Medical Staff
Allied Health Professional Policy

MOUNT CARMEL DUBLIN

A Medical Staff Document

_____, 2024

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DEFINITIONS

The following definitions shall apply to terms used in this Allied Health Professional Policy:

"Adverse" means a recommendation or action of the Medical Executive Committee or Board that denies, limits, or otherwise restricts Privileges on the basis of quality of care, professional conduct or competence, or as otherwise defined in this Policy.

"Affiliate Hospital" means Mount Carmel East/Grove City, Mount Carmel St. Ann's, or Mount Carmel New Albany Surgical Hospital, as applicable.

"Allied Health Professional" or "AHP" means an individual other than a licensed Physician, Podiatrist, Dentist, or Psychologist who functions in a medical support role, or who exercises independent judgment within the area of his/her professional competence and is qualified to render direct or indirect care under the supervision of or in collaboration with a Practitioner who has been granted Privileges for such care in the Hospital. AHPs may include but are not limited to Psychologists (who hold not more than a master's degree), physician assistants, advanced practice nurses, anesthesiologist assistants, or other individuals whose scope of practice has been recognized by the Hospital.

"Board of Trustees" or "Board" means the Board of Trustees of Mount Carmel Health System.

"Bylaws" or "Medical Staff Bylaws" means the articles and amendments that constitute the basic governing documents of the Medical Staff. A reference to the Bylaws shall include Medical Staff Policies and Rules & Regulations as appropriate.

"Chief Clinical Officer" or "CCO" means the physician responsible for providing leadership and oversight of all Mount Carmel Health System clinical programs and physicians. The CCO may be appointed to the Active Medical Staff.

"Chief Executive Officer" or "CEO" means the individual appointed by the Board to serve as the Board's representative in the overall administration of the Hospital.

"Chief Medical Officer" or "CMO" means the Hospital's chief medical officer. A CMO may be appointed to the Active Medical Staff.

"CVO" means Credentialing Verification Office.

"Dentist" means an individual who has received a Doctor of Dental Surgery ("D.D.S.") or Doctor of Dental Medicine ("D.M.D.") degree and who has a current license to practice dentistry.

"Department" means a grouping or division of clinical services as provided for in the Medical Staff Bylaws. A Department may be further divided into “Sections” led by a “Section Chief.”

"Department Chair" means the Active Member of the Hospital with responsibility for Department administration as set forth in the Bylaws.

"*Ex Officio*" means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, without voting rights.

"Federal Healthcare Program" means Medicare, Medicaid, TriCare, or any other federal or state program providing healthcare benefits that is funded directly or indirectly by the United States government.

"Good Standing" means that a Member, at the time the issue is raised, has met the attendance and Department/committee participation requirements during the previous Medical Staff Year as defined in approved Department rules/regulations; is not in arrears in dues payments; and has not received a suspension or restriction of his/her appointment and/or Privileges in the previous twelve (12) months; provided, however, that if a Member has been suspended in the previous twelve (12) months for failure to comply with the Hospital's policies or procedures regarding medical records and has subsequently taken appropriate corrective action, such suspension shall not adversely affect the Member's Good Standing status. A Practitioner who is voluntarily not exercising his/her appointment and/or Privileges shall be considered to be in Good Standing.

“Health System” or “System” means Mount Carmel Health System.

"Hospital" means Mount Carmel Dublin, located in Dublin, Ohio.

"Medical Executive Committee" or "MEC" means the executive committee of the Medical Staff.

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

"Medical Staff Policy(ies)" or "Policy(ies)" means those Medical Staff policies approved by the MEC and Board that serve to implement and supplement the Medical Staff Bylaws including, but not limited to, this Allied Health Professional Policy.

"Medical Staff President" means the Active Member who serves as chief administrative officer of the Medical Staff.

"Medical Staff Year" means the period from January 1 to December 31 of each calendar year.

"Member" means a Practitioner who has been granted appointment to the Medical Staff. A Member must also have applied for and been granted Privileges unless the appointment is to a Medical Staff category without Privileges, or unless otherwise provided by the Bylaws.

"Physician" means an individual who has received a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) degree and who has a current license to practice medicine.

"Podiatrist" means an individual who has received a Doctor of Podiatric Medicine ("D.P.M.") degree and who has a current license to practice podiatry.

"Practitioner" means an appropriately licensed Physician, Dentist, Podiatrist, or Psychologist, to the extent applicable to this Policy.

"Prerogative" means the right to participate, by virtue of Medical Staff category or otherwise, granted to a Member or Allied Health Professional and subject to the ultimate authority of the Board, the conditions and limitations imposed in the Bylaws, this Policy, and applicable Hospital policies.

"Privileges" means the permission granted to a Practitioner or Allied Health Professional to render specific diagnostic, therapeutic, medical, dental, podiatric, surgical, or psychological services within the Hospital based upon the individual's professional license, experience, competence, ability, and judgment.

"Professional Liability Insurance" means professional liability insurance coverage of such kind, in such amount, and underwritten by such insurers as required and approved by the Board.

"Psychologist" means an individual with not less than a master's degree, or who has a doctoral degree in psychology or school psychology, or who has a doctoral degree deemed equivalent by the Ohio State Board of Psychology, with a current license to practice psychology. In the absence of exceptional circumstances, as determined by the Board upon recommendation of the MEC, a Psychologist must hold a doctoral degree in order to be a Member of the Medical Staff.

"Rules & Regulations" means the compendium of rules and regulations adopted by the MEC, and approved by the Board, to govern specific administrative and patient care issues that arise at the Hospital.

"Special Notice" means written notice (a) sent by certified mail, return receipt requested; or (b) delivered personally with the recipient's signature as proof of receipt or other written documentation as to why such signature was not obtained.

Designees: Whenever an individual is authorized to perform a duty by virtue of his/her position, then reference to such individual shall also include the individual's qualified designee.

Time Computation: In computing any period of time set forth in this Policy or the other Medical Staff governing documents, the date of the act from which the designated period of time begins to run shall not be included. The last day of the period shall be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday or legal holiday. When the period of time is less than seven (7) days, intermediate Saturdays, Sundays and legal holidays shall be excluded.

ARTICLE 1: INTRODUCTION

1.1 AHP CATEGORIES

1.1-1 All AHPs must be credentialed and managed through the Medical Staff consistent with this Policy. The Medical Staff shall make recommendations to the Board, upon request, with respect to: (1) the categories of AHPs, based upon occupation or profession, that shall be eligible to be credentialed at the Hospital; (2) for each eligible AHP category, the mode of practice in the Hospital setting (*e.g.* independent or dependent), the scope of practice, and applicable Privilege set or position description for each; and (3) whether any changes should be made to existing AHP categories.

1.1-2 Attached hereto, and incorporated by reference herein, is Appendix A which sets forth the categories of AHPs that shall be credentialed, privileged, and managed through the Medical Staff pursuant to this Policy.

1.2 ROLE OF MEDICAL STAFF SERVICES

The CVO/Medical Staff Office shall be responsible for the administrative duties related to credentialing AHPs, such as distributing application forms and collecting completed applications; assigning the package to Medical Staff Office/CVO personnel or Hospital personnel, as applicable, to conduct primary source verification of qualifications; and forwarding applications and related documentation to the necessary Medical Staff or Hospital leaders for review and processing.

1.3 APPLICABILITY OF AHP POLICY

This Policy is applicable to AHPs credentialed and granted Privileges through the Medical Staff process.

1.4 LIMITATIONS

AHPs are not granted appointment to the Medical Staff, may not hold Medical Staff office, and are not entitled to the fair hearing and appeal rights afforded to Medical Staff Appointees. AHPs may not admit or discharge patients to/from the Hospital but may write admission and/or discharge orders at the direction of a supervising/collaborating physician. AHPs may not vote on Medical Staff matters except within committees when the right to vote is specified at the time of committee assignment.

1.5 NOT A CONTRACT

This AHP Policy is not intended to and shall not create any contractual rights between the Hospital and any AHP or supervising or collaborating

Practitioner(s). Any and all contracts of association or employment shall control contractual and financial relationships between the Hospital and AHPs or Practitioners.

1.6 MEDICAL STAFF POLICIES

AHPs with Privileges at the Hospital shall be subject to all policies of the Medical Staff, including but not limited to the *Medical Staff Rules & Regulations* and the *Medical Staff Peer Review Policy*.

ARTICLE 2: PRIVILEGES

2.1 QUALIFICATIONS FOR PRIVILEGES

2.1-1 Every AHP who applies for Privileges must at the time of application and initial grant of Privileges, and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board of Directors that he/she meets all of the following qualifications and any other qualifications and requirements as hereinafter established by the Board. Each AHP must:

(a) Have a current license, certificate, or registration to practice in Ohio and have never had a license, certificate, or registration to practice revoked by any state licensing agency.

(b) Meet the continuing professional education requirements for such license, certificate, or registration as determined by the applicable state licensure board.

(c) Hold, if appropriate, a current, valid Certificate to Prescribe (“CTP”) and Drug Enforcement Administration ("DEA") registration.

(d) Have educational documentation sufficient to establish that he/she meets the requirements set forth in the applicable Privilege set.

(e) Provide documentation of successful completion of an approved training program in the specialty in which the AHP seeks Privileges and where appropriate documentation of required certifications.

(f) Have documentation evidencing an ongoing ability to provide continuous patient care, treatment, and services consistent with acceptable standards of practice and available resources including current experience, clinical results (including morbidity and mortality data, if available), and utilization practice patterns.

(g) Have demonstrated an ability to work with and relate to Practitioners, other Allied Health Professionals, Hospital employees and administration, the Board, patients and visitors, and the community in general, in a cooperative, professional manner that maintains and promotes an environment of quality and efficient patient care.

