



BOONE HOSPITAL CENTER

CREDENTIALS POLICY

MEC Approval: August 2, 2021
General Medical Staff Approval: September 14, 2021
Board Approval: September 20, 2021

CREDENTIALS POLICY
TABLE OF CONTENTS

	<u>PAGE</u>
1. GENERAL	1
1.A. TIME LIMITS	1
1.B. DELEGATION OF FUNCTIONS	1
1.C. CONFIDENTIALITY AND PEER REVIEW PROTECTION.....	1
1.C.1. Confidentiality	1
1.C.2. Peer Review Protection.....	2
1.D. INDEMNIFICATION.....	2
1.E. DEFINITIONS.....	2
2. QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES	7
2.A. QUALIFICATIONS	7
2.A.1. Threshold Eligibility Criteria.....	7
2.A.2. Extension of Time Frame to Satisfy Board Certification Criterion	10
2.A.3. Waiver of Threshold Eligibility Criteria.....	10
2.A.4. Factors for Evaluation.....	11
2.A.5. No Entitlement to Appointment.....	12
2.A.6. Nondiscrimination.....	12
2.B. GENERAL CONDITIONS OF APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGES	12
2.B.1. Basic Responsibilities and Requirements	12
2.B.2. Burden of Providing Information.....	14
2.C. APPLICATION	15
2.C.1. Information	15
2.C.2. Misstatements and Omissions.....	16
2.C.3. Grant of Immunity and Authorization to Obtain/Release Information.....	16

3. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES20

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES.....20

3.A.1. Application Process20

3.A.2. Initial Review of Application.....20

3.A.3. Department Chief and Chief Nursing Officer Procedure21

3.A.4. Credentials Committee Procedure21

3.A.5. Medical Executive Committee Recommendation22

3.A.6. Board Action.....22

3.A.7. Time Periods for Processing23

4. CLINICAL PRIVILEGES24

4.A. CLINICAL PRIVILEGES24

4.A.1. General.....24

4.A.2. Requests for Limited Privileges Within a Core or Specialty25

4.A.3. Resignation of Limited Clinical Privileges.....26

4.A.4. Resignation of Appointment and Clinical Privileges.....26

4.A.5. Clinical Privileges for New Procedures.....26

4.A.6. Clinical Privileges That Cross Specialty Lines.....28

4.A.7. Clinical Privileges for Dentists and Oral Surgeons29

4.A.8. Clinical Privileges for Podiatrists30

4.A.9. Physicians and Other Practitioners in Training30

4.A.10. Initial Competency Evaluation31

4.B. TEMPORARY CLINICAL PRIVILEGES31

4.B.1. Temporary Clinical Privileges31

4.C. EMERGENCY SITUATIONS33

4.D. DISASTER PRIVILEGES33

4.E. CONTRACTS FOR SERVICES AND EMPLOYED MEDICAL STAFF MEMBERS.....34

4.F. TELEMEDICINE PRIVILEGES36

4.F.1. Processing Requests for Telemedicine Privileges36

4.F.2. Review of Telemedicine Privileges37

	<u>PAGE</u>
5. PROCEDURE FOR REAPPOINTMENT	38
5.A. PROCEDURE FOR REAPPOINTMENT	38
5.B. REAPPOINTMENT CRITERIA	38
5.B.1. Eligibility for Reappointment	38
5.B.2. Factors for Evaluation	38
5.C. REAPPOINTMENT PROCESS	39
5.C.1. Reappointment Application Form	39
5.C.2. Processing Applications for Reappointment	40
5.C.3. Conditional Reappointments	40
5.C.4. Potential Adverse Recommendation	40
6. QUESTIONS INVOLVING MEDICAL STAFF OR ALLIED HEALTH STAFF MEMBERS	41
6.A. INITIAL COLLEGIAL EFFORTS AND PROGRESSIVE STEPS	41
6.A.1. Options Available to Medical Staff Leaders and Hospital Administration	41
6.A.2. Documentation	42
6.A.3. No Recordings of Meetings	42
6.A.4. No Right to Counsel	43
6.A.5. No Right to the Presence of Others	43
6.A.6. Involvement of Supervising Physician in Matters Pertaining to Allied Health Staff Members	43
6.B. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION	43
6.C. MANDATORY MEETING	44
6.D. FITNESS FOR PRACTICE EVALUATION	44
6.E. COMPETENCY ASSESSMENT	45
6.F. AUTOMATIC RELINQUISHMENT	45
6.F.1. Failure to Complete Medical Records	45
6.F.2. Failure to Satisfy Threshold Eligibility Criteria	46
6.F.3. Criminal Activity	46

	<u>PAGE</u>
6.F.4. Failure to Provide Information.....	46
6.F.5. Failure to Attend a Mandatory Meeting.....	46
6.F.6. Failure to Complete or Comply with Training or Educational Requirements.....	46
6.F.7. Failure to Comply with Request for Fitness for Practice Evaluation	47
6.F.8. Failure to Comply with Request for Competency Assessment	47
6.F.9. Failure to Timely Pay Dues	47
6.F.10. Reinstatement from Administrative Relinquishment and Resignation.....	47
6.G. LEAVES OF ABSENCE.....	48
6.G.1. Initiation.....	48
6.G.2. Duties of Member on Leave	49
6.G.3. Reinstatement.....	49
6.H. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES	50
6.H.1. Grounds for Precautionary Suspension or Restriction.....	50
6.H.2. Medical Executive Committee Procedure	51
6.I. INVESTIGATIONS	52
6.I.1. Initial Review.....	52
6.I.2. Initiation of Investigation.....	52
6.I.3. Investigative Procedure.....	53
6.I.4. Recommendation	54
7. HEARING AND APPEAL PROCEDURES	56
7.A. INITIATION OF HEARING.....	56
7.A.1. Grounds for Hearing	56
7.A.2. Actions Not Grounds for Hearing.....	56
7.A.3. Notice of Recommendation	58
7.A.4. Request for Hearing	58
7.A.5. Notice of Hearing and Statement of Reasons	58
7.A.6. Witness List	59
7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer	59
7.A.8. Counsel	61

	<u>PAGE</u>
7.B. PRE-HEARING PROCEDURES	61
7.B.1. General Procedures	61
7.B.2. Provision of Relevant Information.....	62
7.B.3. Pre-Hearing Conference.....	63
7.B.4. Stipulations	63
7.B.5. Provision of Information to the Hearing Panel	63
7.C. THE HEARING.....	63
7.C.1. Time Allotted for Hearing	63
7.C.2. Record of Hearing.....	64
7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing	64
7.C.4. Order of Presentation	64
7.C.5. Admissibility of Evidence.....	64
7.C.6. Persons to Be Present.....	65
7.C.7. Presence of Hearing Panel Members	65
7.C.8. Failure to Appear	65
7.C.9. Postponements and Extensions	65
7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS	65
7.D.1. Basis of Hearing Panel Recommendation.....	65
7.D.2. Deliberations and Recommendation of the Hearing Panel.....	65
7.D.3. Disposition of Hearing Panel Report	66
7.E. APPEAL PROCEDURE.....	66
7.E.1. Time for Appeal.....	66
7.E.2. Grounds for Appeal.....	66
7.E.3. Time, Place and Notice.....	66
7.E.4. Nature of Appellate Review.....	66
7.F. BOARD ACTION	67
7.F.1. Final Decision of the Board	67
7.F.2. Right to One Hearing and One Appeal Only	67
8. CONDITIONS OF PRACTICE APPLICABLE TO ALLIED HEALTH PROFESSIONALS	68
8.A. CONDITIONS OF PRACTICE APPLICABLE TO ALLIED HEALTH PROFESSIONALS	68

	<u>PAGE</u>
8.A.1. Standards of Practice for the Utilization of Advanced Practice Clinicians in the Inpatient Setting.....	68
8.A.2. Oversight by Supervising Physician	69
8.A.3. Questions Regarding the Authority of an Advanced Practice Clinician.....	69
8.A.4. Responsibilities of Supervising Physicians	70
8.B. PROCEDURAL RIGHTS FOR LICENSED INDEPENDENT PRACTITIONERS AND ADVANCED PRACTICE CLINICIANS	70
9. CONFLICTS OF INTEREST	71
10. AMENDMENTS AND ADOPTION.....	73
 APPENDIX A ALLIED HEALTH PROFESSIONALS	
 APPENDIX B CONFLICT OF INTEREST GUIDELINES	
 APPENDIX C DELEGATED CREDENTIALING PROCEDURES	

ARTICLE 1

GENERAL

1.A. TIME LIMITS

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

1.B. DELEGATION OF FUNCTIONS

- (1) When a function is to be carried out by a member of Hospital Administration, by a Medical Staff Leader or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.
- (2) When a Medical Staff or Allied Health Staff member 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 actions or activity, and recommendations made pursuant to this Policy and other Medical Staff policies and procedures will be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the committees charged with such functions, except:

- (a) to another authorized individual and for the purpose of conducting professional review activity;
- (b) as authorized by Medical Staff or Hospital policy; or
- (c) as authorized by the President or by legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a professional review action or appropriate legal action. Breaches of confidentiality will not constitute a waiver of any privilege. Any member of the Medical Staff or the Allied Health Staff members who becomes aware of a breach of confidentiality is encouraged to inform the President, the Chief Medical Officer, or the Chief of Staff (or the Vice Chief of Staff if the Chief of Staff is the person committing the claimed breach).

1.C.2. Peer Review Protection:

Credentialing, professional practice evaluation and peer review activities pursuant to this Policy and other Medical Staff policies and procedures will be performed by peer review committees in accordance with state law. These committees include, but are not limited to:

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

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

1.D. INDEMNIFICATION

The Hospital will provide a legal defense for, and will indemnify, all Medical Staff Leaders, peer review committees, members, and authorized representatives when engaged in those capacities, in accordance with applicable laws and the Hospital’s Bylaws.

1.E. DEFINITIONS

The following definitions apply to terms used in this Policy:

- (1) “ALLIED HEALTH PROFESSIONALS” means individuals other than members of the Medical Staff who are authorized by law and by the Hospital to provide patient care services. A listing of the categories of allied health professionals practicing at the Hospital is included at Appendix A. Allied health professionals include licensed independent practitioners and advanced practice clinicians:
 - “LICENSED INDEPENDENT PRACTITIONER” means an allied health professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted. Licensed independent practitioners also include those physicians not appointed to the

Medical Staff who seek to exercise certain limited clinical privileges as moonlighting residents.

- “ADVANCED PRACTICE CLINICIAN” means a type of allied health professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Physician pursuant to a written supervision or collaborative agreement.
 - Except as otherwise expressly stated in this Policy and the Medical Staff Bylaws, the term “allied health professional” will be limited to Licensed Independent Practitioners and Advanced Practice Clinicians.
- (2) “ALLIED HEALTH STAFF” means those licensed independent practitioners and advanced practice clinicians who have been appointed to the Allied Health Staff by the Board.
 - (3) “BOARD” means the governing body of CH Allied Services, Inc., d/b/a Boone Hospital Center.
 - (4) “BOARD CERTIFICATION” is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, American Board of Podiatric Medicine, or the American Board of Foot and Ankle Surgery, upon an individual, as applicable.
 - (5) “CHIEF MEDICAL OFFICER” means the individual appointed by the Hospital to act as the Chief Medical Officer of the Hospital, in cooperation with the Chief of Staff.
 - (6) “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.
 - (7) “COMPLETED APPLICATION” means that all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.
 - (8) “CORE PRIVILEGES” 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.

