

(44) "RESTRICTION" means a mandatory concurring consultation, where the consultant must approve the proposed procedure or treatment before Clinical Privileges may be exercised. It does not include conditions for performance improvement placed upon the exercise of Clinical Privileges, such as general consultation, second opinions, proctoring, monitoring, education, training, mentoring or specification of a maximum number of patients, nor does it include a limitation on the exercise of Clinical Privileges resulting from an exclusive arrangement with another Practitioner or group of Practitioners or other action by the Board.

(45) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt. Special Notice is deemed delivered on the date actually delivered (or refused) by the addressee or a member of the addressee's office staff.

(46) "SPECIAL CLINICAL PRIVILEGES" means Clinical Privileges that fall outside of the Core Privileges for a given specialty, which the Hospital has determined require additional education, training, or experience beyond that required for Core Privileges in order to demonstrate competence.

(47) "SUPERVISING/COLLABORATING PRACTITIONER" means a Practitioner with Clinical Privileges, who has agreed in writing and has been approved to provide any required delegation, direction or supervision and or collaboration to an Advanced Practice Professional and to accept full responsibility for the actions of the Advanced Practice Professional while he or she is practicing in the Hospital.

(48) "SUPERVISION" means the Supervision of (or collaboration with) an Advanced Practice Professional by a Supervising/Collaborating Practitioner, that may or may not require the actual presence of the Supervising/Collaborating Practitioner, but that does require, at a minimum, that the Supervising/Collaborating Practitioner be readily available for consultation. The requisite level of Supervision (general, direct, or personal) will be determined at the time each Advanced Practice Professional is credentialed and set forth on the delineation of Clinical Privileges, at a minimum to reflect any applicable accreditation or legal requirements.

(49) "RELINQUISH AND RELINQUISHMENT" means an automatic action of giving up certain rights and/or clinical privileges as a result of a practitioner's failure to meet established

criteria or provide information as required or requested. Depending on the basis for the action and as provided in the Credentials Policy or Medical Staff Bylaws, once a matter leading to relinquishment is resolved, the practitioner may be reinstated or failure to resolve may result in an automatic resignation. While taken in the course of medical peer review, a relinquishment is not the result of a professional review action.

(50) "SUSPEND AND SUSPENSION" means an action to temporarily prevent a practitioner from exercising certain rights and/or clinical privileges as a result of a professional review action taken by the Medical Staff or Board of Trustees based on professional competence or conduct. Depending on the circumstances of the action including length of the suspension, it may require a report to the National Practitioner Data Bank and state licensing agency.

(51) "QUALIFIED MEDICAL PERSON OR PERSONNEL ("QMP") means in addition to a physician, QMPs may perform a Medical Screening Examination (MSE). Individuals in the following professional categories, who have demonstrated current competence in the performance of MSEs, and who are functioning within the scope of his or her license and policies of the Hospital, have been approved by the Board as QMP: Registered Nurse in Perinatal Services, Psychiatric Social Worker, Registered Nurse in Psychiatric Services, Psychologist, Physician Assistant, or Advanced Registered Nurse Practitioner.

1.B. DELEGATION OF ADMINISTRATIVE AND MEDICAL STAFF LEADERSHIP FUNCTIONS

(1) Except as follows, when a function is to be carried out by a Member of Hospital Administration, by a Medical Staff Leader or by a Medical Staff committee, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees. Delegation is not permitted in the following situations:

(a) When the Medical Executive Committee is making a recommendation directly to the Board to grant, deny, restrict, suspend, or revoke the Membership or Clinical Privileges of an individual; and

(b) When the Board is rendering its preliminary or final determination to grant, deny, restrict, suspend, or revoke the Membership or Clinical Privileges of an individual.

(2) When a Medical Staff Member or other Practitioner is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.C. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.C.1. Confidentiality:

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

(1) to another authorized individual or body, whether internal or external to the Hospital, for the purpose of conducting Medical Peer Review;

(2) as authorized by Hospital or Medical Staff any policies, including policies governing the sharing of credentialing and peer review information among Affiliated Entities; or

(3) as authorized by the Chief Executive Officer or by legal counsel to the Hospital or as required by law.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a Professional Review Action or appropriate legal action. Breaches of confidentiality shall not constitute a waiver of any legal privilege. Any Practitioner who becomes aware of a breach of confidentiality is encouraged to inform the Chief Executive Officer, the Chief Medical Officer, or the Chief of Staff (or the Chief of Staff-elect if the Chief of Staff is the person committing the claimed breach).

1.C.2 Medical Peer Review Committee Status:

The Medical Executive Committee, the departments, sections and any service lines, and all Medical Staff, department, section and service line committees (whether standing, special, ad hos, subcommittee, joint committee, task force, hearing and appellate review panel), as well as the Medical Staff when meeting as a whole, shall be constituted and operate as a "medical peer review committee," "medical committee," and "professional review body," as such terms are defined by Texas or federal law, and are authorized by the Board through these Bylaws to engage in Medical Peer Review. The provision shall also apply to any Hospital or other committees engaged in Medical Peer Review at the Hospital, including the Board and its committees.

1.C.3. Peer Review Protection:

Medical Peer Review, including but not limited to any Professional Review Activity, will be performed by the peer review committees. Peer review committees include, but are not limited to:

(1) all standing, special, joint, subcommittee, task force, and ad hoc Medical Staff and Hospital committees;

(2) all departments, sections, and service lines and if established;

(3) hearing and appellate review panels;

(4) the Board and its committees; and

(5) any individual or body acting for or on behalf of a peer review committee, Medical Staff Leaders, and experts or consultants retained by a peer review committee to assist in Professional Review Activity.

All oral and written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and privileged records and proceedings of a

medical peer review committee to the fullest extent permitted by Texas law, and also are deemed to be "Professional Review Activity."[3]

1.C.4. Waiver of Confidentiality Privilege:

The privilege of confidentiality for records and proceedings of Medical Peer Review, including but not limited to Professional Review Activity, by peer review committees may only be waived on the written consent of the chair of the committee, department, section, or service line, and the Chief Executive Officer.

1.D. INDEMNIFICATION OF PRACTITIONERS

To the extent permissible under state law, the Hospital or an Affiliated Entity shall indemnify any present or former Practitioner engaged in Hospital or Medical Staff business through committee appointments or other service, to the extent and in the manner set forth in the Medical Staff Bylaws, Credentials Policy, and Organization Manual. Indemnification may take the form of insurance and is intended to cover the cost of settlements or awards, as well as the costs of defending the individual, in any threatened or actual action, suit, or proceeding to which the Practitioner is made a party by virtue of his or her service on behalf of the Hospital, as a result of appointment or election to an office or committee or at the request of the Hospital. Indemnification pursuant to this provision shall not be deemed exclusive of any other rights or protections to which those Practitioners may be entitled under the Bylaws, an agreement, by determination of the Board of Trustees, or through insurance purchased by the Hospital.

Indemnification shall not be provided in matters where the Practitioner is finally adjudged to be liable of willful misconduct amounting to bad faith. Also, indemnification pursuant to this provision shall not extend to the professional practice or clinical activities of any Practitioner.

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[3] 42 U.S.C. §11101 *et seq*.

ARTICLE 2 - QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS[4]

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for or maintain Membership or Clinical Privileges, an individual must submit a Request for Consideration ("RFC"), Recredentialing Request for Consideration ("RRFC"), or other request for Clinical Privileges (on the forms provided by the CPC)" to the Credentialing Processing Center ("CPC") and must continuously demonstrate satisfaction of all of the following threshold eligibility criteria, as applicable:

(1) have a current, unrestricted license to practice in this state that is not subject to any Restrictions, probationary terms, or conditions not generally applicable to all licensees, and have never had a license to practice revoked, restricted or suspended by any professional licensing agency in any state or other jurisdiction. The license required in this Section may be from a state other than Texas only as follows:

(a) the individual is an active duty military member and will be practicing exclusively within the scope of his or her military duties for patients who are members of the armed forces or their dependents; or

(b) the individual is seeking telemedicine Clinical Privileges, in which case the individual must either be licensed or meet the alternative licensing requirements applicable to telemedicine providers in both the state where the individual is located and the state where this Hospital is located.

(c)_ the individual has obtained an official exception to the regular state licensing requirements from the Texas licensing agency or entity or holds a temporary or limited license, and is seeking to practice at the Hospital only in accordance with the exception or temporary or limited license that has been granted;

(2) if the individual is an Advanced Practice Professional that falls within a category that is granted licensure and prescriptive authority separately (whether in this state or in any other state that the individual has ever been licensed or practiced), the individual must have never had his or her prescriptive authority revoked, restricted, or suspended by any professional licensing agency in any state or other jurisdiction;

(3) satisfy the following professional education requirements:

(a) for a Physician, have successfully graduated from a school of medicine accredited by the Association of American Medical Colleges or the American Association of Colleges of Osteopathic Medicine. If the Physician is a foreign medical graduate, he or she must have successfully graduated from a foreign medical school and

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[4] 42 C.F.R. §482.22(c)(4)

have completed the Education Commission for Foreign Medical Graduate (ECFMG) or an accredited Fifth Pathway Program;

(b) for a Dentist or an Oral and Maxillofacial Surgeon, have successfully graduated from a school of dentistry accredited by the Commission on Accreditation of the American Dental Association;

(c) for a Podiatrist, have successfully graduated from a school of podiatry accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(d) for Advanced Practice Professionals, have satisfied the applicable education requirements, as established by their professional certification boards, Hospital policy and the relevant delineation of Clinical Privileges;

(4) satisfy the following professional training requirements:

(a) for a Physician, have successfully completed a residency and, if applicable to the Physician's subspecialty, a fellowship training program both of which must be approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in all specialties in which the Physician seeks Clinical Privileges;

(b) for a Dentist or an Oral and Maxillofacial Surgeon, have successfully completed a training program accredited by the Commission on Dental Accreditation of the American Dental Association;

(c) for a Podiatrist, have successfully completed a podiatric residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(d) for Advanced Practice Professionals, have satisfied the applicable training requirements, as established by Hospital policy and the relevant delineation of Clinical Privileges;

(5) satisfy the following Board Certification requirements:

(a) to be eligible for Membership or Clinical Privileges:

(i) be Board Certified (as defined in this Policy) in their primary area of practice at the Hospital. Individuals who are not Board Certified at the time of Application but who have completed their residency or fellowship or other applicable training within the last five years will be eligible for Medical Staff Membership or Clinical Privileges. However, in order to remain eligible, those individuals must achieve Board Certification in their primary area of practice within five years from the date of completion of their residency, fellowship or other required training;

(ii) maintain Board Certification in their primary area of practice at the Hospital and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed at the time of renewal of Membership or Clinical Privileges; and

Individuals already granted Medical Staff Membership or Clinical Privileges prior to January 1st, 2007, will be governed by the Board Certification, recertification, and maintenance of certification requirements governing eligibility for Membership that were in effect at the time of their initial Membership or initial grant of Clinical Privileges.

(b) to be eligible for specific Clinical Privileges, satisfy any Board Certification, recertification, and maintenance of certification requirements set forth in the applicable delineation of Clinical Privileges and other Hospital and Medical Staff policies;

The above certification requirements do not apply to medical staff members who do not possess clinical privileges (i.e. membership only categories) or to any member who only holds surgical assist clinical privileges.

(6) have a current, unrestricted DEA registration that is linked to an address in this state, as applicable to the Clinical Privileges being sought by the Practitioner;

(7) be lawfully authorized to work in the United States of America, whether through citizenship, permanent resident status, possession of a valid visa, or otherwise;

(8) have current, government-issued photographic identification which is either written in English or has been translated by a professional translation service and which, on its face, verifies the individual's identity;

(9) With the exception of those applying for membership only status (i.e. Affiliate, Emeritus, etc.), have current, valid professional liability insurance coverage in a form acceptable to the Hospital, including insurance through a carrier authorized to do business in the State of Texas as a licensed provider of professional malpractice insurance, insurance for the clinical privileges requested, and with limits of at least $200,000 on for each claim and $600,000 in aggregate. Those practitioners providing locum tenens coverage only shall maintain either continuous coverage as required above or occurrence-based liability insurance applicable to the term of the locum tenens coverage, in no less than the minimum amounts as from time to time may be determined by resolutions of the Board, regardless of when a claim may be asserted;

(10) meet any current privileging eligibility requirements that are applicable to the Clinical Privileges being sought;

(11) if applying for Clinical Privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in the contract or Board resolution setting forth the decision to proceed with that arrangement;

(12) agree to, and fulfill, all responsibilities regarding emergency call for their specialty;

(13) demonstrate recent clinical activity in an acute care hospital, sufficient to support an evaluation of current clinical competence, during the last two years;

(14) be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of inpatients and Emergency Department patients in a prompt, efficient, and conscientious manner. ("Appropriate coverage" means coverage by another member of the Medical Staff with specialty-specific privileges equivalent to the Practitioner for whom he or she is providing coverage.) Compliance with this eligibility requirement means that the Practitioner is willing and able to:

(a) Respond within 15 minutes, via phone, to STAT pages from the Hospital and respond within 30 minutes, via phone, to all other pages; and,

(b) Appear in person to attend to a patient within 30 minutes, when requested to do so by the Practitioner caring for the patient at the Hospital in a situation that requires urgent attention;

(15) have an appropriate coverage arrangement, as determined by the Medical Executive Committee, with other Practitioners who are qualified and have the appropriate Clinical Privileges, for those times when the individual will be unavailable;

(16) if seeking to practice as an Advanced Practice Professional, must have a written agreement with a Supervising/Collaborating Practitioner, which agreement must meet all applicable requirements of state law and Hospital policy;

(17) have never had medical staff membership or clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;

(18) have never resigned medical staff membership or relinquished clinical privileges during an Investigation or in exchange for not conducting an Investigation at any health care facility, including this Hospital;

(19) have never had an RFC, RRFC, RFINCP, other request for Clinical Privileges, or Application for Membership or Clinical Privileges deemed ineligible for continued processing or denied by the Hospital, the CPC, or any Affiliated Entity due to a finding of material omission or misrepresentation;

(20) have never been expelled from a post-graduate training program (residency or fellowship or equivalent program for Advanced Practice Professionals), nor resigned from such a program during an Investigation or in exchange for the program not conducting an Investigation;

(21) since the start of medical or professional education, have not been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to controlled substances, illegal drugs, violent acts, sexual misconduct, moral turpitude, domestic, child or elder abuse, or Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay a civil money penalty for any such fraud or program abuse;

(22) have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances (Substances listed in the federal Controlled Substance Act), illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence; have never been convicted by military court martial or been dishonorably discharged from the military, and;

(23) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program and is not otherwise an Ineligible Person; and

(24) have been elevated to Applicant status through the CPC after submitting an RFC/RRFC/RFINCP or other request for Clinical Privileges.