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

(i) Agree to, and fulfill, the obligations set forth in this Policy and the applicable Privilege set.

(j) Demonstrate an ability to exercise the Privileges requested safely and competently with or without reasonable accommodation.

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

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

(m) Provide the name of the Medical Staff Appointee with Privileges at the Hospital who has agreed to supervise or collaborate with the AHP and a copy of the AHP's current, valid supervision agreement or standard care arrangement, if applicable.

(n) Have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same.

(o) Have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program.

(p) Have never had clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, and have never relinquished privileges during a medical staff investigation or in exchange for not conducting such an investigation.

(q) Have never been convicted of, or entered a plea of guilty or no contest, to any felony; or other serious offense relating to controlled substances, illegal drugs, alcohol, insurance or health care fraud or abuse, or violence.

(r) Complete such documentation as is necessary in order that the Hospital can perform a criminal background check.

(s) Provide documentation evidencing compliance with Hospital and/or Medical Staff vaccination/immunization policies.

2.1-2 **Waiver of Qualifications for Privileges**

(a) Any AHP who does not satisfy one (1) or more of the criteria outlined in §2.1.1 above may request that it be waived. The AHP

requesting the waiver bears the burden of demonstrating that the AHP meets or exceeds the criteria (if applicable) or that other exceptional circumstances exist justifying a waiver.

(b) An application for Privileges that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted in accordance with this section.

(c) A request for a waiver will be submitted to the AHP Credentials Committee for consideration. In reviewing the request for a waiver, the AHP Credentials Committee may consider the specific qualifications of the AHP in question, input from the relevant Department Chair, and the best interests of the Hospital and the communities it serves. Additionally, the AHP Credentials Committee may, in its discretion, consider the application form and other information supplied by the AHP. The AHP Credentials Committee's recommendation will be forwarded to the MEC. Any recommendation to grant a waiver must include the basis for such waiver.

(d) The MEC will review the recommendation of the AHP 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 basis for such waiver.

(e) The Board may grant waivers in exceptional cases after considering the findings of the MEC or other committee designated by the Board, the specific qualifications of the AHP in question, and the best interests of the Hospital and the communities it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other AHP or group of AHPs.

(f) No AHP is entitled to a waiver or to procedural due process rights if the Board determines not to grant a waiver; rather, the decision to grant a waiver is at the sole discretion of the Board. A determination that an AHP is not entitled to a waiver is not a "denial" of Privileges; rather, that AHP is ineligible to request Privileges.

2.2 NO ENTITLEMENT TO PRIVILEGES

No AHP shall be entitled to Privileges at the Hospital merely by virtue of the fact that he/she:

2.2-1 Holds a certain degree or a valid license, certificate, or registration in Ohio or any other state.

2.2-2 Is certified by any clinical board.

2.2-3 Is a member of any professional organization.

2.2-4 Has previously had Privileges in this Hospital or holds or has held privileges in any other hospital or health care facility.

2.2-5 Contracts with or is employed by the Hospital.

2.3 ADDITIONAL CONSIDERATIONS

In the case of initial applications for Privileges, and with respect to requests for new Privileges during a current Privilege period, the requested Privileges must be compatible with any policies, plans, or objectives formulated by the Board concerning:

2.3-1 The Hospital's patient care needs, including current and projected needs.

2.3-2 The Hospital's ability to provide the facilities, equipment, personnel, and financial resources that will be necessary if the application is approved.

2.3-3 The Hospital's decision to contract exclusively for the provision of certain medical services with a Practitioner/AHP or a group of Practitioners/AHP other than the affected AHP.

2.4 NON-DISCRIMINATION

No AHP shall be denied Privileges on the basis of gender, race, age, religion, creed, color, national origin, sexual preference, disability or a handicap unrelated to his/her ability to fulfill patient care and required AHP obligations.

2.5 CONDITIONS AND DURATION OF PRIVILEGES

Subject to §2.6 and §2.7 of this Article, an initial grant of Privileges, modification of Privileges, and regrant of Privileges shall be for a period of not more than two (2) years; provided, however, that the duration of any such initial grant and regrant of Privileges shall be subject to the provisions of Article 7 and may be less than two (2) years if approved by the Board. A grant of Privileges of less than two (2) years shall not be deemed Adverse for purposes of this Policy.

2.6 EXCLUSIVE CONTRACT/CLOSED SPECIALTY

2.6-1 Hospital may enter into exclusive contracts for hospital-based Physician services (anesthesia, radiology, pathology, and emergency medicine). In the event the Hospital is considering entering into an exclusive contract for any other service in which no exclusive contract currently exists, or closing a specialty that is currently open, the following process will be followed:

(a) The Hospital President will give at least thirty (30) days advance written notice to all AHPs with Clinical Privileges in the potentially affected specialty ("Affected AHPs") that the Hospital is considering taking such action; and the date, location, and time when the Affected AHPs may meet with the Board (or a board appointed committee, as determined by the Board at its sole discretion) to present any information the Affected AHPs believe relevant to the decision-making process.

(b) No Affected AHP shall be entitled to any other procedural due process rights with respect to the decision or the effect of the contract on his/her Clinical Privileges notwithstanding any other provision of this Policy. The fact that an AHP is not able to exercise Clinical Privileges because of an exclusive contract/closed specialty does not constitute a reportable event for purposes of federal or state law.

(c) Following the date of the scheduled meeting as provided for in the above paragraph, the Hospital President will give at least thirty (30) days advance written notice to all Affected AHPs of the earliest date in which the Hospital may enter into the exclusive contract or close the specialty.

2.6-2 If the Hospital enters into an exclusive contract for a service(s), any AHP who previously held Privileges to provide such service(s), but who is not a party to the exclusive arrangement, may not provide such service(s) as of the effective date of the Department closure or exclusive contract, irrespective of any remaining time on his/her Privilege term.

2.7 CONTRACT AHPS

2.7-1 An AHP who is or who will be providing professional services pursuant to a contract with the Hospital is subject to all applicable qualification requirements for Privileges and is responsible for fulfilling all obligations related thereto.

2.7-2 The continuation and/or termination of the Privileges of any AHP who has a contractual relationship with the Hospital, or who is an agent, employee, principal of, member, or partner in an entity that has a contractual relationship with the Hospital shall be governed by the terms of the contract. If the contract provides for termination of Privileges upon expiration or termination of the contractual relationship, no procedural due process rights shall apply. If the contract is silent, then the Privileges shall continue subject to this Policy.

2.7-3 In the event of any conflict between this Policy and the terms of any contract, the terms of the contract shall control.

2.8 BASIC OBLIGATIONS

2.8-1 Each AHP granted Privileges at the Hospital must, as applicable:

(a) Provide his/her patients with professional services consistent with the recognized standards of practice in the same or similar communities and the resources locally available.

(b) Comply with applicable law, this Policy, and, as applicable, the Medical Staff Bylaws, Rules & Regulations, the Hospital's code of regulations, and other Hospital and Medical Staff policies and procedures, including applicable vaccination policies.

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

(d) Complete medical records and other records in such manner and within the time period required by the Hospital for all patients he/she provides care for at the Hospital.

(e) Abide by generally recognized standards of professional ethics including, but not limited to, the Ethical and Religious Directives for Catholic Healthcare.

(f) Satisfy the ongoing continuing education requirements as applicable and as established by the Medical Staff, aid in any Medical Staff approved educational programs, and participate in continuing education programs as determined by Medical Staff Policies.

(g) Abide by the terms of the Hospital's corporate compliance plan, and the notice of privacy practices prepared and distributed to patients as required by the federal patient privacy regulations.

(h) Satisfy the obligations of the Department in which he/she is assigned.

(i) Cooperate and participate, as requested by the Medical Staff, in quality assurance activities and utilization review activities, whether related to oneself or others.

(j) Work in a cooperative, professional, and civil manner and refrain from any behavior or activity that is disruptive to Hospital operations.

(k) Cooperate in any relevant or required review of an AHP's (including his/her own) credentials, qualifications, or compliance with this Policy; and refrain from directly or indirectly interfering,

obstructing, or hindering any such review, by withholding information, or by refusing to perform or participate in assigned responsibilities or otherwise.

(l) Promptly notify the Medical Staff President, Chief Medical Officer, Chief Clinical Officer, or the Hospital's Chief Executive Officer of any changes in the information provided to the Hospital by the AHP regarding his/her Privileges during all periods in which the AHP holds Privileges at the Hospital.

2.8-2 Failure to satisfy any of the aforementioned obligations may be grounds for denial of a regrant of Privileges, restriction or revocation of Privileges, or other corrective action pursuant to this Policy.

2.9 RESPONSIBILITIES OF PRACTITIONERS WHO SUPERVISE OR COLLABORATE WITH AHPS

2.9-1 Practitioners who supervise or collaborate with an AHP with Privileges at the Hospital shall:

(a) Submit a signed attestation regarding the AHP's credentials as part of the AHP's application for Privileges.

(b) Acquaint the AHP with the applicable policies of the Medical Staff and/or Hospital as well as the Practitioners and Hospital personnel with whom the AHP shall have contact.

(c) Adhere to the requirements of the AHP's Privilege set and any supervision agreement or standard care arrangement, and otherwise provide appropriate supervision or collaboration consistent with this Policy, accrediting agency requirements and applicable law.

(i) It shall be the responsibility of the supervising Physician to have a current, valid supervision agreement with his/her physician assistant and to assure that the agreement is renewed in a timely manner in accordance with Ohio State Medical Board requirements.

(ii) It shall be the responsibility of the advance practice nurse to maintain, if applicable, a current, valid standard care arrangement, in accordance with applicable law, with his/her collaborating Practitioner.