- (9) “CREDENTIALS POLICY” means the Hospital’s Medical Staff Credentials Policy.
- (10) “DAYS” means calendar days.
- (11) “DENTIST” means a doctor of dental surgery (“D.D.S”) or doctor of dental medicine (“D.M.D.”).
- (12) “HOSPITAL ADMINISTRATION” or “ADMINISTRATOR” means the President, or his or her designee, including the administrator on call.
- (13) “INVESTIGATION” means the process initiated by a resolution of the Medical Executive Committee, or the Board, to evaluate the validity of questions or concerns pertaining to the clinical competence or professional conduct about a member. An investigation is concluded after final action has been taken in accordance with the process as set forth in this Policy. A routine or general review of cases or any evaluation prior to commencement of an investigation by the Medical Executive Committee, or the Board is not considered an investigation.
- (14) “MEDICAL EXECUTIVE COMMITTEE” means the Medical Executive Committee of the Medical Staff as set forth in the Medical Staff Bylaws.
- (15) “MEDICAL STAFF” means all physicians, dentists, oral surgeons, and podiatrists who have been appointed to the Medical Staff by the Board.
- (16) “MEDICAL STAFF LEADER” means any Medical Staff officer, department chief, division chairperson, or committee chairperson.
- (17) “MEMBER” means a physician, dentist, oral surgeon, or podiatrist who has been granted Medical Staff appointment, or a licensed independent practitioner or advanced practice clinician who has been granted Allied Health Staff appointment, by the Board to practice at the Hospital.
- (18) “NOTICE” means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail.
- (19) “ORAL AND MAXILLOFACIAL SURGEON” means an individual with a D.D.S. or a D.M.D. degree, who has completed additional training in oral and maxillofacial surgery and is licensed to practice oral and maxillofacial surgery.
- (20) “PATIENT CONTACTS” includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities. A single

patient contact will be assigned for each patient per admission; multiple consults, procedures or treatments performed during the same admission will not be considered additional patient contacts.

- (21) “PHYSICIAN” includes both doctors of medicine and doctors of osteopathy.
- (22) “PHYSICIAN ASSISTANT” means a person who is a graduate of an approved program or its equivalent or meets standards approved by the state board and is licensed to perform medical services delegated by the Supervising Physician and is acceptable to the Board of the Hospital.
- (23) “PODIATRIST” means a doctor of podiatric medicine.
- (24) “PRESIDENT” means the individual appointed by the Board to act on its behalf in the overall management of Hospital.
- (25) “PROFESSIONAL PRACTICE EVALUATION” refers to the Hospital’s routine ongoing peer review, performance improvement, and professional practice evaluation processes. These processes include, but are not limited to, the review and assessment of an individual’s clinical performance, professionalism, and ability to exercise clinical privileges safely and competently.
- (26) “PROFESSIONAL REVIEW ACTION” has the meaning defined in the Health Care Quality Improvement Act.
- (27) “PROFESSIONAL REVIEW ACTIVITY” has the meaning defined in the Health Care Quality Improvement Act.
- (28) “PSYCHOLOGIST” means an individual with a Ph.D. in clinical psychology or a clinical psychologist licensed by the state of Missouri.
- (29) “RESTRICTION” means a professional review action based on clinical competence or professional conduct which results in the inability of an individual to exercise his or her own independent judgment for a period longer than 30 days (for example, a mandatory concurring consultation, where the consultant must approve the proposed procedure or treatment before privileges may be exercised, or other requirement that another physician must agree to before privileges can be exercised). Conditions built into a performance improvement plan are not considered a restriction.
- (30) “SERVICE LINE” means members of the Medical Staff or Allied Health Staff and Hospital personnel organized to collaboratively address the medical, mental/emotional, nutritional, social, and other needs of patients suffering from a particular condition or group of conditions. In the event that any service lines are developed, until such time as the Medical Staff Bylaws, Rules and Regulations, and policies are amended to specifically address their organizational functions, they

will be guided by the principles applicable to departments and division and will be entitled to the same confidentiality, privilege, indemnification, and immunity protections that apply to departments and division and their leaders.

- (31) “SPECIAL NOTICE” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (32) “SUPERVISING PHYSICIAN” means a member of the Medical Staff who has agreed in writing to supervise or collaborate with an advanced practice clinician and to accept full responsibility for the actions of the advanced practice clinician while he or she is practicing in the Hospital.
- (33) “SUPERVISION” means the supervision of (or collaboration with) an advanced practice clinician by a Supervising Physician, that may or may not require the actual presence of the Supervising Physician, but that does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) will be determined at the time each advanced practice clinician is credentialed and will be consistent with any applicable written supervision or collaboration agreement.
- (34) “UNASSIGNED PATIENT” means any individual who comes to the Hospital for care and treatment who does not have an attending physician with clinical privileges, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him or her care while a patient at the Hospital.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

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

- (a) have a current, unrestricted license to practice in Missouri that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees, and have never had a license to practice revoked, restricted or suspended by any state licensing agency¹;
- (b) have a current, unrestricted DEA registration and state controlled substance license, and have never had a DEA registration or state controlled substance license denied, revoked, or suspended;
- (c) while providing services, be located (office and residence) within 30 minutes and be close enough to fulfill Medical Staff responsibilities and to provide timely and continuous care for his or her patients in the Hospital;
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital and which satisfy the legal requirements established by state law;
- (e) have current, government-issued photographic identification which verifies the individual's identity;
- (f) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

¹ If an individual's license is or was restricted, suspended, or subject to probationary terms or conditions as a result of a disability, as that term is defined under the Americans with Disabilities Act, the restriction, suspension, probationary terms or conditions, standing alone, will not render the individual ineligible for appointment, reappointment, or clinical privileges so long as there is no current restriction on the individual's clinical practice. The Hospital may require that the individual comply with, and successfully resolve, any terms or conditions placed on the individual's license. Nothing herein prohibits the Hospital from determining that an individual is ineligible for appointment, reappointment, or clinical privileges because of failure to meet any other threshold eligibility criteria even if the failure may relate to the individual's disability (e.g., felony conviction for driving while under the influence which the individual claims is a result of alcohol dependence).

- (g) have never had medical staff or allied health staff appointment or clinical privileges, or status as a participating provider denied, revoked, suspended for more than 30 days, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;
- (h) have never resigned medical staff or allied health staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including this Hospital;
- (i) have never had an application for appointment or clinical privileges not processed, nor had appointment or privileges administratively relinquished, at the Hospital or any of its affiliated entities due to an omission or misrepresentation;
- (j) have never been terminated from a post-graduate training program for reasons related to clinical competence or professional conduct (residency or fellowship for physicians or a similarly equivalent program for other categories of practitioners), nor resigned from such a program during an investigation or in exchange for the program not conducting an investigation;
- (k) not be currently under any criminal investigation or indictment and have not within the last ten years, been required to pay a civil money penalty for governmental fraud or program abuse or been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare, Medicaid or other federal or state governmental or private third-party payer fraud or program abuse); (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse;
- (l) agree to fulfill all responsibilities regarding emergency call for their specialty;
- (m) have an appropriate coverage arrangement, as determined by the Medical Executive Committee, with other members of the Medical Staff for those times when the individual will be unavailable;
- (n) document compliance with all applicable training and educational protocols that may be adopted by the Medical Executive Committee and required by the Board, including, but not limited to, those involving electronic medical records, computerized physician order entry, privacy and security of protected health information, infection prevention, and patient safety;
- (o) document compliance with health screening requirements (i.e., TB testing, mandatory flu vaccines, and infectious agent exposures);
- (p) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought or granted;

- (q) if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract;
- (r) demonstrate recent clinical activity in their primary area of practice during the last three years;
- (s) have successfully completed²:
 - (1) a residency and, if applicable, fellowship training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in the specialty in which the applicant seeks clinical privileges;
 - (2) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association;
 - (3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or
 - (4) for allied health professionals, have satisfied the applicable training requirements as established by the Hospital;
- (t) be or have been certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Dental Association, the American Board of Podiatric Medicine, or the American Board of Foot and Ankle Surgery, as applicable. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last seven years will be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within seven years from the date of completion of their residency or fellowship training³; and
- (u) if seeking to practice as an advanced practice clinician, must have a written agreement with a Supervising Physician, which agreement must meet all applicable requirements of Missouri law and Hospital policy.

² The residency training requirement will be applicable only to those individuals who apply for initial appointment after October 12, 2016. Existing members will be governed by the residency training requirement in effect at the time of their initial appointment.

³ The board certification requirement will be applicable only to those individuals who apply for initial appointment after October 12, 2016. Existing members will be governed by the board certification requirement in effect at the time of their initial appointment.

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

In exceptional circumstances, the seven-year time frame for initial applicants to obtain certification and the time frame for recertification by existing members may be extended for one additional appointment term, in order to permit an individual an opportunity to obtain certification. In order to be eligible to request an extension in these situations, an individual must, at a minimum, satisfy the following criteria:

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

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

- (a) Any applicant who does not satisfy one or more of the threshold eligibility criteria may request that it be waived. Waivers of threshold eligibility criteria will not be granted routinely. The applicant requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question. Waivers of threshold eligibility criteria will not be granted routinely.
- (b) A request for a waiver must be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant department chief, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant.
- (c) The Credentials Committee will forward its recommendation, including the basis for such, to the Medical Executive Committee. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (d) The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding

whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

- (e) If a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at subsequent reappointment cycles.
- (f) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the individual who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.
- (g) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the individual who requested the waiver is not entitled to a hearing. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the state licensure board or the National Practitioner Data Bank. A determination to grant a waiver in a particular case is not intended to set a precedent for any other applicant or group of applicants.

2.A.4. Factors for Evaluation:

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

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;
- (c) good reputation and character;
- (d) ability to safely and competently perform the clinical privileges requested;
- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

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

2.A.5. No Entitlement to Appointment:

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

- (a) is employed by this Hospital or its subsidiaries or has a contract with this Hospital;
- (b) is or is not a member or employee of any particular physician group;
- (c) is licensed to practice a profession in this or any other state;
- (d) is a member of any particular professional organization;
- (e) has had in the past, or currently has, medical staff or allied health staff appointment or privileges at any hospital or health care facility;
- (f) resides in the geographic service area of the Hospital; or
- (g) is affiliated with, or under contract to, any managed care plan, insurance plan, health maintenance organization, preferred physician organization, or other entity.

2.A.6. Nondiscrimination:

Credentialing decisions shall not be based on an applicant's gender identity, race, creed, color, ethnic/national identity, age, disability, sexual orientation or the patient type (e.g., Medicaid or high-risk populations) in which the individual specializes.

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

2.B.1. Basic Responsibilities and Requirements:

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

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

- (c) to participate in Medical Staff affairs through committee service and participation in performance improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;
- (d) to provide emergency call coverage, consultations, and care for unassigned patients;
- (e) to comply with clinical practice or evidence-based protocols pertinent to his or her medical specialty, as may be adopted by the Medical Executive Committee or document the clinical reasons for variance;
- (f) to obtain, when requested, an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood and/or urine test) or a complete physical, mental, and/or behavioral evaluation, as set forth in this Policy;
- (g) to obtain, when requested, an evaluation of current clinical competence by a consultant or program selected by the Hospital;
- (h) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;
- (i) to use the Hospital sufficiently to allow continuing assessment of current competence;
- (j) to seek consultation whenever necessary;
- (k) to cooperate with all care management activities;
- (l) to complete in a timely manner all medical and other required records;
- (m) to perform all services and to act in a cooperative and professional manner;
- (n) to promptly pay any applicable dues, assessments, or fines;
- (o) to utilize the Hospital's electronic medical record system;
- (p) to satisfy continuing medical education requirements;
- (q) to attend and participate in any applicable orientation programs at the Hospital before participating in direct patient care;
- (r) to comply with all applicable training and educational protocols that may be adopted by the Medical Executive Committee, including, but not limited to, those involving electronic medical records, computerized physician order entry, privacy and security of protected health information, patient safety, and infection control;

- (s) to maintain a current e-mail address with the Medical Staff Services, which will be the primary mechanism used to communicate all Medical Staff or Allied Health Staff information to the member;
- (t) for emergency uses in accordance with Hospital policy, to maintain a current cell phone number with Medical Staff Services;
- (u) to disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, other vendors or other persons or entities as may be required by Hospital or Medical Staff policies, including, but not limited to, disclosure of financial interests in any product, service, or medical device not already in use at the Hospital that a Medical Staff member may request the Hospital to purchase;
- (v) that, if the individual is a member of the Medical Staff who serves or plans to serve as a Supervising Physician to an advanced practice clinician, the member of the Medical Staff will abide by the supervision requirements and conditions of practice set forth in Article 8; and
- (w) that, if the individual is an advanced practice clinician, he or she will abide by the conditions of practice set forth in Article 8.