2.A.2. Failure to Satisfy Threshold Eligibility Criteria:

(1) Any individual or Applicant who does not satisfy one or more of the threshold eligibility criteria set forth in this Policy will be informed of the threshold eligibility criteria not satisfied. Unless a waiver has been requested and granted, as outlined below, the RFC/RRFC/RFINCP, other request for Clinical Privileges, and/or Application will not be processed.

(2) Process for requesting and granting waivers:

(a) Any individual wishing to request a waiver may submit a written request, along with evidence of exceptional circumstances, to the Hospital's Medical Staff Office. Because waivers are; intended to be used rarely and are an "exception to the rule," the Hospital and Medical Staff Leaders have no obligation to inform an individual of the right to request a waiver, nor to contact an individual to ask whether he or she wishes to request a waiver.

(b) Waivers of threshold eligibility criteria will not be granted routinely and will be considered only if the individual requesting waiver demonstrates that exceptional circumstances exist and that he or she is otherwise qualified. As a general rule, "exceptional" circumstances are those that are outside the norm (e.g. there is a demonstrated community or coverage need for the services provided by the individual and that need cannot reasonably be met by other practitioners, there has been a delay in the individual satisfying the relevant criterion due to a serious illness or injury affecting the individual or an immediate family member, or the individual has provided evidence of mitigating circumstance and/or remediation activities that are above and beyond the norm). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of the requesting individual

(e.g. failure to achieve board certification or recertification due to being busy or forgetful).

(c) Request for waiver will be considered by the Medical Executive Committee. In reviewing the request for a waiver, the Medical Executive Committee may consider input from the relevant department chairperson, and the best interests of the Hospital and the communities it serves. Additionally, the Medical Executive Committee may , in the discretion, consider any aspect of the Practitioner's qualifications, including information from the RFC/RRFC/RFINCP or other request for Clinical Privileges and/or application form, or other information supplies by the individual (for example, a re-entry plan submitted pursuant to the Policy for Practitioner Re-Entry.

The Medical Executive Committee will review the request and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. The Medical Executive Committee must articulate the basis for its recommendation.

The Board will consider the recommendation of the Medical Executive Committee and make a determination regarding whether to grant a waiver. The Board's determination is final.

(d) The individual who requested the waiver will be given Notice of the Board's determination.

(i) if the Board has granted a waiver, the individual will be deemed eligible and in turn, processing of the RFC/RRFC/RFINCP or other request for Clinical Privileges and/or Application will proceed as set forth in this Policy, in the same manner that other eligible individuals are credentialed;

(ii) the individual will be granted the same waiver if he or she requests it again at a future date (e.g. at the time an RRFC or reappointment Application is made, there is no guarantee that the same waiver will be granted);or

(iii) that the criteria for Membership or Clinical Privileges will remain unchanged and the individual will remain eligible indefinitely.

(g) A recommendation of the Medical Executive Committee or a determination of the Board not to grant a waiver of the threshold eligibility criteria is not a "denial" of Membership or Clinical Privileges, nor is it a Professional Review Action.

(h) An individual who requests a waiver is not entitled to a hearing or appeal or any other due process pursuant to the Medical Staff Bylaws, Credential Policy, or other rules, regulation, policies or procedures of the Medical Staff or Hospital for any matter related to the request, the Hospital and Medical Staff Leaders' consideration of the request, and/or the determination to grant a waiver or not to grant a waiver.

2.A.3. Burden of Providing Information:

(1) All Applicants, Members, and other Practitioners have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts. This includes participating in personal or phone interviews in regard to an Application.

(2) All Applicants, Members, and other Practitioners have the burden of providing evidence that all the statements made and all information provided by them in support of the Application are accurate and Complete.

(3) All Applicants, members, and other practitioners are responsible for providing a Complete Application and any supplemental information, including adequate responses from references or other third parties. An Application will be considered not Complete if the need arises for new, additional, or clarifying information. An Application that is not Complete will not be processed. Any Application that continues to not be Complete 30 Days after the Applicant has been notified of the additional information required and that the Application will be withdrawn if the information is not received within 30 days will be deemed to be withdrawn.

(4) During the credentialing process and throughout the term of any Membership and/or Clinical Privileges, Applicants and Practitioners are responsible for immediately (and in no event later than three business days after being provided notice of the change) notifying the Chief of Staff, the Chief Executive Officer, or the CPC, as applicable, of any change in status or any change in the information provided as part of the RFC/RRFC/RFINCP or other request for Clinical Privileges and Application including, and with the addition of, the following:

(a) any investigation commenced by another health care organization, state licensure agency, the federal DEA or a state drug control agency, or a specialty certification board;

(b) any payer contract termination;

(c) any criminal investigation commenced regarding the individual including but not limited to the arrest or conviction of any Class A misdemeanor or felony offense of any nature; or

(d) any investigation commenced or sanction imposed or recommended by any subdivision or office of the Department of Health and Human Services or any other federal or state health care or oversight entity.

2.A.4. Factors for Evaluation:

The following factors will be evaluated as part of the processes of considering individuals for Membership and Clinical Privileges:

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

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

(3) good reputation and character;

(4) ability, with or without reasonable accommodation, to safely and competently perform the Clinical Privileges requested and any other essential functions of Medical Staff Membership and/or the exercise of Clinical Privileges;

(5) ability to communicate in an understandable manner in English and maintain all medical record entries legibly and in English, sufficient for the safe delivery of patient care;

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

(7) recognition of the importance of, and willingness to support, a commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.5. No Entitlement to Membership:

No one is entitled to receive an RFC/RRFC/RFINCP or other request for Clinical Privileges form, to be granted Membership in the Medical Staff, or to exercise or be granted particular Clinical Privileges merely because he or she:

(1) is employed by this Hospital or Affiliated Entities or has a contract with this Hospital;

(2) is or is not a member or employee of any particular Physician group;

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

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

(5) has had in the past, or currently has, medical staff membership or clinical privileges at any hospital or health care facility;

(6) resides in the geographic service area of the Hospital;

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

(8) is certified by any specialty certification board.

2.A.6. Nondiscrimination:

No one will be denied Membership or Clinical Privileges on the basis of race, color, gender, creed/religion, or national origin, or any other grounds prohibited by law.[5]

2.B. GENERAL CONDITIONS OF MEMBERSHIP

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted initial or renewed Membership or Clinical Privileges and as a condition of ongoing Membership or Clinical Privileges, every individual specifically agrees to the following:

(1) to provide continuous and timely care at the generally recognized level of quality and efficiency and refrain from delegating responsibility for Hospital patients to any individual who is not appropriately licensed, qualified, supervised and, as applicable, granted the Clinical Privileges or scope of practice necessary to perform the delegated responsibility;

(2) to abide by the Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff[6], the Code of Conduct of the Medical Staff and HCA, the code of ethical business and professional behavior of the Hospital; all local, state, and federal laws and regulations applicable to the Hospital or to the Practitioner's professional practice; and the Joint Commission and other accreditation standards currently in existence or as may be adopted or amended in the future;

(3) to participate in Medical Staff affairs through committee service and participation in Medical Peer Review activity, including but not limited to, performance improvement, peer review, and professional practice evaluation activities, and to perform such other reasonable duties and responsibilities as may be assigned;

(4) to provide emergency call coverage (in accordance with the call plan established by the department or section and approved by the Medical Executive Committee and Board), consultations, and care for unassigned patients;

(5) to comply with or document the clinical reasons for variance from clinical practice or evidence-based protocols pertinent to his or her medical specialty, as may be adopted by the Medical Executive Committee;

(6) to comply with or document the clinical reasons for variance from clinical practice or evidence-based protocols that have been adopted by the Hospital as part of its performance improvement program or for compliance with or reporting to regulatory or

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5 MS.06.01.07, EP 3

6 42 C.F.R. §482.22(a)(2)

accrediting agencies or patient safety organizations, including those related to national patient safety initiatives, core measures, and other performance measures;

(7) to obtain, when requested, an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood, urine, or hair testing) or a complete physical, mental, and/or behavioral evaluation, as set forth in this Policy and other Medical Staff policies;

(8) to obtain, when requested, an evaluation of current clinical competence by a consultant or program selected by the Hospital;

(9) to use the Hospital sufficiently to allow continuing assessment of current competence;

(10) to seek consultation whenever necessary;

(11) to complete in a timely manner all medical and other required records;

(12) to utilize the Hospital's electronic medical record system and computerized physician order entry as the primary mode of order entry;

(13) to perform all services and to act in a cooperative and professional manner;

(14) to promptly pay any applicable dues, assessments, or fines;

(15) to satisfy continuing medical education requirements as required by the Texas Medical Board and any applicable specialty board;[7]

(16) to attend and participate in any applicable orientation programs at the Hospital before participating in direct patient care;

(17) to comply with all applicable training and educational protocols that may be adopted by the Medical Executive Committee or required by the Hospital, including, but not limited to, those involving electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, patient safety, and EMTALA;

(18) prior to becoming eligible to begin exercising Clinical Privileges and engaging in any patient care at the Hospital, to comply with all health screening and immunization requirements set forth by Hospital policy;

(19) to cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third-party payors;

(20) to maintain a current, direct e-mail address with the Medical Staff Office (in addition to physical office address and other contact information), which may be used as the primary

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[7] MS.12.01.01

mechanism for communicating all information relevant to the individual's Membership status or Clinical Privileges;

(21) to disclose relationships with pharmaceutical companies, device manufacturers, other vendors or other persons or entities as may be required by Hospital or Medical Staff policies, including, but not limited to, disclosure of financial interests in any product, service, or medical device that a Practitioner may request the Hospital to purchase or approve for use;

(22) if the individual is a Member of the Medical Staff who serves or plans to serve as a Supervising/Collaborating Practitioner to an Advanced Practice Professional, the Member of the Medical Staff will abide by the Supervision requirements and conditions of practice set forth in Article 8; and

(23) if the individual is an Advanced Practice Professional, the individual will also abide by the conditions of practice set forth in Article 8.

2.C. CONDITIONS OF APPLICATION AND CONSIDERATION

2.C.1. Scope of Conditions:

The terms set forth in this Section:

(1) commence with the individual's initial contact with the CPC or the Hospital, whether or not an RFC/RRFC/RFINCO or other request for Clinical Privileges is furnished, an Application is processed, or Membership or Clinical Privileges are granted;

(2) apply throughout the credentialing process and the term of any initial or renewed Membership or Clinical Privileges; and

(3) continue, even if Membership or Clinical Privileges are denied, revoked, reduced, restricted, suspended, or otherwise affected as part of the Hospital's professional review activities and even if the individual no longer maintains Membership or Clinical Privileges at the Hospital.

2.C.2. Misstatements and Omissions:

(1) Any misstatement in, or omission from, an RFC/RRFC;RFINCP, or other request for Clinical Privileges form, Application, or any other information submitted as part of the RFC/RRFC/RFINCP or Privileging or Application processes is grounds to stop the process. The Practitioner will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Chief of Staff and Chief Executive Officer will review the response and determine whether the Application should be processed.

(2) If Membership or Clinical Privileges have been granted prior to the discovery of a misstatement or omission, Membership and Clinical Privileges may be deemed to be automatically relinquished pursuant to this Policy.

(3) No action taken pursuant to this Section will entitle an Applicant or Practitioner to a hearing or appeal under the Medical Staff Bylaws or this Policy.

2.C.3. Authorization to Obtain/Release Information:

(1) Information Defined:

For purposes of this Section, "information" means information about the individual, regardless of the form (which shall include oral, electronic, and paper), which pertains to the individual's Membership or Clinical Privileges or the individual's qualifications for the same, including, but not limited to:

(a) information pertaining to the individual's clinical competence, professional conduct, reputation, ethics, and ability to practice safely with or without reasonable accommodation;

(b) any matter addressed on the RFC/RRFC/RFINCP, or other request for Clinical Privileges, Application, or in the Medical Staff Bylaws, Credentials Policy, and other policies and Rules and Regulations of the Hospital, HCA Affiliated Entities, and its Medical Staff;

(c) any reports about the individual which are made to the National Practitioner Data Bank or relevant state licensing boards/agencies; and

(d) any references or peer evaluations received or given about the individual.

(2) Authorization for Background Check:

The individual agrees to sign consent forms to permit a consumer reporting agency to conduct a background check and report the results to the CPC and the Hospital.[8]

(3) Authorization to Share Information Among Affiliated Entities:

The individual specifically authorizes HCA Healthcare Entities (as defined below) and their authorized agents to share with one another any information maintained in any format (verbal, written, or electronic) that involves (i) the evaluation of the quality and efficiency of services ordered or performed by the individual, or (ii) the individual's professional qualifications, competence, conduct, health/ability to safely practice, experience, or patient care practices.. This information and documentation may be shared at any time, including, but not limited to, any initial evaluation of an individual's qualifications, any periodic reassessment of those qualifications, or when a question is raised about the individual.

For the purposes of this Section 2.C., an HCA Healthcare Entity means:

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[8] The Fair Credit Reporting Act, 15 U.S.C. §1681 *et seq.*

(a) any entity which:

(i) offers health care services through Practitioners who are credentialed by the CPC, excluding managed care entities for which the CPC provides services as part of a delegated credentialing agreement; and

(ii) has a formal peer review/professional practice evaluation process and an established peer review committee, as evidenced by internal bylaws or policy; and

(b) any entity not included in section (a) that provides patient care services and that:

(i) has a formal peer review/professional practice evaluation process and an established peer review committee, as evidenced by internal bylaws or policy; and

(ii) has appropriate provisions regarding the sharing of Confidential Information consistent with Ethics & Compliance Policy CSG.PPA.001: "*Sharing Credentialing, Privileging, and PPE Information Among HCA Healthcare Entities*" in a professional services contract or separate agreement with HCA Healthcare or an HCA Healthcare Entity identified in section (a).

(4) Authorization to Obtain Information from Third Parties:

The individual authorizes the Hospital, its Medical Staff Leaders, the HCA Healthcare Entities and any of their representatives to request or obtain information from third parties and specifically authorizes third parties to release information to the Hospital and HCA Healthcare Entities.

(5) Authorization to Disclose Information to Third Parties:

The individual authorizes the Hospital, its Medical Staff Leaders, the HCA Healthcare Entities and any of their representatives to disclose information to other hospitals, any organization providing or managing health care services, managed care organizations and other payers, government regulatory and licensure boards or agencies, and their representatives to assist them in evaluating the individual's qualifications.

(6) Redisclosure of Drug/Alcohol Treatment Information:

In the course of performing credentialing or peer review functions, the Hospital may receive written or verbal information about the treatment of a Practitioner from a federally-assisted drug or alcohol abuse program, as defined by 42 C.F.R. Part 2. The Hospital will not redisclose such information without a signed authorization from the Practitioner. Appendix F to the Practitioner Health Policy includes an authorization that may be used for this purpose.