(d) Provide immediate notice to Medical Staff Services when the Practitioner receives notice of (i) any grounds for suspension or termination of the AHP as required by the terms of the standard care arrangement or supervision agreement; or (ii) the occurrence

of any action that establishes grounds for corrective action against the AHP.

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

(f) Acknowledge and convey to the AHP that the Privileges of the AHP at the Hospital shall be automatically suspended if the AHP's supervision agreement or standard care arrangement expires or is terminated; or, in the event that the Medical Staff appointment and/or Privileges of the supervising/collaborating Appointee lapse, are suspended, or terminated for any reason. In such event, if the AHP does not submit a new, executed standard care arrangement or supervision agreement with another Medical Staff Appointee with Privileges at the Hospital within thirty (30) days of the automatic suspension, the AHP's Privileges shall automatically terminate. Such automatic suspension/termination of Privileges shall not constitute an event that gives rise to any procedural due process rights pursuant to this Policy.

2.9-2 The employer of an AHP shall furnish evidence of Professional Liability Insurance for his/her employee and shall assume full responsibility for care delivered by the AHP and be fully accountable for the conduct of the AHP within the Hospital.

2.9-3 Failure to properly supervise and/or collaborate with the AHP shall be grounds for corrective action against an Appointee under the Medical Staff Bylaws.

ARTICLE 3: CREDENTIALING AND PRIVILEGING PROCEDURES

3.1 NATURE OF PRIVILEGES

An AHP who is granted Privileges is entitled to exercise such Privileges and is responsible for fulfilling such obligations as are set forth in this Policy and the applicable Privilege set. No AHP, including those employed by or contracted with the Hospital, may provide any clinical services to patients in the Hospital unless he/she has been granted Privileges to do so in accordance with the procedures set forth in this Policy.

3.2 APPLICATION

3.2-1 **Purpose**

The purpose of the application is to assure the compilation of sufficient information to establish general competency in the areas of patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

3.2-2 **Content of Application**

Applications for Privileges only shall contain the following:

(a) Detailed information concerning the AHP's qualifications including documentation in satisfaction of the basic requirements set forth in this Policy and the applicable Privilege set.

(b) A specific request for the Privileges for which the AHP wishes to be considered. To the extent the AHP believes his/her request for Privileges will or may require resources not currently available at the Hospital, the AHP is responsible for advising the Hospital of such circumstances so that the Hospital may properly assess whether such resources will be made available.

(c) A complete chronological description of the AHP's education and training.

(d) A complete chronological description of the AHP's professional experience/work history.

(e) The names of at least three (3) Practitioners or AHPs in the AHP's same professional discipline with personal knowledge (must have worked with the AHP at least three (3) months within the past three (3) years) of the AHP's ability to practice. Peer references may not be provided by the AHP’s relatives. Not more than one (1) peer reference may be from the AHP's partner(s) or affiliate(s).

One (1) peer reference shall be from the chair of the clinical department in which the AHP has or most recently had privileges at another hospital, or from the director of the clinical training program from which the AHP recently graduated. Peer recommendations shall be submitted on a Hospital approved form and include information regarding the AHP's: medical/clinical knowledge; technical/clinical skills; clinical judgment; interpersonal skills; communication skills and professionalism. Peer recommendations may include written documentation reflecting informed opinions on the AHP's scope and level of performance or a written peer evaluation of AHP-specific data collected from various sources for the purpose of validating current competence.

(f) Information as to whether the AHP's clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other health care entity or are currently being investigated or challenged.

(g) A copy of all current, valid professional licenses/certificates, certifications, DEA/controlled substance registration, and/or CTP; the date of issuance; license, certificate, registration, or provider number; and information as to whether the AHP's license, certificate, registration, or provider number has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged.

(h) Documentation for the past ten (10) years of Professional Liability Insurance coverage including: the names of present and past insurance carriers and any information concerning the AHP's professional liability litigation experience; past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings; and, the ultimate disposition.

(i) Information as to whether the AHP has ever been named as a defendant in a criminal action and/or convicted of or pled guilty or no contest to a crime (other than minor traffic offenses).

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

(k) Documentation of compliance with any Board approved conflict of interest policy, as such policy may change from time to time.

(l) Information regarding the AHP's ability to safely and competently exercise the Privileges requested with or without a reasonable accommodation.

(m) Results of the AHP's criminal background check.

(n) A current, valid picture identification issued by a state or federal agency (*e.g.,* a driver's license). The picture will remain in Medical Staff Services for purposes of verifying that the AHP requesting Privileges is the same AHP identified in the credentialing documents. The picture will not be circulated with the application during the credentialing process, with the exception that the picture identification will be made available to the appropriate chair during the interview process.

(o) The AHP's signature and current date.

3.2-3 **Effect of Application**

By signing and submitting an application for Privileges, the AHP:

(a) Attests to the truthfulness of the information provided and acknowledges that any material misstatement(s) in or omission(s) from the application constitutes grounds for denial of the application or termination of Privileges. In either situation, there shall be no entitlement to the procedural due process rights set forth in this Policy except for the limited purpose of resolving any dispute as to the actual facts.

(b) Attests that the AHP has received, or has access to, this Policy and, to the extent applicable, the Medical Staff Bylaws, other Policies, and Rules & Regulations, and that he/she agrees to comply with and be bound by the terms thereof, including the authorization, confidentiality, immunity, and release of liability provisions in this Policy and the obligation to exhaust all administrative remedies provided by this Policy before resorting to legal action.

(c) Acknowledges his/her responsibility to meet the obligations set forth in this Policy and the applicable Privilege set.

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

(e) Agrees to notify Medical Staff Services immediately if any information contained in the application changes. The foregoing

obligation shall be a continuing obligation of the AHP so long as he/she has Privileges at the Hospital.

(f) Agrees to comply in all respects with the Hospital's organizational integrity program and notice of privacy practices, and applicable Hospital and Medical Staff policies and procedures.

(g) Acknowledges that the Hospital and Affiliate Hospital(s) are part of the Health System, and that information is shared within the Health System. As a condition of a grant of Privileges, the AHP recognizes and understands that any and all information relative to his/her exercise of Privileges may be shared between the Hospital and Affiliate Hospitals, including peer review that is maintained, received and/or generated by any of them. The AHP further understands that this information can and will be used as part of the respective Hospital's/Affiliate Hospital(s)' quality assessment and improvement activities and can form the basis for corrective action.

3.3 BURDEN OF PRODUCING INFORMATION

3.3-1 AHPs seeking Privileges or a regrant of Privileges have the burden of:

(a) Producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, professional ethics, and other qualifications and for resolving any concerns of the Medical Staff or Hospital.

(b) Appearing for personal interviews, if required, in support of his/her application.

(c) Providing a complete application, including adequate responses from references and evidence that all the statements made, and information given on the application are accurate and complete. An application will not be considered until it is deemed "complete."

(i) An application shall be deemed complete when all questions on the application form have been answered, all related documentation has been supplied, and all information has been appropriately verified.

(ii) An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. If an AHP's file remains incomplete ninety (90) days after the initial application for Privileges, or more than thirty (30) days after any request that the AHP provide additional information, the AHP will be deemed to have withdrawn his/her application. The AHP shall be notified that his/her

application is deemed to have been withdrawn, and that the AHP shall not be entitled to the procedural rights set forth in this Policy with respect to such application. Thereafter, the AHP will need to submit a new application for Privileges.

(iii) The application fee will not be refunded once primary source verification has begun.

(d) Resolving any reasonable doubts with respect to the application and of satisfying reasonable requests for information. This burden may include submission to a medical or cognitive examination, at the AHP's expense, if deemed appropriate for the Privileges requested. In such event, the MEC will select the service provider.

3.4 PROCEDURE FOR GRANTING INITIAL PRIVILEGES

3.4-1 **Request for Application**

Applications shall be in writing and on forms approved by the Board upon recommendation of the MEC. The application form and eligibility criteria for Privileges shall be made available to AHPs.

3.4-2 **Procedure**

(a) A completed application form with copies of all required documents must be returned as provided for in the application within the time period set forth in the CVO Operating Manual. The application must be accompanied by the application fee.

(b) Upon receipt, the application will be reviewed by the CVO to determine that all questions have been answered and that the AHP satisfies all threshold criteria in which event a credentials file shall be established for the AHP. AHPs who fail to return completed applications within the established time period or who fail to meet the threshold criteria will be notified that their application will not be processed with an explanation of the reason for this action.

(c) The CVO will oversee the process of gathering and verifying relevant information, confirming that all references and other information or materials deemed pertinent have been received, and making all appropriate queries, including to the National Practitioner Data Bank, as applicable.

3.4-3 **Interviews**

One (1) or more interviews with the AHP will be conducted. The purpose of the interview(s) is to discuss and review the AHP's qualifications for Privileges. Interviews may be conducted by one (1) or more of the following: the Department Chair (or a designated representative), the MEC (or a designated representative), the Medical Staff President, or the Chief Medical Officer.

3.4-4 **Department Chair Procedure**

(a) The CVO shall transmit the complete application and all related materials to the chair of each Department in which the AHP seeks Privileges.

(b) Each such Department Chair shall complete a form evaluating the evidence of the AHP's training, experience, and demonstrated ability. In doing so, the Department Chair may:

(i) Refer the matter back to the CVO for further consideration and responses to specific questions raised by the Department Chair prior to issuing his/her findings. In such instance, the Department Chair shall set a time frame within which the CVO must respond.

(ii) Defer the application for further consideration. In such event, except for good cause, the Department Chair must issue his/her findings within thirty (30) days thereafter. The Medical Staff President shall advise the AHP in writing, by Special Notice, of any action to defer, including a request for the specific data/explanation or release/authorization, if any, required from the AHP and the time frame for response. Failure of the AHP, without good cause, to respond with the requested information within the specified time frame shall be deemed a voluntary withdrawal of the application.