2.B.2. Burden of Providing Information:

- (a) All applicants and members have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts. This includes information that may be needed to assist in an appropriate assessment of qualifications for appointment, reappointment, and clinical privileges, such as information from other hospitals, the individual's office practice, insurers or managed care organizations, and/or confidential evaluation forms.
- (b) Applicants have the burden of providing evidence that all the statements made and all information provided by the applicant in support of the application are accurate and complete.
- (c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required may be deemed to be withdrawn.
- (d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

- (e) Applicants and members are responsible for notifying Medical Staff Services, the Chief of Staff, or the President of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, at the time the change occurs, and includes, but not be limited to:
 - (1) any information on the application form;
 - (2) any threshold eligibility criteria for appointment or clinical privileges;
 - (3) any and all complaints, documents or other information known to the practitioner regarding, or changes in, licensure status or DEA controlled substance authorization or state controlled substance license;
 - (4) changes in professional liability insurance coverage;
 - (5) the filing of a professional liability lawsuit against the practitioner;
 - (6) arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation;
 - (7) exclusion or preclusion from participation in Medicare, Medicaid or any other federal or state healthcare program or any sanctions imposed with respect to the same;
 - (8) changes in status (appointment, permission to practice, or clinical privileges) at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities;
 - (9) any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction (all of which will be referred for review under the policy on practitioner health).

2.C. APPLICATION

2.C.1. Information:

- (a) The application forms for appointment, reappointment, and clinical privileges existing now (and as may be revised) are incorporated by reference and made a part of this Policy.
- (b) The application will contain a request for specific clinical privileges and will require detailed information concerning the applicant's professional qualifications.

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

2.C.2. Misstatements and Omissions:

- (a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Chief of Staff and President will review the response and determine whether the application should be processed further.
- (b) If appointment has been granted prior to the discovery of a misstatement or omission, the individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The individual will also have an opportunity to meet with the Leadership Council to explain the misstatement or omission. The Leadership Council will review the response and determine whether appointment and privileges should be deemed to be resigned pursuant to this Policy.
- (c) No action taken pursuant to this section will entitle the applicant or member to a hearing or appeal.
- (d) If the determination is made to not process an application or that appointment and privileges should be resigned pursuant to this provision, the individual may not reapply for a period of at least two years.

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

(a) Conditions Prerequisite to Application and Consideration:

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

(b) Scope of Conditions:

The terms set forth in this Section:

- (1) commence with the individual's initial contact with the Hospital, whether an application is furnished or appointment or clinical privileges are granted;
- (2) apply throughout the credentialing process and the term of any appointment, reappointment, or clinical privileges; and
- (3) survive for all time, even if appointment, reappointment, 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 appointment or clinical privileges at the Hospital.

(c) Use and Disclosure of Information about Individuals:

(1) Information Defined:

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

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

(2) Authorization for Criminal Background Check:

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

(3) Authorization to Share Information within the System:

The individual authorizes the Hospital and its affiliates to share information with one another.

(4) Authorization to Obtain Information from Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to consult with any third party who may have information relating to the individual's professional competence or conduct or any other matter relating to his or her qualifications for initial or continued

appointment, and to obtain communications, reports, records, and other documents of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request.

(5) Authorization to Disclose Information to Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to disclose information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives to assist them in evaluating the individual's qualifications.

(6) Access to Information by Individuals:

(i) Upon request, applicants will be informed of the status of their applications for appointment or clinical privileges.

(ii) Except during the hearing and appeal processes, which are governed by Articles 7 and 8 of this Policy, an individual may review information obtained or maintained by the Hospital only upon request and only if the identity of the individual who provided the information will not be revealed.

(iii) If an individual disputes any information obtained or maintained by the Hospital, the individual may submit, in writing, a correction or clarification of the relevant information which will be maintained in the individual's file.

(d) 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 professional review action taken by the Hospital.

(e) 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, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, Allied Health Staff, or Board, and any third party who provides information.

This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, its representatives, or third parties in the course of credentialing and peer review activities or when using or disclosing information as described in this Section.

Nothing herein will be deemed to waive any other immunity or privilege provided by federal or Missouri law.

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other professional review action or activity, or any report that may be made to a regulatory board or agency, and does not prevail, he or she will reimburse the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, or Allied Health Staff, or Board, and any third party who provides information involved in the action for all costs incurred in defending such legal action, including costs and attorneys' fees, and expert witness fees.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.1. Application Process:

- (a) Prospective applicants will be sent information, including the application form and a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges.
- (b) Applications may be provided to residents and fellows who are in the final six months of their training. Final action will not be taken unless all applicable threshold eligibility criteria are satisfied.
- (c) A completed application form with copies of all required documents must be returned to the Credentialing Verification Office (“CVO”) within 60 days after receipt. The application form must be accompanied by the application fee.

3.A.2. Initial Review of Application:

- (a) As a preliminary step, the application will be reviewed by the CVO to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications will be notified that their applications will not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in this Policy and is not reportable to any state agency or to the National Practitioner Data Bank.
- (b) The CVO will oversee the process of gathering and verifying relevant information, and confirming that all references and other information deemed pertinent have been received.
- (c) Evidence of the applicant’s character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant’s past or current department chief at other health care entities, residency training director, and others who may have knowledge about the applicant’s education, training, experience, and ability to work with others. The National Practitioner Data Bank and the Office of Inspector General, Medicare/Medicaid Exclusions will be queried, as required, and a criminal background check will be obtained.

- (d) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview will be conducted by one or any combination of any of the following: department chief, the Credentials Committee, a Credentials Committee representative, the Medical Executive Committee, the Chief of Staff, Chief Medical Officer, or the President. Applicants do not have the right to be accompanied by counsel to interviews being requested by any of the individuals or committees referenced above.

3.A.3. Department Chief and Chief Nursing Officer Procedure:

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

3.A.4. Credentials Committee Procedure:

- (a) The Credentials Committee will consider the report prepared by the department chief(s) and will make a recommendation.
- (b) The Credentials Committee may use the expertise of the department chief(s), or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and privileges, if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment, the Credentials Committee may require a fitness for practice evaluation by a physician(s) satisfactory to the Credentials Committee. The results of this evaluation will be made available to the Committee. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. The cost of the health assessment will be borne by the applicant.
- (d) The Credentials Committee may recommend the imposition of specific conditions on appointment and/or clinical privileges related to behavior, health or clinical issues. The Credentials Committee may also recommend that appointment be

granted for a period of less than two years in order to permit closer monitoring of the applicant's compliance with any conditions.

- (e) If the recommendation of the Credentials Committee is delayed longer than 30 days, the chairperson of the Credentials Committee will send a letter to the applicant, with a copy to the President, explaining the reasons for the delay.

3.A.5. Medical Executive Committee Recommendation:

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

3.A.6. Board Action:

- (a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the Medical Executive Committee and there is no evidence of any of the following:
 - (1) a current or previously successful challenge to any license or registration;
 - (2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or
 - (3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

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

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

3.A.7. Time Periods for Processing:

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

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

- (a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Only those clinical privileges granted by the Board may be exercised, subject to the terms of this Policy.
- (b) A request for privileges will be processed only when an applicant satisfies threshold eligibility criteria for the delineated privileges. An individual who does not satisfy the eligibility criteria for clinical privileges may request that the criteria be waived and the waiver process outlined in Article 2 will be followed.
- (c) Requests for clinical privileges that are subject to an exclusive contract or arrangement will not be processed except as consistent with the applicable contract. Similarly, requests for clinical privileges will not be processed if the Hospital has determined not to accept an application in the specialty or service.
- (d) The granting of clinical privileges includes responsibility to participate in emergency service call obligations sufficient to enable the Hospital to satisfy its obligations under the Emergency Medical Treatment and Active Labor Act.
- (e) Recommendations for clinical privileges will be based on consideration of the following:
 - (1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;
 - (2) appropriateness of utilization patterns;
 - (3) ability to perform the privileges requested competently and safely;
 - (4) information resulting from initial, ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;
 - (5) availability of coverage in case of the applicant's illness or unavailability;

- (6) adequate professional liability insurance coverage for the clinical privileges requested;
 - (7) the Hospital's available resources and personnel;
 - (8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
 - (9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
 - (10) practitioner-specific data as compared to aggregate data, when available;
 - (11) morbidity and mortality data, when available; and
 - (12) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions.
- (f) An applicant has the burden of establishing qualifications and current competence for clinical privileges requested.
 - (g) The report of the relevant department chief, and the Chief Nursing Officer, as applicable, will be processed as a part of the application for privileges.
 - (h) Requests for additional clinical privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the request is complete, it will be processed in the same manner as an application for initial clinical privileges.

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

- (a) When clinical privileges have been delineated by core or specialty, a request for privileges will only be processed if the individual applies for the full core or specialty delineation. (This only applies to requests for privileges within the individual's primary specialty.)
- (b) In appropriate circumstances, the Hospital may grant limited clinical privileges within a core or specialty as requested by an individual on the application. The request must indicate the specific clinical privileges within the core or specialty that the individual does not wish to provide, state a basis for the request, and include evidence that the individual does **not** provide the patient care services in any health care facility in that area.

- (c) A request for limited clinical privileges will be reviewed by the relevant department chief, Credentials Committee, Medical Executive Committee, and Board.
- (d) The following factors, among others, may be considered in deciding whether to grant a waiver:
 - (1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care;
 - (2) the effect of the request on the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act;
 - (3) the expectations of members who rely on the specialty;
 - (4) fairness to the individual requesting the waiver;
 - (5) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them; and
 - (6) the potential for gaps in call coverage that might result from an individual's removal from the call roster and the feasibility of safely transferring patients to other facilities.
- (e) No one is entitled to be granted limited clinical privileges within a core or specialty, and denial of such a request does not trigger a right to a hearing or appeal.

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

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

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

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

4.A.5. Clinical Privileges for New Procedures:

- (a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure

(“new procedure”) will not be processed until a determination has been made that the procedure will be offered by the Hospital and criteria for the clinical privilege(s) have been adopted.

- (b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the department chief and the Credentials Committee addressing the following:
 - (1) minimum education, training, and experience necessary to perform the new procedure safely and competently;
 - (2) clinical indications for when the new procedure is appropriate;
 - (3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;
 - (4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;
 - (5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and
 - (6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The Chief Medical Officer will review this report and consult with the department chief and the Credentials Committee (either of which may conduct additional research as may be necessary) and will make a preliminary recommendation as to whether the new procedure should be offered at the Hospital.

- (c) If the preliminary recommendation is favorable, the Credentials Committee will consider whether the requests constitutes a “new procedure” or if it is an extension of an existing privilege. If it is a “new procedure,” the Credentials Committee will develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:
 - (1) the minimum education, training, and experience necessary to perform the procedure or service;
 - (2) the clinical indications for when the procedure or service is appropriate;
 - (3) the extent (time frame and mechanism) of initial competency evaluation and supervision that should occur if the privileges are granted; and

- (4) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities.
- (d) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.
- (e) If the Board determines to offer the new procedure, it will adopt threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.
- (f) Once the above steps have been completed, specific requests from eligible individuals may be processed.

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

- (a) Requests for clinical privileges that previously have been exercised only by members in another specialty will not be processed until the steps outlined in this section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.
- (b) As an initial step in the process, the individual seeking the privilege will submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the clinical privilege at other similar hospitals, and the experiences of those other hospitals.
- (c) The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chiefs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
- (d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the clinical privileges at issue. If it recommends that individuals from different specialties be permitted to request clinical privileges, the Credentials Committee may develop recommendations regarding:
 - (1) the minimum education, training, and experience necessary to perform the clinical privileges in question;
 - (2) the clinical indications for when the procedure is appropriate;

- (3) the manner of addressing the most common complications that arise, which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;
 - (4) the extent (time frame and mechanism) of initial competency evaluation and supervision that should occur if the privileges are granted in order to confirm competence;
 - (5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and
 - (6) the impact, if any, on emergency call responsibilities.
- (e) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.
 - (f) Once the above steps have been completed, specific requests from eligible individuals may be processed.

4.A.7. Clinical Privileges for Dentists and Oral Surgeons:

- (a) For any patient who meets the classifications of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), dentists and oral surgeons may admit the patient and perform a complete admission history and physical examination, and assess the medical risks of the procedure on the patient, if they are deemed qualified to do so by the Credentials Committee and Medical Executive Committee. They must, nevertheless, have an agreement with a physician on the Medical Staff (established and declared in advance) who is available to respond should any medical issue arise with the patient.
- (b) For any patient who meets ASA 3 or ASA 4 classifications, a medical history and physical examination of the patient will be made and recorded by a physician who is a member of the Medical Staff before dental or oral surgery may be performed. In addition, a designated physician will be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) The dentist or oral surgeon will be responsible for the oral surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Dentists and oral surgeons may write orders within the scope of their licenses and consistent with relevant Hospital policies and rules and regulations.