2.C.4. Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy will be the sole and exclusive remedy with respect to any Medical Peer Review, including but not limited to, any Professional Review Action and Professional Review Activities taken by the Hospital.

2.C.5. Release of Liability and Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital, HCA Affiliated Entities, the Board, the Medical Staff, their authorized representatives, any Members of the Medical Staff or members of the Board, any Practitioner, and any third party who provides information.

This release of liability and immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the above listed individuals and entities in the course of Medical Peer Review including but not limited to, any Professional Review Action, Professional Review Activity , credentialing and peer review/professional practice evaluation activities or when using or disclosing information as described in this Section. Nothing herein shall be deemed to waive any other immunity or privilege provided by federal or state law. This immunity shall be in addition to that afforded by law or set out on any application forms.

2.C.6. Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review/professional practice evaluation, Professional Review Action or Professional Review Activity, or other aspect of Medical Peer Review, and does not prevail, he or she will reimburse the Hospital and HCA Healthcare Entities, any Member of the Medical Staff or other Practitioner, or member of the Board, and any other defendant involved in the action for all costs incurred in defending such legal action, including costs and attorney's fees, expert witness fees, and lost revenues.

ARTICLE 3 - PROCEDURE FOR GRANTING MEMBERSHIP AND CLINICAL PRIVILEGES

3.A. PROCEDURE FOR GRANTING MEMBERSHIP AND CLINICAL PRIVILEGES[9]

3.A.1. Initial Review of Application:

(1) As a preliminary step, once an RFC/RRFC/RFINCP or other request for Clinical Privileges is submitted to the Medical Staff Office as an Application, the Medical Staff Office will review the Application to make sure that all questions have been answered and that the Applicant satisfies the threshold eligibility criteria set forth in this Policy. Applicants whose Applications are not Complete or fail to meet the threshold eligibility criteria set forth in this Policy will be notified that their Applications will not be processed. A determination of ineligibility does not entitle the individual to a hearing or appeal. See Sections 2.A.1-2.A.3 for further detail.

(2) The Medical Staff Office will oversee the process of gathering additional information, if any, relating to the Applicant's character, professional competence, qualifications, behavior, and ethical standing, or any concerns assigned by the CPC. This information may be contained in the Application, and obtained from references and other available sources, including the Applicant's past or current department chairperson at other health care entities, residency training director, and others who may have knowledge about the Applicant's education, training, experience, and ability to work with others. The National Practitioner Data Bank and the Office of Inspector General List of Excluded Individuals/Entities or the General Services Administration's Excluded Parties List System (EPLS) and System for Award Management will be queried, as required, and a background check will be obtained.

(3) An interview(s) with the Applicant may be conducted at this or any stage of the processing of the Application, but is not required. The purpose of the interview is to discuss and review any aspect of the individual's Application, qualifications, and requested Clinical Privileges. This interview may be conducted by one or any combination of any of the following: the department chairperson, the section chair, the Medical Executive Committee, the Chief of Staff, Chief Medical Officer, or the Chief Executive Officer.

(4) The Medical Staff Office will transmit the Complete Application and all supporting materials to the chairperson of each department in which the Applicant seeks Clinical Privileges (and, where applicable, to the section chair).

3.A.2. Department Chairperson Procedure:

The department chairperson or section chair will prepare a written report regarding whether the Applicant has satisfied all of the qualifications for Membership and the Clinical Privileges requested. The report will be on a form provided by the Medical Staff Office. The Chief Nursing Officer will also review and report on the Applications for all advanced registered nurse practitioners.

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[9] MS.01.01.01, EPs 26 & 27

3.A.3. Medical Executive Committee Recommendation:

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

(a) adopt the report and recommendation of the department chief as its own; or

(b) refer the matter back to the department chief for further consideration of specific questions; or

(c) state its reasons for disagreement with the report and recommendation of the department chief.

(2) If the recommendation of the Medical Executive Committee is to grant Membership and/or Clinical Privileges or is otherwise a Favorable Recommendation, the recommendation will be forwarded to the Board.

(3) If the recommendation of the Medical Executive Committee would entitle the Applicant to request a hearing pursuant to the Hearing and Appeals Procedure Article set forth in this Policy, the Medical Executive Committee will forward its recommendation to the Chief Executive Officer, who will promptly send Special Notice to the Applicant in accordance with the Hearing and Appeals Procedures Article set forth in this Policy. All further procedures regarding the Application shall be as set forth in that Article.

3.A.4. Board Action:

(1) Upon receipt of a recommendation that the Applicant be granted Medical Staff Membership and/or Clinical Privileges or an otherwise Favorable Recommendation, and not later than 60 Days from its receipt of a Complete Application, the Board may;

(a) grant Medical Staff Membership and/or Clinical Privileges as recommended; or

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

(c) modify the recommendation.

(2) If the Board disagrees with the Medical Executive Committee's recommendation, it should first discuss the matter with the chairperson of the Medical Executive Committee. If the Board's determination remains in disagreement with the Medical Executive Committee's and would entitle the Applicant to request a hearing pursuant to the Hearing and Appeals Procedure Article set forth in this Policy, the Chief Executive Officer will promptly send Special Notice that the Applicant is entitled to request a hearing. All further procedures shall be as set forth in the Hearing and Appeals Procedures Article in this Policy.

(2) Any final decision by the Board will be communicated to the Applicant or Member within 20 days and otherwise disseminated, both internally and externally as appropriate or required.

3.A.5 Prerequisites to Commencing Medical Staff Membership Activities and Exercise of Clinical Privileges:

Within six (6) months of being granted approval, the individual must complete the orientation process, if applicable (e.g., new Members) and document compliance with all mandatory training and educational protocols that are applicable to the Practitioner and have been adopted by the Medical Executive Committee or Hospital, including, but not limited to, those involving electronic medical records, computerized physician order entry (CPOE), the privacy and security of protected health information, patient safety, and EMTALA.

3.A.6. Conditions on Membership and Clinical Privileges:

(1) At any time during the process of credentialing, the department chairperson, Medical Executive Committee, or Board may recommend/impose specific conditions on the Practitioner's Membership and/or Clinical Privileges. Those conditions may be related to behavior, health, or clinical issues. Those individuals and bodies may also recommend that Membership or Clinical Privileges be granted to a Practitioner for a period of less than two years in order to permit closer monitoring of the Practitioner's clinical performance, professional conduct, and ongoing qualifications for Membership and Clinical Privileges.

(2) In the case of a Practitioner seeking renewal of Membership or Clinical Privileges, if he or she is the subject of an Investigation or a hearing at the time of credentialing, Membership or Clinical Privileges may be granted for a period of less than two years or until the completion of that process, whichever occurs sooner.

(3) At the conclusion of any term of Membership or Clinical Privileges which was conditional or which had a term shorter than two years, the Practitioner must be recredentialed in accordance with the terms of this Policy.

(4) The imposition of conditions on Membership or Clinical Privileges, as described in this Section, does not, in and of itself, entitle a Practitioner to request a hearing or appeal unless the condition is a restriction specifically listed in the Hearing and Appeals Procedure Article.

3.A.7. Time Periods for Processing:[10]

Once an Application is deemed Complete, it is expected to be processed overall within 150 Days and within the specific timeframes set out above, unless it becomes not Complete. This time period is intended to be a guideline only and will not create any right for the Applicant to have the Application processed within this precise time period except as provided by law.

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[10] MS.06.01.07, EP 4

ARTICLE 4 - CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES[11]

4.A.1. General:

(1) Membership will not confer any Clinical Privileges or right to practice at the Hospital. Only those Clinical Privileges granted by the Board may be exercised, subject to the terms of this Policy.

(2) Except as specifically set forth in this Policy,[12] requests for Clinical Privileges will be processed only when an individual satisfies the threshold eligibility criteria for Medical Staff Membership and Clinical Privileges set forth in Article 2 of this Policy. An individual who does not satisfy the threshold eligibility criteria for Clinical Privileges may request that the threshold eligibility criteria be waived as set forth in this Policy.

(3) Requests for Clinical Privileges that are subject to an exclusive contract or arrangement will not be processed except as consistent with the applicable contract or Board resolution.

(4) Requests for Clinical Privileges that are not part of the established delineation of privileges will only be considered if the Board has determined that the Hospital has the resources to offer or support the Clinical Privileges and the criteria for the privilege has been established. If such a determination has not been made by the Board, no Practitioner will be considered eligible to request such Clinical Privileges.[13]

(5) Recommendations for Clinical Privileges will be based on consideration of the following:[14]

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

(b) appropriateness of utilization patterns;

(c) information concerning the individual's ability to perform the Clinical Privileges requested competently and safely;

(d) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;[15]

(e) availability of coverage in case of the individual's illness or unavailability;

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[11] MS.01.01.01, EP 14

[12] See, for example, the provisions governing the grant of temporary Clinical Privileges in this Article.

[13] MS.06..01.01

[14] MS.06.01.03 & MS.06.01.07; 42 C.F.R. §482.12(a)(6)

[15] MS.08.01.03

(f) documentation of required professional liability insurance coverage for the Clinical Privileges requested;

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

(h) any information concerning Professional Review Actions or voluntary or involuntary termination, limitation, reduction, or loss of staff membership or Clinical Privileges at another hospital or healthcare entity;

(i) Practitioner-specific data as compared to aggregate data, when available;

(j) morbidity and mortality data, when available;

(k) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions; and

(l) the Hospital's need, available resources, and personnel.[16]

(6) Requests for new or additional Privileges ("Requests for Increased, New Clinical Privileges, or Changes in Prescriptive Authority" or "RFINCPs")must state the additional Clinical Privileges requested and provide information sufficient to establish eligibility. If the Practitioner is eligible and the request is Complete, it will be processed in the same manner as an RFC/Application for initial Clinical Privileges (and in all such cases, the CPC shall not only verify current professional liability coverage, but also that such coverage specifically applies to the new or increased Clinical Privileges). If the request for new or additional Privileges ("RFINCP") is made at or near the time of renewal of Membership or Clinical Privileges, it may be processed along with the RRFC/Application for Renewal of Membership or Clinical Privileges.

(7) When Clinical Privileges have been delineated by Core or specialty, a request for Clinical Privileges will only be processed if the individual applies for the full Core or specialty delineation. (This only applies to requests for Clinical Privileges within the individual's primary specialty.)

4.A.2. Privilege Waivers:

(1) In limited circumstances, the Hospital may consider a waiver of the requirement that Clinical Privileges be granted by Core or specialty. If an individual wants to request such a waiver, the request must be submitted in writing to the Medical Staff Office. The request must indicate the specific Clinical Privileges within the Core or specialty that the individual does not wish to provide, state a good cause basis for the request, and include evidence that he or she does not provide the relevant patient care services in any health care facility.

[16] MS.06.01.01

(2) Requests for waivers related to Clinical Privileges will be processed in the same manner as requests for waivers of threshold eligibility criteria.

(3) The following factors, among others, may be considered in deciding whether to grant a waiver:

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

(b) the effect of the request on the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act;

(c) the expectations of Practitioners who rely on the specialty;

(d) the interests of the individual requesting the waiver;

(e) fairness to other Members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them; and

(f) the potential for gaps in call coverage that might result from granting a waiver or an individual's removal from the call roster and the feasibility of safely transferring patients to other facilities.

(4) If the Board grants a waiver related to Clinical Privileges, it will specify the effective date and the expiration date, if any.

(5) No one is entitled to a waiver or to a hearing or appeal if a waiver is not granted.

4.A.3. Relinquishment of Individual Clinical Privilege:

A request to relinquish any individual Clinical Privilege, whether or not part of the Core, must provide a good cause basis for the modification of Clinical Privileges. All such requests will be processed in the same manner as a request for waiver, as described above.

4.A.4. Resignation of Membership and Clinical Privileges:

Resignations from the Medical Staff should be submitted in writing and should state the date the resignation becomes effective. Resignations shall be submitted to Medical Staff Services. Resignation of Medical Staff membership and/or clinical privileges may be granted for a Practitioner or APP in good standing provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. The Practitioner's or APP's Department Chairperson, the Medical Executive Committee, and the Board of Trustees shall review letters of resignation. Once submitted, a resignation may not be withdrawn until it has been considered by the Board of Trustees. If a Practitioner or APP requests to withdraw a resignation before the resignation is accepted by the Board of Trustees, the request for withdrawal shall also be forwarded to the Board of Trustees for consideration. The Board of Trustees may, but is not required to, honor the

request for withdrawal of the resignation. Upon acceptance of the resignation by the Board of Trustees, the Practitioner or APP will be notified in writing. When a resignation is accepted or clinical privileges are relinquished during the course of an investigation regarding concerns about behavior, conduct, competence, or professional performance, a report shall be submitted to the state professional licensing board for reporting to the National Practitioner Data Bank (NPDB), as required by federal law and state law.

4.A.5. Clinical Privileges for New Treatments, Procedures, or Therapies:

(1) Requests for Clinical Privileges to perform either a treatment, procedure, or therapy not currently being performed at the Hospital or a new technique to perform an existing treatment, procedure, or therapy ("New Procedure") will not be processed until a determination has been made that the New Procedure will be offered by the Hospital and criteria for the associated Clinical Privilege(s) have been adopted.

(2) As an initial step in the process, any individual proposing that the New Procedure be offered at the Hospital will prepare and submit information to the department chairperson and the Medical Executive Committee addressing at least the following:

(a) clinical indications for when the New Procedure is appropriate;

(b) whether there is empirical evidence of improved patient outcomes with the New Procedure or other clinical benefits to patients;

(c) whether the New Procedure is being performed at other similar hospitals and the experiences of those institutions;

(d) whether the New Procedure is investigational and, if so, whether there has been IRB approval; and

(e) whether the New Procedure has received any regulatory approval (e.g., FDA) and whether it has a favorable safety profile.

(3) The department chairperson and the Medical Executive Committee will review and, as necessary, verify this information and conduct additional research, including at least the following:

(a) whether proficiency for the New Procedure is volume-sensitive and if the requisite volume would be available; and

(b) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the New Procedure.

Based on this information, the department chairperson will make a recommendation to the Medical Executive Committee, which will make a preliminary recommendation as to whether the New Procedure should be offered at the Hospital.

(4) The Medical Executive Committee will forward its recommendations regarding whether the New Procedure should be offered at the Hospital to the Board for final action.