(c) The completed form shall be forwarded to the MEC and shall state the Department Chair's opinion as to whether the AHP has satisfied all of the qualifications for Privileges along with the chair's opinion as to approval or denial of, and any special limitations on, Department/Section assignment, if any, and Privileges.

(d) The Department Chair shall be available to the MEC and the Board to answer any questions that may be raised with respect to the Department Chair's findings.

(e) If the Department Chair fails to submit a completed form within the time period set forth in §3.4-10, the MEC, after querying the Department Chair as to the cause for the delay and establishing a specified period in which a response is to be made, may proceed with its review and recommendation.

3.4-5 **Medical Executive Committee Procedure**

(a) At its next regular meeting after receipt of the Department Chair's recommendation, the MEC may:

(i) Adopt the findings and recommendation of the Department Chair as its own.

(ii) Refer the matter back to the Department Chair for further consideration and responses to specific questions raised by the MEC prior to its final recommendation. In such instance, the MEC shall set a time frame within which the Department Chair must respond.

(iii) Defer the application for further consideration. In such event, except for good cause, a recommendation must be made within thirty (30) days thereafter. The Medical Staff President shall advise the AHP in writing, by Special Notice, of any action to defer, including a request for the specific data/explanation or release/authorization, if any, required from the AHP and the time frame for response. Failure by the AHP, without good cause, to respond with the requested information within the specified time frame shall be deemed a voluntary withdrawal of the application.

(iv) Make a recommendation different from that of the Department Chair stating the basis for its disagreement.

(b) If the recommendation of the MEC is to grant Privileges, the recommendation shall be forwarded to the Medical Staff President for presentation, together with all accompanying information, at the next regularly scheduled Board meeting for a final decision.

(c) If the recommendation of the MEC is Adverse, the recommendation shall be forwarded to the Medical Staff President who shall promptly notify the AHP, by Special Notice, of the MEC's recommendation and of the AHP's procedural rights, if any, as provided in this Policy. The Medical Staff President shall then hold the application until after the AHP has exercised or waived

his/her procedural due process rights, if any, at which time a final decision shall be made by the Board.

3.4-6 **Board Action**

(a) At its next regularly scheduled meeting following receipt of the MEC's recommendation, the Board may take any of the following actions:

(i) Defer the application for further consideration. If, as part of its deliberations pursuant to this section, the Board determines that it requires further information, it may defer action and shall notify the AHP and the Medical Staff President in writing of the deferral and the grounds, therefore. If the AHP is to provide the additional information, the Board chair shall advise the AHP, by Special Notice, including a request for the specific data/explanation or release/authorization, if any, required from the AHP and the time frame for response. Failure by the AHP, without good cause, to respond with the requested information within the time frame specified shall be deemed a voluntary withdrawal of the application.

(ii) Adopt, in whole or in part, the recommendation of the MEC.

(iii) Refer the matter back to the MEC for further consideration and responses to specific questions raised by the Board prior to its final decision. In such instance, the Board shall set a time limit within which the MEC must respond.

(iv) Reject, in whole or in part, the recommendation of the MEC.

(v) Act without benefit of the MEC's recommendation. If the Board, in its determination, does not receive a recommendation from the MEC in timely fashion the Board may, after notifying the MEC of its intent, including a reasonable period of time for response, take action on its own initiative employing the same type of information usually considered by the Medical Staff leadership.

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

(c) In the case of an Adverse MEC recommendation, the Board shall take final action in the matter as provided in §3.4-5 (c).

(d) If the Board's action is Adverse to the AHP, the Board chair shall promptly inform the AHP, by Special Notice, of the Board's action and of the AHP's procedural rights, if any, as provided in this Policy. The Board shall not take final action on the application until after the AHP has exercised or waived his/her procedural due process rights, if any.

(e) In the event that an AHP withdraws his/her initial application prior to commencement of his/her procedural due process rights, the withdrawal shall be deemed to be a voluntary withdrawal of the application, and the AHP's file shall be closed. Upon the commencement of the procedures set forth in Article 7 on an initial application, the application may no longer be voluntarily withdrawn; rather the process shall be completed, and final decision rendered by the Board.

3.4-7 **Conflict Resolution**

Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC, the matter will be submitted to an *ad hoc* Joint Conference Committee for review and recommendation before the Board makes its decision. The *ad hoc* Joint Conference Committee shall be composed of not less than two (2) Medical Staff Members selected by the Medical Staff President and not less than two (2) members of the Hospital Board, selected by the Board chair. There shall be an equal number of Medical Staff Members and Board members on the Joint Conference Committee. The Medical Staff President and Board chair shall each appoint one of its Joint Conference Committee designees to serve as co-chair of the committee.

3.4-8 **Procedure for Application for Privileges at Hospital and Affiliate Hospitals**

(a) In the event that an AHP applies for appointment and/or Privileges at the Hospital and one (1) or more Affiliate Hospitals, he/she shall be asked to declare on the application a primary affiliation with the Hospital or Affiliate Hospital at which he/she intends to concentrate the majority of his/her clinical activity.

(b) The CVO, upon receipt of the application, shall follow the process set forth in §§3.4-2 and 3.4-3.

(c) The Department Chairs at the Hospital each of Affiliate Hospital(s) to which the AHP has applied shall, upon receipt of the application, follow the process set forth in §3.4-4.

(d) If the Hospital is identified as primary, the MEC shall, upon receipt of the application, make a recommendation in accordance with the

process set forth in §3.4-5. The AHP Credentials Committee of the Affiliate Hospital(s) to which the AHP has applied shall table the application. The Hospital's MEC shall notify the AHP Credentials Committee chair of its recommendation with regard to the application.

(i) If the AHP Credentials Committee agrees with the recommendation, the Hospital's MEC recommendation shall be adopted by the AHP Credentials Committee and the recommendations of the AHP Credentials Committee shall be forwarded to the MECs of the respective Affiliate Hospital(s).

(ii) If the AHP Credentials Committee does not agree, representatives from the Hospital's MEC and the AHP Credentials Committee shall meet jointly to review the application and determine if consensus can be achieved. If consensus is reached, the recommendation is forwarded to the MEC of the respective Affiliate Hospital(s). If consensus cannot be reached, the differing recommendations shall be forwarded to the respective Affiliate Hospital MECs.

(e) The Affiliate MECs shall, upon receipt of the application, take the following actions:

(i) If the recommendations of the Hospital's MEC and AHP Credentials Committee are the same, the Affiliate MECs shall follow the process set forth in §3.4-5 (b) or (c), as applicable.

(ii) If the recommendations of the Hospital's MEC and the AHP Credentials Committee are different, the MECs of the Hospital and the respective Affiliate Hospital(s) shall meet jointly to achieve an agreed to recommendation. The MECs may, at their sole discretion, designate subcommittees (rather than the full MECs) to meet and report actions back to their respective MECs for adoption.

a) If the recommendation of the respective MEC following the joint meeting is favorable to the AHP, the MEC shall follow the process set forth in §3.4-5 (b).

b) If recommendation of the respective MEC is Adverse to the AHP following the joint meeting, the MECs shall follow the process set forth in §3.4-5 (c).

c) If the recommendations of the respective MEC continue to differ following the joint meeting, then the affirmative recommendation(s) shall be held in abeyance until the AHP has exercised or waived his/her procedural due process rights, if any, at the Affiliate Hospital whose MEC issued the Adverse recommendation.

3.4-9 **Notice of Final Decision**

(a) Notice of the Board's final decision shall be given by the CEO to the Medical Staff President, the MEC, each applicable Department Chair, and to the AHP by Special Notice.

(b) A decision and notice to grant Privileges shall include, as applicable, the Department to which the AHP is assigned, the Privileges granted, and any special conditions attached to the Privileges.

3.4-10 **Time Periods for Processing Applications**

Completed applications for Privileges shall be considered in a timely and good faith manner by all individuals and groups required to act thereon. The time periods set forth in the CVO Operating Manual provide guidelines to assist these individuals and groups in meeting their obligations and do not create any right for the AHP to have his/her application processed within such periods. This provision shall not apply to the time periods contained in Article 7 of this Policy. When an AHP's procedural due process rights are activated by an Adverse recommendation or action, as provided herein, the time requirements set forth therein shall govern the continued processing of the application.

3.5 REAPPLICATION AFTER FINAL ADVERSE DECISION, RESIGNATION, WITHDRAWAL OR AUTOMATIC TERMINATION

An AHP whose Privileges are automatically terminated pursuant to §7.6-1 of this Policy, who has received a final Adverse decision regarding Privileges/regrant of Privileges, or who has resigned, or withdrawn an application for, Privileges/regrant of Privileges while under investigation or to avoid an investigation may not reapply for Privileges for a period of at least one (1) year from the later of: (i) the effective date of the automatic termination; (ii) the date of the notice of the final Adverse decision; (iii) the effective date of the resignation or application withdrawal; or, (iv) the final court decision, as applicable. Any re-application after the one (1) year period will be processed as an initial application, and the AHP must submit such additional information as required by the MEC, or the Board to show that any basis for the earlier termination, resignation, withdrawal, or Adverse decision has been resolved.

3.6 RESIGNATION/TERMINATION

3.6-1 **Resignation of Privileges**

(a) An AHP with Privileges who determines to no longer exercise, or wishes to restrict or limit the exercise of, particular Privileges which he/she has been granted should send at least thirty (30) days prior written notice to the Medical Staff President indicating the same and identifying the limitation. A request to resign Privileges will be presented to the respective Department Chair, the MEC, and the Board.

(b) Upon review, the Board shall determine if the AHP resigned his/her Privileges in Good Standing. When an AHP does not resign his/her Privileges in Good Standing, consideration shall be given by the Board to notifying the applicable state licensing board.