4.A.8. Clinical Privileges for Podiatrists:

- (a) For any patient who meets the classifications of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), podiatrists may admit the patient and perform a complete admission history and physical examination, and assess the medical risks of the procedure on the patient, if they are deemed qualified to do so by the Credentials Committee and Medical Executive Committee. They must, nevertheless, have an agreement with a physician on the Medical Staff (established and declared in advance) who is available to respond should any medical issue arise with the patient.
- (b) For any patient who meets ASA 3 or ASA 4 classifications, a medical history and physical examination of the patient will be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery will be performed. In addition, a designated physician will be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) The podiatrist will be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with relevant Hospital policies and rules and regulations.

4.A.9. Physicians and Other Practitioners in Training:

- (a) Physicians and other practitioners in training, including but not limited to medical students, advanced practice nurses, and physician assistants in training programs ("Trainees"), will not be granted appointment to the Medical Staff or clinical privileges. The clinical faculty or attending staff member will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each Trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols. The applicable training program will be responsible for verifying and evaluating the qualifications of each physician in training.
- (b) Physicians who are in a residency training program and who wish to moonlight (outside of the training program) will be granted specific privileges as set forth in this Policy. A resident who is moonlighting must comply with the institutional and program training requirements. Failure to comply with these requirements or termination from the residency program will result in the administrative relinquishment of clinical privileges, without a right to the hearing and appeal procedures.

4.A.10. Initial Competency Evaluation:

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

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Temporary Clinical Privileges:

- (a) Temporary privileges may be granted by the President, upon recommendation of the Chief of Staff, to:
 - (1) applicants for initial appointment whose complete application, following a favorable recommendation of the Credentials Committee, is pending review by the Medical Executive Committee and Board. In order to be eligible for temporary clinical privileges, an applicant must have demonstrated ability to perform the clinical privileges requested and have had (i) no current or previously successful challenges to licensure or registration, (ii) no involuntary restriction, reduction, denial or termination of membership or clinical privileges at another health care facility, (iii) unusual pattern (or excessive number of) professional liability actions, (iv) no open malpractice actions, (v) no pending criminal charges or investigations, (vi) an unremarkable medical staff/employment history, (vii) no unexplained gaps of more than 30 days in experience and/or training, (viii) no negative or

questionable evaluations or recommendations from peers, hospitals, or healthcare facilities; and

- (2) non-applicants, when there is an important patient care, treatment, or service need, including the following:
 - (i) the care of a specific patient;
 - (ii) when necessary to prevent a lack of services in a needed specialty area;
 - (iii) proctoring; or
 - (iv) when serving as a locum tenens for a member of the Medical Staff or Allied Health Staff.
- (b) The following verified information will be considered prior to the granting of any temporary clinical privileges: current licensure, relevant training, experience, current competence, current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank and a query to the Office of Inspector General's List of Excluded Individuals/Entities.
- (c) The grant of temporary clinical privileges will not exceed 120 days.
- (d) For non-applicants, who are granted temporary locum tenens privileges, the individual may exercise locum tenens privileges for a maximum of 120 days, consecutive or not, anytime during the 24-month period following the grant of privileges, subject to the following conditions:
 - (1) the individual must notify the Medical Staff Services at least 15 days prior to exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and
 - (2) the individual must inform the Medical Staff Services of any change that has occurred to the information provided on the application form for locum tenens privileges.
- (e) Prior to any temporary clinical privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures and protocols of the Medical Staff and the Hospital.
- (f) The granting of temporary clinical privileges is a courtesy that may be withdrawn by the President at any time, after consulting with the Chief of Staff, the chairperson of the Credentials Committee or the department chief.

- (g) The department chief or the Chief of Staff will assign to another member of the Medical Staff responsibility for the care of patients until they are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

4.C. EMERGENCY SITUATIONS

- (1) For the purpose of this section, an “emergency” is defined as a condition which could result in serious or permanent harm to patient(s) and in which any delay in administering treatment would add to that harm.
- (2) In an emergency situation, a member may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.
- (3) When the emergency situation no longer exists, the patient will be assigned by the department chief or the Chief of Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

- (1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the President or the Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners who will function as volunteers (“volunteers”). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.
- (2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.
 - (a) A volunteer’s identity may be verified through a valid government-issued photo identification (i.e., driver’s license or passport).
 - (b) A volunteer’s license may be verified in any of the following ways: (1) current Hospital picture ID card that clearly identifies the individual’s professional designation; (2) current license to practice; (3) primary source verification of the license; (4) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (5) identification by a current Hospital employee or Medical Staff or Allied Health Staff member who possesses personal knowledge regarding the individual’s ability to act as a volunteer during a disaster.

- (3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.
- (4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.
- (5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.
- (6) Within 72 hours from the time the volunteer begins to provide service at the Hospital, based on the above monitoring, a decision is made whether the disaster privileges should continue.

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

- (1) From time to time, the Hospital may enter into contracts or arrangements with practitioners or groups of practitioners for the performance of clinical and administrative services at the Hospital. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of this Policy.
- (2) To the extent that:
 - (a) any such contract or arrangement confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or
 - (b) the Board by resolution or other arrangement limits the practitioners who may exercise clinical privileges in any clinical specialty to employees of the Hospital or its affiliates,

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

- (3) Prior to the Hospital entering into any exclusive arrangement in a clinical service that has not previously been subject to such an arrangement, the Board 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 developed by the Board and make a recommendation regarding the quality of care and service implications of the proposed arrangement.
- (4) As part of its review, the Medical Executive Committee (or subcommittee) may obtain relevant information concerning quality of care and service matters from (a) members of the applicable specialty involved, (b) members of other specialties who directly utilize or rely on the specialty in question, and (c) Hospital administration. However, the actual terms of any such exclusive arrangement or employment contract, and any financial information related to them, including but not limited to the remuneration, will neither be disclosed to the Medical Executive Committee nor discussed as part of the Medical Executive Committee's review.
- (5) After receiving the Medical Executive Committee's report, the Board will determine whether or not to proceed with the exclusive contract or Board resolution. If the Board determines to do so, and if that determination would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and review procedures (Note: If more than one practitioner in a relevant specialty area will be affected by the determination of the Board, the following procedures will be coordinated to address all requested meetings in a combined and consolidated manner):
 - (a) The affected member will be given at least 30 days' advance notice of the exclusive contract or Board resolution and have the right to meet with the Board to discuss the matter prior to the contract in question being signed by the Hospital or the Board resolution becoming effective. Any such meeting must be requested by the affected member and held within 30 days of the notice, unless this time frame is extended by mutual agreement.
 - (b) At the meeting, the affected member will be entitled to present any information that he or she deems relevant to the decision to enter into the exclusive contract or enact the Board resolution.
 - (c) If, following this meeting, the Board confirms its initial determination to enter into the exclusive contract or enact the Board resolution, the affected member will be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board resolution. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or Board resolution is in effect.

- (d) The affected member will not be entitled to any procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 7 of this Policy.
- (e) The inability of a member to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.
- (6) Except as provided above, in the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract or arrangement, the terms of the contract or arrangement will control.

4.F. TELEMEDICINE PRIVILEGES

4.F.1. Processing Requests for Telemedicine Privileges:

- (a) Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications.
- (b) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.
- (c) Requests for initial or renewed telemedicine privileges will be processed through one of the following options, as determined by the President in consultation with the Chief of Staff:
 - (1) A request for telemedicine privileges may be processed through the same process for Medical Staff and Allied Health Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.
 - (2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), and the hospital or telemedicine entity is accredited by The Joint Commission, a request for telemedicine privileges may be processed using an alternative process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:
 - (i) confirmation that the practitioner is licensed in Missouri;

- (ii) a current list of privileges granted to the practitioner; and
 - (iii) any other attestations or information required by the agreement or requested by the Hospital.
- (3) Prior to granting telemedicine privileges, the National Practitioner Data Bank will be queried and the Office of Inspector General's List of Excluded Individuals/Entities will be checked.
- (4) The information received about the individual requesting telemedicine privileges will be provided to the Medical Executive Committee for review and recommendation and to the Board for final action.
- (d) Notwithstanding the process set forth in this Section, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.
- (e) Telemedicine privileges, if granted, will be for a period of not more than two years.

4.F.2. Review of Telemedicine Privileges:

- (a) Individuals granted telemedicine privileges will be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.
- (b) Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

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

5.B. REAPPOINTMENT CRITERIA

5.B.1. Eligibility for Reappointment:

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

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

5.B.2. Factors for Evaluation:

In considering an application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

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

- (b) participation in Medical Staff duties, including committee assignments, emergency call, consultation requests, quality of medical record documentation, cooperation with case management, participation in quality improvement, utilization activities, and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;
- (c) the results of the Hospital's performance improvement activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);
- (d) any initial competency evaluation or focused professional practice evaluations;
- (e) verified complaints received from patients or staff; and
- (f) other reasonable indicators of continuing qualifications.

5.C. REAPPOINTMENT PROCESS

5.C.1. Reappointment Application Form:

- (a) Appointment terms will not extend beyond two years.
- (b) An application for reappointment will be furnished to members at least three months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Services within 30 days.
- (c) Failure to return a completed application within 30 days will result in the assessment of a reappointment processing fee, which must be paid prior to the application being processed. Failure to return a complete application within 60 days of receipt may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort.
- (d) The application will be reviewed by the Medical Staff Services to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.
- (e) The Medical Staff Services will oversee the process of gathering and verifying relevant information. The Medical Staff Services will also be responsible for confirming that all relevant information has been received.

5.C.2. Processing Applications for Reappointment:

- (a) The CVO will forward the application to the relevant department chief and the application for reappointment will be processed in a manner consistent with applications for initial appointment.
- (b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.

5.C.3. Conditional Reappointments:

- (a) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., professional code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of a member's compliance with any conditions that may be imposed.
- (b) A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.
- (c) If questions or concerns are being addressed at reappointment, or if the applicant for reappointment is the subject of an investigation or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.C.4. Potential Adverse Recommendation:

- (a) If the Credentials Committee or the Medical Executive Committee is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chairperson will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.
- (b) Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated.
- (c) At the meeting, the member 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.
- (d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be represented by legal counsel at this meeting and no recording (audio or video) of the meeting will be permitted or made.

ARTICLE 6

QUESTIONS INVOLVING MEDICAL STAFF OR ALLIED HEALTH STAFF MEMBERS

6.A. INITIAL COLLEGIAL EFFORTS AND PROGRESSIVE STEPS

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

- (a) This Policy encourages the use of collegial efforts and progressive steps to address and resolve questions that may be raised about a member's competence, health or behavior.
- (b) Initial collegial efforts include activities such as:
 - (1) informal mentoring, coaching, or counseling by a Medical Staff Leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, emergency call obligations, or the timely and adequate completion of medical records); and
 - (2) sharing comparative data, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist the individual with conforming his or her practice to appropriate norms.

These efforts are not required to be documented, though documentation may be created in the discretion of the Medical Staff Leader and maintained in the individual's confidential file.

- (c) Progressive steps include, but are not limited to, the following actions:
 - (1) addressing minor performance issues through an informational letter;
 - (2) sending an educational letter that describes opportunities for improvement and provides specific guidance and suggestions;
 - (3) facilitating a formal collegial intervention (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders) in order to directly discuss a matter and the steps needed to be taken to resolve it;
 - (4) communicating expectations for professionalism and behaviors that promote a culture of safety; and
 - (5) developing a performance improvement plan that can be used to address a concern.

Progressive steps are to be documented and included in a member's confidential file. The written response by the member to any of these progressive steps will also be included in the member's confidential file.

- (d) These efforts are fundamental and integral components of the Hospital's professional practice evaluation activities and are confidential and protected in accordance with state law.
- (e) Initial collegial efforts and progressive steps are encouraged, but are not mandatory, and are within the discretion of the appropriate Medical Staff Leaders and Hospital Administration. When a question arises, the Medical Staff Leaders and/or Hospital Administration may:
 - (1) address it pursuant to the initial collegial efforts and progressive steps provisions of this Section;
 - (2) refer the matter for review in accordance with the peer review policy, code of conduct/professionalism policy, practitioner health policy, or other relevant policy; or
 - (3) refer it to the Medical Executive Committee for its review and action.
- (f) There will be no recording (audio or video) or transcript made of any meetings that involve initial collegial efforts or progressive steps activities.