(5) If the Board determines that the New Procedure should be offered at the Hospital, it will refer the matter to the Department and Medical Executive Committee, which will develop eligibility criteria for requesting the Clinical Privileges required to perform the New Procedure at the Hospital. In developing the criteria, the Medical Executive Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(a) the minimum education, training, licensure, experience and, as applicable, additional eligibility criteria (such as an affiliation agreement with a Supervising/Collaborating Practitioner) necessary to perform the New Procedure;

(b) the clinical indications for when the New Procedure is appropriate; and

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

(6) The Medical Executive Committee will forward its recommendations regarding the eligibility criteria for Clinical Privileges to perform the New Procedure to the Board for final action.

4.A.6. Clinical Privileges That Cross Specialty or Practitioner Category Lines:

(1) Requests for Clinical Privileges that previously have been exercised only by Practitioners in one specialty or individuals in another Practitioner category (e.g., Podiatrists vs. advanced practice registered nurses vs. Physicians) will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the Clinical Privilege(s) in question.

(2) As an initial step in the process, any individual proposing that Clinical Privileges be available for members of a new specialty or Practitioner category will prepare and submit information to the Medical Executive Committee addressing at least the following:

(a) clinical indications for when the Clinical Privileges can be safely exercised by members of a new clinical specialty or category of practitioners; and

(b) whether individuals in the new clinical specialty or category of practice are performing the Clinical Privilege at other similar hospitals and the experiences of those institutions.

(3) The Medical Executive Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairpersons and Practitioners with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, allied health training and certification programs, specialty societies). If the individual requesting Clinical Privileges is an Advanced Practice Professional, the Medical Executive Committee will consult with and

obtain the recommendation of the Advanced Practice Professionals Review Committee before making its recommendation.

(4) The Medical Executive Committee may or may not recommend that individuals from different specialties or Practitioner categories be permitted to request the Clinical Privileges at issue. If it does, the Medical Executive Committee may develop recommendations regarding:

(a) the minimum education, training, experience and, as applicable, additional eligibility criteria (such as an affiliation agreement with a Supervising/Collaborating Practitioner) necessary to perform the Clinical Privileges in question;

(b) the clinical indications for when the procedure is appropriate to be performed by individuals in the new clinical specialty or practitioner category;

(c) the manner of addressing the most common complications that arise, which may be outside of the scope of the Clinical Privileges that have been granted to the requesting individual;

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

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

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

(5) The Medical Executive Committee will forward its recommendations to Board for final action.

4.A.7. Individuals in Training Programs:

(1) Individuals will not, by virtue of participation in training programs, be granted Membership in the Medical Staff or Clinical Privileges. Rather, individuals in training programs will be granted permission to perform clinical functions in the Hospital only as set forth in the curriculum requirements, affiliation agreements, and/or training protocols that have been approved by the Medical Executive Committee (or its designee) and the Graduate Medical Education Committee of the Hospital, if applicable. Those documents will, at a minimum, require the applicable program director to verify and evaluate the qualifications of each individual in the training program[17] and require the program director or applicable clinical faculty or attending staff Members to direct and supervise the on-site or day-to-day patient care activities of trainees.

[17] MS.04.01.01

(2) Individuals in training programs who are seeking to practice outside of their training program must apply for Clinical Privileges as set forth in this Policy.

4.A.8. Telemedicine Clinical Privileges:[18]

(1) Telemedicine is the provision of clinical services to Hospital patients by Practitioners from a distance via electronic communications.

(2) A qualified individual may be granted telemedicine Clinical Privileges. An individual who will only hold telemedicine Clinical Privileges is not eligible for Membership on the Medical Staff.

(3) Requests for telemedicine Clinical Privileges will be processed through the same process for RFCs/RRFCs/Applications for Membership and Clinical Privileges, as set forth in this Policy. The individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and responsibility for serving on the emergency call roster that the Hospital maintains for purposes of complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). In addition, telemedicine Practitioners must demonstrate satisfaction of these additional threshold eligibility criteria:

a. if located in a different state than the patient, the Practitioner must be licensed as set forth in Section 2.A.1 of this Policy[19]; and

b. the Practitioner must have evidence of current clinical competence in the use of the applicable telemedicine equipment.

c. must provide evidence of residing in the United States. Telemedicine services may not be provided from outside of the United States.

(4) Telemedicine Clinical Privileges, if granted, will be for a period of not more than two years.

(5) Practitioners granted telemedicine Clinical Privileges will be subject to the Hospital's professional practice evaluation activities. The results of these activities, including any adverse events and complaints filed about the Practitioner providing telemedicine services from patients, other Practitioners or staff, may be shared with the entity providing telemedicine services.

(6) Telemedicine Clinical Privileges granted in conjunction with a contractual agreement will be incident to, contiguous with, and subject to the provisions of the agreement.

4.A.9. Focused Professional Practice Evaluation for Initial Clinical Privileges:[20]

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18 MS.13.01.01 & MS.13.01.03; 42 C.F.R. §482.22(a)(3)-(4); 42 C.F.R. §482.12(a)(8)-(9)

19 42 C.F.R. §482.11(c)

20 MS.08.01.01, EP 1

(1) All initial grants of Clinical Privileges, at any time, will be subject to focused professional practice evaluation. The details of the focused professional practice evaluation process can be found in the FPPE policy.

4.B. TEMPORARY PRIVILEGES[21]

4.B.1. Temporary Privileges for Initial Applicants:

(1) Temporary Privileges may be granted to Applicants for initial Membership or initial Clinical Privileges whose Complete Application is pending review by the Medical Executive Committee and Board.

(2) To be eligible for temporary Privileges, the Applicant must satisfy all qualifications and requirements set forth in this Policy. In addition, Applicants must demonstrate satisfaction of these additional criteria in order to be eligible for temporary Privileges for initial Applicants:

(a) a demonstrated ability to perform the Clinical Privileges requested; and

(b) that the Applicant has had no (i) current or previously successful challenges to licensure or registration or (ii) involuntary Restriction, reduction, denial or termination of Membership or Clinical Privileges at another health care facility.

(3) Requests for temporary Privileges for Applicants will be processed through the same process for RFCs/RRFCs/Applications for Membership and Clinical Privileges, as set forth in this Policy. Once an Applicant who is eligible for temporary Privileges has received a favorable recommendation of the Department Chair as part of that process, a committee of the Board of Trustees composed of the Chief Executive Officer and the Chief of the Medical Staff may grant the Applicant temporary Privileges on behalf of the Board of Trustees, which shall be effective immediately upon Notice to the Practitioner. An authorized designee may be utilized if the committee member is not available, provided the designee also is a voting Board member.

(4) Temporary Privileges for initial Applicants will be granted until final action by the Board on the Application, not to exceed a term of 120 Days. Temporary Privileges for new Applicants will not be renewed. Temporary Privileges shall be automatically withdrawn if the recommendation of the Medical Executive Committee is not favorable as to Membership or Clinical Privileges.

4.B.2. Temporary Privileges for an Important Patient Care Need:

(1) Temporary Privileges may be granted to individuals who are not requesting consideration for Medical Staff Membership or ongoing Clinical Privileges when there is an important patient care, treatment, or service need. This includes, but is not limited to, the following situations:

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[21] MS.06.01.13

(a) for the care of a specific patient;

(b) when necessary to prevent a lack of services in a needed specialty area;

(c) for proctoring or teaching; or

(d) when serving in a locum tenens capacity for another Practitioner.

(2) To be eligible for temporary Privileges for an important patient care need, an individual must satisfy all qualifications and requirements set forth in this Policy, except the following:

(a) those criteria relating to geographic location, coverage arrangements, compliance with education and training protocols, and responsibility for serving on the emergency call roster that the Hospital maintains for purposes of complying with the Emergency Medical Treatment and Active Labor Act (EMTALA); and

(b) any qualifications or requirements waived by the Chief Executive Officer, upon recommendation of the Chief of Staff, balancing the impact of waiving such criteria against the importance of the patient care need justifying the grant of temporary Privileges.

(3) Requests for temporary Privileges for an important patient care need will be processed through a modified process:

(a) RFCs/RRFCs/Applications for temporary Privileges will be verified through the same process for RFCs/RRFCs/Applications for Membership and Clinical Privileges, as set forth in this Policy.

(b) Following verification, a committee of the Board of Trustees composed of the Chief Executive Officer and the Chief of the Medical Staff may grant the Applicant temporary Privileges on behalf of the Board of Trustees, based on:

(i) the individual's satisfaction of applicable threshold eligibility criteria;

(ii) the individual's documented experience and current competence; and

(iii) in the case of temporary Privileges for teaching purposes, the expertise, extent of clinical experience, and reputation of the individual, as well as the Hospital's need for Practitioners trained in the respective procedure/skill.

An authorized designee may be utilized if the committee member is not available, provided the designee also is a voting Board member.

(c) Temporary Privileges for an important patient care need will be effective immediately upon Notice to the Practitioner and shall be granted for a period of time correlating to the important patient care need, not to exceed a term of 120 Days.

4.B.3. Conditions Applicable to Temporary Privileges:

(1) Prior to any temporary Privileges being granted, the individual must sign and return the CMS-required[22] Practitioner Acknowledgment Statement and agree in writing to be bound by the bylaws, rules and regulations, policies, procedures and protocols of the Medical Staff and the Hospital, as may be amended from time to time.

(2) Temporary Privileges are granted as a temporary courtesy only and do not give rise to any expectation of Membership or continued Clinical Privileges at the Hospital. They may be withheld or withdrawn, at any time by the Chief Executive Officer, after consulting with the Chief of the Medical Staff or the department chairperson. If temporary Privileges are withdrawn, the department chairperson or the Chief of Staff will assist patients of the Practitioner to select another Practitioner with appropriate Clinical Privileges to for those patients until they are discharged.

(3) The first time any particular temporary Privileges are granted to a Practitioner, the Practitioner shall be subject to the focused professional practice evaluation process applicable to all initially granted Clinical Privileges.

4.C. EMERGENCY SITUATIONS

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

(2) In an emergency situation, a Practitioner may administer treatment to the extent permitted by his or her license, regardless of Membership status, department status, or specific grant of Clinical Privileges.

(3) When the emergency situation no longer exists, the patient will be assisted by the department chairperson or the Chief of Staff in selecting another Member with appropriate Clinical Privileges to assume responsibility for care of the patient.

4.D. DISASTER PRIVILEGES[23]

(1) When the Hospital Emergency Operations Plan has been implemented and the immediate needs of patients in the Hospital cannot be met, the Hospital Emergency Incident Commander (the Chief Executive Officer or his or her designee) or the Operations Chief (if that position is activated as part of the Hospital Emergency Operations Plan) may, after consulting with the Chief of Staff, Chief of Staff Elect, Chief Medical Officer, or the

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[22] 42 C.F.R. §412.46(c)

[23] EM.02.02.13

Emergency Operations Plan's designated Medical Staff Director, grant disaster Privileges to eligible volunteer licensed independent Practitioners ("volunteers") using the modified credentialing process set forth below.

(2) Before disaster Privileges are granted, the Hospital will obtain:

(a) the volunteer's valid, government-issued photo identification (e.g., driver's license or passport); and

(b) one of the following:

(i) a current picture or identification card from a health care organization that clearly identifies professional designation;

(ii) a current license to practice;

(iii) primary source verification of licensure;

(iv) identification indicating that 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;

(v) identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or

(vi) confirmation by a licensed independent practitioner currently privileged by the Hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

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

(a) current, unrestricted license to practice, which is recognized in this state (e.g., an in-state license, or out-or-state when authorized through a special waiver issued by the state licensing agency, or by the Governor of this state), that is not subject to any Restrictions, probationary terms, or conditions not generally applicable to all licensees;

(b) current, unrestricted DEA registration (linked to a license recognized in this state), as applicable to the disaster Privileges being sought by the Practitioner;

(c) current, valid professional liability insurance coverage in a form and in amounts, as determined by the Hospital;

(d) evidence of relevant training, experience, and current competence;

(e) the results of a query to the National Practitioner Data Bank; and

(f) confirmation that the individual is not an Ineligible Person.

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

(5) Disaster Privileges are granted as a temporary courtesy only and do not give rise to any expectation of continued Clinical Privileges at the Hospital. They may be withheld or withdrawn, at any time, in the discretion of the Hospital Emergency Incident Commander (the Chief Executive Officer or his or her designee) or the Operations Chief (if that position is activated as part of the Hospital Emergency Operations Plan), after consulting with the Chief of Staff or the Emergency Operations Plan's designated Medical Staff Director. Disaster Privileges may continue as long as a disaster-related patient care coverage needs still exist, up to 120 days. Disaster Privileges do not automatically terminate once the facility Emergency Operations Center (EOC) discontinues operation. Disaster Privileges shall terminate automatically, upon Notice to the volunteer, when the disaster is resolved and the immediate needs of patients in the Hospital can be met by Medical Staff Members and other Practitioners, or if the Hospital finds it is unable to confirm the volunteer's qualifications through the primary source verification process. When disaster Privileges are withdrawn or terminated, the department chairperson or the Chief of Staff will assign to another Practitioner with appropriate Clinical Privileges responsibility for the care of patients until they are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute Practitioner.

(6) The following safeguards must be in place to verify that patient safety is assured while care is being provided by volunteers pursuant to disaster Privileges:

(a) Upon granting disaster Privileges to a Practitioner, the Hospital will issue the Practitioner appropriate Hospital security identification and assign that Practitioner to a Medical Staff Member, if possible, with whom to collaborate in the care of disaster victims.

(b) The Medical Staff will oversee the care provided by volunteer Practitioners. The Chief of Staff or the Emergency Operations Plan's designated Medical Staff Director will assign a Member of the Medical Staff to provide oversight to each Practitioner who has been granted disaster Privileges. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

4.E. EXCLUSIVE ARRANGEMENTS

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

(2) To the extent that the Board of Trustees by resolution or other arrangement confers the exclusive right to perform specified services to one or more Practitioners or groups of Practitioners or otherwise closes the department or service, then no Practitioners except those authorized by or pursuant to the resolution or arrangement may exercise Clinical Privileges to perform the specified services. Only Practitioners so authorized are eligible to apply for the Clinical Privileges included in the resolution or arrangement.

(3) Prior to the Hospital entering into any exclusive arrangement in a clinical service that has not previously been subject to such arrangement, the Board of Trustees will request the Medical Executive Committee (or a subcommittee of its members appointed by the Chairperson of the Medical Executive Committee) to review the proposal under consideration by the Board of Trustees and comment on the quality of care and clinical service implications of the proposed arrangement.[24]

(4) After providing the Medical Executive Committee the opportunity to comment, the Board of Trustees will consider whether or not to proceed with the exclusive arrangement. If the Board of Trustees makes a preliminary determination to proceed with an exclusive arrangement that would have the effect of preventing a Practitioner from exercising Clinical Privileges that had previously been granted, the affected Practitioner is entitled to the following notice and review procedures:

   (a) Notice of the proposed exclusive arrangement and the right to request to meet with the Board to discuss the matter prior to the proposed effective date of such arrangement.