(c) Notification of the resignation shall be forwarded to all appropriate Hospital personnel. The Chief Executive Officer will notify the AHP of the Board's receipt of his/her resignation.

3.6-2 **Termination of Privileges**

(a) In those cases when an AHP moves away from the area without submitting a forwarding address or the AHP's written intentions with regard to his/her Privileges, the AHP's Privileges shall be terminated upon approval of the MEC and the Board. If a forwarding address is known, the AHP will be asked his/her intentions with regard to the Privileges and, if the AHP does not respond within thirty (30) days, the AHP's name will be submitted to the MEC and Board for approval of termination.

(b) In the event the AHP is not in Good Standing when his/her Privileges are terminated, consideration shall be given by the Board to notifying the applicable state licensing board. The Chief Executive Officer will inform the AHP of the approved termination by Special Notice.

3.6-3 **No Procedural Due Process Rights**

Provided a resignation or termination pursuant to §§3.6-1 or 3.6-2 above is determined by the Board to be voluntary, such resignation or termination shall not give rise to any procedural due process rights under this Policy.

ARTICLE 4:
PROCEDURE FOR REGRANT OF PRIVILEGES

4.1 APPLICATION FOR REGRANT OF PRIVILEGES

4.1-1 **Due Date**

An application for regrant of Privileges shall be furnished to an AHP prior to the expiration of his/her current Privilege term in accordance with the time frames set forth in the CVO Operating Manual. A completed application must be returned to the CVO within the specified time frame. Failure to submit a complete application within the time frame set forth in the CVO Operating Manual shall result in termination of Privileges at the end of the AHP's current term. Any application filed after such termination pursuant to this section shall be treated as an initial application.

4.1-2 **Time Period**

Regrant of Privileges shall be for a period of not more than two (2) years. A regrant of Privileges for less than two (2) years shall not be deemed Adverse.

4.2 REVIEW OF APPLICATION

4.2-1 Appraisal for regrant of Privileges will be based upon the following:

(a) Updated information provided on the application form.

(b) Ongoing professional practice evaluation data including, but not limited to, data regarding current clinical competence (including morbidity/mortality data to the extent available), judgment, and technical skill in the treatment of patients. If the AHP is subject to the Hospital's low volume/no volume policy, the AHP bears the burden of submitting such additional information as may reasonably be requested to establish current clinical competency before the application will be considered complete and further processed.

(c) Compliance with this Policy and, as applicable, the Medical Staff Bylaws, Rules and Regulations, and Hospital, other Medical Staff, and Department policies.

(d) Fulfillment of his/her AHP duties.

(e) Behavior at the Hospital, including the ability to work harmoniously with all members of the patient care team; recognition of the importance of, and willingness to support, the Hospital's and

Medical Staff's commitment to quality care; and recognition that interpersonal skills, collaboration, communication, and collegiality are essential for the provision of quality patient care.

(f) Current ability to safely and competently exercise the Privileges requested with or without reasonable accommodation.

(g) Capacity to satisfactorily treat patients as indicated by the results of the Hospital's performance improvement and professional and peer review activities.

(h) Appropriate resolution of any verified complaints from patients and/or Hospital staff (defined as no further action deemed necessary by the Hospital or the MEC).

(i) Other reasonable indicators of continuing satisfaction of the qualifications for Privileges.

(j) Attestation of continuing professional training and education activities completed during the prior Privilege period. The Hospital reserves the right to audit such activities upon request.

(k) Any requests for additional or reduced Privileges.

(l) Any requests for changes in Department/Section assignment, if applicable.

(m) Such other information as requested by the Hospital or Medical Staff.

4.3 PROCESSING APPLICATIONS FOR REGRANT OF PRIVILEGES

4.3-1 **In General**

Applications for regrant of Privileges shall be processed in the same manner and pursuant to the same guidelines as those set forth for initial applications for Privileges. In the event that an AHP applies for regrant of Privileges at more than one (1) System Hospital, the process set forth in §3.4-9 shall be followed with the exception that in §3.4-9 (c) only the primary Hospital Department Chair shall review the application and make a recommendation thereon.

4.3-2 **Discretionary Meeting**

The Department Chair or the MEC may meet with the AHP at any time during the process. This meeting is not a hearing, and none of the procedural rights set forth in this Policy shall apply. The Department Chair or applicable committee shall indicate as part of its report whether

such a meeting occurred and shall include a summary of the meeting as part of its minutes.

4.4 REQUESTS FOR MODIFICATION OF PRIVILEGES

An AHP who seeks modification of Privileges may submit such a request at any time upon a form developed by the MEC and approved by the Board, except that such application may not be filed within six (6) months of the time a similar request has been denied unless a different time period is approved by the Board. A request for modification of Privileges shall be processed in the same manner as an application for a regrant of Privileges. The applicable Department Chair will determine the need for focused professional practice evaluation when reviewing requests for new/additional Privileges. An AHP is required to continue to meet all of his/her current responsibilities until such time as the modification request has been approved by the Board.

ARTICLE 5:
DELINEATION OF CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

An AHP may only exercise the Privileges specifically granted to him/her.

5.2 BASIS FOR PRIVILEGES DETERMINATION

Privileges recommended to the Board shall be based upon proof of general competency in the areas of patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice consistent with this Policy and the *OPPE FPPE for Current Practitioners and FPPE and OPPE for New Practitioner Policies*, as such policies may be amended from time to time.

5.3 REQUESTS FOR AND GRANTING OF PRIVILEGES

An application for Privileges must contain a written request for all Privileges sought by the AHP. Requests for Privileges shall be processed in accordance with the procedures outlined in Article 3 or 4, as applicable. Requests for temporary Privileges shall be processed according to §5.5-1 of this Article.

5.4 RECOGNITION OF A NEW SERVICE OR PROCEDURE

5.4-1 **Need for Privilege Criteria**

A Privilege set must be approved by the Board for all new services and procedures except for those that are clinically or procedurally similar to an existing modality.

5.4-2 **Considerations**

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

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

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

(c) The availability of qualified Practitioner(s)/AHP(s) with Privileges at the Hospital to provide coverage for the procedure when needed.

(d) The quality and availability of training programs.

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

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

5.4-3 **Privilege Requests for a New Service or Procedure**

(a) Requests for Privileges for a service or procedure that has not yet been recognized by the Board shall be processed as follows in accordance with the *Request for New or Non-Credentialed Procedures Policy*, as such policy may be amended from time to time.

(b) If the Board approves the Privileges for a new service or procedure, the requesting AHP(s) may apply for such Privileges consistent with this Policy. If the Board does not approve the Privileges for a new service or procedure, the requesting AHP(s) will be so notified. A decision by the Board not to recognize a new service or procedure does not constitute an appealable event for purposes of this Policy.

5.5 TYPES OF PRIVILEGES

5.5-1 **Temporary Privileges**

(a) **Conditions**

Temporary Privileges may be granted only in the circumstances and under the conditions described below. Special requirements of consultation and reporting may be imposed by the Department Chair responsible for supervision of the AHP exercising temporary Privileges as applicable. Under all circumstances, the AHP requesting temporary Privileges must agree in writing to abide by this Policy and, as applicable, to the Bylaws, other Policies, Rules & Regulations, and policies of the Hospital in all matters relating to his/her activities in the Hospital.

(b) **Circumstances**. Upon recommendation of the Medical Staff President, the Hospital CEO may grant temporary Privileges on a case-by-case basis in the following circumstances:

(i) **Pendency of a Completed Application**: To an applicant for new Privileges but only after: receipt of a completed application; consultation with the chair of the applicable Department; verification of the qualifications required by this Policy relating to current licensure, competency, relevant professional education, training, and experience,

CTP and DEA/controlled substances registration, and adequate Professional Liability Insurance; completion and evaluation of National Practitioner Data Bank queries, as applicable; a fully positive written reference specific to the AHP's current competence for the Privileges being requested from a responsible medical staff authority at the AHP's current hospital affiliation; ability to perform the Clinical Privileges requested; results of a criminal background check; and a positive recommendation by the MEC or, if so authorized by the MEC, the Medical Staff President. Along with the completed application, the record must establish that the AHP has no current or previously successful challenges to his/her licensure or registration; has not been subject to any involuntary limitation, reduction, denial, or loss of privileges; and has not been suspended or terminated from any Federal Healthcare Program.

Temporary Privileges may be granted in this circumstance for a period not to exceed the pendency of the application or one hundred twenty (120) days, whichever is less. Under no circumstances may temporary Privileges be initially granted or renewed if the application is still pending because the AHP has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

(ii) **Important Patient Care Need:** To an AHP to meet an important patient care need (*e.g*., care of a specific patient or class of patients, necessary to prevent a lack or lapse of services in a needed specialty area, *etc.*) but only after: receipt of a written request for the specific Privileges desired; telephone verification (or receipt of a copy) of appropriate current licensure; CTP/DEA/controlled substances registration, and adequate Professional Liability Insurance; a fully positive written reference specific to the AHP's current competence for the Privileges being requested from a responsible medical staff authority at the AHP's current hospital affiliation; results of a National Data Bank query, as applicable; and, results of a criminal background check.

Temporary Privileges may be granted in this circumstance for an initial period of thirty (30) days and may be renewed for additional thirty (30) day periods as necessary. Temporary Privileges granted for an important patient care need shall be restricted to the specific patients or class of patients for which they are granted.