6.A.2. Documentation:

- (a) Except as otherwise expressly provided, Medical Staff Leaders and Hospital Administration may use their discretion to decide whether to document any meeting with an individual that may take place pursuant to the processes and procedures outlined in this Article.
- (b) A summary of documentation that is prepared for and maintained in the individual's confidential file may be shared with the individual; however, pursuant to policy, the identity of any person who prepared a complaint or written concern will not be shared. The individual will have an opportunity to review the summary of the documentation and respond to it. The initial documentation, along with any response that is submitted, will also be maintained in the individual's confidential file.

6.A.3. No Recordings of Meetings:

It is the policy of the Hospital to maintain the confidentiality of all Medical Staff meetings, including, but not limited to, discussions relating to credentialing, quality assessment, performance improvement, and peer review activities. The discussions that take place at such meetings are private conversations that occur in a private place. In addition to existing

bylaws and policies governing confidentiality, individuals in attendance at such meetings are prohibited from making audio or video recordings at such meetings unless authorized to do so in writing by the individual chairing the meeting or by the President, provided, however, that meetings may be recorded for the purpose of creating meeting minutes. Such recordings shall be erased following the adoption of the meeting minutes.

6.A.4. No Right to Counsel:

- (a) Members do not have the right to be accompanied by counsel when the Medical Staff Leaders and Hospital Administration engage in initial collegial efforts or other progressive steps. These efforts are intended to resolve issues in a constructive manner. By agreement of the Chief of Staff and Chief Medical Officer, an exception may be made to this general rule.
- (b) If the individual refuses to meet without his or her lawyer present, the meeting will be canceled, and it will be reported to the Medical Executive Committee that the individual failed to attend the meeting.

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

Credentialing and peer review activities are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends, relatives or colleagues when attending a meeting that takes place pursuant to this Article.

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

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

6.B. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

- (1) Individuals who are initially granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation to confirm their competence.
- (2) All individuals who provide patient care services at the Hospital will have their care evaluated on an ongoing basis. This ongoing professional practice evaluation process may include an analysis of data to provide feedback and to identify issues in an individual's professional performance, if any.
- (3) When concerns are raised about an individual's practice through the ongoing practice evaluation process or through a specialty-specific trigger, a reported concern, or other triggers (i.e., clinical trend or specific case that requires further

review, patient complaint, corporate compliance issue, or sentinel event), a focused professional practice evaluation will be undertaken to evaluate the concern.

6.C. MANDATORY MEETING

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

6.D. FITNESS FOR PRACTICE EVALUATION

- (1) An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test), or a comprehensive fitness for practice evaluation, which may include a physical, psychological, or cognitive assessment, to determine his or her ability to safely and competently practice.
- (2) A request for a fitness for practice evaluation may be made of an applicant during the initial appointment or reappointment processes or of a member during an investigation.
- (3) A request for an **immediate** evaluation may also be made when two Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital Administration) are concerned with the individual's ability to safely and competently care for patients.
- (4) The Medical Staff Leaders, Hospital Administration, or committee that requests the evaluation will: (i) identify the health care professional(s) to perform the evaluation; (ii) inform the individual of the time period within which the evaluation must occur; and (iii) provide the individual with all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to discuss and report the results to the Medical Staff Leaders or relevant committee.
- (5) Failure to obtain the requested evaluation may result in an application being withdrawn or an administrative relinquishment of appointment and privileges as set forth below.

6.E. COMPETENCY ASSESSMENT

- (1) An individual may be requested to participate in a competency assessment to determine his or her ability to safely and competently practice.
- (2) A request for a competency assessment may be made of a member during the reappointment process, as part of the collegial intervention process, or during an investigation. The request may be made by Medical Staff Leaders, the Credentials Committee, the Medical Executive Committee, an Investigating Committee or the Professional Practice Evaluation Committee.
- (3) The Medical Staff Leaders or committee that requests the assessment will:
 - (i) identify the health care professional(s) to perform the assessment;
 - (ii) inform the individual of the time period within which the assessment must occur; and
 - (iii) provide the individual with all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the assessment and to allow the health care professional to discuss and report the results of the assessment to the Medical Staff Leaders or relevant committee.
- (4) Failure to obtain the requested assessment may result in an administrative relinquishment of appointment and privileges as set forth below.

6.F. ADMINISTRATIVE RELINQUISHMENT

- (1) Any of the occurrences described in this Section will constitute grounds for the administrative relinquishment of an individual's appointment and clinical privileges. An administrative relinquishment is considered an administrative action and, as such, it generally does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank. Hospital legal counsel will recommend whether any relinquishment of appointment and privileges triggers an obligation on the part of the Hospital to file a report.
- (2) Except as otherwise provided below, an administrative relinquishment of appointment and privileges will be effective immediately upon actual or special notice to the individual.

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

Failure of an individual to complete medical records, after notification by the medical records department of delinquency in accordance with the rules and regulations and Delinquent Medical Records Policy, may result in administrative relinquishment of all clinical privileges.

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

Failure of an individual to continuously satisfy any of the threshold eligibility criteria set forth in this Policy will result in administrative relinquishment of appointment and clinical privileges, unless a waiver is granted pursuant to Section 2.A.2. of this Policy.

6.F.3. Criminal Activity:

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

6.F.4. Failure to Provide Information:

- (a) Failure of an individual to notify the Chief of Staff, the Chief Medical Officer, or the President of any change in any information provided on an application for initial appointment or reappointment may, as determined by the Medical Executive Committee, result in the administrative relinquishment of appointment and clinical privileges.
- (b) Failure of an individual to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request from the Credentials Committee, the Medical Executive Committee, or any other authorized committee may, as determined by the Medical Executive Committee, result in the administrative relinquishment of appointment and clinical privileges until the information is provided to the satisfaction of the requesting party.

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

Failure to attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration, after appropriate notice has been given, may, as determined by the Medical Executive Committee, result in the administrative relinquishment of appointment and clinical privileges. The relinquishment will remain in effect until the individual attends the mandatory meeting and reinstatement is granted as set forth below.

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

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

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

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

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

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

6.F.9. Failure to Timely Pay Dues:

- (a) If an individual fails to pay dues by February 1, the amount of the dues will be doubled.
- (b) If an individual fails to pay dues by March 1, including any amount assessed in (a) above, such will result in the administrative relinquishment of the individual's appointment and privileges.

6.F.10. Reinstatement from Administrative Relinquishment and Resignation:

- (a) If an individual believes that the matter leading to administrative relinquishment of appointment and privileges has been resolved within 90 days of the relinquishment, the individual may request to be reinstated.
- (b) A request for reinstatement from an administrative 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 administrative resignation from the Medical Staff or Allied Health Staff. Medical

Staff Services may automatically reinstate the individual once the delinquent medical records are completed.

- (c) Requests for reinstatement from an administrative relinquishment following the expiration or lapse of a license, controlled substance authorization, or insurance coverage or failure to pay dues will be processed by Medical Staff Services. Medical Staff Services may automatically reinstate the individual once the license, controlled substance authorization, or insurance coverage issue is resolved or the dues are paid. If any questions or concerns are noted, the Medical Staff Services will refer the matter for further review in accordance with (d) below.
- (d) All other requests for reinstatement from an administrative relinquishment will be reviewed by the relevant department chief, the chairperson of the Credentials Committee, the Chief of Staff, the Chief Medical Officer, and the President. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee and Board for review and recommendation.
- (e) Failure to resolve a matter leading to an administrative relinquishment within 90 days of the relinquishment, and to be reinstated as set forth above, will result in an automatic resignation from the Medical Staff or Allied Health Staff.

6.G. LEAVES OF ABSENCE

6.G.1. Initiation:

- (a) A leave of absence of up to one year must be requested in writing and submitted to the Chief of Staff or Chief Medical Officer. The request should, when possible, state the beginning and ending dates and the reasons for the leave. Except in extraordinary circumstances, the request will be submitted at least 30 days prior to the anticipated start of the leave.
- (b) The Chief of Staff or Chief Medical Officer will determine whether a request for a leave of absence will be granted, after consulting with the relevant department chief. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records. The Chief of Staff or Chief Medical Officer has the authority to determine the length of the initial grant of the leave.
- (c) Except for maternity leaves (of three months or less) members of the Medical Staff or Allied Health Staff must report to the Chief of Staff or Chief Medical Officer

any time they are away from Medical Staff, Allied Health Staff, or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Upon becoming aware of such circumstances, the Chief Medical Officer or Chief of Staff may trigger an automatic medical leave of absence at any point after becoming aware of the Medical Staff member's absence from patient care. The member will be sent special notice that a medical leave has been triggered.

- (d) The Chief of Staff or the Chief Medical Officer will inform the Medical Executive Committee whenever a leave of absence is approved.
- (e) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

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

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

6.G.3. Reinstatement:

- (a) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the relevant department chief, the chairperson of the Credentials Committee, the Chief of Staff, and the Chief Medical Officer.
- (b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. Notice of the reinstatement will be forwarded to the Medical Executive Committee. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board. The recommendation for reinstatement from the leave of absence may be subject to specific conditions such as proctoring or monitoring in order to allow for a closer assessment of the individual's competence.
- (c) If the leave of absence was for health reasons (except for maternity leave of three months or less), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is capable of resuming a hospital practice and safely exercising the clinical privileges requested. A request

for reinstatement for a leave of absence for health reasons will be processed in accordance with the Practitioner Health Policy. The Practitioner Health Committee may also require that the individual submit to a comprehensive fitness for practice evaluation by a physician(s) satisfactory to it.

- (d) Absence for longer than one year will result in resignation of Medical Staff or Allied Health Staff appointment and clinical privileges unless an extension is granted by the Chief of Staff or Chief Medical Officer. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.
- (e) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will expire at the end of the appointment period, and the individual will be required to apply for reappointment. However, an individual whose appointment expired during a leave may not be reinstated prior to final action on his or her reappointment application.

6.H. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

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

- (a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the President, the Chief of Staff, the Chief Medical Officer, the Medical Executive Committee, or the Board chairperson is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed; or (2) suspend or restrict all or any portion of an individual's clinical privileges.
- (b) A precautionary suspension can be imposed at any time, including after a specific event, a pattern of events, or a recommendation by the Medical Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension will meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.
- (c) Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.
- (d) A precautionary suspension is effective immediately and will be promptly reported to the President and the Chief of Staff. The President will notify the Board. A precautionary suspension will remain in effect unless it is modified by the President or Medical Executive Committee.
- (e) Within three days of the imposition of a suspension, the individual will be provided with a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any).

- (f) The relevant Supervising Physician will be notified when the affected individual is a member of the Allied Health Staff.

6.H.2. Medical Executive Committee Procedure:

- (a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension, restriction, or voluntary agreement to refrain from exercising privileges, the Medical Executive Committee will review the reasons for the suspension.
- (b) As part of this review, the individual will be invited to meet with the Medical Executive Committee. In advance of the meeting, the individual may submit a written statement and other information to the Medical Executive Committee.
- (c) At the meeting, the individual may provide information to the Medical Executive Committee and should respond to questions that may be raised by committee members. The individual may also propose ways, other than precautionary suspension, restriction, or voluntary agreement to refrain from exercising privileges, to protect patients, employees or others while the matter is being reviewed.
- (d) After considering the reasons for the suspension and the individual's response, if any, the Medical Executive Committee will determine whether the precautionary suspension, restriction, or voluntary agreement to refrain from exercising privileges should be continued, modified, or lifted. The Medical Executive Committee may also determine whether to begin an investigation or whether to refer the matter for further review consistent with this or another policy.
- (e) If the Medical Executive Committee decides that the suspension, restriction, or voluntary agreement to refrain from exercising privileges must be continued, it will send the individual written notice of its decision, including the basis for it.
- (f) There is no right to a hearing based on the imposition or continuation of a precautionary suspension, restriction, or voluntary agreement to refrain from exercising privileges. The procedures outlined above are deemed to be fair under the circumstances.
- (g) Upon the imposition of a precautionary suspension, the Chief of Staff or the Chief Medical Officer will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

6.I. INVESTIGATIONS

6.I.1. Initial Review:

- (a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue regarding the following, the matter may be referred to the Chief of Staff, the department chief, the chairperson of a standing committee, the Chief Medical Officer, the President, or the chairperson of the Board:
 - (1) clinical competence or clinical practice, including patient care, treatment or management;
 - (2) the safety or proper care being provided to patients;
 - (3) the known or suspected violation of applicable ethical standards or the bylaws, policies, rules and regulations of the Hospital or the Medical Staff; or
 - (4) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital, its Medical Staff or its Allied Health Staff, including the inability of the member to work harmoniously with others.
- (b) If the Board becomes aware of information that raises concerns about the qualifications of any Medical Staff or Allied Health Staff member, the matter will be referred to the Chief of Staff, the Chief Medical Officer, or the President.
- (c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, will forward it to the Medical Executive Committee. If the question pertains to a member of the Allied Health Staff, the Supervising Physician may also be notified.
- (d) To preserve impartiality, the person to whom the matter is directed will not 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 or the Chief Medical Officer.
- (e) No action taken pursuant to this section will constitute an investigation.