   (b) At the meeting, the affected Practitioner will be entitled to present information relevant to the decision to enter into the arrangement.

   (c) If, following this meeting, the Board determines to enter into the exclusive arrangement, the affected Practitioner will be notified that he or she is ineligible to continue to exercise the Clinical Privileges covered by the exclusivity. The ineligibility begins as of the effective date of the exclusive arrangement.

   (d) The procedural rights outlined above will be the Practitioner's exclusive remedy. The provisions in Article 7 of this Policy are inapplicable to this administrative determination.

[24] LD.04.03.09

(e) The inability of a Practitioner to exercise Clinical Privileges because of an exclusive contract or arrangement is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

(5) After these procedures, the Board will make a final determination regarding whether to proceed with the exclusive arrangement.

(6) In the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract or Board resolution, the terms of the contract or Board resolution will control.

4.F. USE OF OUTPATIENT ANCILLARY SERVICES BY NON-PRIVILEGED PRACTITIONERS

Non-Privileged Practitioners may order outpatient diagnostic tests and other outpatient services at the Hospital only in accordance with state and federal law and any Hospital policy governing the use of outpatient ancillary services by Non-Privileged Healthcare Practitioners.

ARTICLE 5 - PROCEDURE FOR RENEWAL OF MEMBERSHIP AND CLINICAL PRIVILEGES

5.A. PROCEDURE FOR RENEWAL OF MEMBERSHIP AND CLINICAL PRIVILEGES

All terms, conditions, requirements, and procedures relating to initial Membership and Clinical Privileges will also apply to renewal and continuation of Membership and Clinical Privileges.

5.B. RENEWAL CRITERIA

5.B.1. Eligibility for Renewal:

To be eligible for renewal of Membership and Clinical Privileges and have an Application regarding the same processed, an individual must have, during the previous term of Membership and Clinical Privileges:

(1) completed all medical records such that he or she is not delinquent, as per the Medical Staff Rules and Regulations and Hospital policy at the time he or she submits the RRFC and Application for renewal of Membership or Clinical Privileges and was not suspended for delinquent records more than **4 times** during the 12 months prior to the end of current appointment period;

(2) completed all continuing medical education requirements;

(3) satisfied all responsibilities applicable to Medical Staff Members and other Practitioners, including payment of any dues, fines, and assessments;

(4) continued to meet all qualifications and criteria for Membership and the Clinical Privileges requested;

(5) paid any applicable Application processing fee; and

(6) had sufficient Patient Contacts to enable the assessment of current clinical judgment and competence for any Clinical Privileges requested. Any Practitioner seeking renewal of Membership or Clinical Privileges who has had insufficient Patient Contacts, as determined by Hospital or Medical Staff policy, or who has been requested to submit additional evidence of current clinical competence, must submit such information as has been requested. The Application will not be considered Complete and processed further until the evidence has been received, reviewed, and deemed satisfactory. Information which may be requested includes, but is not limited to, a copy of the individual's confidential quality profile from his or her primary hospital or other organization, clinical information from his or her private office practice or other organization, or a quality profile from a managed care organization or insurer.

5.B.2. Factors for Evaluation:

In considering an Application for renewal of Membership or Clinical Privileges, the factors listed in Section 2.A.4 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the renewal process:

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

(2) participation in Medical Staff duties, including committee assignments and emergency call;

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

(4) any ongoing and focused professional practice evaluations, peer review activity, and other evaluations;

(5) feedback received from patients and their families, visitors, or staff; and

(6) other reasonable indicators of continuing qualifications.

5.C. RENEWAL PROCESS

5.C.1. Request for Renewal of Membership and/or Clinical Privileges:

(1) Membership terms and terms of Clinical Privileges will not extend beyond two years.[25]

(2) Practitioners will be provided notification of the need to apply for renewal of Membership and/or Clinical Privileges at least 180 Days prior to the expiration of their current term of Membership and/or Clinical Privileges.

(3) Failure to cause a Complete Application for renewal of Membership and/or Clinical Privileges to be submitted to the Medical Staff Office within the prescribed deadline, which shall be included in the renewal notification that is sent to the Practitioner, may result in the automatic expiration of Membership and Clinical Privileges at the end of the then current term.

(4) Applications for Renewal of Membership and/or Clinical Privileges shall be processed in the same manner as Applications for Initial Membership and Clinical Privileges, as outlined in this Policy.

5.C.2. Potential Adverse Recommendation:

(1) If the Medical Executive Committee is considering a recommendation to deny the renewal of Membership or Clinical Privileges or to reduce Clinical Privileges, the committee chairperson or Chief Medical Officer will notify the Practitioner of the possible recommendation and invite the Practitioner to meet prior to any final recommendation being made.

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[25] MS.06.01.07, EP 9

(2) Prior to this meeting, the Practitioner will be notified of the general nature of the information supporting the recommendation contemplated.

(3) At the meeting, the Practitioner will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation.

(4) This meeting is not an Investigation or hearing, and none of the procedural rules for Investigations or hearings will apply. The Practitioner will not have the right to be represented by legal counsel at this meeting.

ARTICLE 6 - MANAGING CONCERNS ABOUT PRACTITIONERS

6.A. OVERVIEW AND GENERAL PRINCIPLES

6.A.1. Options Available to Medical Staff Leaders and Hospital Administration:

(1) This Policy empowers Medical Staff Leaders and Hospital Administration to use various options to gather information and address and resolve concerns about Practitioners. The various options available to Medical Staff Leaders and Hospital Administration and the mechanisms they may use when concerns pertaining to competence, health or behavior are raised are outlined below and include, but are not limited to, the following:

(a) ongoing and focused professional practice evaluation;

(b) clinical competency evaluation;

(c) fitness for practice evaluation;

(d) collegial intervention and progressive steps;

(e) mandatory meetings;

(f) preliminary fact finding;

(g) automatic relinquishment of Membership and Clinical Privileges;

(h) leaves of absence;

(i) precautionary suspension; and

(j) formal Investigation for purposes of possible corrective action, including but not limited to, a Professional Review Action.

(2) In addition to these options, Medical Staff Leaders and Hospital Administration also have the discretion to determine whether a matter should be handled in accordance with another policy (e.g., the Medical Staff's policies on professionalism, health, and professional practice evaluation/peer review) or should be referred to the Medical Executive Committee for further action.

6.A.2. Documentation:

(1) Except as otherwise expressly provided, Medical Staff Leaders and Hospital Administration may use their discretion to decide whether to document any meeting with a Practitioner that may take place pursuant to the processes and procedures outlined in this Article. Documentation should be in the form of a memorandum for record.

(2) Medical Staff Leaders and Hospital Administration may prepare a summary of the meeting held with the Practitioner, in which case the summary will be shared with the

Practitioner and he or she will be provided an opportunity to review the summary and respond to it.

(3) The initial documentation, any summary, and any response to the summary provided by the Practitioner will be maintained in the Practitioner's confidential file.

6.A.3. No Recordings of Meetings:

It is the policy of the Hospital to maintain the confidentiality of all Medical Peer Review activities conducted at Medical Staff meetings, including, but not limited to, discussions relating to Professional Review Activities, credentialing, quality assessment, performance improvement, peer review, and professional practice evaluation activities. The discussions that take place at such meetings are conducted with the expectation of privacy. In addition to existing bylaws and policies governing confidentiality, individuals in attendance at such meetings are prohibited from making audio or video recordings at such meetings unless authorized to do so in writing by the individual chairing the meeting or by the Chief Executive Officer, in which case a copy of the recording must be promptly provided to the Chief Executive Officer following the meeting. This does not prevent recording by the Medical Staff Services or Quality department staff for the sole purpose of preparing minutes of meetings, following which recordings are destroyed.

6.A.4. No Right to Counsel:

(1) The processes and procedures outlined in this Article are designed to be carried out in a collegial manner. Therefore, lawyers will not be present for any meeting that takes place pursuant to this Article. By agreement of the Chief of Staff and Chief Executive Officer, an exception may be made to this general rule, in which case both parties will be allowed to have lawyers present.

(2) If the Practitioner refuses to meet without his or her lawyer present, the meeting will be canceled and it will be reported to the Medical Executive Committee that the individual declined to attend the meeting.

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

All Medical Peer Review activities, including all activities set forth in this Article, are confidential and privileged to the fullest extent permitted by law. Accordingly, except as permitted in this Article, the Practitioner may not be accompanied by friends, relatives or colleagues when attending a meeting that takes place pursuant to this Article unless otherwise provided in this policy.

6.A.6. Involvement of Supervising/Collaborating Practitioner in Matters Pertaining to Practitioners Under Their Supervision:

If any Medical Peer Review Activity, including any activity pursuant to this Article, pertains to the clinical competence or professional conduct of a Practitioner with a Supervising/Collaborating Practitioner, that Supervising/ Collaborating Practitioner will be notified and may be invited to participate if agreed to by the Practitioner.

6.B. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

(1) Practitioners who are initially granted Clinical Privileges, whether at the time of the initial grant, renewal, or during the term of Clinical Privileges, will be subject to focused professional practice evaluation to confirm their competence.[26]

(2) All Practitioners who provide patient care services at the Hospital, pursuant to Clinical Privileges that have been granted, will have their care evaluated on an ongoing basis.[27] This ongoing professional practice evaluation process may include an analysis of data to provide feedback, to validate clinical competence and to identify issues in an individual's professional performance.

(3) Concerns raised about a Practitioner's practice through the ongoing professional practice evaluation process or through a specialty-specific performance measure, a reported concern, or other triggers (e.g., clinical trend or specific case that requires further review, patient feedback, or sentinel event) will be evaluated or otherwise addressed through the focused professional practice evaluation process, as applicable.

(4) Issues and concerns that cannot be appropriately and constructively resolved through collegial intervention or the relevant policy (e.g., professional practice evaluation/peer review; professionalism; health) may be referred to the Medical Executive Committee for its review in accordance with Section 6.J of this Policy. Such collegial interventions and other progressive steps, however, are not mandatory prerequisites to Medical Executive Committee review.

6.C. CLINICAL COMPETENCY EVALUATION

(1) A Practitioner may be requested to immediately submit to a partial or complete clinical competency evaluation to determine his or her ability to competently exercise Clinical Privileges.

(2) A request for an evaluation may be made as follows:

(a) of an Applicant, by the Medical Executive Committee in accordance with Section 3.A.4 of this Policy;

(b) of any Practitioner who has been granted Clinical Privileges, by the Investigating Committee, during an Investigation;

(c) of any Practitioner who has been granted Clinical Privileges, by any one of the following groups, if the group is concerned with the individual's current clinical competence:

(i) at least two Medical Staff Leaders;

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26 MS.08.01.01, EP 1

27 MS.08.01.03

(ii) one Medical Staff Leader and one Member of the Hospital Administration;

(iii) any Hospital or Medical Staff committee that conducts credentialing or peer review activities; or

(iv) the Board of Trustees.

(3) The Medical Staff Leaders or committee that requests the evaluation will: (i) identify the individual or program to conduct the evaluation; (ii) inform the individual of the time period within which the evaluation must occur; and (iii) provide the individual with all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss the reasons for the evaluation with the individual/program performing the evaluation and to allow the individual/program to discuss and report the results of that evaluation to the Medical Staff Leaders or relevant committee.

(4) Failure to obtain the requested evaluation and to do so within the required time frame may result in an Application being withdrawn or an automatic relinquishment of Membership and Clinical Privileges as set forth below.

6.D. FITNESS FOR PRACTICE EVALUATION

(1) A Practitioner may be requested to immediately submit to a partial or complete fitness for practice evaluation to determine his or her ability to safely practice.

(2) A request for an evaluation may be made as follows:

(a) of an Applicant, by the Medical Executive Committee, in accordance with Section 3.A.4 of this Policy;

(b) of any Medical Staff Member or Practitioner who has been granted Clinical Privileges, by the Investigating Committee, during an Investigation;

(c) of any Practitioner who is requesting reinstatement from a leave of absence that was taken for health reasons;

(d) of any Medical Staff Member or Practitioner who has been granted Clinical Privileges, by any one of the following groups, if the group is concerned with the Practitioner's ability to safely and competently care for patients:

(i) at least two Medical Staff Leaders;

(ii) one Medical Staff Leader and one Member of the Hospital Administration;

(iii) any Hospital or Medical Staff committee that conducts credentialing or peer review activities; or

(iv) the Board of Trustees.

(3) The Medical Staff Leaders or committee that requests the evaluation will: (i) identify the health care professional(s) or organization(s) to perform the evaluation; (ii) inform the Practitioner of the time period within which the evaluation must occur; and (iii) provide the Practitioner with all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) or organization(s) the reasons for the evaluation and to allow the health care professional/organization to discuss and report the results to the Medical Staff Leaders or relevant committee.

(4) Failure to obtain the requested evaluation and to do so within the required time frame may result in an Application being withdrawn or an automatic relinquishment of Membership and Clinical Privileges as set forth below.

6.E. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

(1) The use of collegial intervention efforts and progressive steps by Medical Staff Leaders (two or more of either the CMO, Chief of Staff, or Immediate Past Chief of Staff) and Hospital Administration (CEO) is encouraged. All such efforts are fundamental and integral components of the Hospital's professional practice evaluation activities and are confidential and protected in accordance with state law.

(2) The goal of those efforts is to arrive at voluntary, responsive actions by the Practitioner to resolve an issue that has been raised. Collegial efforts and progressive steps may be carried out, within the discretion of Medical Staff Leaders and Hospital Administration, but are not mandatory.

(3) Collegial intervention efforts and voluntary progressive steps are part of the Hospital's ongoing and focused professional practice evaluation activities and may include, but are not limited to, the following:

(a) sharing and discussing applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

(b) counseling, mentoring, monitoring, proctoring, consultation, and education, including formal retraining programs;

(c) facilitating a formal collegial intervention meeting (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders, Hospital administrators, and/or Board members) in order to directly discuss a matter and the steps that need to be taken to resolve it;

(d) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist an individual to conform his or her practice to appropriate norms;

(e) communicating expectations for professionalism and behaviors that promote a culture of safety;

(f) informational letters of guidance, education, or counseling; and

(g) developing a performance improvement plan, which may include a variety of tools and techniques that can result in a constructive and successful resolution of the concern.

6.F. MANDATORY MEETING

(1) Whenever there is a concern regarding a Practitioner's clinical practice or professional conduct, Medical Staff Leaders or members of Hospital administration may require the Practitioner to attend a mandatory meeting.

(2) Special Notice will be given at least three Days prior to the meeting and will inform the Practitioner that attendance at the meeting is mandatory and that an automatic relinquishment will be imposed for failure to attend as provided below.

(3) Failure of a Practitioner to attend a mandatory meeting will result in an automatic relinquishment of Membership and Clinical Privileges as set forth below.