5.5-2 ***Locum Tenens* Privileges**

AHPs seeking *locum tenens* Privileges shall submit an application for such Privileges and shall have such application processed in accordance with Article 3. An approved application for Privileges as a *locum tenens* shall be valid for a period of one (1) year. In exceptional circumstances, a *locum tenens* AHP may initially qualify for temporary Privileges pursuant to §5.5-1 above. For purposes of this Policy, the term "locum tenens" shall include AHPs providing temporary coverage during another AHP's absence (*e.g.,* due to illness, vacation, *etc.*) and those AHPs who provide additional temporary staffing at the Hospital as needed from time to time at the request of the Hospital.

5.5-3 **Emergency Privileges**

In case of an emergency as defined in this paragraph, any AHP is authorized and shall be assisted to render treatment to attempt to save the patient's life, or to save the patient from serious harm, as permitted within the AHP's scope of practice, and notwithstanding the AHP's Department/Section affiliation or level of Privileges. An AHP exercising emergency Privileges must obtain all consultative assistance deemed necessary and arrange for appropriate post-emergency care. For purposes of this section, "emergency" is defined as a situation where serious permanent harm is imminent or in which the life of a patient is in immediate danger and delay in administering treatment could increase the danger to the patient.

5.5-4 **Disaster Privileges**

(a) Disaster Privileges may be granted to volunteer AHPs when the Hospital's emergency operations plan is activated in response to a disaster and the Hospital is unable to meet immediate patient needs.

(b) The Chief Executive Officer or Medical Staff President may grant such disaster Privileges on a case-by-case basis after verification of a valid government-issued picture identification in addition to at least one (1) of the following: (i) primary source verification of licensure, certification, or registration; (ii) a current license, certificate, or registration to practice; (iii) a current picture identification card from a health care organization that identifies professional designation; (iv) identification indicating the individual is a member of a Disaster Medical Assistance Team ("DMAT"), The Medical Reserve Corps. ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP") or other recognized state or federal response organization

or group; (v) identification indicating the individual has been granted authority to render patient care, treatment or services in disaster circumstances by a government entity; or, (vi) confirmation of the identity of the volunteer AHP and his/her qualifications by a Hospital employee or Practitioner/AHP with Hospital Privileges.

(c) The granting of disaster Privileges shall be done in the same manner as for temporary Privileges to meet an important patient care need to meet an important patient care need, except that primary source verification of licensure, certification, or registration may be performed after the situation is under control and as circumstances allow. It is anticipated that these disaster Privileges may be granted to state-wide and out-of-state AHPs as necessary.

(d) Primary source verification of licensure, certification, or registration shall be conducted as soon as the immediate situation is under control, or within seventy-two (72) hours from the time the volunteer AHP presents to the Hospital, whichever comes first. If primary source verification cannot be completed within seventy-two (72) hours (due to, for example, no means of communication or a lack of resources), verification shall be performed as soon as possible. In such event, the Hospital will document why primary source verification could not be performed in the required time frame; evidence of the volunteer AHP's demonstrated ability to continue to provide adequate care, treatment, and services; and, an attempt to rectify the situation as soon as possible. A reassessment/decision must be made within seventy-two (72) hours after initial disaster Privileges have been granted to determine if there should be a continuation of disaster Privileges for the volunteer AHP.

(e) All AHPs who receive disaster Privileges shall be issued a temporary Hospital identification badge to assist Hospital and Medical Staff personnel to readily identify these volunteer AHPs.

(f) The activities of AHPs who receive disaster Privileges shall be managed by and under the supervision of the Medical Staff President or an appropriate designee (*e.g.,* the chair of the Department of emergency services).

(g) The disaster Privileges shall cease upon alleviation of the circumstances of disaster as determined by the Chief Executive Officer.

5.6 TERMINATION OF TEMPORARY, *LOCUM TENENS*, EMERGENCY, OR DISASTER PRIVILEGES.

5.6-1 Termination

The Chief Executive Officer or the Medical Staff President may, at any time, terminate any or all of an AHP's temporary, *locum tenens*, emergency, or disaster Privileges. Where the life or well-being of a patient is determined to be endangered, the AHP's Privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Bylaws.

5.6-2 Due Process Rights

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

5.6-3 Patient Care

In the event an AHP's Privileges are revoked, the AHP's patients then in the Hospital shall be assigned to another Practitioner or AHP by the Medical Staff President. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner or AHP.

5.7 FOCUSED PROFESSIONAL PRACTICE EVALUATION.

The Hospital's focused professional practice evaluation ("FPPE") process is set forth, in detail, in the Professional Practice Evaluation Policy and shall be implemented for all: (a) AHPs requesting initial Privileges; (b) existing AHPs requesting Privileges during the course of a Privilege period; and (c) in response to concerns regarding an AHP's ability to provide safe, high quality patient care. The FPPE period shall be used to determine the AHP's current clinical competence and ability to perform the requested Privileges.

5.8 ONGOING PROFESSIONAL PRACTICE EVALUATION.

Upon conclusion of the FPPE period, ongoing professional practice evaluation ("OPPE") shall be conducted on all AHPs with Privileges. The Hospital's OPPE process is set forth, in detail, in the *OPPE FPPE for Current Practitioners Policy* and requires the Hospital to gather, maintain and review data on the performance of all AHPs with Privileges on an ongoing basis.

ARTICLE 6: LEAVE OF ABSENCE

6.1 GENERALLY

6.1-1 General

An AHP may request a voluntary leave of absence ("LOA") from the MEC or may be put on an administrative LOA. The Medical Staff President, with the concurrence of the MEC, may grant a voluntary LOA if conditions warrant such action. The Medical Staff President, with the concurrence of the Chief Medical Officer, may place an AHP on an administrative LOA if conditions warrant such action. An LOA means that the AHP may not exercise Privileges at the Hospital, and that the AHP's rights and responsibilities will be inactive, with the exception that the AHP's obligation to pay dues and assessments, if any, will continue unless waived by the MEC for good cause shown.

6.1-2 Medical Records/Patient Care

All medical record deficiencies must be resolved before an LOA is granted, unless the Medical Staff President grants a specific exemption based upon extraordinary circumstances. In addition, prior to an LOA being granted, the AHP shall have made arrangements, acceptable to the MEC, for the care of his/her patients during the leave.

6.1-3 Focused Professional Practice Evaluation

An AHP returning from an LOA six (6) months or more in duration will undergo a period of Focused Professional Practice Evaluation ("FPPE"). The FPPE will begin immediately upon the granting or reinstatement of Privileges and will follow the protocol outlined in the AHP's Department. The duration of FPPE can be modified at the discretion of the AHP's Department Chair.

6.1-4 Regrant of Privileges During LOA

In the event an AHP's Privilege period ends during the AHP's LOA, he/she may not apply for a regrant of Privileges during the LOA and the AHP's Privileges shall terminate at the end of his/her current Privilege period without recourse to the procedural due process rights set forth in this Policy.

6.1-5 Professional Liability Insurance Coverage During LOA

In order to qualify for reinstatement following an LOA, the AHP must maintain Professional Liability Insurance coverage during the LOA or purchase tail coverage for all periods during which the AHP held Privileges. The AHP shall provide information to demonstrate

satisfaction of continuing Professional Liability Insurance coverage, or tail coverage, as required by this provision upon request for reinstatement.

6.1-6 **Power of Attorney**

In the event the AHP is incapacitated or unavailable due to military obligation, the AHP's legal representative (*e.g.,* a POA) may act on the AHP's behalf.

6.2 VOLUNTARY LEAVE OF ABSENCE

6.2-1 **Request for Leave**

An AHP may request an LOA at any time by submitting a written request to the MEC stating the approximate period of the leave desired (which may not exceed one (1) year or be less than thirty (30) days), the reason for the leave, and a description of the activity that will occur during the leave. During the period of the leave, the AHP may not exercise Clinical Privileges at the Hospital, and the AHP's rights and responsibilities will be inactive. The obligation to pay dues and assessments, if any, will continue unless waived by the MEC for good cause shown. Subject to any limitations in this section, upon written request and a finding of good cause, the Medical Staff President, with the concurrence of the MEC, may extend an existing LOA, but in no event may an LOA be extended beyond one (1) year**.**

6.2-2 **Termination of Voluntary Leave**

At least thirty (30) days prior to the termination of a voluntary LOA, an AHP shall request reinstatement of Privileges by submitting a written notice to that effect to the MEC. The AHP must submit a summary of relevant activities during the leave and may be requested to submit proof of current competency and such additional information, as requested by the MEC, as is reasonably necessary to reflect that the AHP is qualified for reinstatement. If the AHP requested an LOA based upon health issues, the AHP may be requested to establish that the basis of these concerns has been resolved such that he/she is able to perform his/her Privileges with or without a reasonable accommodation. Once the AHP's request for reinstatement is deemed complete, the MEC shall take final action on the request for reinstatement and shall send notice of the MEC's decision to the AHP and to the Board of Directors. In the event of an Adverse action by the MEC, the AHP shall be entitled to the procedural due process rights granted under this Policy.

6.2-3 **Failure to Request Reinstatement**

Failure to timely request reinstatement will be deemed a voluntary resignation of Privileges without entitlement to any procedural due process pursuant to this Policy unless the MEC determines, after consultation with the Chief Medical Officer, that a reportable event exists. Reapplication will not be accepted for one (1) year after termination of Privileges; after that time, reapplication will be treated as a new application for Privileges.

6.3 ADMINISTRATIVE LEAVE OF ABSENCE

6.3-1 **Grounds**

In the event the Medical Staff President is unable to reasonably contact an AHP, and it appears that the AHP is absent from his/her practice, has a health problem, has a licensure problem, or if the Medical Staff President, in consultation with the Chief Medical Officer, believes that an AHP may not be currently competent to exercise existing Privileges, the Medical Staff President, with the concurrence of the Chief Medical Officer, may place the AHP on an administrative LOA. An administrative LOA means that the AHP may not exercise Privileges at the Hospital, and that the AHP's rights and responsibilities are inactive, with the exception that the obligation to pay dues and assessments, if any, continues.