6.I.2. Initiation of Investigation:

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

- (b) The Medical Executive Committee will inform the individual that an investigation has begun. Notification may be delayed if, in the judgment of the Medical Executive Committee, informing the individual immediately might compromise the investigation or disrupt the operation of the Hospital, Medical Staff, or Allied Health Staff.
- (c) 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.

6.I.3. Investigative Procedure:

- (a) Once a determination has been made to begin an investigation, the Medical Executive Committee will investigate the matter itself or appoint an individual or committee (“Investigating Committee”) to do so. The Investigating Committee may include individuals not on the Medical Staff or Allied Health Staff. The Investigating Committee will not include any individual who:
 - (1) is in direct economic competition with the individual being investigated;
 - (2) is a relative of the individual being investigated;
 - (3) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or
 - (4) actively participated in the matter at any previous level.
- (b) Whenever the questions raised concern the clinical competence of the individual under review, the Investigating Committee will include a peer of the individual (e.g., physician, dentist, oral surgeon, podiatrist, advanced practice nurse, or physician assistant).
- (c) The individual will be notified of the composition of the Investigating Committee. Within five days of receipt of this notice, the individual must submit any reasonable objections to the service of any Investigating Committee member to the President or the Chief Medical Officer. The objections must be in writing. The President or the Chief Medical Officer will review the objection and determine whether another member should be selected to serve on the Investigating Committee.
- (d) The Investigating Committee may:
 - (1) review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;
 - (2) conduct interviews;

- (3) use outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; or
 - (4) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated will execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.
- (e) As part of the investigation, the individual will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual will be informed of the questions being investigated and will be invited to discuss, explain, or refute the questions. A summary of the interview will be made and included with the Investigating Committee's report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report. The individual may review the interview summary and recommend any suggested changes. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.
- (f) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 60 days, provided that an outside review is not necessary. When an outside review is used, the Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.
- (g) At the conclusion of the investigation, the Investigating Committee will prepare a report to the Medical Executive Committee. The report will include a summary of the investigation process, including a list of documents that were reviewed and individuals who were interviewed, along with witness summaries that were prepared. The report will also include specific findings, conclusions, and recommendations.

6.I.4. Recommendation:

- (a) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, the Medical Executive Committee may:
- (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;

- (3) impose conditions for continued appointment;
 - (4) require monitoring, proctoring or consultation;
 - (5) require additional training or education;
 - (6) recommend reduction or restriction of clinical privileges;
 - (7) recommend suspension of clinical privileges for a specific period of time or until specified conditions have been met;
 - (8) recommend revocation of appointment or clinical privileges; or
 - (9) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the Medical Executive Committee that does not entitle the individual to request a hearing, will take effect immediately and will remain in effect unless modified by the Board.
 - (c) A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing will be forwarded to the President, who will promptly inform the individual by special notice. The recommendation will not be forwarded to the Board until after the individual has completed or waived a hearing and appeal.
 - (d) If the Board makes a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the President will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

- (a) An individual is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations:
 - (1) denial of initial appointment, reappointment or requested clinical privileges;
 - (2) revocation of appointment or clinical privileges;
 - (3) suspension of clinical privileges for more than 30 days (other than precautionary suspension);
 - (4) restriction of clinical privileges for more than 30 days, meaning a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance; or
 - (5) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.
- (b) No other recommendation or action will entitle the individual to a hearing.
- (c) If the Board determines to take any of these actions without an adverse recommendation by the Medical Executive Committee, an individual is entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Medical Executive Committee. When a hearing is triggered by an adverse proposed action of the Board, any reference in this Article to the “Medical Executive Committee” will be interpreted as a reference to the “Board.”

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

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

- (a) determination that an individual is ineligible for appointment or clinical privileges and that the individual’s application will not be processed because he or she fails to meet threshold eligibility criteria;

- (b) determination that an individual is ineligible to request appointment or privileges, or to continue appointment or the exercise of privileges because a specialty is closed under a staff development plan or is covered by an exclusive contract;
- (c) determination that an application will not be processed because it is incomplete or untimely;
- (d) determination that an application will not be processed due to a misstatement or omission;
- (e) expiration of appointment and clinical privileges due to a failure to timely submit an application for reappointment;
- (f) change in assigned staff category or a determination that an individual is not eligible for appointment to a specific staff category;
- (g) issuance of a letter of guidance, counsel, warning, or reprimand;
- (h) adoption or imposition of conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult, but need not get prior approval for the treatment);
- (i) adoption of condition or imposition of a requirement for additional training or continuing education;
- (j) adoption of a performance improvement plan;
- (k) a requirement that an individual complete a fitness for practice evaluation;
- (l) the grant of conditional appointment or reappointment or the grant of appointment or reappointment for a period of less than two years;
- (m) imposition of a precautionary suspension;
- (n) administrative relinquishment of appointment or privileges;
- (o) denial of a request for a leave of absence or for an extension of a leave;
- (p) activation of administrative medical leave of absence;
- (q) removal from the on-call roster or any other reading or rotational panel;
- (r) decision not to grant, or the withdrawal of, temporary privileges;
- (s) requirement to appear for a mandatory meeting; and

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

7.A.3. Notice of Recommendation:

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

- (a) a statement of the recommendation and the general reasons for it;
- (b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
- (c) a copy of this Article.

7.A.4. Request for Hearing:

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

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

- (a) The President will schedule the hearing and provide to the individual requesting the hearing, by special notice, the following:
 - (1) the time, place, and date of the hearing;
 - (2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;
 - (3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and
 - (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days (including adjourning and reconvening the hearing), to review and respond with additional information.
- (b) The hearing will begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.A.6. Witness List:

- (a) At least 15 days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.
- (b) The witness list will include a brief summary of the anticipated testimony.
- (c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party. If the witness list is amended, the other party may request a postponement if additional time is needed to prepare for the new witness.

7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

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

- (1) The Hearing Panel will consist of at least three members, one of whom will be designated as chairperson.
- (2) The Hearing Panel may include any combination of:
 - (i) any member of the Medical Staff or Allied Health Staff, or
 - (ii) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or Allied Health Staff or laypersons not affiliated with the Hospital).
- (3) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Hearing Panel.
- (4) Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Panel.
- (5) The Hearing Panel will not include any individual who:
 - (i) is in direct economic competition with the individual requesting the hearing;
 - (ii) is a relative of the individual requesting the hearing;

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

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

(b) Presiding Officer:

(1) The President, after consultation with the Chief of Staff, will appoint an attorney to serve as Presiding Officer. The Presiding Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing. The Presiding Officer will not act as an advocate for either side at the hearing.

(2) The Presiding Officer will:

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

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

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

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

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

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

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

(4) The Presiding Officer may participate in the private deliberations of the Hearing Panel, 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.

(c) Hearing Officer:

- (1) As an alternative to a Hearing Panel, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies and not issues of clinical competence, knowledge, or technical skill, the President, 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.
- (2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the “Hearing Panel” or “Presiding Officer” will be deemed to refer to the Hearing Officer.

(d) Compensation:

Members of the Hearing Panel, the Presiding Officer, or the Hearing Officer may be compensated for their service by the Hospital. The individual requesting the hearing may participate in that compensation. Compensation will not constitute grounds for challenging the impartiality of the Hearing Panel members.

(e) 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 receipt of notice, to the President. 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 President will rule on the objection and give notice to the parties. The President may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.A.8. Counsel:

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

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

The pre-hearing and hearing processes will be conducted in an informal manner. Formal rules of evidence or procedure will not apply. Neither party has the right to issue subpoenas or interrogatories or to depose witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in the hearing or pre-hearing process.

7.B.2. Provision of Relevant Information:

- (a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.
- (b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:
 - (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
 - (2) reports of experts relied upon by the Medical Executive Committee;
 - (3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
 - (4) copies of any other documents relied upon by the Medical Executive Committee.

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

- (c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical Staff or Allied Health Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.
- (d) Ten days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits.
- (e) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees, Medical Staff members or Allied Health Staff members 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, Medical Staff members or Allied Health Staff members, and confirmed their willingness to meet. Any employee, Medical Staff or Allied Health Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.B.3. Pre-Hearing Conference:

- (a) The Presiding Officer will require the individual and the Medical Executive Committee (or a representative of each, who may be counsel) to participate in a pre-hearing conference.
- (b) All objections to exhibits or witnesses will be submitted, in writing, five days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- (c) At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses.
- (d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges will be excluded.
- (e) The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination.

7.B.4. Stipulations:

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

7.B.5. Provision of Information to the Hearing Panel:

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

- (a) a pre-hearing statement that either party may choose to submit;
- (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and
- (c) stipulations agreed to by the parties.

7.C. THE HEARING

7.C.1. Time Allotted for Hearing:

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

7.C.2. Record of Hearing:

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

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

- (a) At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:
 - (1) to call and examine witnesses, to the extent they are available and willing to testify;
 - (2) to introduce exhibits;
 - (3) to cross-examine any witness;
 - (4) to have representation by counsel who may be present but not call, examine, and cross-examine witnesses and present the case;
 - (5) to submit a written statement at the close of the hearing; and
 - (6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.
- (b) If the individual who requested the hearing does not testify, he or she may be called and questioned.
- (c) The Hearing Panel may question witnesses, request the presence of additional witnesses, or request documentary evidence.

7.C.4. Order of Presentation:

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

7.C.5. Admissibility of Evidence:

The hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. The guiding principle will be that the record contains information sufficient

to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.C.6. Persons to Be Present:

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

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

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

7.C.8. Failure to Appear:

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

7.C.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but will be permitted only by the Presiding Officer or the President 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 on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel will recommend in favor of the Medical Executive Committee unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.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 the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel will conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel will render a recommendation, accompanied by a report, which will contain a statement of the basis for its recommendation.

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

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

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

- (a) Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the President in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.
- (b) If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

- (a) there was substantial failure by the Hearing Panel to comply with this Policy or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; or
- (b) the recommendations of the Hearing Panel were made arbitrarily or capriciously or were not supported by credible evidence.

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

Whenever an appeal is requested, the chairperson of the Board will schedule and arrange for an appeal. The individual will be given special notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

- (a) The Board may serve as the Review Panel or the chairperson of the Board may appoint a Review Panel, composed of members of the Board or others, including but not limited to reputable persons outside the Hospital.
- (b) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the Medical Executive Committee and Hearing

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

- (c) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten days to respond. 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.
- (d) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

7.F. BOARD ACTION

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

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

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

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

ARTICLE 8

CONDITIONS OF PRACTICE APPLICABLE TO ALLIED HEALTH PROFESSIONALS

8.A. CONDITIONS OF PRACTICE APPLICABLE TO ALLIED HEALTH PROFESSIONALS

8.A.1. Standards of Practice for the Utilization of Advanced Practice Clinicians in the Inpatient Setting:

- (a) Advanced practice clinicians are not permitted to function independently in the inpatient Hospital setting. As a condition of being granted permission to practice at the Hospital, all advanced practice clinicians specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of advanced practice clinicians in the Hospital, all Medical Staff members who serve as Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.
- (b) The following standards of practice apply to the functioning of advanced practice clinicians in the inpatient hospital setting:
 - (1) Admitting Privileges. Advanced practice clinicians are not granted inpatient admitting privileges and therefore may not admit patients independent of the Supervising Physician.
 - (2) Consultations. Advanced practice clinicians may not independently provide patient consultations in lieu of the practitioner's Supervising Physician. An advanced practice clinician may gather data and order tests; however, the Supervising Physician must personally perform the requested consultation within 24 hours (or more timely in the case of any emergency consultation request).
 - (3) Emergency On-Call Coverage. It will be within the discretion of the Emergency Department physician requesting assistance whether it is appropriate to contact an advanced practice clinician prior to the Supervising Physician. Advanced practice clinicians may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Supervising Physicians), in lieu of the Supervising Physician. The Supervising Physician (or his or her covering physician) must personally respond to all calls directed to him or her in a timely manner, in accordance with requirements set forth in this Policy. Following discussion with the Emergency Department, the Supervising Physician may direct an advanced practice clinician to see the patient, gather data, and order tests for further review by the Supervising Physician.