6.G. AUTOMATIC RELINQUISHMENT[28]

Any of the occurrences described in this Section will constitute grounds for the automatic relinquishment of a Practitioner's Membership and/or Clinical Privileges. An automatic relinquishment, while taken in the course of Medical Peer Review, including but not limited to, Professional Review Activities, does not entitle the Practitioner to the rights in Article 7 of this Policy and is not subject to mandatory reporting to the Practitioner's licensing agency or with the National Practitioner Data Bank.

Except as otherwise provided below, an automatic relinquishment of Membership and/or Clinical Privileges will be effective immediately upon actual or Special Notice to the Member.

6.G.1. Failure to Complete Medical Records:

Failure of a Practitioner to complete medical records in accordance with applicable policies and rules and regulations, after notification by the medical records department of delinquency, may result in automatic relinquishment of all Clinical Privileges.

6.G.2. Failure to Satisfy Threshold Eligibility Criteria:

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[28] MS.01.01.01, EP 28

Failure of a Practitioner to continuously satisfy any of the threshold eligibility criteria set forth in Section 2.A.1 of this Policy will result in automatic relinquishment of Membership and Clinical Privileges.

6.G.3. Failure to Provide Information:

(1) Failure of a Practitioner to notify in writing, immediately (and in no event later than one business day after being provided notice of the change), the Chief of Staff or Chief Executive Officer of any change in any information provided on or in conjunction with an RFC, RRFC, RFINCP, other request for Clinical Privileges, or Application for initial or renewed Membership or Clinical Privileges or of their failure to continuously satisfy any of the threshold eligibility criteria set forth in Article 2 of this Policy or failure to provide the additional information required by Section 2.A.3.(3) of this Policy will result in the automatic relinquishment of Membership and Clinical Privileges.

(2) Failure of a Practitioner to provide information pertaining to that Practitioner's qualifications for Membership or Clinical Privileges in response to a written request from the Medical Executive Committee, Professional Review Committee, or any other authorized committee will result in the automatic relinquishment of Membership and Clinical Privileges. The information must be provided within the time frame established by the requesting party. Any relinquishment will continue in effect until the information is provided to the satisfaction of the requesting party.

6.G.4. Criminal Activity:

The occurrence of specific criminal actions will result in the automatic relinquishment of Membership and Clinical Privileges. Specifically, with respect to any felony or misdemeanor pertaining to the following items: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; (g) domestic, child or elder abuse or violence; or (h) military court martial:

(1) a conviction, plea of guilty or plea of no contest will result in an automatic relinquishment of Membership and all Clinical Privileges; and

(2) an arrest, charge, or indictment will result in automatic relinquishment of Membership and all Clinical Privileges until such time as the appropriate individual or body (MEC, Board, CEO, or CMO) can review the matter to determine whether the circumstances surrounding the arrest, charge, or indictment are such that reinstatement pending resolution of the matter can be granted without affecting patient safety, quality of care, and hospital operations. The burden is on the Practitioner to provide evidence showing that reinstatement is appropriate despite the unresolved concerns raised by the arrest, charge, or indictment. Reinstatement will be within the discretion of the appropriate individual or body (MEC, Board, CEO, or CMO), the decision of which shall be final without recourse to the hearing and appeal processes in Article 7 of this Policy or any other procedures.

6.G.5. Failure to Attend a Mandatory Meeting:

Failure to attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration, after appropriate Special Notice has been given, will result in the automatic relinquishment of Membership and Clinical Privileges. The relinquishment will remain in effect until the Practitioner attends the mandatory meeting and reinstatement is granted as set forth below.

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

Failure of a Practitioner to comply with or complete within required time limits training and educational requirements that are adopted by the Medical Executive Committee and/or required by the Board, including, but not limited to, those pertinent to electronic medical records or patient safety or EMTALA requirements, will result in the automatic relinquishment of Clinical Privileges.

6.G.7. Failure to Comply with Request for Fitness for Practice Evaluation or a Clinical Competency Evaluation:

Failure of an Applicant or Practitioner to undergo a requested fitness for practice evaluation or clinical competency evaluation and to do so within the requested time frame, to submit to diagnostic testing (such as blood, urine, or hair testing) immediately upon request, or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will, for Applicants, be considered a voluntary withdrawal of the Application or, for Practitioners, will result in the automatic relinquishment of Membership and Clinical Privileges.

6.G.8. Reinstatement from Automatic Relinquishment and Automatic Resignation:

(1) A request for reinstatement from an automatic relinquishment following completion of all delinquent records will be processed in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required will result in automatic resignation from the Medical Staff and resignation of all Clinical Privileges.

(2) Requests for reinstatement from an automatic relinquishment following the expiration or lapse of a license, controlled substance authorization, insurance coverage, or any other failure to satisfy any of the threshold eligibility criteria by virtue of the natural expiration of the Practitioner's qualification, will be processed by the Medical Staff Office. If any questions or concerns are noted, the Medical Staff Office will refer the matter for further review in accordance with subsection (4) of this Section, below.

(3) Requests for reinstatement from an automatic relinquishment related to a criminal arrest or charge will be as set forth in 6.G.4(2) above.

(4) All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant department chairperson, the Chief of Staff, the Chief Medical Officer, and the Chief Executive Officer. If all these individuals make a favorable recommendation on

reinstatement, the Practitioner may immediately resume clinical practice at the Hospital. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Medical Executive Committee and Board for review and recommendation.

(5) The Practitioner requesting reinstatement bears the burden of demonstrating that the matter leading to automatic relinquishment has been resolved.

(6) Failure, within 90 Days of a relinquishment, to resolve the matter leading to the automatic relinquishment, provide notice to the Medical Staff Office of the resolution, provide any additional requested information, and be reinstated as set forth above, will result in an automatic resignation from the Medical Staff and resignation of all Clinical Privileges. An automatic resignation, while taken in the course of Medical Peer Review, including but not limited to, Professional Review Activities, does not entitle the Practitioner to the rights in Article 7 of this Policy and is not subject to mandatory reporting to the Practitioner's licensing agency or the National Practitioner Data Bank.

6.H. LEAVES OF ABSENCE

Shall be processed as outlined in the Leave Of Absence Policy.

6.I. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES[29]

6.I.1. Grounds for Precautionary Suspension or Restriction:

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief Executive Officer, the Chief of Staff, the chairperson of the relevant clinical department, the Chief Medical Officer, the Medical Executive Committee, or the Board Chairperson is authorized to immediately suspend or restrict all or any portion of a Practitioner's Clinical Privileges. If the Practitioner voluntarily refrains from exercising Clinical Privileges for longer than 30 days while the matter is being reviewed, it must be reported to the National Practitioner Data Bank.

(2) A precautionary suspension or Restriction can be imposed at any time, including as a result of a specific concern, the occurrence of a specific event, a pattern of events, or a recommendation by the Medical Executive Committee that would entitle the Practitioner to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension or Restriction will meet with the Practitioner and review the concerns that support the suspension or Restriction and afford the Practitioner an opportunity to respond.

(3) Precautionary suspension or restriction is taken in the course of Medical Peer Review, is an interim step in the Professional Review Activity and does not imply any final findings regarding the concerns supporting the suspension or Restriction.

[29] MS.01.01.01, EP 29; The Health Care Quality Improvement Act, 42 U.S.C. §11112(c)

(4) On imposition of the precautionary suspension or Restriction, the Practitioner shall be informed orally as soon as possible, followed by Special Notice. A precautionary suspension or restriction is effective immediately and will be promptly reported to the Chief Executive Officer and the Chief of Staff. A precautionary suspension or Restriction will remain in effect unless it is modified by the Chief Executive Officer or Medical Executive Committee.

(5) Within three Days of the imposition of a suspension or Restriction, the Practitioner will be provided with a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any). The Notice will advise the Practitioner that suspensions or Restrictions lasting longer than 30 Days must be reported to the National Practitioner Data Bank and that the Hospital also will comply with any state law requirements on reporting.

(6) If the Practitioner has a Supervising/Collaborating Practitioner, that Supervising/Collaborating Practitioner will be notified.

<u>6.I.2. Medical Executive Committee Procedure</u>:

(1) Within a reasonable time, not to exceed 14 Days after the imposition of the suspension or Restriction, the Medical Executive Committee will review the reasons for the suspension or Restriction.

(2) As part of this review, the Practitioner will be invited to meet with the Medical Executive Committee and provided with Special Notice of the date, time and place of the meeting at least three Days in advance. In advance of the meeting, the Practitioner may submit a written statement and other information to the Medical Executive Committee.

(3) At the meeting, the Practitioner may provide information to the Medical Executive Committee and should respond to any questions that may be raised by committee Members. The Practitioner may provide information to the Medical Executive Committee, including alternatives to the precautionary suspension or Restriction which will protect patients, employees or others while the matter is being reviewed.

(4) After considering the reasons for the suspension or Restriction and the Practitioner's response, if any, the Medical Executive Committee will determine whether the precautionary suspension should be continued, modified, or lifted. The Medical Executive Committee may take the following actions:

(a) Affirm or modify the precautionary suspension or restriction without further action or investigation;
(b) Continue or modify the precautionary suspension or restriction pending completion of further investigation using the procedures in Section 6.J. on an expedited basis to the extent possible;
(c) Terminate the precautionary suspension or restriction pending completion of further investigation using the procedures in Section 6.J;.; or
(d) Terminate the precautionary suspension or restriction without further action or investigation.

(5) The Medical Executive Committee will send the Practitioner written Notice of its decision, including the basis for it. If the Medical Executive Committee's recommendation is to terminate the precautionary suspension or restriction, the action shall be terminated effective immediately, subject to a final decision by the Board of Trustees to affirm, modify or reject the Medical Executive Committee's recommendation. If the Board of Trustees affirms the Medical Executive Committee's recommendation, it will be a final decision and the Chief of Staff will provide the Practitioner with Special Notice of the decision within five days. The Board of Trustees may also take an action listed in subsection (4) above.

(6) There is no right to a hearing based on precautionary suspension or Restriction. The procedures outlined above are deemed to be fair under the circumstances and the only right to a hearing is as set out below.

(a) If the Medical Executive Committee's recommendation (or the Board of Trustees' action under subsection (5)) is to affirm or modify the precautionary suspension or restriction without further Investigation and the suspension or restriction itself is grounds for a hearing under Section 8.G. of the Medical Staff Bylaws, all further procedures shall be as set forth in Article 7 of the Credentials Policy.

(b) If the precautionary suspension or restriction remains in place pending further Investigation under Section 6.J. of the Credentials Policy, and that Investigation results in an action which is grounds for a hearing under Section 8.G. of the Medical Staff Bylaws, all further procedures shall be as set forth in Article 7 of the Credentials Policy. The Practitioner shall be entitled to only one hearing concerning the results of the precautionary suspension and restriction and the results of the corrective action Investigation.

(7) Upon the imposition of a precautionary suspension or restriction, the Chief of Staff will assist any hospitalized patients of the Practitioner to select another Practitioner with appropriate Clinical Privileges to assume responsibility for their care until discharge and the Practitioner will be removed from the call schedule.

6.J. INQUIRIES AND INVESTIGATIONS[30]

6.J.1. Initial Inquiry:

(1) Whenever a serious question has been raised, where collegial efforts have not resolved an issue, or a precautionary suspension or restriction has been continued regarding any of the following, the matter may be referred to the Chief of Staff, the department chairperson, the chairperson of a standing committee, the Chief Medical Officer, the Chief Executive Officer, or the chairperson of the Board:[31]

(a) clinical competence or clinical practice, including patient care, treatment or management and failure to follow adopted protocols and guidelines;

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30 MS.09.01.01

31 MS.01.01.01, EP 30

(b) the known or suspected violation of applicable internal and external ethical standards, or the bylaws, policies, rules and regulations, and other adopted standards of the Hospital or the Medical Staff, or applicable laws and regulations;

(c) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the Practitioner to work harmoniously with others;

(d) ability to perform, with or without reasonable accommodation, the essential functions of Medical Staff Membership and/or Clinical Privileges; or

(e) the qualifications of the individual for Medical Staff Membership or Clinical Privileges.

(2) The person or committee to whom the concern is referred will make a sufficient inquiry to determine whether the concern is credible and, if so, shall forward it to the Medical Executive Committee. If the Practitioner has a Supervising/ Collaborating Practitioner, that Supervising/Collaborating Practitioner may also be notified.

(3) To preserve impartiality, the person to whom the matter is directed shall <u>not</u> be a member of the same practice as, or a relative of, the person that is being reviewed, unless such Restriction is deemed not practicable, appropriate, or relevant by the Chief of Staff.

(4) No inquiry or other action taken pursuant to this Section will constitute an Investigation.

<u>6.J.2. Initiation of Investigation</u>:

(1) The Medical Executive Committee will review the matter in question, may discuss the matter with the Practitioner, and will determine whether to conduct an Investigation or direct that the matter be handled pursuant to another policy. An Investigation will commence only after a determination by the Medical Executive Committee or the Board.

(2) The Medical Executive Committee will inform the Practitioner that an Investigation has begun. In rare instances, notification may be delayed if, in the judgment of the Medical Executive Committee, informing the Practitioner immediately might compromise the integrity of the Investigation or disrupt the operation of the Hospital or Medical Staff.

(3) The Board may also determine to commence an Investigation and may delegate the Investigation to the Medical Executive Committee, a subcommittee of the Board, or an ad hoc committee.

<u>6.J.3. Investigative Procedure</u>:

(1) Once a determination has been made to begin an Investigation, the Medical Executive Committee will investigate the matter itself or appoint an individual or ad hoc committee to do so. The individual or committee conducting the Investigation, including the Medical Executive Committee, will be referred to as the "Investigating Committee" throughout

this Article. The Investigating Committee may include individuals who are not Members of the Medical Staff and have not been granted Clinical Privileges at the Hospital. The Investigating Committee will not include any individual who:

(a) is in direct economic competition with the Practitioner being investigated;

(b) is professionally associated with, a relative of, or involved in a referral relationship with, the Practitioner being investigated;

(c) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

(d) actively participated in the matter at any previous level.

(2) Whenever the questions raised concern the clinical competence of the Practitioner under review, the Investigating Committee will include a peer of the Practitioner (e.g., Physician, Dentist, oral surgeon, or Podiatrist).

(3) The Investigating Committee may:

(a) review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;

(b) conduct interviews;

(c) use outside consultants, as needed; or

(d) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated will execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.