6.3-2 **Notice**

The Medical Staff President shall send the AHP written notice, by Special Notice to the last known address of the AHP as reflected in the AHP's credentials file, of the action placing the AHP on an administrative LOA. Within thirty (30) days of receipt of the written notice the AHP may, in writing to the Medical Staff President, either:

(a) Request that the administrative LOA be changed to a voluntary LOA consistent with §6.2 of this Policy; or,

(b) Request that the administrative LOA be lifted explaining the reason(s) why the AHP has been out of contact.

Upon receipt of a request pursuant to (a), the process as set forth in §6.2 of this Policy will be followed. The administrative LOA will remain in effect until the voluntary LOA is granted or the request is denied, and alternative action is taken.

Upon receipt of a request pursuant to (b) above, the request must be granted; provided, however, that the Medical Staff President may thereafter take whatever other action is appropriate consistent with the applicable Medical Staff governing documents (*e.g.*, no action, imposition of a summary suspension, recommendation for corrective action, *etc*.)

6.3-3 **Failure to Request Reinstatement**. If an AHP placed on an administrative LOA does not contact the Medical Staff President, in writing, within thirty (30) days of receipt of the written notice from the Medical Staff President, the AHP shall be deemed to have voluntarily resigned his/her Privileges as of that date unless the circumstances are such that the MEC, in consultation with the Chief Medical Officer, determines that a reportable event exists.

ARTICLE 7: CORRECTIVE ACTION; SUMMARY SUSPENSION; AUTOMATIC SUSPENSION AND TERMINATION; PROCEDURAL DUE PROCESS

7.1 APPLICABILITY

The procedural due process rights set forth in this Policy are only applicable to AHPs applying for or granted Privileges through the Medical Staff process. The provisions of the Medical Staff Fair Hearing Policy setting forth the procedural due process rights of Medical Staff Appointees do not apply to AHPs.

7.2 ACTION ON APPLICATION FOR PRIVILEGES (RECOMMENDATION OF DENIAL OF PRIVILEGES)

7.2-1 Unless otherwise provided in this Policy, when the MEC proposes to make a recommendation to deny an application for Privileges or to modify or limit Privileges based upon quality of care or professional behavior concerns, the AHP shall be provided written notice, by Special Notice, of the MEC's proposed action. The AHP shall then have five (5) days in which to submit a written response to the MEC as to why such recommendation should be withdrawn and a favorable recommendation made. At the MEC's discretion, it may meet (or have a subcommittee of the MEC meet) with the affected AHP. After reviewing the AHP's written response and results of the meeting, if any, the MEC shall make its final recommendation to the Board. The AHP shall be advised, by Special Notice, of the MEC's final recommendation and, if applicable, the AHP's right to appeal.

7.2-2 If the MEC's recommendation continues to be unfavorable to the AHP, the AHP shall have five (5) days in which to submit a written appeal to the Board. At the Board's discretion, it may meet (or have a subcommittee of the Board meet) with the affected AHP. During this meeting, the basis of the Adverse action that gave rise to the appeal will be reviewed with the AHP, and the AHP will have the opportunity to present any additional information the AHP deems relevant to the review and appeal of the MEC's recommendation. After reviewing the recommendation of the MEC and the AHP's written response/appeal and results of meetings with the AHP, if any, the Board shall take action.

7.2-3 Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC and the matter has not previously been submitted to an *ad hoc* Joint Conference Committee, the matter will be submitted to such committee for review and recommendation before the Board makes its final decision.

7.2-4 The AHP will receive written notice, by Special Notice, of the Board's final decision.

7.3 CORRECTIVE ACTION; SUSPENSION/TERMINATION OF PRIVILEGES

7.3-1 Either the CEO or Medical Staff President has the right to limit an AHP's Clinical Privileges, up to and including suspension or termination, at any time when, in the judgment of the CEO or Medical Staff President such action is in the best interest of patient care.

7.3-2 Unless otherwise provided in this Policy, in the event the CEO or Medical Staff President:

(a) summarily suspends or immediately terminates an AHP's Privileges, such Adverse action shall become effective immediately but shall be followed by written notice of such action and the basis therefore, given to the AHP by Special Notice.

(b) seeks to recommend a suspension or termination of Clinical Privileges, the AHP shall be advised, by Special Notice, of the Adverse recommendation and the basis for such recommendation.

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

7.3-3 If the MEC's recommendation is unfavorable to the AHP, the AHP shall have five (5) days in which to submit a written appeal to the Board. At the Board's discretion, it may meet (or have a subcommittee of the Board meet) with the affected AHP. During this meeting, the basis of the Adverse action that gave rise to the appeal will be reviewed with the AHP, and the AHP will have the opportunity to present any additional information the AHP deems relevant to the review and appeal of the MEC's recommendation. After reviewing the recommendation of the CEO or Medical Staff President the recommendation of the MEC, and the AHP's written response/appeal and results of meetings with the AHP, if any, the Board shall take action.

7.3-4 Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC and the matter has not previously been submitted to an *ad hoc* Joint Conference Committee, the matter will be submitted to such committee for review and recommendation before the Board makes its final decision.

7.3-5 The AHP will receive written notice, by Special Notice, of the Board's final decision.

7.4 NOTICE TO EMPLOYER

When an AHP's Clinical Privileges are restricted, suspended or terminated, the AHP's employer (if applicable) shall be notified as to the reasons for such action.

7.5 AUTOMATIC SUSPENSION

7.5-1 Imposition of Automatic Suspension

The following events shall result in an automatic suspension or limitation of an AHP's Privileges without recourse to the procedural rights set forth in this Article.

(a) **Licensure**

Action by any federal or state authority suspending or limiting an AHP's professional license/certificate shall result in an automatic comparable suspension/limitation on the AHP's Privileges. Whenever an AHP's license/certificate is made subject to probation, the AHP's right to practice shall automatically become subject to the same terms of the probation.

(b) **Controlled Substance Authorization**

Whenever an AHP's CTP or federal or state-controlled substance registration/certificate is suspended, limited, or revoked, the AHP shall automatically and correspondingly be divested and/or limited of the right to prescribe medications covered by the registration/certificate as of the time such action becomes effective and through its term. Whenever an AHP's CTP or state or federal controlled substance registration/certificate is made subject to probation, the AHP's right to prescribe such medications shall automatically become subject to the same terms of the probation.

(c) **Federal Healthcare Program**

Whenever an AHP is suspended from participating in a Federal Healthcare Program, the AHP's Privileges shall be immediately and automatically suspended.

(d) **Professional Liability Insurance Coverage**

If an AHP's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases

to be in effect, in whole or in part, the AHP's Privileges shall be automatically suspended or restricted, as applicable, until the matter is resolved, and adequate Professional Liability Insurance coverage is restored or the AHP's Privileges are terminated pursuant to §7.6-1 (b). Medical Staff Services shall be provided with a copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the previous insurance cancellation or non-renewal, any limitation on the new policy, and a summary of relevant activities during the period of no coverage. For purposes of this section, the failure of an AHP to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this paragraph.

(e) **Failure to Complete Medical Records**

Whenever an AHP fails to complete medical records as provided for in the Medical Staff Rules & Regulations and/or applicable policies, the AHP's Privileges shall be automatically suspended if consistent with such Rules & Regulations or policies.

(f) **Standard Care Arrangement/Supervision Agreement**

Termination or expiration of the AHP's standard care arrangement or supervision agreement shall result in an automatic suspension of the AHP's Privileges.

(g) **Supervising/Collaborating Practitioner**

Lapse, suspension, or termination of the supervising or collaborating Practitioner's Medical Staff appointment and/or Privileges, for any reason, shall result in an automatic suspension of the AHP's Privileges.

(h) **Failure to Comply with Vaccination Policies**

If an AHP does not comply with applicable vaccination policies and fails to obtain required vaccinations, the AHP's Privileges shall be automatically suspended until the AHP provides proof of vaccination. For purposes of this section, the failure of an AHP to provide proof of vaccination shall constitute a failure to meet the requirements of this paragraph.

7.5-2 **Impact of Automatic Suspension/Limitation**

During such period of time when an AHP's Privileges are suspended or limited pursuant to §7.5-1 (a) – (d), (f), (g) or (h) above, he/she may not exercise any rights or Privileges at the Hospital. An AHP whose

Privileges are suspended or limited pursuant to §7.5-1 (e) is subject to the same limitations except that such AHP may:

(a) Attend an obstetrical patient who has been under his/her active care and management and who comes to term and is admitted to the Hospital.

(b) Attend to the management of any patient under his/her care whose admission or outpatient procedure was scheduled prior to the effective date of the suspension and which occurs within forty-eight (48) hours of the suspension.

7.5-3 Action Following Imposition

At its next regular meeting after imposition of an automatic suspension, or sooner if the MEC deems it appropriate, the MEC shall convene to determine if further corrective action is necessary in accordance with this Article. The lifting of the action or inaction that gave rise to an automatic suspension or limitation of the AHP's Privileges shall result in the automatic reinstatement of such Privileges; provided, however, that to the extent the suspension or limitation remained in effect for a period of more than thirty (30) days, the AHP shall be obligated to provide such information as Medical Staff Services shall reasonably request to assure that all information in the AHP's credentials file is current.

7.6 AUTOMATIC TERMINATION

7.6-1 Imposition of Automatic Termination

The following events shall result in an automatic termination of an AHP's Privileges without recourse to the procedural rights contained in this Article.

(a) **Licensure**

Action by any federal or state authority terminating a AHP's professional license/certificate shall result in an automatic termination of the AHP's Privileges.