However, the Supervising Physician must still personally see the patient when requested by the Emergency Department physician.

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

8.A.2. Oversight by Supervising Physician:

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

8.A.3. Questions Regarding the Authority of an Advanced Practice Clinician:

- (a) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an advanced practice clinician to act or issue instructions outside the presence of the Supervising Physician, such individual will have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the advanced practice clinician. Any act or instruction of the advanced practice clinician will be delayed until such time as the individual with the question has ascertained that the act is clearly within the clinical privileges granted to the individual.

- (b) Any question regarding the conduct of an advanced practice clinician will be reported to the Chief of Staff, the chairperson of the Credentials Committee, the relevant department chief, the Chief Medical Officer, or the President for appropriate action. The individual to whom the concern has been reported will also discuss the matter with the Supervising Physician.

8.A.4. Responsibilities of Supervising Physicians:

- (a) Physicians who wish to utilize the services of an advanced practice clinician in their clinical practice at the Hospital must notify the Medical Staff Services of this fact in advance and must ensure that the individual has been appropriately credentialed before the advanced practice clinician performs services or engages in any kind of activity in the Hospital.
- (b) Supervising Physicians who wish to utilize the services of advanced practice clinicians in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 8.A.1 above.
- (c) The number of advanced practice clinicians acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician will make all appropriate filings with the state regarding the supervision and responsibilities of the advanced practice clinician, to the extent that such filings are required.
- (d) It will be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the advanced practice clinician in amounts required by the Board. The insurance must cover all clinical activities of the advanced practice clinician in the Hospital. The Supervising Physician will furnish evidence of such coverage to the Hospital, including the specialty and medical care covered. The advanced practice clinician will act in the Hospital only while such coverage is in effect.

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

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

ARTICLE 9

CONFLICTS OF INTEREST

- (a) All those involved in credentialing and professional practice evaluation activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review process.
- (b) It is also essential that peers participate in credentialing and professional practice evaluation review activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.
- (c) When performing a function outlined in this Policy, the Bylaws, the Medical Staff Rules and Regulations, or a related policy, if any member has or reasonably could be perceived as having a conflict of interest or a bias, that member will not participate in the final discussion or voting on the matter, and will be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.
- (d) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the Chief Medical Officer or the Chief of Staff or the applicable department chief or committee chairperson.
- (e) Additionally, any member whose clinical practice or professional conduct is subject to review, is obligated to notify the Chief of Staff, the Chief Medical Officer or the applicable department chief or committee chairperson of any known or suspected conflicts of interest of those who are involved in conducting the review. Any potential conflict of interest that is not timely raised will be deemed to be waived.
- (f) The Chief Medical Officer or the Chief of Staff (or the applicable department chief or committee chairperson) will make a final determination as to whether the provisions in this Article should be triggered or may submit the issue of whether there is a conflict of interest to a vote of the entire committee.
- (g) The fact that a department chief or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.

- (h) The fact that a department or committee member or Medical Staff Leader chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of actual conflict.
- (i) Conflict of Interest Guidelines, which are attached as Appendix B, may be used to provide guidance in addressing potential conflict of interest situations.

ARTICLE 10

AMENDMENTS AND ADOPTION

- (a) The amendment process for this Policy is set forth in the Bylaws.
- (b) This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Medical Staff Rules and Regulations, and Hospital or Medical Staff policies pertaining to the subject matter thereof.

Adopted by the MEC: August 2, 2021

Adopted by the General Medical Staff: September 14, 2021

Approved by the Board: September 20, 2021

APPENDIX A

ALLIED HEALTH PROFESSIONALS

Licensed Independent Practitioners:

- Audiologists and Speech Pathologists
- Massage Therapists
- Psychologists
- Moonlighting residents

Advanced Practice Clinicians:

- Advanced Practice Nurses
- Certified Registered Nurse Anesthetists
- Nurse Practitioners
- Perfusionists
- Physician Assistants
- Assistant Physicians
- Assistant Physicians (limited to Community Affiliate Staff only)

APPENDIX B

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation							
	Provide Information	Individual Reviewer	Committee Member				Hearing Panel	Board
			Leadership Council	PPEC	MEC	Ad Hoc Investigating		
Self or family member	Y	N	N	N	N	N	N	N
Employment relationship with hospital	Y	Y	Y	Y	Y	Y	Y	Y
Significant financial relationship	Y	M	M	M	M	N	N	N
Direct Competitor	Y	M	M	M	M	N	N	N
Close Friends	Y	M	M	M	M	N	N	N
History of conflict	Y	M	M	M	M	N	N	N
Personally involved in care of patient	Y	M	M	M	M	N	N	N
Other than Leadership Council, MEC, or department chair, reviewed at prior level	Y	M	M	M	M	N	N	N
Raised the concern	Y	M	M	M	N	N	N	N

Y – means the Interested Member may serve in the indicated role, no extra precautions are necessary.

N – means the individual may not serve in the indicated role and should be recused in accordance with the rules for recusal (*see next page*). If the facts and circumstances are contentious or otherwise unclear, the Chair of the Leadership Council, PPEC, or MEC may submit the issue to a vote of the entire committee.

M – means the Interested Member may have a conflict of interest. The Chair of the Leadership Council, PPEC, or MEC should consider the facts and circumstances and determine whether the conflict would make it difficult for the individual to be fair and objective in performing a review, whether the individual’s service might inhibit the full and fair discussion of the issue, skew the recommendation of the committee, or otherwise be unfair to the practitioner under review. In considering the facts and circumstances, the Chair may determine that a potential conflict is not significant enough to prohibit the person from serving in the designated role because of the check and balance provided by the multiple levels of review and the fact that the Leadership Council and PPEC have no disciplinary authority. The Chair of the Leadership Council, PPEC, or MEC may submit the issue of whether there is a conflict of interest to a vote of the entire committee. No Medical Staff member has the right to demand the recusal of another member.

CONFLICT OF INTEREST GUIDELINES *(cont'd.)*

Rules for Recusal

- An Interested Member may answer questions and provide input before leaving the meeting. The Interested Member should leave the meeting prior to the final deliberation and determination of the committee or the Board.
- If an Interested Member is recused from serving on a committee or on the Board, on a particular issue, the recusal should be recorded in the minutes.
- Whenever possible, an actual or potential conflict should be raised and resolved by the committee chair or the Board chair, prior to the meeting. Time permitting, the Interested Member should be informed of the recusal determination in advance of the meeting.
- No Medical Staff member has the right to demand the recusal of another member. The determination to recuse a Medical Staff member, because of a conflict of interest, is within the discretion of the chair of the committee or the chair of the Board.
- Voluntarily choosing to refrain from participating in a particular situation is not a finding or an admission of an actual conflict or any improper influence on the process.

APPENDIX C

DELEGATED CREDENTIALING PROCEDURES

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

C-1. Scope

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

C-2. Sub-Delegation

Sub-delegation to an entity outside Boone Hospital Center (the “Hospital”) of the functions described in this Policy and Appendix will not occur.

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

- (a) a delegation agreement that:
 - (1) is mutually agreed upon;
 - (2) describes the delegated activities and the responsibilities of the Hospital and the sub-delegated entity;
 - (3) requires at least semi-annual reporting by the sub-delegated entity to the Hospital;
 - (4) describes the process by which the Hospital evaluates the sub-delegated entity’s performance;
 - (5) specifies that the Hospital retains the right to approve, suspend, and terminate individual practitioners; and
 - (6) describes the remedies available to the Hospital if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement;

- (b) a pre-delegation evaluation that evaluates the capacity of the sub-delegated entity to meet regulatory and accreditation requirements;
- (c) an annual review of the sub-delegate's delegated activities; and
- (d) for arrangements in effect for more than 12 months, identification of and follow-up on opportunities for improvement at least once every two years.

C-3. Confidentiality of Credentialing Information

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

C-4. Practitioner Rights

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

- (a) to review information submitted in support of their application consistent with this Policy and the Policy on Practitioner Access to Confidential Files;
- (b) to be informed, upon request, of the status of their application (requests will be submitted to the Medical Staff Office which will respond to such requests in a reasonable amount of time, not to exceed 60 days); and
- (c) to correct erroneous information from other sources (if information is received from other sources that appears to be erroneous, the Medical Staff Office will notify the practitioner, who will have 60 days to provide information to support the need to correct such information. The Medical Staff Office will also inform the practitioner of the format for submitting the information and where such information should be submitted).

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

C-5. Review of Policy

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

C-6. Oversight of Delegated Credentialing Program

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

C-7. Credentialing System Controls

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

- (a) Credentialing applications and supporting documents, such as primary source verified information, is received via an electronic application and other electronic means, reviewed by the Medical Staff Office staff (the receipt of which is dated, tracked, and stored within the practitioner's electronic credentialing file).
- (b) Access to practitioner electronic credentialing files, including initially verified information, is limited to users within the Medical Staff Office department and database administrators through the use of security groups, configured within the credentialing software.
- (c) Modification or deletion of specific fields in electronic credentialing files are managed through the database administrator granting security permissions to specific user groups. Information may be modified or deleted when inaccurate or duplicative (e.g., incorrect insurance carrier/broker).
- (d) Modifications to credentialing records are tracked through the credentialing software, which has an audit log showing the date/time of change, what was modified, and the user who made the modification. If a modification is made to change the verification date/user/source, a note will be made to reflect the reason for the change.
- (e) Authorized individuals who are given access to confidential credentialing information and credentialing platforms create a username and password and are periodically instructed on best practices for maintaining the confidentiality of this information (e.g., using a strong password, avoiding writing down passwords, using different passwords for different accounts, and changing passwords when appropriate or at defined intervals). Appropriate staff (e.g., those in the IT department) are alerted when an employee with access leaves the organization so that his or her account and access can be disabled and when there is a potential breach of security (e.g., through a virus) so that authorized individuals may be instructed on the need to change their password or take other remedial steps.
- (f) An audit report is completed on a sample of initial and recredentialing files at least every six months. This report includes a list of the credentialing criteria verified,

individual performing the verification, verification source, and expiration date, if applicable. The report shows the person conducting the audit and date the audit was performed. If any information is found to be inaccurate, or outside of the Policy requirements, the auditor will contact the individual who performed the credentialing to address the issue. Audits are performed by a member of the Medical Staff Office who did not work on the file being reviewed. The Medical Staff Office manager will oversee the audit process for initial and recredentialing files.

C-8. Application

- (a) The Hospital will use the state-mandated application form. The application will specifically seek, among other things, information pertaining to the following:
 - (1) reasons for inability to perform the essential functions of the position, if applicable;
 - (2) lack of present illegal drug use;
 - (3) history of loss of license and felony convictions;
 - (4) history of loss or limitation of privileges or disciplinary actions;
 - (5) current malpractice insurance coverage or, if no current malpractice insurance coverage, eligibility for malpractice insurance coverage on the effective date of membership; and
 - (6) clinical privileges, or evidence of an admitting arrangement, for admitting patients to the Hospital.
- (b) The application will also include a requirement for the applicant to attest, via signature, to the correctness and completeness of the application.
- (c) A complete application for an individual eligible for an unrestricted DEA license, in which the Applicant's DEA license is in active-pending status, may still be presented to the Credentials Committee provided that the individual has confirmed that a practitioner with appropriate clinical privileges with a current, unrestricted DEA license is willing to write all prescriptions requiring a DEA Number for the individual until his or her DEA license is granted.
- (d) Within two working days after receipt of a credentialing application, the Medical Staff Office will send a notice of receipt to the applicant.
- (e) If applicable, applicants will be provided access to the web portal which allows them to receive notice of the status of an electronically submitted application.

- (f) The Hospital will notify applicants that there is a need for additional information within ten days of determining that an application is incomplete. If the applicant provides the requested information sufficient for a determination that the application is complete, the applicant will be notified within two days of such a determination.