(4) As part of the Investigation, the Practitioner will have an opportunity to meet with the Investigating Committee. At least seven (7) Days prior to this meeting unless otherwise agreed upon by both the Practitioner and the Investigating Committee, the Practitioner will be provided with Special Notice of the time, date and place of the meeting and the concerns being investigated and will be invited to discuss, explain, or refute the questions or to submit a written statement prior to, or in lieu of, the meeting. A summary of the interview will be made and included with the Investigating Committee's report, but is not available to the Practitioner. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting

(5) The Investigating Committee will make a reasonable effort to complete its portion of the Investigation and issue its report within 30 Days, provided that an outside review is not necessary. When an outside review is used, the Investigating Committee will make a reasonable effort to complete its portion of the Investigation and issue its report within 30 Days of receiving the final results of the outside review. These time frames are

intended to serve as guidelines and, as such, will not be deemed to create any right for a Practitioner to have the Investigating Committee complete its portion of the Investigation or issue its report within such time periods.

(6) At the conclusion of the Investigating Committee's portion of the Investigation, it will prepare a written report to the Medical Executive Committee with its findings, conclusions, and recommendations on whether any action should be taken.

6.J.4. MEC Recommendation:

(1) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee and shall make a recommendation to the Board in accordance with (2) and (3) of this Section, as set forth below. Specifically, the Medical Executive Committee may:

(a) determine that additional information , inquiry, or Investigation is required and refer the matter to the appropriate individual or body;

(b) Determine that no action is justified;

(c) issue a letter of guidance, education or counseling, or take another collegial intervention, which would not be considered disciplinary or corrective action;

(d) issue a letter of warning or reprimand;

(e) recommend monitoring, proctoring or consultation;

(f) recommend additional training or education;

(g) recommend reduction or restriction of Clinical Privileges;

(h) recommend suspension of Clinical Privileges for a specified period of time;

(i) recommend revocation of Membership or Clinical Privileges; or

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

(2) Unless the recommendation by the Medical Executive Committee entitles the Practitioner to request a hearing in accordance with Article 7, the recommendation will be considered a final action, which will take effect immediately and will remain in effect, unless modified by the Board.

(3) A recommendation by the Medical Executive Committee that would entitle the Practitioner to request a hearing will be forwarded to the Chief Executive Officer, who will promptly inform the individual by Special Notice. All further procedures shall be as set forth in Article 7 of this Policy.

(4) If the Board makes a modification to the recommendation of the Medical Executive Committee that would entitle the Practitioner to request a hearing, the Chief Executive Officer will inform the Practitioner by Special Notice. In that case, no final action will occur until the Practitioner has completed or waived a hearing and appeal.

(5) If final action has been taken on any matter that was subject to an investigation or if the Board formally resolves to close an Investigation, the Investigation will be considered concluded.

6.K. Actions Occurring at Other Affiliated Entities

In accordance with Section 2.C.3(3) of this Policy, and any other policy governing the sharing of credentialing and peer review information among Affiliated Entities, all Affiliated Entities may share with each other information regarding peer review/professional practice evaluation activites, including but not limited to any activity set forth in the Article 6.

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ARTICLE 7 - HEARING AND APPEAL PROCEDURES[32]

The procedures set forth in this Article apply only to Members of the Medical Staff and to Physicians, Dentists and Oral Maxillofacial Surgeons, and Podiatrists applying to the Medical Staff. Procedures applicable to Advanced Practice Professionals are set forth in Article 8.

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

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

(a) Denial of initial Medical Staff Membership, renewed Medical Staff Membership, or requested Clinical Privileges;

(b) Revocation of Membership or Clinical Privileges;

(c) Suspension of Clinical Privileges for more than 30 Days (other than precautionary suspension);

(d) Restriction of clinical privileges for more than 30 days that is the result of a professional review action based on clinical competence or professional conduct that leads to the inability of a practitioner to exercise his or her own independent judgement in a professional setting (e.g., a mandatory concurring consultation requirements); or

(e) Denial of reinstatement from a leave of absence as set forth in Section 6.H.(3), if the reasons relate to professional competence or conduct.

(2) No other recommendations or action will entitle the individual to a hearing.

(3) If the Board determines to take any of these actions without an adverse recommendation by the Medical Executive Committee, an individual is entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Medical Executive Committee. When a hearing is triggered by an adverse proposed action of the Board, any reference in the Article to the "Medical Executive Committee" will be interpreted as a reference to the "Board."

7.A.2 Actions Not Grounds for Hearing:

None of the following actions constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her file:

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32 MS.10.01.01; MS.01.01.01, EP 34

(1) A letter of guidance, counsel, warning, or reprimand;

(2) Conditions, monitoring, proctoring, or a general consultation requirement;

(3) A lapse, withdrawal of, or decision not to grant temporary Privileges;

(4) Automatic relinquishment of Membership or Clinical Privileges;

(5) A requirement for additional training or continuing education;

(6) Precautionary suspension;

(7) Denial of a request for leave of absence or for an extension of a leave;

(8) Activation of a leave of absence on behalf of a practitioner, by the Chief Executive Officer and/or Chief Medical Officer, in accordance with this policy;

(9) Removal from the on-call roster or any reading or rotational panel;

(10)The voluntary acceptance of a performance improvement plan;

(11)Determination that an Application in not Complete;

(12)Determination that an Application will not be processed due to a misstatement or omission;

(13)Determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of Hospital need or resources, or because of an exclusive contract;

(14)Changes to Medical Staff Membership prerogatives (e.g., voting, rights, eligibility for committee membership); or

(15)Any other collegial intervention as defined in Section 6.E.

7.A.3 Notice of Recommendation:

The Chief Executive Officer will promptly give Special Notice of a recommendation which entitles an individual to request a hearing. The Special Notice will contain:

(a) a statement of the recommendation and the general reason(s) for it;
(b) a statement that the individual has the right to request a hearing on the recommendation within 30 Days of receipt of this Special Notice; and
(c) a summary of the individual's rights at the hearing as set out in Section 7.C.3(.(1) and a copy of this Article.

<u>7.A.4. Request for Hearing;</u>

An individual has 30 Days following receipt of the Special Notice to request a hearing, in writing to the Chief Executive Officer, including the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing within the required time frame will constitute a waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

7.A.5. Notice of Hearing and Statement of Reasons

The Chief Executive Officer will schedule the hearing and provide to the individual requesting the hearing, by Special Notice, the following.

(a) the time, place, and date of the hearing;
(b) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;
(c) the names of the Hearing Panel Member and Presiding Officer (or Hearing Officer) if known; and
(d) a statement of the specific reason(s) for the recommendation, including a list of patient records (if applicable), and information or documents supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 Days, to review and respond with additional information.

The hearing will begin as soon as practicable but no sooner than 30 Days after the Special Notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.A.6. Hearing Panel, Presiding Officer, and Hearing Officer:[33]

(1) Hearing Panel:[34]

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

(a) The Hearing Panel will consist of at least three members, one of whom will be designated as chairperson. The chairperson will serve as the Presiding Officer when one has not been appointed.

(b) The Hearing Panel may include any combination of:

(i) Members of the Medical Staff; and

(ii) Physicians, Dentists, Oral Maxillofacial Surgeons, Podiatrists, other health care professionals, or laypersons not connected with the Hospital.

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33 The Health Care Quality Improvement Act, 42 U.S.C. §11112(b)(3)

34 MS.01.01.01, EP 35 & MS.10.01.01, EP 4

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

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

(e) The Hearing Panel will not include any individual who:

(i) is in direct economic competition with the individual requesting the hearing;

(ii) is professionally associated with, a relative of, or involved in a referral relationship with, the individual requesting the hearing;

(iii) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

(iv) actively participated in the matter at any previous level.

(2) Presiding Officer:

(a) The Chief Executive Officer, after consultation with the Chief of Staff, may appoint an attorney to serve as Presiding Officer. The Presiding Officer will not act as an advocate for either side at the hearing.

(b) The Presiding Officer will:

(i) schedule and conduct a pre-hearing conference;

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

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

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

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

(vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

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

(d) The Presiding Officer may participate in the private deliberations of the Hearing Panel, may be a legal advisor to it, and may draft the report of the Hearing Panel's decision based upon the findings and discussions of the Panel, but will not vote on its recommendations.

(3) Hearing Officer:

(a) As an alternative to a Hearing Panel, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies and not issues of clinical competence, knowledge, or technical skill, the Chief Executive Officer, after consulting with and obtaining the agreement of the Chief of Staff, may appoint a Hearing Officer. The Hearing Officer, who should preferably be an attorney, will perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

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

(4) Objections:

Any objection to any Member of the Hearing Panel, to the Hearing Officer, or to the Presiding Officer, will be made in writing, within ten Days of the individual's receipt of Notice of the names of the Hearing Panel, Hearing Officer or Presiding Officer, to the Chief Executive Officer. The objection must include reasons to support it. A copy of the objection will be provided to the Chief of Staff. The Chief of Staff will be given a reasonable opportunity to comment. The Chief Executive Officer will rule on the objection and give Notice to the parties. The Chief Executive Officer may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.A.7. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party must be attorneys at law licensed to practice, without restriction, in good standing, in Texas.

7.A.8. Representative of Medical Executive Committee:

The Chief of Staff or his or her Member designee will represent the Medical Executive Committee at the hearing. The Chief Executive Officer will appoint counsel to assist and accompany the MEC representative in the hearing.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

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

7.B.2. Witness List:

(1) At least 15 Days before the pre-hearing conference, the parties will exchange a written list of the names of witnesses expected to offer testimony on their behalf.

(2) The witness lists will include a brief summary of the anticipated testimony.

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

7.B.3. Time Frames:

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

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

(2) the parties will exchange proposed exhibits at least 10 Days prior to the pre-hearing conference; and

(3) any objections to witnesses and/or proposed exhibits must be provided to the Presiding Officer at least five Days prior to the pre-hearing conference.

7.B.4. Provision of Relevant Information:

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

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

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

(b) reports of experts relied upon by the Medical Executive Committee that will be presented at the hearing; and

(c) copies of any other documents relied upon by the Medical Executive Committee that will be presented at the hearing.

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

(3) The individual will have no right to discovery beyond the above information. No information will be provided regarding other Practitioners. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(4) Ten Days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits.

(5) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees or Practitioners whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this Section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the hearing once it has contacted such employees or Practitioners, and confirmed their willingness to meet. Any employee or Practitioner may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.B.5. Pre-Hearing Conference:

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

(2) All objections to exhibits or witnesses will be submitted, in writing, five Days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(3) At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses.

(4) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for Membership or the relevant Clinical Privileges will be excluded.

(5) The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination.

7.B.6. Stipulations:

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

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

The following documents will be provided to the Hearing Panel in advance of the hearing:

(1) a pre-hearing statement that either party may choose to submit;

(2) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and

(3) stipulations agreed to by the parties.

7.C. THE HEARING

7.C.1. Time Allotted for Hearing:

The Presiding Officer will determine the length of the hearing at the pre-hearing conference. As a general rule, it is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 15 hours. Considering the complexity of the case and fundamental fairness, the Presiding Officer may, after considering any objections, modify the time frame for the hearing.

7.C.2. Record of Hearing:

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

7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:[35]

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

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

(b) to introduce exhibits;

(c) to cross-examine any witness;

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

(e) to submit a written statement at the close of the hearing; and

(f) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

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

[35] The Health Care Quality Improvement Act, 42 U.S.C. §11112(b)(3)

(3) The Hearing Panel and Presiding Officer may question witnesses, request the presence of additional witnesses, or request documentary evidence.

7.C.4. Order of Presentation and Burden:

The Medical Executive Committee will first present evidence in support of its recommendation. Thereafter, the burden will shift to the individual who requested the hearing to present clear and convincing evidence that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.C.5. Admissibility of Evidence:

The hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any evidence that is relevant to the individual's qualifications for Membership and Clinical Privileges will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs.

7.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding. The presence of the individual who requested the hearing is mandatory. Administrative personnel may be present as requested by the Chief Executive Officer or the Chief of Staff. Witnesses other than parties may not be present in the hearing except when testifying.

7.C.7. Presence of Hearing Panel Members:

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

7.C.8. Failure to Appear:

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

7.C.9. Postponements and Extensions:

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

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

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

Consistent with the burden set forth in Section 7.C.4, as well as the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial Membership, renewed Membership, and Clinical Privileges, the Hearing Panel will recommend in favor of the Medical Executive Committee unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

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

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

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

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

7.E. APPEAL PROCEDURE[36]

7.E.1. Time for Appeal:

(1) Within 10 Days after receipt of Notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the Chief Executive Officer in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

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

7.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

(1) there was substantial failure by the Hearing Panel or the Presiding Officer to comply with this Article, so as to deny a fair hearing; or

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

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[36] MS.10.01.01, EP 5

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

Whenever an appeal is requested, the chairperson of the Board will schedule and arrange for the appellate review. The individual will be given special Notice of the time, place, and date of the appeal and the Medical Executive Committee's representation will also be notified. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

(1) The Board may serve as the Appellate Review Panel (Review Panel) or the chairperson of the Board may appoint a at least three individuals to serve as the Review Panel, composed of members of the Board or others, including but not limited to reputable persons outside the Hospital.

(2) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the Medical Executive Committee and Hearing Panel and any other information that it deems relevant, and recommend final action to the Board.

(3) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have 10 Days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(4) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

7.F. BOARD ACTION

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

(1) The Board will take final action within 30 Days after it (i) considers the appeal as a Review Panel, (ii) receives a written recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report when no appeal has been requested.

(2) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel (if applicable).

(3) Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.

(4) The Board will render its final decision in writing, including the basis for its decision, and will send Special Notice to the individual within 20 Days of the decision. A copy will also be provided to the Chief of Staff.

(5) Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

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

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

7.G. MEDIATION

7.G.1. Statutory Provision:

The following procedures shall apply to a Practitioner who requests and is entitled to mediation as provided in Section 8.I of the Medical Staff Bylaws ("Eligible Practitioner"), and to the mediation. The Hospital shall have no obligation to offer mediation to Practitioners who are not Eligible Practitioners or to notify an Eligible Practitioner of the statutory right to request mediation.

7.G.2. Request:

The Eligible Practitioner must submit a request for mediation by Special Notice to the Chief Executive Officer within 14 days of: (i) receipt of the notice of a recommendation or action that entitles the Practitioner to request a hearing as provided by Section 8.H.1 of the Medical Staff Bylaws and Section 7.A.1 above; or (ii) the 90th day from the *Medical Executive Committee's* receipt of a Complete Application. If both a request for mediation and a request for hearing have been submitted, the mediation shall be conducted first and the timelines for scheduling the hearing temporarily suspended until the mediation is completed.

7.G.3. Conditions of Mediation:

(1) The mediation must be scheduled within 30 days of receipt of the Eligible Practitioner's request, and begin and be completed within 75 days of receipt of the request.