(b) **Professional Liability Insurance**

If an AHP's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect for a period greater than thirty (30) days, the AHP's Privileges shall automatically terminate as of the thirty-first (31st) day. For purposes of this section, the failure of an AHP to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this paragraph.

(c) **Federal Healthcare Program**

Whenever an AHP is excluded from participating in a Federal Healthcare Program, the AHP's Privileges shall be automatically terminated.

(d) **Plea of Guilty to Certain Offenses**

If an AHP pleads guilty or no contest to, or is found guilty of a felony or other serious offense relating to controlled substances, illegal drugs, alcohol, insurance, or health care fraud or abuse, or violence, the AHP's Privileges shall be immediately and automatically terminated; provided, if the behavior which triggered the conviction is based upon the AHP's impairment, then the matter shall be referred to the Peer Support Committee for consideration and recommendation to the MEC as to what action should be taken.

(e) **Failure to Pay Dues/Assessments**

Failure to pay dues or fines as required within one hundred and twenty (120) days after the date that such dues or fines are due shall result in an automatic termination of the AHP's Privileges if consistent with applicable policy.

(f) **Standard Care Arrangement/Supervision Agreement**

If the AHP's Privileges are suspended pursuant to §7.5-1 (f) above and the AHP does not submit a new, executed standard care arrangement or supervision agreement with an Appointee with Privileges at the Hospital within thirty (30) days of the automatic suspension, the AHP's Privileges shall automatically terminate.

(g) **Supervising/Collaborating Practitioner**

If the AHP's Privileges are suspended pursuant to §7.5-1 (g) above and the AHP does not submit a new, executed standard care arrangement or supervision agreement with an Appointee with Privileges at the Hospital within thirty (30) days of the automatic suspension, the AHP's Privileges shall automatically terminate.

(h) **Failure to Comply with Vaccination Policies**

If an AHP fails to comply with vaccination policies for period greater than forty-five (45) days after automatic suspension pursuant to §7.5-1 (h), the AHP's Privileges shall automatically terminate as of the forty-sixth (46th) day. For purposes of this

section, the failure of an AHP to provide proof of vaccination shall constitute a failure to meet the requirements of this paragraph.

7.7 CONTINUITY OF PATIENT CARE

Upon the imposition of a summary suspension, automatic suspension or automatic termination, the Medical Staff President or the applicable Department Chair shall provide for alternative coverage for the affected AHP's Hospital patients. The wishes of the patient shall be considered, where feasible, in choosing a substitute AHP. The affected AHP shall confer with the substitute Practitioner(s)/AHP(s) to the extent necessary to safeguard the patient.

7.8 SHARING OF INFORMATION

7.8-1 So that there is consistency between the Hospital and Affiliate Hospital(s) regarding corrective action and the status of privileges considering that the Hospital and the Affiliate Hospital(s) are part of the same Health System, and that the Hospital and the Affiliate Hospital(s) have agreed to share information regarding privileges, the following automatic actions shall occur:

(a) If an AHP's privileges are automatically suspended or terminated, in whole or in part, at an Affiliate Hospital(s), the AHP's Privileges at this Hospital shall automatically and immediately become subject to the same action without recourse to the procedural due process provisions set forth in this Policy.

(b) If an AHP's privileges are summarily suspended or if the AHP voluntarily agrees not to exercise privileges while undergoing an investigation at an Affiliate Hospital(s), such suspension and/or agreement shall automatically and equally apply to the AHP's Privileges at this Hospital and shall remain in effect until such time as the Affiliate Hospital(s) renders a final decision or otherwise terminates the process.

(c) If an AHP's privileges are terminated, revoked, or limited at an Affiliate Hospital(s), in whole or in part, based on quality of care or professional behavior concerns, the AHP's Privileges at this Hospital shall automatically and immediately become subject to the same decision without recourse to the procedural due process provisions set forth in this Policy, unless otherwise provided in the final decision at the Affiliate Hospital(s).

ARTICLE 8: CONFIDENTIALITY, AUTHORIZATIONS, IMMUNITY AND RELEASES

8.1 SPECIAL DEFINITIONS

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

8.1-1 "Information" means records of proceedings, minutes, interviews, reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications, whether in electronic, written, or oral form, relating to any of the subject matter specified in §8.5.

8.1-2 "Representative" means the Hospital Board and any trustee or committee thereof; the Hospital, Chief Executive Officer, and other Hospital employees; the Medical Staff organization and any officer or committee thereof; any Practitioner with a Medical Staff appointment and Privileges; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.

8.1-3 "Third Parties" means any individual or organization providing Information to any Representative.

8.2 AUTHORIZATIONS AND CONDITIONS

By applying for or exercising Privileges at the Hospital, an AHP:

8.2-1 Authorizes Representatives and Third Parties, as applicable, to solicit, provide and act upon Information bearing on the AHP's professional ability and qualifications.

8.2-2 Authorizes the release of all Information necessary for an evaluation of his/her qualifications for Privileges and agrees to sign such authorizations as requested by the Hospital.

8.2-3 Agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative or Third Party who acts in accordance with the provisions of this Article.

8.2-4 Acknowledges that the provisions of this Article are express conditions to his/her application for, acceptance of, and continuation of Privileges at the Hospital.

8.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any AHP submitted, collected or prepared by any Representative of this or any other health care facility or organization or medical

staff for the purpose of: evaluating, monitoring or improving the quality, appropriateness and efficiency of patient care; evaluating the qualifications, competence, and performance of an AHP or acting upon matters relating to corrective action; reducing morbidity and mortality; contributing to teaching or clinical research; determining that health care services are professionally indicated and performed in compliance with the applicable standards of care; or, establishing and enforcing guidelines to help keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential. Such Information shall not be disclosed or disseminated to anyone other than a Representative or other health care facility or organization of health professionals engaged in an official, authorized activity for which the Information is needed, nor be used in any way except as provided in this Policy or as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be provided by/to Third Parties. This Information shall not become part of any particular patient's record. It is expressly acknowledged by each AHP that violation of the confidentiality provisions provided herein is grounds for immediate termination of Privileges.

8.4 IMMUNITY FROM LIABILITY

Submission of an application for the exercise of Privileges at the Hospital constitutes an AHP's express release of liability of the following:

8.4-1 **For Action Taken**

No Representative or Third Party shall be liable to an AHP for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as a Representative or Third Party provided that such Representative or Third Party does not act on the basis of false Information knowing such Information to be false.

8.4-2 **For Gathering/Providing Information**

No Representative or Third Party shall be liable to an AHP for damages or other relief by reason of gathering or providing Information, including otherwise confidential or privileged Information, within the scope of his/her duties as a Representative or Third Party provided that such Representative or Third Party does not act on the basis of false Information knowing it to be false.

8.5 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article applies to Information in connection with this or any other health care facility's or organization's activities including, but not limited to:

8.5-1 Applications for Privileges

8.5-2 Applications for addition, modification, or re-grant of Privileges

8.5-3 Corrective action

8.5-4 Procedural due process

8.5-5 Performance improvement/quality assessment activities

8.5-6 Utilization review/management activities

8.5-7 Claims reviews

8.5-8 Profiles and profile analysis

8.5-9 Risk management activities

8.5-10 Any other Hospital, committee, Department, or Medical Staff activities related to evaluating, monitoring, and maintaining quality and efficient patient care and professional conduct.

8.6 RELEASES

Upon request of the Hospital, each AHP shall execute releases necessary to obtain documents and information necessary to evaluate the competency and/or conduct of an AHP. Such releases will operate in addition to the provisions of this Article. Execution of such releases shall not be a prerequisite to the effectiveness of this Article.

8.7 CUMULATIVE EFFECT

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

ARTICLE 9: INTERNAL CONFLICTS OF INTEREST

In any instance where an AHP has or reasonably could be perceived to be biased or to have a conflict of interest in any matter that comes before the Medical Staff, a Department, Section, or committee, the AHP shall not participate in the discussion or vote on the matter and shall absent himself/herself from the meeting during that time. The AHP may be asked and may answer any questions concerning the conflict before leaving. The Medical Staff officers, Department or committee chair, or Section Chief may routinely inquire, prior to initiating discussion, as to whether any AHP has any bias or conflict of interest regarding the matter(s) to be addressed. The existence of a bias or potential conflict of interest on the part of any AHP shall be called to the attention of the Medical Staff officers, Department or committee chair, or Section Chief by any Practitioner or AHP with knowledge of the conflict.

A Department Chair shall have the duty to delegate review of applications for grant/regrant of Privileges to the Department Vice Chair if the Department Chair has a conflict of interest with the individual under review which could be reasonably perceived to create bias. The fact that a Department Chair and member(s) of the Department are competitors or partners shall not, in and of itself, constitute a conflict of interest requiring delegation.

ARTICLE 10: ADOPTION, AMENDMENT, REPEAL

This Allied Health Professional Policy may be adopted, amended, or repealed as set forth in the Medical Staff Bylaws.

ADOPTION AND APPROVAL

This Allied Health Professional Policy is adopted and made effective upon approval of the Board, superseding, and replacing any and all previous Medical Staff documents pertaining to the subject matter thereof.

ADOPTED by the Provisional Medical Executive Committee of Mount Carmel Dublin on _____, 2024.

_____
Bryan Grischow, D.O.
Provisional Medical Staff President
Mount Carmel Dublin

APPROVED by the Credentialing Sub-committee of the Board on November 25, 2024.

_____
Cherie Richey, M.D., Chair
Credentialing Sub-Committee of the Board
Mount Carmel Health System

Appendix A

Allied Health Professionals Credentialed and Privileged by the Medical Staff

Physician Assistants

Certified Nurse Practitioners

Clinical Nurse Specialists

Certified Nurse Midwives

Certified Registered Nurse Anesthetists

Anesthesiologist Assistants