C-9. Time Periods for Processing

- (a) Once an application is deemed complete, it will be processed in accordance with state time requirements, and not to exceed NCQA time frames, unless it becomes incomplete. Notification of credentialing to applicants will be made within 60 days of the decision unless an applicable accreditation and/or regulatory requirement requires that notification be made in a shorter time frame.
- (b) The verifications to be performed and the relevant NCQA time limits are as follows:
 - (1) Current, valid license and any sanctions or restrictions on licensure or limitations on scope of practice – must be reviewed within 180 calendar days of verification;
 - (2) Valid DEA or state-controlled substance certificate – for non-pending DEA or state-controlled substance certificates, must be reviewed within 180 calendar days of verification;
 - (3) Education and training – must be reviewed within 180 calendar days of the verification;
 - (4) Board certification status if practitioner states on application that he or she is board certified – must be reviewed within 180 calendar days of verification;
 - (5) Work history – a minimum of five years of work history must be reviewed within 180 calendar days of verification;
 - (6) Malpractice history (i.e., claims that resulted in settlement or judgment paid on behalf of the practitioner) – a minimum of five years of malpractice history must be reviewed within 180 calendar days of verification;
 - (7) State sanctions, restrictions on licensure and limitations on scope of practice – a minimum of the most-recent five-year period must be reviewed within 180 calendar days of the verification;
 - (8) Medicare and Medicaid sanctions – must be reviewed within 180 calendar days of verification; and

- (9) Attestation on application – must be reviewed within 180 calendar days of the date the attestation is made.

The NCQA time limits set forth above are current as of the adoption date of this Policy. If these time limits are shortened before this Appendix can be amended, the shorter time limits will be used until this Appendix can be amended.

C-10. Verification Sources

Verification of information required for credentialing and recredentialing (verification of education and training and work history are not applicable for recredentialing) will be performed as follows:

- (a) Licensure and limitations or restrictions on licensure or limitations on scope of practice – directly from state licensing or certification agency (the National Practitioner Data Bank may be used for restrictions on licensure for physicians).
- (b) DEA or state-controlled substance certificate – DEA or state-controlled substance licensing agency, DEA or state-controlled substance certification, documented visual inspection of the original DEA or state-controlled substance certificate, or confirmation from the American Medical Association (“AMA”) Masterfile (DEA only).
- (c) Education and training – primary source, the state licensing agency or specialty board if the state agency and specialty board, respectively, perform primary source verification (if the state licensing agency or specialty board is used for verification, written confirmation will be obtained that they perform verification of education and training or other method approved by accreditation standards), or sealed transcripts if there is written documentation that the transcript was inspected and confirmation that the practitioner completed the appropriate training program. For physicians, other acceptable verification sources include (when appropriate for the degree) AMA Physician Masterfile, American Osteopathic Association (“AOA”) Official Osteopathic Physician Profile Report or Physician Masterfile, and the Educational Commission for Foreign Medical Graduates for international medical graduates licensed after 1996.
- (d) Board certification status – primary source (appropriate specialty board) and the state licensing agency. For physicians, other acceptable verification sources include the ABMS or its member boards, or an official ABMS Display Agent, where a dated certificate of primary source authenticity has been provided, AMA Physician Masterfile, AOA Official Osteopathic Physician Profile Report or Physician Masterfile, and boards in the United States that are not members of the ABMS or AOA if the organization documents within its policies and procedures which specialty boards it accepts and obtains annual written confirmation from the board that the board performs primary source verification of completion of education and training.

- (e) Work history – application or CV.
- (f) Gaps in work history – application or CV (A review of work history and any gaps will be documented. If a gap in employment exceeds six months, the practitioner will be required to clarify the reasons for the gap verbally or in writing. If a gap in employment exceeds one year, the practitioner will be required to clarify the reasons for the gap in writing).
- (g) Malpractice history – the malpractice carrier or the National Practitioner Data Bank.
- (h) State sanctions, restrictions on licensure and limitations on scope of practice –
 - For physicians: appropriate state agency or Federation of State Medical Boards.
 - For oral surgeons: State Board of Dental Examiners or State Medical Board.
 - For podiatrists: State Board of Podiatric Examiners or Federation of Podiatric Medical Boards.
 - For Advanced Practice Professionals: applicable state licensure or certification board or other appropriate state agency.
- (i) Medicare and Medicaid sanctions – National Practitioner Data Bank or other NCQA-approved source.

During initial credentialing and recredentialing, the Hospital will review the National Plan and Provider Enumeration System, Centers for Medicare & Medicaid Services’ (“CMS”) Opt-Out Affidavit List to determine if an applicant has elected to opt out of Medicare (the CMS Opt-Out Affidavit List also will be reviewed quarterly during credentialing cycles) and a CMS-approved sanctions list (e.g., Office of Inspector General List of Excluded Individuals/Entities) to determine if an applicant is eligible for participation in Medicare. The Hospital will also review the General Services Administration’s System for Awards Management, the Missouri Medicaid Terminations List, and the Social Security Administration Death Master File during initial credentialing and recredentialing to verify that the applicant is a living person.

C-11. Documentation of Information and Activities in Credentials Files

The Medical Staff Office will use an electronic checklist to document verification of information for practitioner credentials files. The electronic checklist includes, among other things, the source used for verification purposes, the date that the verification was

conducted, the electronic signature of the individual conducting the verification, and, where applicable, the report date.

C-12. Site Assessments

- (a) Site assessments may be conducted to ensure that the offices of all practitioners meet office site standards. If site assessments are conducted as a part of the delegated credentialing process, the provisions in this section will apply.
- (b) The quality, safety and accessibility of practitioners' offices will be assessed based on the following factors:
 - (1) Physical accessibility, including for the handicapped accessible/parking;
 - (2) Physical appearance, that is, cleanliness, adequate seating, hours posted, etc.;
 - (3) Adequacy of waiting and examining room space; and
 - (4) Adequacy of medical/treatment record keeping.

Patient complaints for practitioner office sites will also be monitored.

- (c) The results of the assessments will be scored on a 0 to 100% compliance scale.
 - (1) For sites demonstrating 80% or greater compliance, no follow-up is required.
 - (2) For sites demonstrating less than 80% compliance, an action plan will be developed and monitored. Follow-up to the site assessment action plan will occur, and be documented, at least every six months until the deficiency is resolved.
- (d) A site assessment will be completed as follows:
 - (1) At initial credentialing of a practitioner at a site which has not been assessed;
 - (2) Every three years after the initial site assessment;
 - (3) When patient complaints for a site exceed the threshold established (under such circumstances, site visits will be conducted within 60 days of the threshold being met and communicated to the Chief Medical Officer); and
 - (4) As part of the follow-up when a site demonstrates less than 80% compliance.

C-13. Ongoing Monitoring

- (a) The following will be reviewed as part of the ongoing monitoring process (i.e., during the credentialing cycle/period):
 - (1) Medicare and Medicaid sanctions;
 - (2) sanctions or limitations on licensure;
 - (3) confirmed and validated grievances from patients or complaints from staff, including any history of such grievances or complaints (confirmed and validated grievances will be reviewed upon their receipt and any history of such grievances will be evaluated at least every six months); and
 - (4) information from identified adverse events, which will be evaluated at least every six months.
- (b) Sanctions information will also be reviewed within 30 days of its release by the reporting entity. If the reporting entity does not publish sanctions information on a set schedule, it will be documented that the reporting entity does not release information on a set schedule, and a query of the reporting entity for the necessary information will occur at least every six months. If there is a subscription to a sanctions alert service, the information provided through the service as a part of an alert will be reviewed within 30 days of a new alert being issued.
- (c) Concerns identified through the ongoing monitoring procedures outlined in this Section will be addressed through the Professional Practice Evaluation Policy and process.

C-14. Reporting to Authorities

- (a) Reporting to the National Practitioner Data Bank:
 - (1) A report will be submitted to the National Practitioner Data Bank after a physician or dentist has exercised or waived his or her hearing rights and the Board takes one of the following reportable professional review actions:
 - (i) denial of request for initial or renewed Medical Staff membership or clinical privileges;
 - (ii) revocation of Medical Staff membership or clinical privileges; or
 - (iii) suspension of Medical Staff membership or clinical privileges, including a precautionary suspension, for more than 30 days.

- (2) A report will also be submitted to the National Practitioner Data Bank if the Hospital accepts the surrender, restriction, or resignation of a physician's or dentist's Medical Staff membership or clinical privileges while under an investigation, or in return for not conducting an investigation, or in return for not taking an adverse professional review action. Under such circumstances, the physician or dentist will be informed that a report will be made to the National Practitioner Data Bank.
- (3) Reports to the National Practitioner Data Bank of adverse actions and surrender involving practitioners other than physicians and dentists are **not** mandatory under federal law and will not be made.
- (4) Reports to the National Practitioner Data Bank and query results received by the National Practitioner Data Bank are confidential and will not be shared with third-party payors who have delegated credentialing. However, the fact that a query was conducted may be disclosed to third-party payors. Copies of all information obtained through queries to the National Data Bank shall be maintained as part of the individual's permanent confidential credentials file.

(b) State law reporting requirements

The state law reporting requirements are not identical to the National Practitioner Data Bank requirements. On a case-by-case basis, legal counsel will be consulted to determine if there is an obligation to file a report under the state reporting requirements when a practitioner has his or her request for membership or clinical privileges denied or current membership or clinical privileges are revoked, denied, restricted, or suspended, or surrenders or relinquishes membership or clinical privileges for any period of time. Reports will be made consistent with applicable state law.

C-15. Managed Care Credentials Committee

- (a) Purpose: The Managed Care Credentials Committee is responsible for credentialing and conducting quality oversight of practitioners for purposes of delegated credentialing performed by the Hospital for third-party payors.
- (b) Composition and Terms:
 - (1) The Managed Care Credentials Committee will be composed of physicians representing primary care and specialty care and other practitioners as indicated. The Chief Medical Officer will serve as a permanent member of the Managed Care Credentials Committee. The Chief Medical Officer (or other committee member if unavailable) will chair the Managed Care Credentials Committee.

- (2) Other than the Chief Medical Officer, members of the Managed Care Credentials Committee will serve for a term of one-year and continue in such service until a successor is appointed.
- (3) Other credentialed practitioners, including physicians from certain specialties, may be invited to attend a Managed Care Credentials Committee meeting (as ad hoc committee members, without vote) when needed to assist the Committee in its discussions and deliberations regarding an issue on its agenda. This includes the credentialing and recredentialing of specialists when the input from a practitioner in that same specialty is required. These individuals will be present only for the relevant agenda item and will be excused for all others. Such individuals are an integral part of the peer review process and are bound by the same confidentiality requirements as the standing members of the Committee.
- (4) A quorum for Managed Care Credentials Committee meetings is 50% of the voting members.

(c) Duties:

The Managed Care Credentials Committee will:

- (1) review, discuss, and make recommendations concerning applications for initial credentialing and recredentialing for participation with third-party payors;
- (2) review information collected as a part of ongoing monitoring activities to identify matters involving practitioners that require further review;
- (3) maintain minutes which document its consideration of applications for credentialing and recredentialing and its review of ongoing monitoring activities;
- (4) submit its minutes to the Board for review; and
- (5) review the effectiveness of this Policy and recommend revisions or modifications on a yearly basis.

C-16. Miscellaneous

- (a) When a practitioner requests a hearing for one of the recommendations enumerated in the Credentials Policy that are grounds for a hearing, a Hearing Panel will be convened for the hearing and the Hearing Officer option will not be used when the recommendation would affect the individual's credentialing with third-party payors. Moreover, the majority of the Hearing Panel members will be "peers" of the practitioner requesting the hearing.

- (b) For purposes of delegated credentialing and reporting practitioner effective dates to third-party payors, the date that the Credentials Committee or Chief Medical Officer approves the practitioner's credentialing will be used as the practitioner's effective date. Practitioners will be notified of initial credentialing decisions and recredentialing denials in a time frame that does not exceed 60 days from the Credentials Committee's decision/recommendation.
- (c) The Hospital will not discriminate in credentialing and recredentialing consistent with the Non-Discrimination section of this Policy. Monitoring and preventing such discrimination shall be done by completing audits, at least annually, of the files of individuals who are denied membership or have their membership revoked or suspended. All Credentials Committee members will be required to sign annually an affirmative statement that any decisions or recommendations that they make will be done in a nondiscriminatory manner.
- (d) For delegated credentialing purposes, a practitioner's credentialing term will not extend beyond 36 months.