(2) The Eligible Practitioner and the Hospital will share the costs of the mediator equally. The mediator will be selected by mutual agreement of the Eligible Practitioner and the Chief Executive Officer, and must be qualified as required by Section 241.101(d) of the Texas Health & Safety Code unless otherwise agreed by the Eligible Practitioner and the Chief Executive Officer.

(3) The mediation shall occur either at the Hospital or the mediator's office, and shall be limited to a half-day of mediation unless otherwise agreed by the Eligible Practitioner and the Chief Executive Officer.

(4) The Medical Executive Committee or Board of Trustees, whichever recommended the Adverse Recommendation or Action, shall be represented in the mediation by the Chief Executive Officer

and the Chief of Medical Staff, or their designees. Attorneys for the parties may attend and participate in the mediation, as may the Chair of the Board of Trustees.

7.G.4. Mediation Agreement

(1) The Hospital's representatives at the mediation shall not have the authority to bind the Hospital to any agreement with the Eligible Practitioner. Any agreement reached during mediation shall be characterized as "proposed," and shall be in writing, signed by the Eligible Practitioner and the Hospital's representatives, and signed by any participating attorneys.

(2) The proposed mediation agreement shall be presented to the Medical Executive Committee at the next available opportunity for a recommendation. The Medical Executive Committee's recommendation and the proposed mediation agreement shall then be presented to the Board of Trustees for consideration. If the Board of Trustees approves the proposed mediation agreement, it shall become binding and final, and the Eligible Practitioner will be deemed to have waived all his remaining rights including, if applicable, the right to a hearing under the Bylaws. The Chief Executive Officer shall provide the Eligible Practitioner with Special Notice of the approval.

(3) If the Board of Trustees does not approve the proposed mediation agreement, the Chief Executive Officer will provide the Eligible Practitioner with Special Notice of the lack of approval. In such case, the Eligible Practitioner will retain any applicable procedural rights provided by the Bylaws but has no right to further mediation. Any time lines for procedural rights contained in the Bylaws that were temporarily suspended as a result of the mediation will resume on the date of the Special Notice of the lack of approval.

(4) If the mediation does not result in a proposed agreement as provided in subsection (1) above, the time lines for procedural rights shall resume on the date following the mediation.

(5) Under no circumstances may a mediation agreement require any action not permitted by law or require the Hospital, Medical Staff, or Board of Trustees to violate any legal or accreditation requirement.

ARTICLE 8 - CONDITIONS OF PRACTICE APPLICABLE TO ADVANCED PRACTICE PROFESSIONALS

8.A. CONDITIONS OF PRACTICE APPLICABLE TO ADVANCED PRACTICE PROFESSIONALS

8.A.1. General:

The Board, following consultation with the Medical Executive Committee, shall determine what categories of health care professionals are eligible for clinical privileges as Advanced Practice Professionals. Those categories that have been approved are set forth in the Advanced Practice Professional Policy. As a condition of being granted permission to practice at the Hospital, all Advanced Practice Professionals specifically agree to abide by the standards of practice set forth in the privilege delineation that they have been granted by the Board and the terms of the agreement with their Supervising/Collaborating Practitioner, if any. In addition, as a condition of being permitted to utilize the services of Advanced Practice Professionals in the Hospital, all Practitioners who serve as Supervising/Collaborating Practitioners to such individuals also specifically agree to abide by the applicable standards set forth in the Article and the terms of their agreements.

Supervising/Collaborating Practitioner oversight and responsibilities, and APP authority are outlined in the APP Policy.

8.B. PROCEDURAL RIGHTS FOR ADVANCED PRACTICE PROFESSIONALS

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

(1) In the event a recommendation is made by the Medical Executive Committee that an Advanced Practice Professional not be granted Clinical Privileges or that the Clinical Privileges previously granted be restricted for a period of more than 30 Days, terminated, or not renewed, the individual will receive Special Notice of the recommendation. The special Notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing.

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

(3) If the Advanced Practice Professional wants to request a hearing, the request must be in writing, directed to the Chief Executive Officer, within 30 Days after receipt of written Notice of the adverse recommendation.

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

8.B.2. Hearing Panel:

(1) If a request for a hearing is made timely, the Chief Executive Officer, in consultation with the Chief of Staff, will appoint a Hearing Panel composed of up to three individuals (including, but not limited to, Members of the Medical Staff, Hospital management, individuals not connected with the Hospital, or any combination of these individuals). A peer of the APP requesting the hearing shall be included if feasible. The Hearing Panel will not include anyone who previously participated in the recommendation, any relatives or practice partners, including the Supervising/Collaborating Practitioner of the Advanced Practice Professional, or any competitors of the affected individual.

(2) The Chief Executive Officer, in consultation with the Chief of Staff, will appoint a Presiding Officer ("Presiding Officer"), who may be an attorney. The role of the Presiding Officer will be to allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination. The Presiding Officer will maintain decorum throughout the hearing and provide guidance to the Hearing Panel.

(3) As an alternative to a Hearing Panel in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, and/or compliance with Medical Staff Rules, regulations and/or policies, and does not involve issues of clinical competence, the Chief Executive Officer, in consultation with the Chief of the Medical Staff, may appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Panel. The Hearing Officer will preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and will not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Panel, all references in the Article to the Hearing Panel or Presiding Officer will be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

8.B.3. Hearing Process:

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

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

(3) At the hearing, a representative of the Medical Executive Committee will first present the reasons for the recommendation. The Advanced Practice Professional will be invited to present information to refute the reasons for the recommendation.

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

(5) The Advanced Practice Professional and the Medical Executive Committee may be represented at the hearing by legal counsel. However, while counsel may be present at

the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.

(6) The Advanced Practice Professional will have the burden of demonstrating, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by substantial evidence.

(7) The Advanced Practice Professional and the Medical Executive Committee will have the right to submit proposed findings, conclusions, and recommendations, as well as a post-hearing statement, for consideration by the Hearing Panel. The Presiding Officer will establish a reasonable schedule for the submission of these items. The hearing will be considered to have concluded on the date that any post-hearing statements are required by the Hearing Officer to be submitted.

(8) The personal presence of the Advanced Practice Professional who requested the hearing is mandatory. Failure to appear shall constitute a waiver of the right to a hearing and any other rights of review. If such individual does not testify, he or she may be called and questioned.

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

8.B.4. Hearing Panel Report:

(1) Within 20 Days after the conclusion of the hearing, the Hearing Panel will prepare a written report and recommendation. The Hearing Panel will forward the report and recommendation, along with all supporting information, to the Chief Executive Officer. The Chief Executive Officer will send a copy of the written report and recommendation by special Notice to the Advanced Practice Professional and to the Medical Executive Committee.

(2) Within ten Days after receipt of the Special Notice of such recommendation, the Advanced Practice Professional and/or the Medical Executive Committee may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.

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

(4) The request for an appeal will be delivered to the Chief Executive Officer by Special Notice.

(5) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information of the Hearing Panel will be forwarded to the Board for final action. If a timely request for appeal is submitted, the Chief Executive Officer will forward the report and recommendation, the supporting

information and the request for appeal to the Board. The Chairperson of the Board will arrange for an appeal.

8.B.5. Appellate Review:

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

(2) The Advanced Practice Professional and the Medical Executive Committee will each have the right to present a written statement on appeal.

(3) At the sole discretion of the Appellate Review Committee, the Advanced Practice Professional and a representative of the Medical Executive Committee may also appear personally to discuss their position. They may be accompanied by counsel, but counsel may not address the Appellate Review Committee or the other party.

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

(5) The Advanced Practice Professional will receive Special Notice of the Board's action within 20 days of the final action. A copy of the Board's final action will also be sent to the Medical Executive Committee for information.

ARTICLE 9 - CONFLICTS OF INTEREST

*Appendix A includes a chart that provides guidance for implementing these conflict of interest rules.

9.A.1 General Principles:

(1) Anyone involved in Medical Peer Review, including but not limited to, Professional Review Activities, credentialing, professional practice evaluation or other Hospital or Medical Staff activities, must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the process.

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

9.A.2 Practitioner and Immediate Family Members:

No practitioner may participate in the review of his or her own Application or the professional practice evaluation of care he or she provide, except to provide information. No immediate family member (spouse or domestic partner, parent, child, sibling, or in-law) of a Practitioner whose Application or care is being reviewed will participate in any aspect of the review process, except to provide information.

9.A.3 Relevant Treatment Relationship:

An individual who has provided professional health services to a Practitioner whose Application or provision of care is under review shall not participate in the review process regarding the Practitioner except as follows:

(a) if the patient-physician relationship has terminated and the review process does not involve the health condition for which the Practitioner sought professional health services;

(b) to provide information the was not obtained through the treatment relationship; or

(c) to provide information the was obtained through the treatment relationship, as authorized by the Practitioner.

9.A.4 Employment by or Contractual Relationship with the Hospital:

Employment by, or other contractual arrangement with, the Hospital or an Affiliated Entity will not, in and of itself, preclude an individual from participating in Medical Peer Review Activities. Rather, participation by such individuals will be evaluated as outlined in the paragraphs below.

9.A.5 Actual or Potential Conflict Situations:

With respect to a Practitioner whose Application or care is under review, the following individuals (hereinafter referred to as "Interested Persons") have an actual or perceived conflict:

(1) significant financial relationship(e.g., members of small, single specialty group; significant referral relationships; partners in business venture);

(2) direct competition;

(3) close friends;

(4) a history of personal conflict;

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

(6) raising the concern that triggered the review; and

(7) those whose prior participation in review of the matter at a previous level.

9.A.6 Guidelines for Participation in Medical Peer Review Activities:

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

(1) Initial Reviewers. An Interested Person may participate as an initial reviewer in situations where a check and balance is provided by subsequent review by a Medical Staff committee. For example, this applies, but is not limited to, the following situations:

   a. participation in the review of Applications for initial and renewed Membership and Clinical Privileges (which are subsequently reviewed by the Department, CNO, and/or Medical Executive Committee); and

   b. participation as a case reviewer in professional practice evaluation activities (which are subsequently reviewed by the Peer Review Committee, Investigating Committee, and/or Medical Executive Committee).

(2) Peer Review Committees. An Interested Person may fully participate as a Member of these committees because these committees do not make any final recommendation that could adversely affect the Clinical Privileges of a Practitioner which is only within the authority of the Medical Executive Committee. However, the chairs of these committees always have the discretion to recuse an Interested Person if they determine that the Interested Person's presence would inhibit full and fair discussion of the issue or would skew the recommendation or determination of the committee.

(3) Investigating Committee. Once a formal Investigation has been initiated, additional precautions are required. Therefore, an Interested Person may not be appointed as a Member of an investigating committee, but may be interviewed and provide information to

the investigating committee if necessary for the committee to conduct a full and thorough Investigation.

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

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

9.A.7 Guidelines for Participation in Development of Privileging Criteria:

Recognizing that the development of privileging criteria can have a direct or indirect financial impact on particular Practitioners, the following guidelines apply. Any individual who has a personal interest in privileging criteria, including criteria for Clinical Privileges that cross specialty lines or Practitioner categories or criteria for New Procedures, may:

(1) provide information and input to the Advanced Practice Professional Committee , MEC, or an ad hoc committee charged with development of such criteria;

(2) serve on the Advanced Practice Professional Committee, MEC, or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the chairperson of the Advanced Practice Professional Committee, MEC, or ad hoc committee always has the discretion to recuse an Interested Person in a particular situation); but

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

9.A.7 Rules for Recusal:

(1) When determining whether recusal in a particular situation is required, the Chief of the Medical Staff or Board or committee chair will c consider whether the Interested Person's presence would inhibit full and fair discussion of the issue, would skew the recommendation or determination of the committee, or otherwise be unfair to the Practitioner under review.

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

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

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

9.A.8 Other Considerations:

(1) Any Member of the Medical Staff who is concerned about a potential conflict of interest on the part of any other Member, including but not limited to the situations noted in the paragraphs above, must call the conflict of interest to the attention of the Chief of Staff or the applicable committee/Board chair. The Member's failure to notify will constitute a waiver of the claimed conflict. The Chief of Staff or the applicable committee/Board chair has the authority to make a final determination as to how best to manage the situation, guided by this Article, including recusal of the Interested Person, if necessary. If the Chief of Staff or the applicable committee/Board is the individual reported to have a conflict of interest, the Chief of Staff elect, vice chairperson of the committee, or another officer of the Board (as determined by the corporate bylaws), as applicable, shall be authorized to make final determinations regarding management of the conflict.

(2) No Member has a right to compel the disqualification of another Practitioner or Hospital representative based on an allegation of conflict of interest.

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

ARTICLE 10 - ADOPTION AND AMENDMENTS

(1) This Policy is adopted as provided in Article 9 of the Medical Staff Bylaws, and made effective upon approval of the Board, superseding and replacing any and all other conflicting policies and rules and regulations of the Medical Staff or Hospital pertaining to the subject matter thereof.

(2) The amendment process for this Policy is set forth in the Bylaws.

Adopted by the Medical Executive Committee [Medical Staff]: November 9, 2018

Approved by the Board of Trustees: December 20, 2018

Revised: June 2019

APPENDIX A - CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Individual Reviewer Application/ Case	Committee Member					Hearing Panel	Board
			Credentials	Leadership Council	MCEC	MEC	Investigating Committee		
Employment/contract relationship with hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N	R
Relevant treatment relationship*	Y	N	R	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior PIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally Raised the concern	Y	Y	Y	Y	Y	R	N	N	R

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

Y – (yellow "Y") means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials Committee, Leadership Council, and MCEC have no disciplinary authority. In addition, the Chair of the Credentials Committee, Leadership Council, or MCEC always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the Practitioner under review.

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

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

<table>
<tr><th colspan="2">RULES FOR RECUSAL</th></tr>
<tr><td>STEP 1
Confirm the conflict of interest</td><td>The Committee Chair or Board Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.</td></tr>
<tr><td>STEP 2
Participation by the Interested Member at the meeting</td><td>The Interested Member may participate in any part of the meeting that does not involve the conflict of interest situation.

When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Board Chair will note that the Interested Member will be excused from the meeting prior to the group's deliberation and decision-making.

Prior to being excused, the Interested Member may provide information and answer any questions regarding the following:

(i) any factual information for which the Interested Member is the original source;

(ii) clinical expertise that is relevant to the matter under consideration;

(iii) any policies or procedures that are applicable to the committee or Board or are relevant to the matter under consideration;

(iv) the Interested Member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the MEC prior to being excused from the meeting); and

(v) how the committee or Board has, in the past, managed issues similar or identical to the matter under consideration.</td></tr>
<tr><td>STEP 3
The Interested Member is excused from the meeting</td><td>The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's or Board's deliberation and decision-making.</td></tr>
<tr><td>STEP 4
Record the recusal in the minutes</td><td>The recusal should be documented in the minutes of the committee or Board. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making.</td></tr>
</table>